Rehabilitation Framework Self-Assessment Tool: Analysis of Survey Responses

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Executive summary

1. In August 2020, the Scottish Government published its *Framework for Supporting People through Recovery and Rehabilitation during and after the COVID-19 Pandemic* (referred to as the Framework). A survey of frontline staff was carried out by the National Advisory Board for Rehabilitation to ensure that the implementation of the Framework was informed by an up-to-date picture of rehabilitation services across the country.

2. The survey received 280 responses from rehabilitation professionals and teams across the country. Respondents represented a range of inpatient, outpatient and community teams and services, and professional groups. Physiotherapists and occupational therapists (OTs) were the two professional groups most commonly represented – over half the responses included one or both of these professions.

3. The survey addressed issues relating to service delivery, workforce and patient wellbeing across three timeframes: pre-, during and post-pandemic. A summary of the main points made by survey respondents in relation to each of these issues is presented below, while a final section looks at the future development of rehabilitation services.

Survey findings

4. In relation to **service delivery**, survey respondents identified a great deal of good work and positive activity in relation to the development, delivery and ongoing improvement of rehabilitation services. Rehabilitation staff were proud of the services they provided. Respondents described a wide range of services that were (i) providing timely patient-centred care, prompt referrals and appropriate professional input, and (ii) achieving good outcomes for patients. They were committed to multidisciplinary and joined up working, with some noting this as a positive feature of current service delivery. However, others said there could be challenges – mainly practical and logistical, but also sometimes cultural – to this way of working.

5. The pandemic had significant impacts on services. Some services had been reduced or stopped, while others had to adapt to a new way of working – particularly in relation to the adoption of digital working and infection control procedures. Respondents were proud of the work undertaken by their teams during the pandemic. They were also committed to building on positive developments linked to the pandemic such as improved communication within and across teams and services, and making greater use of digital methods for working with colleagues and delivering patient-facing services.

6. However, survey respondents reported growing demands on services – in terms of increasing caseloads and the increasing complexity of individual cases – as a major challenge in service delivery. Teams were often said to feel under-resourced, with staff working to full capacity, and balancing the different demands of their job. The additional demands, related to patients affected by COVID-19, were seen as a compounding factor. Respondents highlighted the increasing need to respond to the psychological, as well as physical, needs of their patients.

7. Respondents highlighted variance in how services are delivered across the country. They also highlighted key challenges in service delivery related to resources (staff and non-staff), the availability and knowledge of local services, and the recognition and prioritisation of rehabilitation in service planning.

8. In relation to **workforce issues**, the survey highlighted ongoing challenges with staff recruitment and retention, with services often reported to be operating below their full complement. This was a particularly acute problem for services in rural areas. In addition, there was concern about staff workloads, staff morale and fatigue during the pandemic. Respondents thought that, going forward, further measures would be needed to protect staff health and wellbeing.

9. The survey responses described a highly skilled and committed workforce, but also identified a range of specific skills gaps. The survey also identified challenges in terms of achieving an appropriately skilled workforce – these included the cost and time implications of undertaking training and difficulties in undertaking supervision and on-the-job training alongside clinical duties.

10. In relation to **patient health and wellbeing**, a recurring theme in the survey responses was that, increasingly, patients were presenting to services with multiple and complex long-term conditions. Prior to the pandemic the ageing population was identified as a key factor in the deteriorating health and wellbeing of patients. Since the start of the pandemic, respondents noted additional concerns about the physical deterioration of different patient groups, and the impact that isolation (often linked to shielding) had had on mental wellbeing. It was noted that deteriorating physical and mental health in patient groups has led to increased demands on staff and services, and the type of services required – with respondents emphasising the need for holistic person-centred services that met the psychological and physical needs of patients.

The future of rehabilitation services

11. Overall, the survey responses suggested that the pandemic has not resulted in significant changes or new challenges for rehabilitation services, but rather the findings highlighted ongoing challenges and existing issues. Survey respondents saw a need for greater understanding and awareness of the role of AHPs and rehabilitation services and further strategic action at local and national level in order for rehabilitation services to meet the challenges ahead. More specifically, respondents called for:

- Greater recognition of the value of rehabilitation services in health and social care planning
- Improved leadership and communication – with more leadership roles for AHP and rehabilitation professionals and greater representation of AHP and rehabilitation services in strategic management
- Improved workforce planning (nationally and locally), and improved training and development opportunities
- Increased funding and resources for rehabilitation services
- Increased emphasis on multidisciplinary and joined up working
- Greater focus on preventative services
- Greater consistency and equity in service provision – including in community services
- Greater use of research, and evidence-based practice.

1. Introduction

1.1 This report presents an analysis of responses to a survey issued by the Scottish Government's National Advisory Board for Rehabilitation to support the implementation of its Framework for Supporting People through Recovery and Rehabilitation during and after the COVID-19 Pandemic, published in August 2020.

Background to the Framework

1.2 As the long-term physical and psychological effects of the COVID-19 pandemic are beginning to be more widely understood, it is clear that rehabilitation is going to play an increasingly important role in helping people to recover. In order to address this, the Scottish Government published its *Framework for Supporting People through Recovery and Rehabilitation during and after the COVID-19 Pandemic* (referred to in this report as the Framework).

1.3 The Framework sets out overarching principles and priorities for planning and delivering high-quality, person-centred rehabilitation and recovery services in the wake of the pandemic. The aim is to develop a 'Once for Scotland Approach' which provides a practical, accessible strategy to deliver quality rehabilitation to everyone who needs it. The Framework focuses on adults 16 years and older, and identifies three distinct groups for consideration in the development of services: (i) people who have had COVID-19 and continue to present with COVID-related symptoms, (ii) people whose health and wellbeing has been negatively impacted as a consequence of 'lockdown' restrictions, and (iii) people whose diagnosis, treatment or ongoing rehabilitation may have been negatively impacted by the pausing of non-critical services during the pandemic.

1.4 The Scottish Government is now focusing on implementation of the Framework, which will be taken forward by a National Advisory Board for Rehabilitation chaired by Scotland's Chief Allied Health Professions Officer and operationally led by an AHP Professional Advisor for Rehabilitation.

1.5 The National Advisory Board recognised the need for the implementation of the Framework to be informed by an up-to-date picture of rehabilitation services across the country. Thus, in May 2021, the Board launched a self-assessment tool, in the form of an online survey, to gather the views and experiences of those working in frontline services.

The survey

1.6 The National Advisory Board self-assessment tool survey (referred to in this report as the survey) was launched on 24 May 2021 with a closing date for responses of 18 June 2021. It was circulated to rehabilitation services across the health and social care sector via AHP (allied health profession) Directors, Chief Officers and other health and social care professionals who were asked to forward the survey to relevant services and teams in their area. A webinar hosted by NHS Education Scotland on behalf of the Scottish Government provided an opportunity for staff to learn more about the Framework, and to ask questions about the survey.

1.7 The survey contained 15 questions split into three timeframes: pre-, during and post-pandemic. Within each timeframe, a series of open questions addressed issues related to (i) service delivery, (ii) workforce and (iii) patient wellbeing.

1.8 The survey also included a series of questions about the services provided by responding teams, the settings in which they operate, and their geographical / organisational location.

1.9 Two additional related pieces of work have also been carried out: a survey of third sector organisations undertaken by the ALLIANCE, and two workshops with care home staff carried out by the Care Inspectorate. In both cases, this work was undertaken and will be reported on separately and is therefore not considered as part of the analysis presented in this report.

About the analysis

1.10 This report is based on a robust and systematic analysis of the responses to the survey and is intended to provide a transparent and balanced overview of the experiences and views expressed by survey respondents.

1.11 Quantitative analysis was undertaken to describe the services, settings and geographical / organisational location of teams responding to the survey. This analysis provides important context to help understand the experiences and views outlined in the response to the open questions.

1.12 Thematic qualitative analysis was undertaken to identify the main themes in the responses, and to explore and report on the main points raised in relation to those themes.

1.13 The analysis presented here is not exhaustive but aims to give an overview of the main themes discussed and views expressed by respondents.

The report

1.14 The remainder of this report is structured as follows:

- Chapter 2 presents information on the respondents to the survey and the responses submitted.
- Chapters 3 to 5 present the results of the analysis of the responses in the three time frames – before the pandemic, during the pandemic, and post-pandemic.
- Chapter 6 provides concluding remarks and considers how the survey findings relate to the underpinning principles set out in the Rehabilitation Framework.

2. The respondents and responses

2.1 This chapter provides information about the respondents to the survey and the responses submitted.

Number of responses received and number included in the analysis

2.2 The survey received 281 responses. Nearly all of these (278) were submitted through the online response form. However, three responses were submitted by email. Following an initial review, one response was removed because it had been submitted by a paediatric rehabilitation team. This response was considered to be out of scope, since the Framework and the survey were intended to cover adult rehabilitation services.

2.3 Thus, the total number of responses included in the analysis was 280.

About the respondents

2.4 The survey included four introductory questions which asked respondents for information about their service, in particular:

- The area of rehabilitation covered by their service
- Who their service was **mainly** delivered to (i.e. inpatients, outpatients, or patients / clients in community or primary care services)
- The type of rehabilitation professionals involved in delivering their service
- The geographical location (i.e. health board or health and social care partnership (HSCP) area) of their service.

2.5 At each question, respondents were asked to select an answer from a list of options.[1] The responses indicated that rehabilitation teams in Scotland are configured in a wide variety of ways and are operating in a complex landscape. Teams often include a range of specialists providing services to different patient groups in a variety of settings. See Annex 1 for further details.

Area of rehabilitation covered

2.6 Survey respondents indicated that their teams covered a wide range of different service areas. The most common area was ‘community rehabilitation’ (selected by 18% of respondents), followed by ‘older people’s rehabilitation’ (10%), ‘musculoskeletal rehabilitation’ (7%) and ‘neuro rehabilitation’ (6%). ‘Specialist rehabilitation’, ‘mental health – adult rehabilitation’, ‘stroke-related rehabilitation’, and ‘cardiac rehabilitation’ were the main area of activity for 5% of respondents. All the other options offered in the questionnaire were selected by fewer than 5% of respondents. However, a fifth of

[1] Note that some respondents found these questions difficult to answer – especially in cases where they were replying on behalf of rehabilitation services that covered multiple areas of rehabilitation, or that served patients / clients in multiple settings. In such cases, respondents sometimes ticked ‘other’ and then provided further details about their service. However, other respondents ticked only one of the options provided, but then described their service in more detail elsewhere in their response. This means that there is likely to be a certain amount of inconsistency in the way respondents answered these questions.

respondents (20%) chose 'other', rather than one of the 22 options listed in the survey. Those who chose 'other' often said their team provided rehabilitation in more than one area. (See Table A1.1 in Annex 1.)

Main service user group

2.7 The largest proportion of respondents (40%) provided a service to people in the community. Just over a quarter (27%) and just under a fifth (19%) provided a service to hospital inpatients and outpatients respectively. A small proportion of respondents (3%) provided rehabilitation to people in primary care services. (See Table A1.2 in Annex 1.)

