

Adult Social Care Inquiry
Community and Local Government Committee
Written evidence from the Chartered Society of Physiotherapy

About the physiotherapy profession

The CSP is the professional, educational and trade union body for the UK's 54,000 registered physiotherapists, physiotherapy students and support workers.

Physiotherapists are autonomous practitioners, able to independently assess, diagnose and prescribe medicines. While the physiotherapy workforce is predominantly employed in health, typically it operates at the interfaces between sectors and is key to supporting the health and wellbeing of disabled people and to reducing levels of disability.

The physiotherapy workforce reduces adult social care needs by reversing the impact of illness and disability for people who have long term conditions – for example elderly people at risk of falling, dementia, stroke, chronic heart disease and obstructive pulmonary disease, neurological conditions and many more. Using therapeutic exercise, education and social integration, physiotherapists and support workers enable individuals to lead active lives.¹

The contribution of physiotherapy can be seen at many points of a care pathway as physiotherapists work as clinical leaders and multi-professional team members, to support patients in hospital, home, community, work and leisure environments.

Summary of CSP evidence

There are unnecessary social care needs created by failures of the health sector to adequately meet population need (particularly out of hospital health care) and unnecessary costs to the NHS caused by inadequacies and delays in social care services.

The CSP's evidence concentrates on areas where rehabilitative and preventative services can reduce adult social care needs, and learning so far from the physiotherapy workforce about how integration can support the delivery of this and lessons from implementation of integration policies. The evidence highlights the important role physiotherapists already play in empowering and enabling patients to manage their own conditions, supporting a move away from the traditional approach to social care of managing the existing mental and physical state of the patient.

We have drawn on intelligence from 440 CSP members across Britain who responded to a survey on integration in March 2016 and a more detailed survey of members in the south west of England with 77 respondent's experience of working in integrated initiatives, in July 2016.

The CSP supports the principle of an integrated approach as a means to improve the quality of services, reduce social care support needs and improve the long-term sustainability of social care. 90 per cent of CSP members agree greater integration could result in improved care for patients.²

¹ The Chartered Society of Physiotherapy. Physiotherapy works for social care. London: The Chartered Society of Physiotherapy; 2014. URL: www.csp.org.uk/node/561528

² Newton R. It's your call: how members help shape CSP policies. Frontline. London: The Chartered Society of Physiotherapy. June 2016; 22(10). URL: <http://www.csp.org.uk/frontline/article/its-your-call-how-members-help-shape-csp-policies>

There are six areas that the CSP proposes action to meet social care needs sustainably:

1. An increase in overall resourcing of the health and care sector is key – reversing the decline in health and care spending
2. Refocus goals of integration policies on improving quality of care and outcomes, rather than on illusory and counter-productive short-term savings
3. Service contracts need to build in time and resources for service and workforce development - integrated approaches, cross-professional learning, cultural change and meaningful engagement with local communities and the paid and unpaid workforce
4. Sustainability and Transformation Plan areas need to support a transition to a social model of patient care, with prioritisation of prevention, rehabilitation and service-user empowerment
5. Workforce planning and investment in the current health and care workforce development needs to support this transition
6. Coordinated effort to ensure access to seamless technology, including booking and record keeping systems to allow access and communication across boundaries, in common language and with shared standards.

1. The impact of the 2015 Spending Review and Local Government Finance Settlement

- 1.1 Addressing these problems is not simply about putting more money into the system. As outlined below, there are significant savings to be made by changing how health and care services are organised, and to support this, changes to how the costs and risks are shared across different budget holders across the system.
- 1.2 However, the question of the overall amount of money going into the health and care system cannot be avoided. It is of serious concern that spending on social care services for the elderly has fallen by 17 per cent since 2009/10³ and that as a proportion of GDP, spending on health in the UK since 2009 has been less than both the European and OECD average and declining average of spending per head of population.⁴⁵ 2014 research by the National Audit Office (NAO) showed that since 2010 three quarters of the reduction in local authority social care spending has resulted in cutting the amount of care provided.⁶
- 1.3 At the same time as this declining funding pattern a strong consensus has been built around policies to support the radical transformation of the overall health and care system to be able to meet the growing needs of a modern population sustainably and efficiently. This includes the strategic goal of integration of the two systems.
- 1.4 These policies are not aligned, and one is threatening to undermine the success of the other. System change can only be achieved through adequate levels of funding. We hope that the new Chancellor will take the initiative to commit to reversing the pattern of decline in funding for health and care to support long-term change.

