CHARTERED SOCIETY OF PHYSIOTHERAPY

Commission on the future of health and social care in England
Chartered Society of Physiotherapy
Consultation response

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The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the UK's 51,000 chartered physiotherapists, physiotherapy students and support workers.

The CSP welcomes the opportunity to provide evidence to the King's Fund commission on the future of health and social care in England.

Our response is focussed on the areas in which we feel we can most effectively contribute to the debate. We would be pleased to supply additional information on any of the points raised in our evidence at a later stage.

The contribution of physiotherapy

Physiotherapy enables people to move and function as well as they can, maximising quality of life, physical and mental health and well-being. With a focus on quality and productivity, it puts meeting patient and population needs, and optimising clinical outcomes and the patient experience, at the centre of all it does.

As an adaptable, engaged workforce, physiotherapists have the skills to address healthcare priorities, meet individual needs, and to develop and deliver integrated services in clinically and cost-effective ways.

Physiotherapy can help reverse the barriers to independence. Increasing care needs are not inevitable. Physiotherapists work to return patients to the baseline of functioning prior to crisis or admission. Patients with dementia can also benefit from physiotherapy rehabilitation. Physiotherapy can therefore save costs in health and social care.

Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity. Physiotherapists work with children, those of working age and older people; across sectors; and in hospital, community and workplace settings. Physiotherapists facilitate early intervention, support self management and promote independence, and help prevent episodes of ill health and disability developing into chronic conditions. Physiotherapy supports people across a wide

range of areas including musculoskeletal disorders (MSD); many long-term conditions, such as stroke, MS and Parkinson's disease; cardiac and respiratory rehabilitation; children's disabilities; cancer; women's health; continence; mental health; falls prevention.

Physiotherapy delivers high-quality, innovative services in accessible, responsive, timely ways. It is founded on an increasingly strong evidence base, an evolving scope of practice, clinical leadership and person-centred professionalism.

1. The case for change

What in your experience are the most significant problems that the current arrangements cause?

1.1 Increasing life expectancy and therefore growing numbers of older people with health and social care needs means rapid growth in demand for health and social care services.

1.2 Current systems can make it difficult for patients, particularly vulnerable older people, to navigate their way through multiple agencies/providers and get the joined up care they need.

1.3 Many patients would prefer care to be provided 'closer to home' in their local community; but funding is not yet transferring adequately from acute care into community-led care.

1.4 There is inadequate provision of early intervention and prevention services that could reduce the numbers of people developing preventable health problems which then cost both health and social care services in the longer term. For example, action to increase levels of physical activity and encourage healthy eating could reduce the prevalence of obesity in children and young people, reducing the likelihood of a wide range of health problems in adulthood. Or greater investment in physiotherapy-led falls prevention services could prevent the need for hip replacements and residential care for many older people (every hip fracture avoided could save approximately £10k[1]).

1.5 While the Outcomes Frameworks for Health, Public Health and Social Care are aligned at a national level, the priorities and outcomes for health, public health and social care are not delivered in an integrated way at a local level. This can put barriers in the way of efforts to deliver a joined up approach to preventing health problems, improving the health of the population and delivering integrated person centred care pathways.

Some of the issues identified by the Commission are included in Appendix A. Do you think there are any further issues of problems with the current arrangements that we should give more, or less, attention to in our work?

1.6 Better integration of health services and social care has the potential to improve the quality of care at the same time as being a more efficient use of resources.

1. Based on 2009/10 costs each hip fracture avoided saves £10,170 (HRG HA111-14 inpatient).

1.7 In many areas of the UK, health inequalities are currently increasing, rather than reducing. The pressures on the health and social care systems will continue to increase unless some of the wider determinants of health are addressed, and greater attention is paid to the long term public health agenda.

1.8. In the CSP's view there are insufficient community based services for the treatment and management of long term conditions. There is a wealth of evidence demonstrating the clinical and cost effectiveness of physiotherapy in community based and intermediary services, including reducing A&E attendance and avoidable hospital admissions for people with long term conditions. Physiotherapy rehabilitation has a crucial role in enabling older people to remain healthy and independent for longer, and restoring their ability to be independent following illness or injury. This can reduce the numbers of people requiring social care support or residential care, or reduce the level of that support needed. It can also delay the need for such support, which comes at considerable cost to local authorities and to the individuals (who may not want to go into care), their families and carers.