Rehabilitation professionals included in the responses

2.8 The two rehabilitation professionals involved most often in responding teams were physiotherapists (69% of respondents said their team had one or more physiotherapists) and occupational therapists (55% said their team had one or more OTs).

2.9 Relatively high proportions of respondents also said their teams included healthcare support workers (37%), nurses (29%), and speech and language therapists (18%). Between 10% and 15% of respondents reported having a dietitian, doctor or psychologist in their team. Fewer than 10% reported having a prosthetist / orthotist, podiatrist, radiographer, paramedic, orthoptist, art therapist or music therapist. None of the respondents said they had a drama therapist in their team. (See Table A1.3 in Annex 1.)

2.10 It is worth noting that nearly half of respondents (126 out of 280, 45%) reported that their response covered just one type of rehabilitation professional. A similar proportion (122 out of 280, 44%) said their response included between two and five types of rehabilitation professionals. Just over a tenth of respondents (32 out of 280, 11%) were responding on behalf of teams with more than five types of rehabilitation professionals.

Geographical location of responses

2.11 Most respondents, 84% (234 out 280) were based in NHS services, while 16% (46) said they were based in an HSCP. In addition, all 14 territorial NHS boards plus the Golden Jubilee National Hospital[2] were represented in the responses, compared to around three-quarters of Scotland's HSCPs (23 of the 31). (See Table A1.4 in Annex 1.)

2.12 The largest proportion of respondents were from NHS Lothian (14%) and NHS Greater Glasgow and Clyde (13%). Other NHS boards with a relatively large proportion of respondents (between 5–10%) were NHS Grampian, NHS Fife, NHS Highland, NHS Tayside and NHS Forth Valley.

Responses to individual questions

2.13 Nearly all those who responded to the survey provided an answer at every question. There were only five questions which received fewer than 280 replies, and in each case, only one or two of the respondents did not answer these questions. Thus, there was a 100% or nearly 100% response rate to all questions. See Annex 2 for details.

[2] Golden Jubilee National Hospital provides a national service in key elective specialisms.

3. Pre-pandemic rehabilitation services

3.1 This chapter discusses issues relating to the delivery of rehabilitation services prior to the pandemic. It discusses respondents' views given in response to five survey questions.

> **Question 1:** Pre-pandemic, what specific parts of your services were you most proud of?
>
> **Question 2:** Pre-pandemic, what challenges did you experience with recruitment and retention of staff?
>
> **Question 3:** Pre-pandemic, were there any specific skill gaps within the workforce of your service?
>
> **Question 4:** Pre-pandemic, in terms of service delivery – What were the biggest challenges day to day?
>
> **Question 5:** Pre-pandemic, how would you describe the health and wellbeing of your local patient groups; did you notice any emerging issues?

3.2 Responses to these questions covered a wide range of issues, with individual respondents often making multiple different points. The analysis presented below focuses on the **main** points raised across the responses, and focuses in turn on:

- Service delivery – sources of pride (Q1)
- Service delivery – challenges (Q4)
- Workforce issues (covering Questions 2 and 3)
- Patient health and wellbeing – emerging issues (covering Question 5)

Service delivery – sources of pride

3.3 Question 1 asked respondents about the aspects of service they were most proud of prior to the pandemic. Respondents indicated a great deal of pride in the services provided by their teams, with answers focusing on: (i) the nature of their service – its characteristics and ethos, (ii) service quality and improvement, and (iii) staff and staff development. Each of these is discussed below.

3.4 In some cases, respondents noted that the successes and achievements of their teams were made despite the challenges they faced. Such points are picked up later in this chapter.

Service characteristics and ethos

3.5 Respondents who answered this question by focusing on particular service features commonly said that they were proud of the:

- Variety of treatment and delivery options offered, and the development of particular treatment pathways
- Effective management of referrals via triaging and assessment

- Timely input that supported recovery, and helped prevent hospital admissions and facilitate discharges to the community
- Continuity of care, and 'smooth' transitions between different services
- Ease of access to services – including self-referral and drop-in services.

3.6 Respondents also mentioned a wide range of other service features on a more occasional basis. These included the use of an evidence-based approach, a positive approach to risk management, and the facilities on offer to support patient rehabilitation.

3.7 Some respondents discussed certain aspects of the **ethos** of their service as a source of pride. They highlighted the responsiveness, flexibility and adaptability of their service in meeting the needs of individuals. Others talked in more detail about 'ways of working', or approaches or philosophies that underpinned services. Key amongst these were:

- **Multidisciplinary and joined up working:** Respondents frequently referred to 'good teamwork', or their team's multidisciplinary or joined up working as points of pride. They highlighted, for example, (i) good links and working relationships between teams, and across services and sectors, (ii) good levels of understanding of the contributions made by different teams, (iii) the sharing of skills and the use of shared competencies, and (iv) the joint management of cases and the benefits this brought in terms of timely and appropriate input and improved outcomes for patients.
- **Person-centred approaches to care and treatment:** Person-centred care was described in many types of service but broadly involved (i) engaging and working in partnership with patients and their families, (ii) a focus on self-management, (iii) supporting patients to achieve individualised goals, (iv) offering choice in services, ease of access and timely response and referrals, and (v) ensuring input from relevant professionals.

3.8 The following two quotes illustrate some of the aspects of their services that respondents were proud of prior to the pandemic.

> 'Our interdisciplinary working maximising best use of resources, crossing professional boundaries and ensuring patients receive care from the right person at the right time in the right place. The team has good links with other community services both statutory and 3rd sector.' (Community rehabilitation team)

> 'Our personalised, client-centred programmes of rehabilitation and our ability to act quickly to change programmes to accommodate changes with our client's abilities.' (Community rehabilitation team)

Service quality and improvement

3.9 Respondents often said they were proud of the quality of service provided by their teams, citing achievements in relation to (i) waiting time targets, (ii) compliance with national standards, (iii) reducing hospital admissions or the length of stays in hospital, (iv) reducing demands on GPs, and (v) supporting people returning to work.

3.10 In some cases, respondents described specific work that had been undertaken to improve the quality of their services:

> 'We had previously done quality improvement work to improve our waiting times and capacity for all team members which had significantly reduced these from 28 to 14 weeks.' (Community rehabilitation team)

3.11 Additionally, respondents often noted the importance of workplace 'culture' to service improvement. They variously described an 'open learning environment', a 'supportive culture towards audit and research', 'having a quality improvement agenda imbedded in our working practice', and staff 'empowered to recognise where service[s] can improve'.

3.12 Alongside this, other respondents discussed 'quality' in a more person-centred way, citing the positive patient feedback received by their service or the difference their service made to the lives of individual patients.

Staffing

3.13 Some respondents focused on staffing and workforce-related issues in their responses, noting (i) the key contribution made by staff to the delivery of services and / or (ii) work undertaken to develop and support staff. These are covered briefly here. Other pre-pandemic workforce issues are discussed at paragraph 3.33 onwards.

3.14 Staff were repeatedly described as 'highly skilled', 'experienced', 'competent', 'flexible and adaptable' and as showing 'enthusiasm for new developments and service re-design'. Staff were also described as exhibiting specific personal qualities that made a real difference to the service (e.g. 'committed', 'highly-motivated', 'caring', 'compassionate'). Other respondents noted the importance of their 'whole team approach', describing, for example, good team dynamics, supportive managers and clear leadership, respect for all team members, staff working together in a supportive and caring way, and a 'wellbeing culture' within the team.

3.15 Some respondents noted the positive work done with regard to the learning opportunities provided to staff and students. These included, for example: (i) in-service training, CPD opportunities, and training provided to other professions, (ii) mentoring and supervision arrangements, (iii) links with universities and good quality practice-based learning placements, and (iv) contributions to national training initiatives.

Service delivery – challenges

3.16 Question 4 asked respondents about the challenges they faced in day-to-day service delivery. Respondents reported a range of challenges; however, the two **main** ones were in relation to (i) meeting (growing) demands on services and (ii) staffing levels and other workforce issues. Other challenges mentioned relatively frequently related to: (iii) multidisciplinary and joined up working; (iv) other (non-staff) resources; (v) geographic factors; and (vi) awareness, understanding and appreciation of rehabilitation services within other health and social care services. Each of these issues is covered below.

Meeting demands on services

3.17 The most commonly reported challenge was that of meeting demands on services. Survey respondents repeatedly said that they were dealing with increasing caseloads, and cases of increasing complexity, which often entailed additional communication and coordination with other professionals.

3.18 Respondents described 'year on year increases in referrals', and services and individual staff operating at 'full capacity' or 'above capacity'. Respondents highlighted a number of challenges related to this situation, including (i) balancing the needs of different aspects of their service or different groups of patients (i.e. acute / urgent vs more routine cases), (ii) meeting waiting times targets, (iii) balancing the time spent on patient-facing work with other activities such as case documentation, team management, staff management, staff development, service development, etc., (iv) ensuring staff wellbeing.

3.19 A number of respondents said that the issue of increasing demand was compounded by inappropriate referrals and 'scattergun' or duplicate referrals from other services. Some also expressed concern that the perceived mismatch between demand and capacity was having repercussions for service quality and patient outcomes.

Staffing

3.20 Some respondents explicitly linked the issue of staffing levels to the challenges they faced in relation to service demands. Respondents frequently referred to a 'lack of staff' or 'not enough staff' across services or in particular areas. This took different forms. In some cases, it reflected increasing demands on teams without a corresponding increase in staff. In other cases, respondents reported (i) teams operating below their full staff complement and insufficient cover for absences (planned or unexpected), or (ii) there not being the right level of skills or experience or the right overall skill mix within teams. Workforce issues are discussed in greater detail at paragraph 3.33 onwards.

Multidisciplinary and joined up working

3.21 As outlined above, some respondents saw their team's approach to multidisciplinary and joined up working as a source of pride. However, for others this was also an area that presented challenges because of the cross-service, cross-professional and cross-sector nature of rehabilitation and the needs of clients.

3.22 For some this was a practical issue that arose with regard to the effective treatment of individual patients. It could, for example, be challenging to communicate with or get input from other professionals at the appropriate time. Other respondents described challenges relating to a perceived 'lack of a collaborative approach to delivering rehabilitation', 'lack of communication between services', or absence of 'shared values' across services.

3.23 The complexity of the organisational context in which rehabilitation takes place was also seen as sometimes presenting challenges. One hospital-based respondent described dealing with multiple HSCPs and health boards as follows:

> 'There are [X] HSCPs within [X] area which means different community rehabilitation teams – there [are] inequalities between rehabilitation teams which influences

> discharges. There is also [a] difference between timing of package of care, availability of day centres, befriending service and food train services – all influencing discharge pathways.' (Inpatient front door acute team)

3.24 Additionally, the challenges of different organisations having different IT systems that did not 'talk to each other' could result in difficulties in sharing of information across services and settings.

Non-staff resources

3.25 Some respondents highlighted challenges relating to the availability of local resources – both within their own organisation, and in their communities.

3.26 Respondents discussed difficulties in accessing resources such as IT hardware and software; accommodation and facilities (i.e. clinic space, gym space, pools, etc.); equipment; and patient transport.

