The Lord Kamall
Parliamentary Under Secretary of State for Technology, Innovation and Life Sciences
Department of Health and Social Care
39 Victoria Street London, SW1H 0EU
Sent by email: PSLords@dhsc.gov.uk

cc Maggie Throup MP, Parliamentary Under Secretary of State for Vaccines and Public Health
cc Ed Scully, Director of Primary and Community Health Care, Department of Health and Social Care

XX February 2022

Dear Lord Kamall

We are writing on behalf of the Community Rehabilitation Alliance of 54 patient organisations, charities and professional bodies to welcome your recent response to Baroness Finlay of Llandaff's amendment 100 of the Health and Care Bill.

We would like to expand further on the importance of this amendment and the need for specific guidance to Integrated Care Systems (ICSs) on rehabilitation to be clearly set out as the Bill goes forward.

Baroness Finlay's amendment required Integrated Care Boards (ICBs) to produce an annual rehabilitation plan. In responding you expressed your hope that "ICBs will be required to provide, and improve provision of, community rehabilitation services". We welcome your recognition of the importance of rehabilitation services however it is not clear how – without legislation or clear reference to rehabilitation services in Bill guidance – this will be achieved.

As you are aware, the repercussions of Covid-19 on the nation's health are still being felt. An estimated 1.3 million people as of January 2022 are living with Long Covid, with most needing support with rehabilitation in order to regain their health.

People living with frailty and dementia, at home and in residential care, continue to suffer from the effects of restricted lives and social isolation.

People with acute onset disability resulting from accident or illness were prematurely discharged from hospital when beds needed to be cleared for Covid patients.

Furthermore, people with pre-existing long-term conditions and disabilities have become deconditioned - affecting mobility, wellbeing, communication and confidence. Even before Covid, people with long-term conditions already accounted for 55% of all GP appointments, 68% of all outpatients and emergency admissions and 77% of all inpatient bed days.

Across these populations there are high levels of rehabilitation need combined with anxiety and depression, leading to increased need for care and support.

If action isn't taken now, the impact on health will be long-term and for some, irreversible, deepening health inequity. We know that rates for having multiple long-term conditions are higher amongst women and people from certain ethnic groups and managing those conditions is therefore key to reducing health inequities.

Clearing the elective backlog, enabling people to recover as well as they possibly can and return to work where appropriate is dependent on equitable access to the appropriate rehabilitation service. This includes generalist, condition specific, community and intermediate bed-based, local authority rehabilitation services and occupational health. All rehabilitation services are essential to assist timely hospital discharge, keep people out of

hospital and in secondary prevention to enable people to manage long-term conditions successfully so that they can lead active lives.

However access is patchy and unable to cope with rising demand. This results in a revolving door to GPs surgeries, delayed discharge and increased demand on expensive hospital services and a struggling social care system.

ICSs are intended to bring about major changes in how health and care services are planned, paid for and delivered, and are a key part of the future direction for the NHS as set out in the NHS Long Term Plan. It is clear that in order to deliver on many of the Long Term Plan commitments, equitable access to high quality community rehabilitation is essential.

Despite rising demand on underfunded and overstretched services there is no plan or additional funding for rehabilitation services and workforce in either the Elective Recovery Plan or Integration White Paper published earlier this month. It is therefore clear that strong encouragement is not enough and ICSs will require specific guidance on the provision and improvement of rehabilitation services.

We also share the Allied Health Professions Federation's continued support for the requirement on ICBs to have at least one person who is an allied health professional (AHP). This will ensure that ICSs benefit from strategic AHP clinical leadership. It is not clear why AHPs, the third largest workforce, whose roles are key in treatment, recovery and rehabilitation are not included. AHPs are critical to many of the developments outlined in the Long-Term Plan which ICSs will be seeking to deliver. They are also the clinicians working on the boundaries between health and social care and therefore crucial to delivering true integration.

We are a broad coalition with expertise and would welcome the opportunity to discuss next steps with you or the Bill team. To arrange a meeting please contact our Co-Chair of the Community Rehabilitation Alliance, Sara Hazzard at hazzards@csp.org.uk.

Yours Sincerely

XXXX (list of names of CEOs from CRA