1.9. There is strong evidence that positive and fair employment conditions, practices and relationships make a major contribution to enhancing the performance of employers and companies in all sectors. In the health and social care sector this has been shown to lead to improved quality of patient care.CSP is concerned by the increasing use of zero hours contracts across the public sector including in health and social care, and the insecurity, uncertain pay and fear that they result in. Their use results in employees being denied rights associated with employee status such as paid holidays, maternity pay and sick pay. They can also lead to staff being denied training and career development opportunities; problems with financial planning and access to loans and mortgages due to variable wages and short notice changes to hours; difficulties planning childcare and family life including holidays; and staff working while unwell in order not to lose pay.

How far do you think the need for fundamental change is recognised by professions and organisations within the NHS and care system?

1.10 The CSP believes that many health professionals already work well in multidisciplinary teams and would embrace opportunities to work in a more integrated way with social care colleagues. However, until there is joint commissioning and funding of entire care pathways, the ability to deliver truly integrated care for patients will be limited.

1.11 The expansion of competition and the increased number of providers in the NHS has been shown to build barriers between services which lead to a postcode lottery and a decline in patient outcomes rather than delivering increased co-operation and integration.

1.12 The CSP believes that there is very little appetite among health professionals or patients for any further radical top-down restructure of health services. There is emerging evidence that the recent restructure has increased costs and reduced the quality of patient care in many areas.

1.13 Physiotherapists and other allied health professionals are often well placed to act as 'integrators of care'. Physiotherapy-led, multi-disciplinary teams can act as a bridge between hospital and community, including, for example, early discharge models,

and post operative rehabilitation, which have the potential to reduce costs in social care.

1.14 Some patients can be ‘written off’ as unlikely to benefit from further health service care (such as ongoing rehabilitation), and become dependent on social care services when in fact they could remain independent for longer with the appropriate care and support in place.

1.15 Allied health professionals, including physiotherapists, should be involved in decisions about the planning or commissioning of integrated health and social care pathways in order to improve patient outcomes. We believe that without the involvement of allied health professionals in strategic level commissioning, acute services will not be joined up with community care and social care, and new innovations and models of care will not be adopted, leading to more expensive fragmented services and poorer health outcomes for patients.

1.16 Recent innovations in physiotherapy, such as self-referral or direct access models, which are proven to improve outcomes and be cost effective; and the extension of independent prescribing rights to physiotherapists; are able to support the delivery of patient centred integrated care. These services should be fully adopted and available to patients in all areas of the country.

How far do you think the need for fundamental change is recognised by people who use health and care services, including carers?

1.17 The CSP is aware that some patients report that access to health and social care services and the quality of services can vary in different areas, leading to a postcode lottery for patients. Provision of physiotherapy-led rehabilitation services in the community for stroke survivors for example, is patchy, and in some cases completely inadequate.

1.18 The CSP believes that many patients would prefer a single assessment of their health and social care needs, and a single point of contact to help mange and plan their care as their needs change over time.

1.19 The provision of, and investment in, community physiotherapy services for people with long term conditions, such as stroke, MS, Parkinson's disease, or chronic obstructive pulmonary disease (COPD), remains poor or patchy. So there may be costs to social care that could be avoided. The CSP believes that this needs to be addressed. For example, research conducted by the CSP and the Stroke Association in 2010 found that more than a third of stroke survivors felt there had been a delay in receiving community based physiotherapy after discharge from hospital. Better integration between the community and acute setting is needed to put an end to fragmented transitions which could potentially slow, limit or reverse an individual’s recovery.

1.20 The CSP is aware that many patients with serious or long term conditions are currently waiting for unacceptable lengths of time before being referred to a physiotherapist. The National Rheumatoid Arthritis Society (NRAS) and the CSP published a UK-wide report in 2011 highlighting the medical evidence around the benefits of physiotherapy in the treatment of Rheumatoid Arthritis (RA). The report found that 32 per cent of people with RA waited more than a year for referral to

physiotherapy, with a similar number having never been referred. 65 per cent of people with RA felt physiotherapy helped to improve their function; and 58 per cent thought physiotherapy had improved their mobility.

2. The boundary between health and social care

Does the boundary between health and social care need to be redrawn to ensure that people can receive good-quality well-co-ordinated treatment, care and support that meets their needs in a timely, safe and dignified way?