3.27 In relation to community resources, some respondents reported good access to community services which helped support rehabilitation (e.g. social prescribing, exercise classes, dementia cafés, men's sheds, day centres). However, more often respondents highlighted the challenges in identifying and arranging input from local services that would help patients remain safely in their community. For some this was an issue of waiting lists and delays in accessing services, and for others it was knowing what was available in the community to support individuals.

3.28 In some cases, respondents also noted issues of 'equity', saying that the availability of services varied from one area to another, within and across health board and HSCP boundaries.

Geographic factors

3.29 Most often the issue of geography was raised in connection with community teams operating in rural areas (or covering large areas), who had to travel long distances to reach patients. The issue of patients having to travel to access centrally located services (including specialist hospital-based services) was also noted, with public transport not always being available.

3.30 This was not only a practical challenge of travel time, as operating in rural areas could also leave staff feeling isolated in situations where a single representative of a profession was responsible for delivering a service over a large area; it also presented challenges for small 'generalist' teams expected to cover a wide range of conditions.

Awareness, understanding and recognition of rehabilitation services

3.31 The level of awareness, understanding and recognition of rehabilitation and AHP activities in health and social care was highlighted by some respondents. Some felt, for example, that AHPs / rehabilitation services were not always sufficiently represented in strategic and resource discussions or decision making; others felt that health and social care colleagues did not always understand the role of rehabilitation or the services offered.

3.32 The following quote illustrates these problems:

> 'There was frustration amongst the team that often referrals were coming through late in a person's journey which resulted in poorer outcomes for the individuals. Referrals were often dependant on when a nurse, psychologist or psychiatrist felt the person may require OT, and staff felt they had to constantly explain their roles, how they could make a difference and that timely access was essential.' (Inpatient and community specialist adult mental health team).

Workforce challenges

3.33 Question 2 in the survey asked respondents about the challenges they had experienced with staff recruitment and retention prior to the pandemic, and Question 3 asked about specific skills gaps in the workforce of their service prior to the pandemic. The **main** points made in the responses to each of these questions are summarised here.

Staff recruitment and retention

3.34 Recruitment and retention were commonly reported as challenges of varying degrees prior to the pandemic – and were expected to continue to do so looking ahead to the immediate future.

3.35 Factors which respondents said contributed to difficulties in recruitment and retention were wide ranging and included: (i) national shortages of graduates in some professions, (ii) limited opportunities for promotion and career progression including at senior level (iii) the use of short-term or temporary posts, (iv) the absence of local higher education courses in some disciplines, (v) competition for staff between HSCPs and NHS boards, and (vi) competition from the private sector.

3.36 Although there was a general view that recruitment posed a challenge for some services, there was a more mixed picture on the issue of staff retention. Some respondents who reported difficulties with recruitment suggested that, once in post, staff tended to remain. However, others reported success in attracting entry-level staff, who subsequently moved on to access career progression opportunities.

3.37 Problems with recruitment and retention were also reported to be associated with geography and the profile of the workforce. With respect to geography, there was a view that larger urban areas were better able to attract and retain staff because they could offer more choice of jobs and better prospects for career progress. With respect to the profile of the workforce, respondents highlighted issues relating to (i) an ageing workforce and the prospect of losing a significant number of staff to retirement in coming years, (ii) a predominantly female workforce and the related need to accommodate maternity leaves and flexible working, and the importance of taking demographic factors into account in workforce planning.

3.38 A number of respondents noted that organisation-wide policies, processes and resources could result in recruitment being slow, bureaucratic and a time-consuming process. Respondents highlighted (i) difficulties in securing approval for new posts or filling vacant posts, (ii) the time taken to advertise posts and / or appoint a successful candidate,

and (iii) inflexibility (and perceived inequality) in relation to the grading of posts. Some respondents also mentioned ‘Jobtrain’, an IT-based recruitment platform, with the survey revealing both positive and negative experiences of using the system.

Skills gaps

3.39 Respondents addressed the question of skills gaps in their services in a variety of ways.

3.40 Some discussed very specific gaps, highlighting a need for specialist skills within individual services or professions. Examples included: neurological conditions, stroke, vocational rehabilitation and psychological therapies for OTs; mental health, allergies and adult addictions for dietitians; aquatic therapies for physiotherapists; and wound care for podiatrists.

3.41 Some respondents noted other types of skills gaps, for example, related to:

- Input from particular professions
- The balance of staff of different grades, or perceived inappropriate grading of posts
- Limited access to administrative, technical and support staff that meant that professional skills were not used efficiently.

3.42 Other respondents identified gaps elating to more generic skills, such as research, data collection, and quality improvement methodologies; digital working; and multidisciplinary working. For more senior staff, leadership and management skills were also noted by some respondents. Indeed, this was a two-sided issue with some respondents reporting that they would like to see more opportunities for AHPs to develop (or demonstrate) leadership skills within their professional roles, and be able to access more training opportunities to gain such skills.

3.43 More generally, however, respondents described a range of issues which presented challenges in ensuring the appropriate mix of skills in their teams. For example:

- The increasing complexity of caseloads has increased the need for highly or broadly skilled staff. This could be a particular challenge for teams providing a ‘generalist’ service to community patients in which staff typically had a broad spectrum of knowledge but may need to gain new skills in response to the demands of new cases.
- Changes in service configuration or patient pathways could lead to changes in skill requirements for staff, with, for example, patients who had previously been cared for in hospital being discharged earlier into the care of community teams.
- Rurally based teams had particular issues ensuring appropriate skill mixes among staff because of difficulties being aware of and accessing relevant training locally and / or the expense of attending training in other areas.
- Skills gaps could arise when experienced staff members left teams and/or new team members joined, and some said that appropriate planning was needed to ensure the continued availability of skills across teams, and resilience within teams. The skills

mix in small teams, including those in more rural areas, was seen as particularly 'fragile' when individuals moved on or were absent for any reason.

3.44 Respondents also reported issues related to continuous professional development (CPD) for team members. They said, for example, that funding for (external) courses was not always available, and that clinical work pressures could make it difficult for staff to be released for training activities or to provide supervision and on-the-job training for other colleagues. Some noted the specific issue of teams supporting newly qualified staff while also meeting the demands of clinical work.

Patient health and wellbeing

3.45 Finally, Question 5 asked respondents about the health and wellbeing of their patient groups prior to the pandemic – and whether they had noticed any emerging issues.

3.46 Occasionally, respondents said that they saw 'no emerging issues' in their local patient populations prior to the pandemic. Instead, they said there were a number of long-standing issues (for example, relating to poverty and lifestyle) which had an ongoing impact on patient health and wellbeing.

3.47 However, more often, respondents identified a range of issues. The specifics of these varied from one type of rehabilitation service to another, but a common theme in the responses was that of Scotland's ageing population. Respondents frequently said they had observed that their patients were increasingly elderly and physically frail with:

- Poor and worsening health involving long-term conditions and multiple co-morbidities
- Complex mental health and social issues (e.g. increasing levels of depression and anxiety, cognitive decline, social isolation, poly-pharmacy and substance misuse)
- High levels of obesity and low levels of physical activity
- Poor motivation and compliance
- Greater dependence on public services (due to a lack of family or adequate carer support in the area)
- Expectations of rehabilitation that were sometimes unrealistic (often linked to a reluctance to engage in self-management).

3.48 Respondents often commented that their patients were staying longer in their own homes and, in cases where hospital admission was necessary, patients were being moved through acute services back into their own homes much more quickly. Some respondents referred to 'increasingly complex discharges'; others said that 'delayed discharges' were common when services were not readily available to support people at home. There was a recurring view that patients in these circumstances did not always have access to the necessary care, support, or internal physical and mental resources to engage fully with their rehabilitation. They were also less able to travel (to attend appointments). This meant that the primary purpose of rehabilitation for this group of patients had become to be about maintaining safety and quality of life, rather than achieving independence.

> ‘Therapy staff were seeing clients past the point of rehabilitation. Our role was more to maintain and increase safety / comfort /quality of life of the client, family and carers, than to see progression of independence or achieving specific goals.’ (Community rehabilitation service for older people).

3.49 Less often, respondents said that **some** of their patients (including those who were younger and / or more affluent) were keen to self-manage and follow good health advice.

4. Rehabilitation services during the pandemic

4.1 This chapter discusses respondents' views about the changes they saw (in their service, in their workforce, and in the health and wellbeing of their patients) during the COVID-19 pandemic. The chapter focus on respondents' answers to the following four survey questions.

> **Question 6:** During the pandemic, what specific parts of your service were you most proud of? (e.g. innovation, service changes, staff skills, etc.)
>
> **Question 7:** During the pandemic, how was the delivery of your services impacted by the pandemic: please discuss examples of specific changes you had to make to your service.
>
> **Question 8:** During the pandemic, were there any examples of staff skills gaps that emerged?
>
> **Question 9:** During the pandemic, what changes did you observe in the health and wellbeing of your patient group?

4.2 The analysis below focuses on the **main** issues raised in response to each of these questions and discusses, in turn:

- How service delivery changed during the pandemic
- Sources of pride in service delivery during the pandemic
- Workforce skills gaps which emerged during the pandemic
- How patient health and wellbeing changed during the pandemic.

Service delivery

4.3 Question 7 asked respondents about the impact of the pandemic on the delivery of their service. Respondents were asked to discuss examples of specific changes they had made to their service during the pandemic.

4.4 Respondents' comments at this question were very diverse and it was clear from the comments that the pandemic had a massive impact on the delivery of rehabilitation services of all types. Respondents often provided long lists of changes that were made, and they explained that their service not only changed overnight with the introduction of the first lockdown in March 2020, but it also had to continuously adapt throughout the pandemic to prevent the transmission of COVID-19.

4.5 Although the impacts of the pandemic varied in different services, there were some recurring themes and, at a very broad level, all respondents discussed the impacts of the pandemic on their services in terms of (i) activities that **started** or were introduced, and (ii) activities that **stopped**. Staffing / workforce issues, and the effects on team cohesion, communication and workload, was a third major theme; and issues relating to infection control was a fourth theme. Each of these is discussed below. (Issues relating to skills gaps in the workforce during the pandemic are discussed below at paragraph 4.27).

4.6 It is worth noting that very few respondents suggested that they had seen little or no impact on the delivery of their service during the pandemic. Overwhelmingly, respondents highlighted significant changes.

Activities that started or increased during the pandemic

4.7 By far, the most common theme in respondents' explanations of how their services changed during the pandemic related to the introduction – or increased use of – digital and telephone systems for delivering services. Even in rural areas, where the use of telephone / video was already common in some services, the complete cessation of face-to-face rehabilitation was a significant change.

4.8 Respondents working in all areas of rehabilitation and across all types of settings reported:

- The use of video for patient consultations (Near Me / Attend Anywhere[3]) and staff meetings (MS Teams) – telephone consultations were also used where it was not possible to use digital systems (i.e. in cases where patients were unable to use the technology or did not have a computer or laptop available)
- Providing more advice over the phone (e.g. to patients, care homes, etc.), rather than face-to-face – some services put in place daily calls to patients or their carers to ensure they were coping at home
- More time spent working with patients and their families to help them make the best use of video consultations – some teams developed digital support materials for their patients
- The need to purchase (or borrow) laptops and mobile phones and roll these out quickly to staff without adequate training (some respondents noted that their service had few laptops, initially)
- The introduction of virtual groups (some, but not all, patients found these helpful)
- Increased signposting to online resources.