2. Innovation: Progress made to deliver integrated health and care by 2020

- 2.1 There is undoubted waste and inefficiency caused by duplication of care and delays across health and social care. Local evaluations of integrated approaches show the potential to reduce costs through reducing emergency admissions. For example, the Greenwich Integration Pioneer brings together teams of nurses, social workers, occupational therapists

³ The Kings Fund. Spending on Social Care for Older People. NHS in a Nutshell. London: Kings Fund. 2015. URL: <http://www.kingsfund.org.uk/projects/nhs-in-a-nutshell>

⁴ Nuffield Trust. NHS in Numbers. London: Nuffield Trust. 2016. URL: <http://www.nuffieldtrust.org.uk/nhs-numbers-0>

⁵ Buchan J, Seccombe I, Charlesworth A. Staffing matters; funding counts. London: The Health Foundation, July 2016. URL: <http://www.health.org.uk/publication/staffing-matters-funding-counts>

⁶ National Audit Office. Adult social care in England: overview. London: National Audit Office. March 2014. URL: <https://www.nao.org.uk/wp-content/uploads/2015/03/Adult-social-care-in-England-overview.pdf>

and physiotherapists to provide a multidisciplinary response to emergencies they are alerted to within the community at care homes, A&E and through GP surgeries. They handle those of which could be dealt with through treatment at home or through short-term residential care. In 2 and a half years over 2,000 patient admissions were avoided due to immediate intervention from the Joint Emergency Team. There were no delayed discharges for patients over 65 and over £1m has been saved from the social care budget.⁷

- 2.2 However, evidence from integration initiatives overall suggests that integration may not achieve significant short-term savings, indeed the NAO found evidence that the benefits of integration take time to manifest⁸. The experience of CSP members suggests that the current pressure to achieve efficiencies and squeezing of budgets is undermining the success of integration. The CSP's March 2016 member survey showed that 75 per cent of members agreed that lack of funding was a barrier to successful integration. This is in line with the evaluation of the Better Care Fund by the Public Accounts Committee in 2015 and we wait with interest to see the results of the NAO investigation into this later on this year.⁹
- 2.3 One CSP member in the south-west told the CSP: *"We work closely with the short term enablement team (STEPS), in adult social care. This works really well as we can create plans so that they are able to support the patient daily and promote their independence rather than making them dependent on care. Unfortunately funding has been cut for this excellent team, meaning less staff and shorter hours. Staff are unable to support with as many washing & dressing activities in the morning or getting patients ready for bed."* This is reflective of the wider views of CSP members in the two 2016 surveys.
- 2.4 International studies also suggest costs increase while initial changes are being implemented and bedded in. For example, when Jönköping County Council in Sweden integrated services for frail older people it resulted in improved quality, outcomes and cost effectiveness.¹⁰ But this was achieved over a long period of time, driven by long term population need, during a decade of funding stability and growth, and significant investment in workforce development, learning and innovation.
- 2.5 There is however, clear potential to improve patient's outcomes and patient experiences through greater integration between health and social care.¹¹ People with multiple conditions tend to receive less continuity of care because of a lack of integration.¹² Providing those patients suffering from long term conditions or with complex needs with a coordinated and joined up service can address this through improving poor communication between care providers and easing transition between care settings.
- 2.6 In the long term, care costs may be reduced (or at least the rise in case costs mitigated) if the health and care system was better able to support patients and carers to be more

⁷ Department of Health. Integration pioneers leading the way for health and care reform. London: Department of Health. 2013. URL: <https://www.gov.uk/government/news/integration-pioneers-leading-the-way-for-health-and-care-reform--2>