2.1 The CSP is supportive of moves to integrate health and care services more closely but it believes firmly that the NHS does not need any more structural reorganisation – which carries significant associated costs and disruption. The NHS is facing huge pressures from the implementation of the Health and Social Care Act 2012, from increasing patient demand and from financial restraints leading to reduced budgets. The CSP maintains that closer working/integration between health and social care can be achieved without structural reorganisation. Physiotherapists, and other allied health professionals, are ideally placed to deliver integrated care based on individual need.

2.2 Health and Wellbeing Boards will have a crucial role to play in ensuring that there is a collective understanding of the health and social care needs of local communities, and a truly integrated plan for service delivery which meets people's needs along their whole journey or pathway of health and care. The CSP believes that ensuring these Boards have access to information and advice from allied health professionals will be important in enabling them to ensure effective, integrated and person centred services are delivered in their area.

2.3 Decisions about an individual's capacity to manage independently are too often based on assessment of them in inappropriate settings and too early in their recovery. Assessments are often conducted separately for health needs and social care needs. This may lead to commitment of unnecessary health and social care resources, or conversely, may trigger the withdrawal of rehabilitation or other services too soon, when the patient might actually have the potential to still continue to improve.

2.4 Working as part of a multi-disciplinary team, with a strong focus on rehabilitation as well as reablement, physiotherapists can prevent many people from needing high levels of long term care and support.

2.5 Physiotherapists and social care professionals share commitments to building personal and social capital, rehabilitation, promoting, maintaining and improving independence and social function, improving the outcomes for people with long term conditions, and supporting self-care, choice and control.

2.6 The CSP believes strongly that there is a need for better prevention and early intervention services to improve health, independence and wellbeing. These are core areas of work for physiotherapy and we believe that physiotherapists and their teams should play a key role in the delivery of this very important agenda.

2.7 Significant and sustained resource reallocation is needed to ensure the necessary prevention and early intervention services are in place to stop people reaching a

crisis point and requiring a hospital admission. It will take several years for the balance to shift but without additional investment in appropriate community based rehabilitation/reablement programmes, the number of hospital admissions and readmissions will continue to increase, in-patient stays are likely to be longer and then longer term social care costs will be incurred.

2.8 Investment in community physiotherapy services for older people is very poor in many parts of England. The result is that older people discharged from hospital and needing continued rehabilitation, or those who have had a fall or a musculoskeletal injury at home, face long waiting times for access to physiotherapy or no access to a service at all. This has significant cost implications of increased dependency for both social services and for the NHS faced with increased hospital admissions.

2.9 The Westminster Falls Prevention Service is provided by a multidisciplinary team of physiotherapists and other allied health professionals. Older people at risk of falling are most commonly referred to the service after a hospital admission, by their GP or the local fracture clinic. Following an assessment, individuals begin a 12-week rehabilitation, exercise and advice programme appropriate to the level of intervention they need. Upon completion of the programme, clients are given individually tailored exercises to continue at home, and they are followed up by telephone at three, six and 12 months. The service has linked up with a local charity, Open Age, to run 'steady and stable classes' for those at lower risk and also worked with Transport for London and Metroline to look at ways of improving safety on buses and reducing the number of falls. The service has proved that it stops older people from falling, reduces GP visits and keeps people out of hospital. Its 2012 review, of clients that completed the programme during 2011, found that the number of falls reported had dropped by 47 per cent; A&E admissions had fallen by 25 per cent and GP visits reduced by 28 per cent. This approach to prevention of health problems could result in savings in social care costs.

What are the barriers to achieving better co-ordinated and integrated care? Why have they not been overcome in the past? What would be needed to surmount them?

2.10 The introduction of increased competition has been shown to build barriers between services which lead to a postcode lottery and a decline in patient outcomes rather than delivering increased co-operation and integration. Currently many services are delivered with no joint commissioning, separate budgets and sometimes 'silo working'. A better solution could be 'outcomes based commissioning' focussed on all the needs and desired outcomes of the patient (for example to get back to work, to do their own shopping/gardening etc).

Should the entitlements and criteria used to decide who can access health and care be aligned? If so, who should be entitled to what and on what grounds? Is it possible to balance national consistency with different local needs?