4.9 Respondents discussed the variety of systems put in place to enable communication between teams, and to ensure that staff were supported, supervised, trained and kept up to date with changing guidance. Examples included (i) daily 'check-ins' between staff working from home and their managers and daily team 'huddles', (ii) a 'virtual whiteboard' to share information on work patterns, annual leave, sickness absence, etc, and (iii) staff working in 'bubbles' to minimise contacts within teams. These systems did not work well in all cases, or they took time to be implemented. Some respondents specifically said that communication within teams was difficult during the pandemic.

Activities that stopped or were adversely affected during the pandemic

4.10 Some respondents (particularly those in community and outpatient settings) said that their services ceased entirely during the first phase of the pandemic. Other respondents said that their service continued, but in a very different and much reduced form than prior

[3] Near Me is the public-facing name used to describe video consulting services provided via the Attend Anywhere platform in Scotland.

to the pandemic. There was a recurring message that their focus became making people safe at home, and ensuring quality of life, rather than providing active rehabilitation.

4.11 As time went on, and the initial wave of the pandemic passed, services that had closed began to re-open, but measures had to be put in place to ensure social distancing.

4.12 Activities or other things that **stopped or reduced** during the pandemic included:

- Face-to-face contact with patients, except in essential or critical cases – some respondents said that their staff became very skilled at assessing patients via phone or video and deciding who needed to be seen face-to-face and who could wait; others said that their staff found this very challenging
- Collaboration with patients' families – visiting restrictions meant that families were not able to attend inpatient therapy sessions and so had to be briefed and trained by video to be able to support their family member upon discharge from hospital
- Rehabilitation clinics, groups and classes (inpatient, outpatient and in the community) – respondents reported that there were no services to refer their patients to
- Administrative support for rehabilitation practitioners
- Student placements (an exception was in some primary care services).

4.13 There were differing reports among respondents about the issue of waiting times. Some respondents said that clients in their area did not receive a timely service during the pandemic and that waiting lists grew significantly. However, others said that they had no waiting lists during the pandemic because staff were not travelling and therefore had more time to meet (virtually) with patients. Some respondents working in inpatient teams reported that delayed discharges increased because there were no community services in place to support people at home. These differing experiences are illustrated in the following two quotes.

> 'Group sessions were no longer allowed to run, with delivery of critical workstreams only. This resulted in many patients being abandoned mid-course, or on a waiting list for a service with no start date in sight.' (Community falls team)

> 'Virtual approach allowed us to make a positive impact on waiting lists which are now significantly lower than pre-pandemic despite significantly increasing referral rates in the last 5 months.' (General outpatient rehabilitation team)

4.14 Some respondents reported that, as their services began opening up again after the first wave of COVID-19, referrals increased dramatically, and most were critical in nature.

4.15 Finally, one other frequently raised issue was the loss of office accommodation during the pandemic. This was partly the result of space (in hospital or community settings) being used for other essential purposes, or because offices were too small to allow social distancing. Some respondents reported that, at the time they took part in the survey, they still had no access to office accommodation.

Staffing

4.16 Respondents made a wide range of comments about the impacts of the pandemic on their staffing and teams. Some of the recurring issues were that:

- Staff were under significant amounts of pressure.
- Staff were dispersed due to home working, shielding and sickness.
- Many staff were redeployed to assist with critical care or vaccination programmes. This led to reduced capacity in teams.
- Workloads increased as some teams stepped in to provide cover when other services were stopped.
- Student placements in some teams ceased entirely. However, there were also reports that student webinars and case study sessions were established in collaboration with universities.

Infection control

4.17 Respondents described a variety of infection control measures that were introduced in their services. These changed frequently as additional information and guidance became available. One common theme was that the use of personal protection equipment (PPE) during patient contact was seen to be a significant barrier to communication (with patients and carers), patient rapport, and to the provision of complex rehabilitation in critical care situations.

> 'The one difficulty I have noted is due to wearing more PPE and in particular masks. This makes communication with people more difficult. It was difficult to create solid rehabilitative rapport with patients due to them feeling distant from us and not being able to read our caring and encouraging facial expressions. One patient reported feeling the PPE to be 'scary' – particularly because all staff were wearing it – and he struggled to identify who was who (nurse, OT, physiotherapist, doctor).' (Orthopaedic inpatient rehabilitation service)

4.18 Examples of some of the specific changes put in place to prevent the spread of COVID-19 included:

- Systems for the distribution of PPE to staff, and for ensuring that staff were correctly fitted for PPE and kept up to date with changing requirements
- New risk assessments and protocols for infection control
- COVID-19 screening questionnaires for patients / carers – used prior to all face-to-face visits (in essential / critical cases)
- New guidelines regarding the cleaning of equipment in advance of it being returned to equipment stores – resulting in equipment supply and delivery delays
- New guidelines in OT kitchen environments
- Requirements to socially distance in offices – resulting in less available office space.

Service delivery – sources of pride

4.19 Question 6 asked respondents to provide details of the specific parts of their service they were most proud of during the pandemic.

4.20 Despite the significant changes and challenges experienced during the pandemic, respondents often emphasised that their team had continued to provide a high-quality service – keeping person-centred care at the heart of all they did – and that their service remained responsive within a constantly changing situation. At the same time, some respondents also made the point that what they were **most** proud of was that their service had been able to continue at all.

4.21 It was clear in the replies to Question 6, that the behaviour of their staff / teams was, by far, the main thing that respondents were proud of during the pandemic. Staff were described as flexible, adaptable, resilient, courageous, resourceful, professional, compassionate, forward-thinking, committed, willing to embrace change, willing to upskill, dedicated, and determined to continue to provide a high-quality service. There were reports of teams contacting every person that they worked with to make sure that they were safe.

4.22 Respondents repeatedly said that their staff 'embraced' the use of video technology and the telephone to be able to continue to deliver their service. They quickly learned how to triage patients and prioritise their workloads while at the same time having to cope (in most cases) with a very limited workforce. Staff were also reported to have 'pulled together' – supporting and looking after each other. Other respondents spoke of the 'leadership' and 'creativity' that their staff demonstrated. Respondents from inpatient services specifically praised their staff for their willingness to work with COVID-19 positive patients.

4.23 Some respondents also talked about a 'blurring of roles' which took place during the pandemic, as staff stepped up to support each other.

> 'There was a blurring of roles in multi-disciplinary teams in a positive way to address wider issues during essential community visits (i.e. Dietician taking OT equipment during their visit; Speech and Language Therapist weighing patient for Dietician, etc.)' (Multidisciplinary rehabilitation team – inpatients, outpatients and community)

4.24 In addition to the behaviour and responses of staff, other things that respondents said they were proud of during the pandemic included (i) the ways in which communication improved – with patients, within teams, between the rehabilitation team and other community or hospital services, and between management and frontline staff – and (ii) the wide range of new systems and resources that were introduced to support the safe, high-quality delivery of services.

4.25 Regarding the latter point, examples included (i) new digital resources for patients to support self-management, (ii) resources to support staff wellbeing, (iii) new assessment, risk assessment and triage systems to manage referrals and decisions about which patients needed to be seen face-to-face, (iv) systems to ensure adequate stocks of PPE and reliable decontamination processes, and (v) training resources for redeployed staff.

4.26 Finally, respondents also drew attention to the **ongoing** pandemic situation – and commented that they were proud of how their services were still **continuing** to adapt.

> 'Since returning to substantive service we have been receiving double the referrals as pre-pandemic and the majority of these are Long Covid. We have had to quickly build our expertise in this emerging clinical presentation and keep up-to-date with new evidence as it emerges. We are particularly proud of how we have been able to adapt to this and support each other and we have tried to influence future service provision based on our experience.' (Outpatient vocational rehabilitation team)

Skills gaps emerging during the pandemic

4.27 Question 8 asked about skills gaps that had emerged during the pandemic. Most respondents said that skills gaps had emerged. Comments focused on four main themes: (i) clinical skills, knowledge and experience, (ii) the adoption of virtual working, (iii) COVID-19 safe working, and (iv) staff and self-management. Each of these is discussed briefly below. In addition, issues relating to training (to address skills gaps) are also covered. A final section covers positive views on staff skills.

Clinical skills, knowledge and experience

4.28 The additional clinical skills gaps reported by survey respondents were wide ranging and varied. They covered skills directly related to the care and treatment of COVID-19 patients, as well as those of a more generic nature. Specific skills noted by respondents related to the management of critically ill patients including those in intensive care units and following discharge (for example, related to respiratory care competencies for physios, and nutritional support competencies for dietitians); moving and handling skills; and end of life care (for example, dealing with families, and dealing with emotional, psychological and mental health issues).

4.29 In some cases, skills gaps were attributed to staff redeployment during the pandemic with staff being (temporarily) assigned to different teams or roles working with different patient groups or in different settings which required different knowledge, skills and experience. Some, however, saw this as an issue of confidence or as something that could be dealt with via 'refresher' training.

Digital working

4.30 The sudden change to virtual and remote working featured heavily in the survey responses, with staff having to become proficient in using a range of different systems and software packages in order to do their jobs. Although some teams had been familiar with digital working prior to the pandemic the wholesale shift to this way of working had presented significant challenges, with some staff finding this 'overwhelming at first'.

4.31 In terms of online delivery of services to patients, respondents were clear that the challenges were not just technical but also related to skills and confidence in carrying out telephone or online consultations and assessments, the delivery of interventions (to individuals or groups) and communicating effectively with patients and families.

4.32 Some respondents said the skills gap in this area had quickly closed as staff 'had adapted to the challenges of digital working'. However, in other cases respondents said that training and support had not always been available, and that some staff continued to lack confidence and competence in this area.

Infection control

4.33 Another area in which survey respondents identified skills gaps was that of infection control and COVID-19 safe working. On this issue, respondents noted the need to ensure staff were familiar with infection controls procedures, social distancing in the workplace and the use of PPE. This was said by some respondents to have presented a 'steep learning curve' for staff, and that this had been compounded by 'constantly changing' guidance and protocols.

Staff and self-management

4.34 Respondents also commented on the emergent need for enhanced skills in the areas of staff management and self-management that took account of the new pressures and new working environments associated with the pandemic. The skills gaps identified related to contingency planning, the management of the health and wellbeing needs of staff, particularly in the virtual working environment, and building resilience and equipping staff to manage stress and anxiety.

4.35 One respondent described the uniqueness of the challenges presented by the COVID-19 pandemic, and what this meant for the skills required of staff:

> 'None of our team had ever managed a crisis of this nature and therefore on reflection it is apparent that the skill-set required to deal with this situation both physically and emotionally was incredibly complex. Building resilience and crisis management skills would seem to be not only relevant but necessary for all in health care.' (Inpatient and outpatient physiotherapy service in gynaecology, obstetrics and pelvic health)

Training challenges

4.36 As well as identifying specific skills gaps, respondents also highlighted the challenges in ensuring that such gaps were addressed during the pandemic. In particular, they said that training – both for new recruits and existing staff – had not always been readily available or easy to access, or that training (e.g. induction training) had been provided virtually rather than in-person. In addition, some respondents noted that providing on-the-job training and ongoing support for redeployed staff had placed an additional demand on existing teams.