⁸ National Audit Office. Adult social care in England: overview. London: National Audit Office. March 2014. URL: <https://www.nao.org.uk/wp-content/uploads/2015/03/Adult-social-care-in-England-overview.pdf>

⁹ Public Accounts Committee. Planning for the Better Care Fund report. London: Public Accounts Committee. 2015 URL: <http://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news/report-planning-for-the-better-care-fund>

¹⁰ Alderwick H, Ham C, Buck D. Population health systems. Going beyond integrated care. London: Kings Fund. February 2015. URL: <http://www.kingsfund.org.uk/publications/population-health-systems>

¹¹ Curry N, Ham C. Clinical and service integration: the route to improved outcomes. London: The King's Fund. 2010. URL: <https://www.kingsfund.org.uk/sites/files/kf/Clinical-and-service-integration-Natasha-Curry-Chris-Ham-22-November-2010.pdf>

¹² Mathers N, Patel V, Thomas M. General Practice and the Integration of Care: An RCGP Policy Report. Royal College of General Practitioners. London: RCGP. No date. URL: http://www.rcgp.org.uk/policy/rcgp-policy-areas/~media/Files/Policy/A-Z-policy/General_Practice_and_the_Integration_of_Care%20An_RCGP_Report.ashx

actively involved in their care and reducing levels of need.¹³ This requires an approach to integration that goes beyond integration at the level of organisations and an approach to care that goes beyond the limited medical model that dominates the health system.

- 2.7 The CSP is concerned that there has been narrowing of focus in the implementation of integration policies as a means of achieving short-term savings. As well as doubting this as a means to save money, our concern is that decoupling integration from the longer-term goals on quality and the transformation agenda for long-term sustainability serves to undermine these.
- 2.8 A major barrier to integration at a service level is the lack of investment in technology and systems to provide seamless shared access, communication across boundaries, in a common language with shared standards. This is required for example for booking and record keeping systems. The March 2016 CSP member survey found that 85% per cent of CSP members agreed that different IT systems are a barrier to integration in their experience. One member in the South West summed this up: *“Fundamentally our IT services are all completely different: The acute trust, community trust, social services, mental health trust and GP practices all have systems that don’t talk to each other. This wastes so much time, effort and money!”*
- 2.9 Current payment systems create perverse incentives that can also act as a barrier to a better use of resources across health and care. For example, the activity-based payment in the acute sector discourages a shift of care outside of hospital settings¹⁴, critical to reducing social care needs. The move to capitated budgets being explored by NHS England is a positive development, and needs to be central to integration.

3. Innovation: A social and rehabilitative model of patient care in localities

- 3.1 Reducing unnecessary social care needs in the population requires a new model of care that reduces reliance on medical services, cuts waiting time and enhance wellbeing through empowering patients, carers and local communities. The current medical model in health focuses on individual episodes of care. This is increasingly out of kilter with population need, with growing numbers of people managing multiple long-term conditions. One aspect of this is that once people have left hospital they face long waits for rehabilitation services, if they can access them at all, which drives up long term social care needs.
- 3.2 For example, stroke, is the largest cause of complex disability and more people than ever before are surviving strokes. Yet for too many their rehabilitation needs are not being met. This means that progress in recovery is halted and goes backwards, needlessly causing lasting disability and dependency. In a recent study by the Stroke Association 45 per cent of patients said they felt abandoned when they left hospital and only 30 per cent of eligible stroke survivors receive the vital six month assessment of their care needs.¹⁵
- 3.3 The cost of each hip fracture to health and social care budgets, based on 2009/10 prices, is £16 000. Half of all people who suffer a hip fracture will suffer a permanent disability as a result¹⁶. For many this would be avoided or minimized if they had had better access to rehab in the community after leaving hospital. A national review of adult elective

¹³ Hibbard JH, Peters E, Dixon A, Tusler M. Consumer competencies and the use of comparative quality information: it isn't just about literacy. *Med Care Res Rev.* US: Sage Periodicals Press. Aug 2007; 64(4):379-94.