2.11 The CSP believes that healthcare should remain universally free at the point of need.

2.12 The criteria for who can access what health services are in the main determined by nationally recognised clinical evidence brought together by NICE and similar agencies. However, the implementation of NICE clinical guidelines is still not

mandatory, leading to variation in local availability of services which NICE has deemed effective and efficient.

2.13 The CSP believes that a patient presenting with a health need should have access to the most appropriate service regardless of their postcode, and that these services should be based on the best available evidence.

2.14 Where care packages are required that positively support the maintenance of quality of life and independence in a person's own home, the CSP believes that these too should be free at the point of need.

3. The funding of health and social care

Should the funding of NHS and social care be brought closer together?

3.1 The CSP supports the drive to integrate health and social care so that services can be delivered around the person, and so that health and care provision feels seamless to the patient.

3.2 Integration needs to be properly funded and this is not fully achievable by moving existing resources to social care, or vice versa.

3.3 It is important that funding in the NHS that has been ring-fenced for integration is not allowed to be used to plug the gap in funding for existing social care services.

3.4 In the longer term, the pooling of health and social care budgets could drive better planning to meet the health and social care needs of the local population. It could reduce duplication, and so free up resources for frontline care. However, social care is currently chronically underfunded; and the CSP is concerned that integration of budgets could result in decreased funding to vital healthcare services. Equally, measures must be put in place to ensure that funding is not pulled into the acute sector and investment is increased in community health and social care services.

3.5 Incentives would need to be better aligned across health and social care to enable pooled budgets to deliver effective care.

3.6 The issue of 'pooled budgets' is not new but will need to be properly addressed if health and social care services are to be better integrated.

3.7 The CSP believes it is imperative that community based intermediate care services, which are currently provided by NHS services, must remain free at the point of need. If these services are transferred to be the responsibility of local government they must not become subject to means testing.

If so, how could this be done and should it be at local or national level, or a mixture of both?

3.8 The CSP believes that mechanisms such as the joint strategic needs assessment could be used to demonstrate the approach by local organisations to ensure the provision of services meets the needs of local populations.

3.9 The CSP believes that the existing mechanisms for partnership working should be adequate without further direction regarding funding arrangements but it is imperative that planning mechanisms are collaborative and integrated and that they are monitored through shared governance arrangements.

What is the right balance between the individual and the state in paying for services? Could this be made more consistent between the NHS and social care?

3.10 The CSP supports the principle of integrating health and social care around the needs of the individual. Integration needs to be properly funded and is not fully achievable by moving existing health resources to social care, or vice versa.

3.11 Access to integrated care should be based on the principles of the NHS – funded through general taxation and free at the point of delivery, based on need and not the ability to pay.

3.12 The reality of the funding for health and social care services needs to be addressed. The rapid expansion of demand in the NHS and social care cannot be met with static resource and whilst health and social care services need to be delivered in the most cost effective manner, efficiency savings alone will not solve the financial crisis. Therefore, the link between health and social care funding and taxation needs to be looked at carefully and difficult decisions to increase taxation may have to be taken to ensure the future sustainability of a safe, quality service.

What values and principles do you think should be used to guide our thinking about how health and care should be funded?

3.13 Investment up stream will benefit public health in the long term so funding of Local Authority services needs further consideration (i.e. they are currently subject to radical cuts).

3.14 Quick accessible health interventions based on best available evidence can reduce the costs of long term care, reduce admissions, and reduce the length of stay.

3.15 Integration should underpin all future policy and guidance – the integration of planning, patient pathways etc so that the patient experiences a truly seamless service that easily flows across organisational boundaries, and where IT systems enable all members of the multi-disciplinary team to engage and contribute at the right time.

Phil Gray
Chief Executive
Chartered Society of Physiotherapy
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For further information on anything contained in this response or any aspect of the Chartered Society of Physiotherapy's work, please contact:
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Appendix one

An example of what can be achieved through integrated care working across healthcare settings is the HOPE specialist service in North East Lincolnshire for people with COPD and for older people at risk of falling. The service is provided by a team comprising multidisciplinary specialists and volunteers, including expert patients. The service has demonstrated clinically significant improvements in clinical capabilities and quality of life. It has saved one hospital admission per person attending the pulmonary rehabilitation course, and over four years, the falls and post hip fracture rehabilitation programme has seen an 8% reduction in visits to A&E and a 13% reduction in hospital admissions for people who have fallen over the same period.