Positive views on staff skills

4.37 Occasionally, respondents said that no skills gaps had emerged in their area during the pandemic or said that the skills gaps remained the same as prior to the pandemic. Indeed, in some cases, respondents said the pandemic had highlighted the good range of skills present within their teams.

4.38 Some also identified positive impacts of the pandemic in terms of staff skills as team members had, for example, learned new skills, demonstrated good leadership or gained new experience (in their current roles, or as a result of redeployment). Some had also taken the opportunity to pursue self-directed learning.

Patient health and wellbeing

4.39 Question 9 asked respondents what changes they had observed in the health and wellbeing of their patient group during the pandemic. Respondents generally replied to this question by providing a long list of changes, and there was a great deal of consistency in the points mentioned. Overall, respondents reported that the pandemic had had a significant negative impact on patient functioning and wellbeing. Specific reported impacts related to: (i) mental health, (ii) physical health, (iii) social isolation, (iv) reduced access to and reduced willingness to engage with services, and (v) carer exhaustion.

4.40 Each of these is discussed briefly below, followed by a short section which discusses some of the positive impacts on patient health and wellbeing noted by some respondents.

Mental health

4.41 Respondents repeatedly highlighted the impact of the pandemic on their patients' mental health and wellbeing. They also frequently pointed to the knock-on effect that a decline in mental health had on their patients' physical health and functioning. Respondents working in all areas of rehabilitation and with all service user groups said that they had observed a wide range of changes in their patients' mental health including increased anxiety (including fear of catching COVID-19); lower mood and depression; increased incidences of agoraphobia; increased suicidal feelings and suicide attempts among older people and patients with pre-existing mental health problems; self-neglect; loneliness; loss of confidence; poor motivation; increased confusion; boredom; grief; and distress.

4.42 Occasionally, respondents reported that some of their patients were 'stoical', and so their decline in wellbeing was less obvious.

Physical health

4.43 In terms of the physical impacts of the pandemic on patient health and wellbeing, a recurring theme was that of patients becoming 'deconditioned' as a result of inactivity and an inability to access care and support services. This deconditioning led to an increase in frailty and falls among older patients in particular. A wide range of other physical impacts were identified including weight gain (or weight loss), malnutrition and increases in eating disorders; increased alcohol and drug use; loss of fitness; reduced mobility; deterioration in communication skills; cognitive decline; increased pain; and increased incidence of diabetes.

Social isolation

4.44 Social isolation was seen to be a major impact of the pandemic and one which had a significant knock-on effect on patients' mental (and physical) health and wellbeing.

Respondents often noted that their patients had to shield during the pandemic, and that the loss of contact with family, friends and services was keenly felt by all patient groups.

4.45 Very occasionally, respondents reported that some of their patients seemed to prefer to be in hospital (one respondent said they 'loved being in hospital') rather than at home because of the loneliness they had experienced at home alone. This was not a common observation, however, as most respondents stated that their patients were fearful of going to hospital during the pandemic.

Reduced access to, and reduced willingness to engage with, services

4.46 Another common theme in respondents' comments about the impacts of the pandemic on their patients was that of restricted access to healthcare services during this period. As noted in paragraph 4.10–4.12 above, face-to-face delivery of rehabilitation services (including clinics and group classes) largely stopped during the pandemic for all but the most urgent cases. Third sector support services and leisure / gym services were also unavailable.

4.47 At the same time, respondents said that many patients were reluctant – even when it was possible – to attend outpatient or other hospital appointments, for fear of contracting COVID-19. Moreover, some patients found it difficult, or were unwilling to, engage with medical and rehabilitation professionals through virtual appointments – or they struggled to articulate their needs because of technology / broadband issues.

4.48 The general unavailability of services and the reluctance of patients to engage with services that **were** available had a significant impact on patient health and wellbeing. Some of the reported impacts included patients being unable to take part in pre-surgery rehabilitation (prehabilitation); patients presenting to health services with more severe / complicated conditions requiring more intensive / aggressive interventions; and an increase in acute admissions (because patients had waited too long to seek help).

Carer exhaustion

4.49 Some respondents commented that carer stress and exhaustion was a further significant issue that had had an impact on the health and wellbeing of their patients. With the withdrawal of face-to-face services at the start of the pandemic, carers found themselves having to take on increased responsibilities with no access to respite services. Respondents noted that, during the pandemic, patients were often being discharged from hospital more quickly than normal, leaving families feeling unprepared to support their relatives. This situation was exacerbated in cases where family members did not live locally and were unable to visit. In addition, not all carers had access to, or had the skills to use, IT devices. These individuals were unable to engage in digital consultations.

4.50 The following quote illustrates the wide range of negative impacts of the pandemic on patient health and wellbeing reported by respondents.

> 'Our patient group have been quite significantly impacted mainly via the effects of shielding – which applied to the majority of our patients living with a chronic lung condition. Anxiety and depression were already closely linked with living with a lung condition, but we have found the majority of people we are now back in touch with

> are struggling much more with mental well-being. This is a combination of fear in relation to contracting COVID-19, loss of social contact, isolation from families including grandchildren, reduced contact with GP practices and other support groups, and a fear that their condition has worsened. We have also found the majority of our patients to be much more breathless over the pandemic which is mainly due to shielding and therefore reduced activities, increased sedentary living, reduced motivation to do home exercise and then a cycle of avoiding exertion due to breathlessness. We have had people whose breathing has deteriorated, and they have taken to their bed, assuming that their condition has progressed and not knowing where to turn. Patients have also been avoiding contacting GP practices as they assume they are too busy, or report that they don't feel supported by online GP consultations or telephone appointments therefore are asking us for support with problems that require medical attention.'
> (Outpatient pulmonary rehabilitation service)

Positive impacts

4.51 Very occasionally, respondents noted **positive** impacts of the pandemic on the health and wellbeing of some of their patients. For example, there were examples of (i) increased walking and physical activity, (ii) patients being willing and able to self-manage and engage in virtual appointments, (iii) patients valuing and benefiting from online groups, (iv) patients with mental health problems experiencing a respite from worrying about their own inactivity, lack of social contact or absence from work.

5. The future of rehabilitation services – post-pandemic

This chapter presents findings from the survey responses in relation to post-pandemic service delivery and discusses respondents' views about what needs to be done – locally and nationally – to provide consistently good rehabilitation services. Six questions in the survey addressed general issues related to learning from the pandemic experience, opportunities for services, workforce challenges, patient health and wellbeing, and requirements for providing good rehabilitation – within services and at national level.

> **Question 10:** Learning from the last year what will you keep doing?
>
> **Question 11:** What would you say is the biggest opportunity for your service post-pandemic?
>
> **Question 12:** What would you consider as the biggest challenges within your workforce over the next couple of years? (e.g. gaps in education / training, recruitment concerns)
>
> **Question 13:** Do you have concerns about the long-term impact of the pandemic on the health and wellbeing of your patient groups?
>
> **Question 14:** Within your service what needs to happen in order to consistently provide 'good rehab' – please try to be specific.
>
> **Question 15:** What ambitions would you like to see collectively across Scotland in order to consistently provide good rehab?

5.1 The responses across four of these questions covered very similar ground, and together presented a picture of respondents' intentions, aspirations and ambitions for services in the post-pandemic period. Thus, the analysis below is not presented on a question-by-question basis. Instead, the analysis looks at (i) service delivery, (ii) strategic action required to bring about the desired changes in rehabilitation services and outcomes, (iii) workforce issues, and (iv) patient health and wellbeing.

Service delivery

5.2 Respondents anticipated or were keen to see a wide range of changes in rehabilitation services in the post-pandemic period. The **main** themes identified in their comments related to (i) digital working; (ii) multidisciplinary and joined up working; (iii) service quality and improvement; and (iv) non-staff-related resources. Each of these is addressed below.

5.3 It should also be noted that in a few cases respondents said that it was (i) 'too early' to consider future plans and opportunities for services, (ii) that services had had 'little time to regroup' and were still working in challenging times, or (iii) that they did not feel they were yet working in a 'post-pandemic' environment. Additionally, one respondent said, 'it doesn't feel like there are many opportunities' while another said that 'staff see no opportunities due to lack of funding for outpatient services and low staff morale'.

Digital working

5.4 With few exceptions, survey respondents said they intended to continue using remote and digital working for both (i) communication with team members and colleagues in other teams and services, and (ii) patient-facing service delivery activities (e.g. telephone and online triaging, assessments and reviews, delivery of groups and classes, and providing information and advice). Respondents noted that digital working:

- Improved efficiency by saving on travel time for staff and easing the burden on accommodation and facilities, thus freeing up capacity for other work and allowing those most in need to be prioritised for face-to-face care
- Supported good quality care by facilitating regular communication with patients, offering choice (online versus face-to-face appointments, classes and interventions) and convenience to patients and making it easier to engage with and involve families and carers in a patient's care
- Allowed staff to engage with a wider range of colleagues, regardless of their location – for managing cases, for service management and development purposes
- Allowed staff easier access to training, saving on time and money, and allowed staff to provide training to other groups (e.g. care home staff)
- Gave staff flexibility to work from home – which could be more productive and could support an improved work-life balance.

5.5 Respondents saw remote and digital working as a way to further enhance patient choice, promote self-management, improve efficiency, and provide more equitable services. However, while there was widespread enthusiasm for continuing with digital working, respondents often said that this should be part of a 'blended' and / or 'balanced' approach with a range of service delivery options available to patients to meet their needs and preferences. It was noted that not all patients had access to digital devices or reliable internet connections, or the necessary skills or confidence to use technology successfully. Respondents also recognised that online service delivery had limitations and should only be used 'where appropriate'; some stressed the need for a cautious approach incorporating monitoring and evaluation of the impact of digital working. In a few cases respondents said they were looking forward to a return to face-to-face working and anticipated minimal use of digital working within their team, or they emphasised the importance of face-to-face contact.

5.6 Respondents also said that staff training, and access to reliable IT equipment and internet connections were needed to support work in this area.

Multidisciplinary and joined up working

5.7 Respondents also commonly drew attention to the move towards greater multidisciplinary and joined up working during the course of the pandemic as a positive development and something they intended to continue and build on further.

5.8 They were looking ahead to closer collaboration between teams both within and across professions, services, sites, organisations, and sectors. This type of collaboration would involve further development of their knowledge of, and working relationships with,

community-based and third sector organisations – to allow early intervention, to facilitate timely discharge of patients from acute settings, and to prevent future admissions.

5.9 Respondents were keen to continue, re-establish, or explore options for: (i) more collaborative multi-agency service delivery – e.g. joint assessments and decision-making, and shared caseloads and case management, (ii) improved communication and information sharing and (iii) joint training and CPD activities. The increased use of technology was often seen as a key enabler in this.

5.10 Respondents also talked about an intention to continue with a flexible, innovative, and ambitious approach to delivering services, with staff contributing to and moving between different teams, as required, and working beyond traditional boundaries. Some saw the need for further development of a 'shared rehab ethos', which would involve social work, nursing and care staff as well as GPs and hospital staff (as appropriate) in supporting people's rehabilitation goals. Others suggested that time and space for honest conversations within multidisciplinary teams was the key to innovation in services.