¹⁴ Marshall L, Charlesworth A, Hurst J. The NHS payment system: evolving policy and emerging evidence. London: The Nuffield Trust. 2014. URL:

http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140220_nhs_payment_research_report.pdf

¹⁵ Stroke Association A New Era for Stroke. London: Stroke Association. May 2016. URL:

<https://www.stroke.org.uk/what-we-do/our-campaigns/new-era-stroke>

¹⁶ Magaziner J, Hawkes W, Hebel JR, et al. Recovery from hip fracture in eight areas of function. *J Gerontol A BiolSci Med Sci.* US: Oxford University Press. Sept 2000;55(9):M498-507

orthopaedic services in England found significant variation in rehabilitation practice, a lack of emphasis on rehabilitation in the immediate post-surgery period for hip fracture patients on acute wards and a lack of integrated commissioning and provision of rehabilitation services and social services.¹⁷

- 3.4 Bradford Enablement Support Team (BEST Plus) is a multidisciplinary service that enables older people to remain living independently in the community. 91-year old Mr A lives alone and is normally independent. While dog-walking, he had a stroke, a fall and a broken hip. He had hip replacement surgery but the stroke left him with slight left-sided weakness and problems with concentration and executing tasks. Mr A was transferred to a community hospital for rehabilitation where the therapy team facilitated recovery of mobility and balance: climbing stairs; independence with personal care and kitchen tasks. He was discharged with four visits daily. Joint physiotherapist and occupational therapist sessions were delivered. Physiotherapists facilitated improvements in hip strength and independent mobility, ensuring safety and independence in his home and community. They set goals in partnership with Mr A. Six weeks later he'd regained such mobility and independence that all support could be withdrawn and he returned to his usual active and social life.¹⁸

4. Innovation: Empowering service users, carers and communities

- 4.1 The way that patients can access the services they need to successfully manage long term conditions also needs to be overhauled. Often people who need support to manage their long-term conditions have difficulties and delays in re-accessing services, and need to go back to the start for a GP referral. This builds in duplication and delays into the system. A modern and more efficient model of care within communities puts more power into the hands of individual service users with long-term conditions to refer themselves to see the right professional at the right time.
- 4.2 Hope Street in Grimsby is an example of how rehabilitation services can reconnect with communities to release additional capacity. Part of the social enterprise, Care Plus, Hope Street provides rehab programmes and support for patients with COPD and older people at risk of falls, set up to improve quality of life, support early discharge, prevent hospital readmission, increase people's capacity to self-manage long term conditions. With no additional resources to staff the service or a place to provide the services from, they have to look creatively at how to use existing resources differently. They identified that bringing the services together made sense in terms of productivity and quality of care for patients. The team is made up of physios, occupational therapists, generic technical instructors, rehab assistants and 80 volunteers. Volunteers have been at the heart of the service from day one. They are former patients and carers, who act as motivators, role models and community health educators. When the service was established it took over Hope Street Medical Centre, a GP surgery. In an area of high deprivation, the centre was run down and used to be a target for vandalism - costing £3500 every month. Using Neighbourhood Renewal Funding, they turned it into a modern rehab centre. Since then they have raised money locally to develop a gym (rehab plus), outdoor exercise facilities, a garden and a café – with gardening forming part of people's rehab and produce from the garden is used in the café. In order to fundraise, they established a charity The Hope Street Trust, with volunteers on the Board. The impact of the service has been considerable: There is one less hospital admission per patient on the 8 week programme – an efficiency saving of £2600 per patient, the volunteer-led quit smoking classes are 60 per cent more successful than national average, hip fractures have been reduced, patients report significantly higher

¹⁷ Briggs T. Executive Summary A national review of adult elective orthopaedic services in England, Getting it Right First Time. London: British Orthopedic Association. March 2015. URL: <https://www.boa.ac.uk/wp-content/uploads/2015/03/GIRFT-Executive-Summary-Mar15.pdf>

¹⁸The Chartered Society of Physiotherapy. Physiotherapy works for social care. London: The Chartered Society of Physiotherapy; 2014. URL: www.csp.org.uk/node/561528

confidence and ability to undertake daily activity and much reduced levels of anxiety and depression, and a valued community asset has been created.¹⁹