5.11 Respondents identified national-level actions and initiatives that would support enhanced joined up working. Key amongst these were shared access to IT systems / electronic notes between health and social care professions, and (ii) clearer rehabilitation pathways and referral processes across Scotland to promote greater continuity of care between inpatient, outpatient and community services.

Service quality and improvement

5.12 Respondents noted how working through the pandemic had encouraged flexibility, the development of new and adaptive ways of working, and 'thinking outside the box'. Respondents were keen to build on this 'enthusiasm for change', and 'continue to support innovative [and] creative ways of working'.

5.13 Respondents said they wanted to 'do things differently' or to 'not go back to what we had been doing pre-COVID-19'. There was also a view that the pandemic had created an opportunity to be 'braver' in looking at service options, and to 'push things through more quickly'.

5.14 Respondents said they saw opportunities to: (i) reflect on and redefine services, (ii) consider service priorities – what was delivered, how and why, and the allocation of resources, (iii) review and redesign services – taking account of feedback from patients and staff and (iv) introduce efficiencies, remove duplication and streamline services.

5.15 Some respondents also saw specific service development opportunities related to the ongoing and future treatment of patients recovering from COVID-19, or suffering from long-COVID, or patients with pre-existing conditions whose health and physical and mental wellbeing had been impacted by pandemic – either because of difficulties accessing treatment or because they had been shielding. These respondents pointed out that their teams had the necessary skill-set to respond to this situation and provide the appropriate rehabilitation input to affected patients.

5.16 It was also common for respondents to identify specific areas of their service where learning from the pandemic could be used to improve current systems and approaches.

5.17 For example, in relation to case management, some respondents wished to continue to pursue (i) improved triaging systems (using telephone and virtual assessment methods), (ii) stricter application of service criteria, (iii) effective case reviews, and (iv) effective discharge planning and management. Although such approaches had sometimes been expedited by the pandemic, respondents saw opportunities for further development of case management approaches and patient pathways, supported by the use of virtual working, in order to support more efficient service delivery and improved prioritisation of resources, so that support could be focused on those most in need.

5.18 At a more general level, respondents frequently said that they intended to continue to provide evidence-based services in a person-centred way that encouraged and supported self-management and prioritised patient and family / carer engagement. Going forward, respondents wanted to see the 'right' rehabilitation service provided at the 'right' time to each individual who needs a service. Respondents highlighted the importance of a 'person-centred approach' based on the principles of Realistic Medicine (i.e. the concept that people using healthcare services feel empowered to discuss their treatment, and can engage in shared decision-making with healthcare professionals).

5.19 Respondents also repeatedly said that there was a need for a greater focus on 'prevention' – rather than the current resource-intensive focus on crisis interventions. They called for a 'proactive', rather than 'reactive' approach to service delivery. This would involve, among other things, a greater emphasis on self-management. Respondents suggested there is a need – not only to educate GPs and other professionals to refer patients 'at the right time' to facilitate proactive rather than reactive interventions – but also to educate the public about their role in managing their own conditions 'rather than expecting services to fix everything for them'. It was suggested that a change in 'language' and 'culture' would help to encourage more self-management.

> 'Put in place 'prevention' that works, for example: the falls prevention groups, day centres, best in class information sessions, exercise referral schemes. [Provide] easy access for patients to gyms, swimming pools, etc. Redevelop Day Rehabilitation for generalised deconditioned patients with complex health and social care needs. [Deliver] appropriate rehabilitation in the community – providing rehab to patients rather than just ensuring that they are safe.' (Outpatient musculo-skeletal rehabilitation team)

Non-staff resources

5.20 Respondents repeatedly made the point that future plans and aspirations for services were dependent on the necessary funding, resources and infrastructure being available.

5.21 Specifically, they said there was an urgent need for adequate and appropriate ('fit for purpose') space in which to see patients. There were calls for more clinic space, and greater access to gym / exercise space and equipment (including in hospital wards). Some respondents also highlighted a need for specialist rehabilitation equipment to meet the specific needs of their patient groups; quiet private space on wards; and suitable office space.

5.22 While the main need appeared to be for physical space, other resource needs identified by respondents included (i) better IT equipment, (ii) (additional) administrative support, and (iii) easier access to equipment and materials to support patient rehabilitation.

Strategic actions required to support rehabilitation services

5.23 In addition to the more operational issues outlined above, respondents also discussed a number of more strategic issues which they thought needed to be addressed in order to achieve 'good rehab'. Key amongst these were (i) equality of access to services; (ii) research, evaluation and evidence-based practice; and (iii) the contribution, profile, and future development of rehabilitation services. The need for a strategic approach to the planning of rehabilitation services was also frequently highlighted, with these comments discussed at paragraph 5.32.

Equality of access to services

5.24 Respondents often commented on inequality in services within and between areas. They reported that long waiting lists in some areas are preventing people from getting the rehabilitation service they need. Inequality of access was also noted among certain population groups – for example, poor access to podiatry services was reported for people in prisons. Concerns were also expressed about the withdrawal of certain types of rehabilitation services in some parts of Scotland for particular patient groups and the inconsistent standards which are used at local level to plan / prioritise different rehabilitation services.

5.25 In order to tackle this, respondents wanted to see national-level action to achieve more equitable services and a strategy that truly tackles health inequalities. Respondents talked about having 'national guidelines' to ensure the correct levels of staffing and 'standards of care' based on current evidence to address existing variations in practice.

5.26 As discussed above, there were some suggestions that the technology and systems that services had invested in over the past year presented an opportunity for more accessible, more equitable services. There was also a suggestion that there was a need, at national level, to develop rehabilitation services in care homes in order to focus on improving quality of life.

Research, evaluation and evidence-based practice

5.27 The importance of evidence-based practice was repeatedly highlighted by respondents across all types of rehabilitation services. Respondents thought there was a need to 'close the gap' between current evidence of best practice and existing practice. At a local level, there was a keen interest in developing research capacity and capability to enable staff to evaluate the outcomes from their services. There was also a specific suggestion that more consistent data was needed to evaluate self-management approaches.

5.28 In terms of national ambitions, respondents wanted to see national benchmarking, a national repository (or network) to share good practice, and more opportunities for rehabilitation practitioners to participate in research – to develop the evidence base for effective rehabilitation. The point was made that staff needed to have time and resources,

both to participate in research / evaluation and to make changes to practice in light of evaluation findings. There was also a suggestion that any national rehabilitation strategy should be based on evidence of what works and that any such strategy should be evaluated for effectiveness in an ongoing way.

The contribution, profile and future development of rehabilitation services

5.29 A range of respondents identified opportunities to raise the profile of and highlight the contribution made by their profession or service in the post-pandemic environment. Respondents saw this as important both at organisational level and with regard to patients and the wider public. They said that the work done during the pandemic and the continuing need to support patients affected by COVID-19 had highlighted the importance of rehabilitation services, and they thought there was an opportunity, assisted by the Rehabilitation Framework, to build on this to ensure that 'the value and importance of rehab within health and social care is recognised and supported'.

5.30 Respondents saw an opportunity to 'really address the rehab agenda' by (i) promoting the needs of particular patient groups or the value of particular services, and (ii) further developing services that prioritised rehabilitation work and the principles underpinning it.

5.31 There was a broad view that good leadership and effective strategic management were important to the future development of AHP and rehabilitation services. Respondents wanted this to encompass greater recognition of the role of rehabilitation services in health and social care planning, improved workforce planning, a greater focus on preventative action and holistic person-centred care, increased funding and resources, greater consistency and equity in services.

Workforce challenges for the future

5.32 Question 12 asked respondents what they considered to be the biggest challenges within their workforce over the next couple of years. In general, respondents saw workforce issues as ongoing but said the pandemic had further highlighted these issues. At the same time, they identified specific workforce-related impacts that had emerged during the pandemic and were likely to continue into the future. Key amongst these were (i) staff morale and wellbeing and (ii) the need to adapt to new ways of working.

5.33 Respondents also raised workforce issues in their responses to Questions 14 and 15 about what needs to happen in their own service and at a national level to consistently provide 'good rehab'. In relation to these questions, they highlighted issues of (i) staff recruitment and retention, and (ii) staff training and development.

5.34 The main points made regarding these issues are covered below.

Staff morale and wellbeing

5.35 In terms of staff morale and wellbeing, respondents commonly referred to staff 'burnout' or 'fatigue', or 'disillusionment' as issues for their service going forward. This situation was linked to working through the pandemic which had been a period of intense pressure and stress for staff – because of high workloads, new ways of working, constant

change and uncertainty and concerns about health risks to individuals and families. However, this was also linked to the continuing situation as Scotland emerged from the pandemic with ongoing high demands for services and long waiting lists as a result of the backlog of cases that had built up in some areas. Respondents suggested that maintaining staff wellbeing and resilience would become increasingly challenging the longer COVID-19 restrictions and the effects of the pandemic continued.[4]

5.36 Respondents said that the pandemic had highlighted the importance of supporting colleagues, looking after the health and wellbeing of the workforce and enhancing staff resilience, and they wished to maintain a focus on this moving forward. Respondents discussed their intentions to (i) offer flexible home working as an option to staff, (ii) improve staff engagement and allow time for reflection and the sharing of concerns within teams, (iii) improve communication with individual staff members, including regular 'check-ins' and improved supervision and mentoring, and (iv) empower staff in their professional roles, to prevent overload and ensure an appropriate balance of work that allowed time for non-clinical activities.

Digital working

5.37 The introduction and expected continuation of 'blended' working incorporating remote working and the use digital technology was also seen as presenting workforce challenges. As discussed above, respondents often said they saw 'blended' approaches to service delivery as offering advantages and playing a part in re-establishing services. However, it was also common for respondents to note that this was, nevertheless, likely to present a number of challenges over the coming years, including in relation to (i) staff competence and confidence in the use of IT and (ii) the provision of suitable equipment and an appropriate working environment. Respondents also highlighted challenges in relation to:

- **Staff development and training:** Some noted that digital or blended service delivery offered fewer opportunities for shadowing of new or rotational staff and meant that it was harder for new staff to gain a full range of necessary experience if face-to-face work with patients was restricted. There were particular concerns that staff who had completed their undergraduate training during the pandemic would not have all the necessary skills to work safely and effectively in the workplace. However, some suggested that there were advantages – particularly for those in more remote areas – in being able to access national training remotely.
- **Team and staff management:** Some respondents said that remote working and virtual meetings could have an impact on communication and informal networking, and could affect team dynamics and the quality of discussion at meetings.
- **Staff perceptions and job satisfaction:** Some noted that staff 'do not like managing patients virtually' or that they preferred face-to-face working, and that a move away from in-person working could affect job satisfaction. There was a concern that staff who had chosen to work in a 'hands on' profession may leave if the nature of their job changed too much.

[4] Note that the survey was completed over May to early July 2021 when Scotland was covered by Level 1 or 2 restrictions.

Recruitment and retention

5.38 Survey respondents saw recruitment and retention as ongoing issues within AHP and rehabilitation services. However, some respondents saw the issue of staff morale and wellbeing as potentially exacerbating existing challenges in this area. In particular, there were suggestions that the experience of working through the pandemic may lead to individual staff members (i) bringing forward retiral plans, (ii) choosing to leave NHS jobs as they reassessed their lives and prioritised their own health and wellbeing and lifestyle factors, (iii) seeking improved pay and conditions elsewhere, or (iv) being reluctant to take on the challenge of a new job. In addition, respondents anticipated that there may be increasing requests for part-time working, flexible working and remote working as staff tried to adjust their work-life balance in the wake of the pandemic.

Ensuring staff have the right skills for the job

5.39 Respondents not only said that their services needed to have **enough** staff to meet the demands for rehabilitation services, but they also needed: (i) staff who are appropriately trained, (ii) teams with the right skills mix (respondents highlighted the need for a 'flexible, skilled workforce'), (iii) ongoing opportunities for continuing professional development, and (iv) good pathways for career progression. Respondents saw opportunities to further consider staff training needs and to invest in developing the workforce to meet the changing demands of future services.

5.40 Respondents emphasised the importance of linking with colleges and schools and maintaining support for students. However, respondents identified a challenge in ensuring that new entrants to the workforce had the necessary skills to confidently carry out their jobs, given the increased use of 'virtual placements' and the reduced use of face-to-face working.

5.41 Looking ahead, respondents were keen that staff continued to:

- Maintain, use and build on new skills gained during the pandemic
- Keep their skills and knowledge up to date
- Develop skills to meet the physical and emotional needs of patients.

5.42 They also noted the importance of protecting staff development time, supporting new staff, and continuing to offer placement opportunities for students.

Responding to workforce challenges

5.43 At both local and national levels, respondents felt that improvements could be made to workforce planning and suggested that, at a national level, improved guidance on this subject could be provided (e.g. in relation to staffing levels and workforce planning). There was also mention of developing a 'workforce planning tool'. Respondents also wished to see a more consistent approach to training, greater use of multidisciplinary training, and adequate funding to ensure staff could access the necessary training.

Patient health and wellbeing

5.44 Finally, respondents were asked (Question 13) if they had any concerns about the long-term impact of the pandemic on the health and wellbeing of their patient groups.

5.45 Very occasionally, respondents said that they foresaw **no** long-term impact from the pandemic. Those who answered in this way and provided further comment suggested that long-term impacts on patient health and wellbeing could be avoided if a clear exit plan (from the pandemic) was implemented. There was also a suggestion that the negative impacts seen **during** the pandemic were likely to continue in the short term, but not necessarily in the long term.

5.46 However, more commonly, respondents **did** highlight concerns about possible long-term impacts of the pandemic, and they thought that these impacts were likely to be seen for many years to come. The main themes in respondents' comments related to (i) mental health, (ii) physical health, and (iii) social isolation. Each of these is discussed briefly below.

5.47 First, however, respondents' views about the factors that may **cause** or **contribute to** possible long-term adverse impacts are presented.

Causal factors

5.48 Respondents expected the pandemic to have a range of long-term impacts on their patients. The two main causes of these anticipated impacts were identified as (i) ongoing difficulties for patients in accessing services and (ii) patients' own disengagement from services.

5.49 Some respondents highlighted continuing delays and / or barriers for patients in accessing a wide range of services – not only rehabilitation services, but also primary care services, drug and alcohol services, and community leisure / exercise classes. Others suggested that certain support services (e.g. falls groups, lunch clubs, walking groups, etc.) were still closed, and there were concerns voiced that some of these services may, not re-open.

5.50 Respondents made the point that without better access to these key services, patients may become increasingly unwell and not come to the attention of services until a crisis occurs, by which point recovery will be more difficult. Respondents also noted that the loss of contact with services is likely to have a particularly severe impact on older people in particular.

Mental health

5.51 Respondents said that they expected to see long-term impacts on patient mental health from the pandemic, including in relation to increased anxiety, loss of confidence, bereavement, increased drug and alcohol use, and increased cognitive impairment.

Physical health

5.52 Respondents thought that the physical deconditioning of patients, which had begun during the pandemic, was likely to worsen. Some reported that improved function which

they had seen in some patients had been entirely reversed during the pandemic. In addition, they expected – and were already seeing evidence of – increasing frailty and debility among older patients.

5.53 In addition, the implications of long-COVID were also a concern for respondents. Those who did provide further comment on this issue suggested that long-COVID was likely to exacerbate many long-term conditions, and to require sustained rehabilitation. There was a suggestion that services (at least in some areas) did not currently have the capacity to support people suffering from this condition.

Social isolation

5.54 Respondents also expected that, in the long term, there would be increased loneliness and social isolation within their patient groups. They attributed this partly to people's poorer mental health and a loss of confidence among their patients in engaging in social interaction, but also to the lack of structure in people's lives during the pandemic. Others pointed to the loss, for many people, of long-established friendship and support networks.

6. Concluding remarks

6.1 This report has presented an analysis of the main points raised by rehabilitation teams in their responses to a survey about rehabilitation services. The survey was commissioned by the Scottish Government on behalf of the National Advisory Board for Rehabilitation, and was carried out in May / June 2021. It captured a wealth of information from staff involved in the delivery of rehabilitation services on their experiences of and views on working before and during the COVID-19 pandemic, and on their intentions and aspirations looking ahead to the future of rehabilitation services.

6.2 The findings of the survey will be used to support the effective implementation of the Scottish Government's *Framework for Supporting People through Recovery and Rehabilitation during and after the COVID-19 Pandemic* (The Framework). The Framework sets out the priorities and objectives for rehabilitation services in Scotland during the ongoing pandemic and into the post-COVID-19 period.

6.3 The Framework is underpinned by eight principles which are intended to support a consistent approach to planning and re-shaping services to meet a broader range of needs and circumstances – including any health impacts associated with COVID-19. This final section considers the findings of the survey in the context of the eight principles:

- Leadership
- Person-centred
- Outcomes-focused
- Multidisciplinary and multiagency workforce
- Innovation
- Education and research
- Digital
- Quality improvement.

Leadership

> Attentive compassionate leadership at government and local levels, enabling collaboration, collective endeavour, and enabling the aspirations of the National Performance Framework, is essential because rehabilitation has far-reaching health, social and economic benefits, with the potential to enable greater participation in education, employment and community living. (Framework for Supporting People through Recovery and Rehabilitation during and after the COVID-19 Pandemic)

6.4 The findings of the survey suggest that good leadership and effective management were seen as important to the future development of AHP and rehabilitation services. While some respondents were positive about current leadership and management in their area, or highlighted examples of good leadership during the pandemic, others saw this as an issue that needed to be further addressed.

6.5 There was a view that the pandemic had highlighted the contribution made to health and wellbeing by rehabilitation services. Respondents spoke of the 'leadership' and 'creativity' that their staff demonstrated during the pandemic, and they suggested that there

was now an opportunity to further raise the profile of these services and make the case for more strategically focused and better resourced services in the future.

6.6 Leadership is also needed at a national level. Respondents wished to see full recognition of rehabilitation services in strategic planning so that **all** patients in all areas had equal access to good services to support their rehabilitation.

Person-centred services

> Rehabilitation focuses on the person not the disease and where the individual – with their support from friends, family and / or carer – is empowered to lead and manage their situation and remain as independent as possible (Framework for Supporting People through Recovery and Rehabilitation during and after the COVID-19 Pandemic)

6.7 Providing person-centred care was a significant focus for survey respondents and many highlighted, as a point of pride, the patient-centred approach taken by their services before the pandemic. They described the key aspects of these services as: (i) engaging and working in partnership with patients and their families, (ii) focusing on self-management, (iii) supporting patients to achieve individualised goals, (iv) offering choice in services, ease of access and timely response and referrals, and (v) ensuring input from relevant professionals. They spoke of the importance of working with patients and families to devise individualised treatment plans that achieved the best outcomes for patients. Multidisciplinary and multiagency working was seen as important to this way of working, as was good local access to community services.

6.8 There was a general view that the pandemic had made it much harder to deliver truly person-centred services. However, some respondents emphasised that, despite the massive changes and challenges experienced in the pandemic, they kept person-centred care at the heart of all they did.

6.9 In terms of service delivery in the post-pandemic period, respondents identified a number of challenges that need to be overcome if rehabilitation services are to continue to provide person-centred care. There were concerns about the long-term impact of the pandemic on local services, and the implications this would have for patient health and wellbeing. Respondents described services that are under pressure and highlighted a number of resource-related issues which they felt needed to be addressed to enable rehabilitation services to be able to fully meet the increasing demands on services.

Outcomes-focused services

> Personal outcomes approaches mean acknowledging individual strengths and working towards establishing a shared sense of purpose to which everyone can contribute, including the person, their family, carers and other community resources, as well as services. (Framework for Supporting People through Recovery and Rehabilitation during and after the COVID-19 Pandemic)

6.10 There was a strong focus on patient outcomes in the responses to this survey, and there was a clear indication that rehabilitation teams are keen to develop their research capacity in order to be able to better evaluate the outcomes from their services.

6.11 Prior to the pandemic, respondents were already aware that their patients were increasingly elderly and frail, with multiple long-term conditions and complex mental health and social issues. Respondents commented that referrals to rehabilitation were frequently made too late, resulting in poorer outcomes for the individuals. They suggested that the primary purpose of rehabilitation for patients was, increasingly, about maintaining safety and quality of life, rather than achieving independence.

6.12 This situation was exacerbated by the pandemic. During this time, services were less available, but patients were also less willing to engage with services. Respondents suggested that this situation would only be reversed if services were fully opened again and accessible, and if patients began engaging with services.

6.13 Respondents highlighted the need for a greater focus on prevention – and a move away from resource intense reactive services – at both a local and national level.

Multidisciplinary and multiagency workforce

> Rehabilitation in any setting should include physical, mental, social assessment and intervention utilising a biopsychosocial model collaborating towards a common goal. This should be undertaken through a strong multidisciplinary teams approach including mental health and be multiagency including a trauma-informed workforce where a unified approach across professional groups, and systems is essential. (Framework for Supporting People through Recovery and Rehabilitation during and after the COVID-19 Pandemic)

6.14 Multidisciplinary working was seen as a point of pride for many of those involved in the delivery of rehabilitation services, with respondents often reporting this as being key to effective service delivery and describing good working relationships with colleagues and with other services, including those in other sectors.

6.15 However, some saw also identified challenges with this way of working – both in terms of 'ethos' and understanding, and in terms of practicalities relating to communication channels between teams and organisations, and variation in IT systems.

6.16 Some survey respondents suggested that multidisciplinary and multiagency working had increased during the pandemic, and there was a broad view that further development of multidisciplinary working was important to the future improvement of services.

Innovation

> New ways of working in response to coronavirus (COVID-19) challenges have led to creative solutions and good practice. New and evolving models of working need to be encouraged alongside the promotion and continuation of best practice supported where possible by evaluation. (Framework for Supporting People through Recovery and Rehabilitation during and after the COVID-19 Pandemic)

6.17 Survey respondents reported massive changes in their services which had been taken forward during the pandemic and reported an appetite for innovation and service improvement, and a commitment to taking stock, learning from the pandemic, and doing things differently (where appropriate) in the future. They highlighted the importance of

good communication – and the time and space to be able to share learning – within multidisciplinary teams as key to making this happen.

Education and research

> Partnership development of a skilled workforce considering educational, resources and emerging research evidence supporting rehabilitation outcomes for people. (Framework for Supporting People through Recovery and Rehabilitation during and after the COVID-19 Pandemic)

6.18 Respondents described a highly committed and highly skilled AHP and rehabilitation workforce, while also indicating where there were opportunities for further training and education. They highlighted the importance of further upskilling of the workforce and the need for appropriate resources to support this.

6.19 Respondents emphasised the importance of new entrants to the workforce in the post-pandemic period having the necessary skills to carry out their jobs. This was seen to be important because of the increased use the increased use of 'virtual placements' and the reduction in face-to-face working during the pandemic.

6.20 Respondents wanted to see **all** rehabilitation professionals delivering evidence-based services, and they expressed a commitment to the sharing of good practice across and between professions and an interest in participation in research. They voiced a need for greater capacity (and skills) to participate in research and called for greater cross-professional initiatives, and greater consistency in practice supported by appropriate guidance, standards, and training.

Digital

> There can be considerable benefits associated with the use of digital platforms and the information they generate (video consultation, home and health monitoring; apps; social media; clinical records) to support direct care and self-management to promote a safe and convenient way of patients accessing services to improve efficiency and cost-effectiveness for better outcomes. There is recognition that some sections of the population are more likely to be digitally excluded and there must be caution not to reinforce social exclusion of these groups and to recognise where additional support may be required. (Framework for Supporting People through Recovery and Rehabilitation during and after the COVID-19 Pandemic)

6.21 The huge increase in digital working during the pandemic was a key theme in the survey responses. This had been used (for the most part) very successfully during the pandemic for communication within and between teams and services and for patient-facing activities. Respondents suggested that the continuation of a form of 'blended working' provided an opportunity to introduce further innovation to services and to offer patients greater choice in the post-pandemic period.

6.22 The need for appropriate funding for IT hardware and software and training for staff, was highlighted. Respondents also suggested that the increased use of digital platforms needed to be managed carefully and appropriately. In addition, respondents noted the

potential (negative) impact on job satisfaction and staff wellbeing which could arise from increased digital working.

Quality improvement

> Implementation and improvement actions and supports should be informed by the elements that form part of effective quality management systems – specifically quality planning, control, assurance and improvement that is linked to leadership, learning systems and processes that promote collaboration with staff and people involved with services. (Framework for Supporting People through Recovery and Rehabilitation during and after the COVID-19 Pandemic)

6.23 The survey indicated that those involved in frontline rehabilitation services were committed to the development of high-quality effective services that took account of the views of staff and patients. They expressed an openness to innovation and change, and thought there was an opportunity, looking to the future, to review services in light of experiences and learning which took place during the pandemic. Respondents thought that research evidence, national guidelines and standards could all play a part in further improving quality in the future.

Conclusion

6.24 Overall, the survey responses endorsed the principles set out in the Rehabilitation Framework. However, survey respondents saw a need for strategic action – including improved leadership, greater recognition of the role of rehabilitation services in health and social care planning, improved workforce planning, increased funding and resources, greater consistency and equity in services– at both a local and national level in order for the Framework to be successfully implemented and for rehabilitation services to meet the increasing demands and challenges of the future.

Annex 1: Information about teams responding to the survey

Area of rehabilitation covered

Respondents to the survey were asked which area of rehabilitation their service covered. The question provided a list of 22 options, ranging from 'cardiac rehab' to 'vocational rehab', and respondents were asked to select one of the options, or to select 'other', and then to provide further details.

The most common response to this question was 'other' selected by 20% of respondents.

Table A1.1: Which area of rehabilitation do you mainly cover?

Area of rehabilitation	Number	Percent
Community rehab	49	18%
Older people's rehab	27	10%
Musculoskeletal rehab	20	7%
Neuro rehab	18	6%
Specialist rehab	14	5%
Mental health – adult	13	5%
Stroke rehab	13	5%
Cardiac rehab	13	5%
Reablement / intermediate care	10	4%
Mental health – older adult	8	3%
Orthopaedics	7	3%
Pulmonary rehab	7	3%
Front door – acute	5	2%
Critical care	4	1%
Surgical	3	1%
Learning disability – adult	3	1%
Prisons	2	1%
Palliative care	2	1%
Falls	2	1%
Leisure trusts	2	1%
Vocational rehab	1	0%
Prehabilitation	1	0%
Other	56	20%
Total	**280**	**100%**

Respondents who ticked 'other' often stated that they provided more than one type of rehabilitation service. Respondents also ticked 'other' if they were delivering what they described as a 'general' or 'generalist' rehabilitation service. Examples of the latter included 'a small generalist team in a rural environment providing all types of rehab within inpatient, community and outpatient settings'; a 'general medical service for adults who experience psychological distress caused and maintained by their health condition'; and 'a

generalist team in an island community that covers community, falls, older adults, palliative, prehab, reablement, stroke and neuro'.

Some respondents who selected 'other' in response to this question also said that they provided some form of specialist service. Examples included rehabilitation relating to oncology, cystic fibrosis, lymphoedema, major trauma and rheumatology, among others. Hand therapy and hydrotherapy were also included.

Main service user group

Respondents were asked to say who their service was mainly delivered to: (i) inpatients, (ii) community patients / clients, (iii) outpatients, or (iv) primary care patients.

The largest proportion of respondents (40%) said that they delivered rehabilitation to patients in the community. Just over a quarter (27%) said their service was delivered to inpatients.

Table A1.2: Is this service mainly delivered to…?

Service user group	Number	Percent
Community	112	40%
Inpatients	75	27%
Outpatients	52	19%
Primary care	7	3%
Total	**280**	**100%**

Rehabilitation professionals included in the responses

Respondents were provided with a list of 16 rehabilitation professionals and were asked to tick all those involved in their response. If a member of their team was not included in the list, the respondent could tick 'other' and provide further details.

The two rehabilitation professionals involved most often in responding teams were physiotherapists (69% of respondents said their team had one or more physiotherapists) and occupational therapists (55% said their team had one or more OTs).

Respondents also reported a wide range of 'other' professionals involved in their teams including managers; social workers; fitness instructors; pharmacists; counsellors; third sector staff; and equipment service staff.

Table A1.3: Relevant professionals involved in the responses

Type of rehabilitation professional	Number of teams including each professional	Percentage of teams including each professional (out of total 280)
Physiotherapists	193	69%
Occupational therapists (OTs)	153	55%
Healthcare support workers	104	37%
Nurses	82	29%
Speech and language therapists	50	18%
Dieticians	41	15%
Doctors	38	14%
Psychologists	33	12%
Prosthetics and orthotists	18	6%
Podiatrists	17	6%
Radiographers	7	3%
Paramedics	4	1%
Art therapists	2	1%
Orthoptists	2	1%
Music therapists	1	0%
Drama therapists	0	0%
Other	30	11%

*Respondents were invited to tick multiple professionals where appropriate – it is therefore not relevant to show totals for number or percentage columns.

* Other rehabilitation professionals also include managers; social workers; pharmacists; counsellors; third sector staff; equipment service staff; administrative staff; etc.

Geographical location of responses

Respondents were asked to say where in Scotland their service was delivered. A list of NHS boards and HSCPs was provided, and respondents were asked to select one.

Most respondents, 234 out 280, (84%) reported being based in NHS services, while 46 (16%) said they were based in an HSCP.

A1.4: In which part of Scotland do you deliver your service?

	Number of respondents from NHS boards	Number of respondents from HSCPs	Total number of respondents	Percentage of respondents
NHS Ayrshire and Arran	16		16	6%
HSCP East Ayrshire		2	2	1%
HSCP North Ayrshire		1	1	<1%
NHS Borders	2		2	1%
NHS Dumfries and Galloway	16		16	6%
HSCP Dumfries and Galloway		3	3	1%
NHS Fife	23		23	8%
HSCP Fife		2	2	1%
NHS Forth Valley	18		18	6%
HSCP Falkirk		2	2	1%
NHS Golden Jubilee	4		4	1%
NHS Grampian	24		24	9%
HSCP Aberdeen City		2	2	1%
HSCP Moray		1	1	<1%
NHS Greater Glasgow and Clyde	35		35	13%
HSCP Argyll and Bute		4	4	1%
HSCP East Dunbartonshire		1	1	<1%
HSCP East Renfrewshire		2	2	1%
HSCP Inverclyde		1	1	<1%
HSCP West Dunbartonshire		4	4	1%
NHS Highland	20		20	7%
NHS Lanarkshire	6		6	2%
HSCP North Lanarkshire		1	1	0%
HSCP South Lanarkshire		2	2	1%
NHS Lothian	40		40	14%
HSCP East Lothian		2	2	1%
HSCP Edinburgh City		4	4	1%
HSCP Midlothian		1	1	<1%
HSCP West Lothian		1	1	<1%
NHS Orkney	4		4	1%
HSCP Orkney		1	1	<1%
NHS Shetland	3		3	1%
HSCP Shetland		1	1	<1%
NHS Tayside	20		20	7%
HSCP Dundee City		3	3	1%
HSCP Perth and Kinross		4	4	1%
NHS Western Isles	3		3	1%
HSCP Western Isles		1	1	<1%
Total	**234**	**46**	**280**	100%

Annex 2: Response rates for individual questions

Table A2.1: Response rates, by question

Question number	Number of responses	Response rate (out of 280)
Q1: Pre-pandemic, what specific parts of your services were you most proud of?	280	100%
Q2: Pre-Pandemic, what challenges did you experience with recruitment and retention of staff?	279	99.6%
Q3: Pre-pandemic, were there any specific skill gaps within the workforce of your service?	280	100%
Q4: Pre-pandemic, in terms of service delivery – What were the biggest challenges day to day?	280	100%
Q5: Pre-pandemic, how would you describe the health and wellbeing of your local patient groups; did you notice any emerging issues?	279	99.6%
Q6: During the pandemic, what specific parts of your service were you most proud of? (e.g. innovation, service changes, staff skills, etc.)	279	99.6%
Q7: During the pandemic, how was the delivery of your services impacted by the pandemic? Please discuss examples of specific changes you had to make to your service.	280	100%
Q8: During the pandemic, were there any examples of staff skill gaps that emerged during the pandemic?	278	99%
Q9: During the pandemic, what changes did you observe in the health and wellbeing of your patient group?	279	99.6%
Q10: Learning from the last year what will you keep doing?	280	100%
Q11: What would you say is the biggest opportunity for your service post-pandemic?	280	100%
Q12: What would you consider as the biggest challenges within your workforce over the next couple of years? (e.g. gaps in education / training, recruitment concerns).	280	100%
Q13: Do you have concerns about the long term impact of the pandemic on the health and wellbeing of your patient groups?	280	100%
Q14: Within your service what needs to happen in order to consistently provide 'good rehab' – please try to be specific.	280	100%
Q15: What ambitions would you like to see collectively across Scotland in order to consistently provide good rehab?	280	100%

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