5. Innovation: Prevention and public health

- 5.1 People with disabilities face particular barriers to managing their own health through exercise and active lifestyles. A survey commissioned by the charity Leonard Cheshire found that 57 per cent of disabled adults had not completed 30 minutes or more of moderate exercise on any day of the past week, and 21 per cent said fear of injury was their main barrier to exercise. This compared with 28 per cent of non-disabled adults who had not completed this amount of exercise, and only 8 per cent of non-disabled people for whom fear of injury was a barrier to exercise.²⁰
- 5.2 The whole health and care workforce, paid and unpaid, need to support disabled people to have confidence in exercising safely. The physiotherapy workforce have a significant contribution to make in building this capability in the system, as well as directly supporting disabled people to be physically active.
- 5.3 Falls among older people, and the economic burden their management generates, could be significantly reduced through the introduction of community-wide preventative strategies to those population groups who are at risk. One of these strategies will be improving the ability of the health and care workforce to identify those at risk of falling and referring them for appropriate support, including physiotherapy, along with various exercise and physical activity programmes,
- 5.4 Physiotherapists and support workers help reduce falls by supporting patients to strengthen their bones and muscles, increasing their confidence to be mobile and to exercise. Physio-led group exercise programmes have been shown to be effective and to reduce falls by 29 per cent and the risk of falling by 15 per cent – and individual exercise programmes by 32 per cent and 22 per cent respectively.²¹ Every £1 spent on physiotherapy produces a return on investment of over £4.²²
- 5.5 The first point of access for most people with health and care needs is their GP surgery. Many long-term social care and health needs can be prevented by reorganising services so that people have faster access to a wider range of professionals in GP teams (for example, see 6.4 below).

6. Innovation: Development of the health and care workforce

- 6.1 Projections suggest the demand on health and care workforce time will grow more than twice as fast as the rate of the overall population growth to 2035, and that 86 per cent of this is driven by healthcare and support needs associated with long-term conditions.²³ This

¹⁹ Currently unpublished. Can provide further information if requested. URL (service website): <http://www.careplusgroup.org/services/hope-specialist-service>

²⁰ Leonard Cheshire Disability. The Leonard Cheshire Disability/ComRes Disability and Exercise Research. London: Leonard Cheshire Disability. October 2015. URL: <https://www.leonardcheshire.org/what-we-do/latest-news/press-releases/pre-paralympic-games-poll-shows-disabled-people-feel-shut-out>

²¹ The Chartered Society of Physiotherapy. Physiotherapy Works Falls and Frailty. London: The Chartered Society of Physiotherapy; 2014. URL: <http://www.csp.org.uk/professional-union/practice/evidence-base/physiotherapy-works/falls-and-frailty>

²² The Chartered Society of Physiotherapy. Falls economic modelling tool. London: The Chartered Society of Physiotherapy; 2015.

URL: <http://www.csp.org.uk/professional-union/physiotherapy-works-programme/what-you-can-do-show-physiotherapy-works/download-c>

²³ Centre for Workforce Intelligence. Future Demand for Skills – initial results. Horizon 2035. London: Centre for Workforce Intelligence. August 2015 URL: <http://www.cfw.i.org.uk/publications/horizon-2035-future-demand-for-skills-initial-results>

will require a long-term shift in the mix of staff and skills within the health and care workforce needs to shift, with a greater proportion of staff working in integrated multi-disciplinary teams to provide education, support, prevention and rehabilitative services.

- 6.2 Many integration initiatives are being held back by the lack of time and resource put into staff development and cultural change. 72 per cent of CSP members surveyed in March 2016 agreed that they do not have enough paid time to undertake continuous professional development and 64 per cent of the South West CSP members surveyed identified different cultures and ways of working as a barrier to success.
- 6.3 Moving to models of care that reduce social care needs requires full utilisation of the existing workforce, working flexibly and to the height of their capabilities. This means registered physiotherapists and other allied health professionals not doing tasks that can be performed just as adequately by support workers. It also means doctors not doing tasks that can be done just as well – or in some cases better – by an advanced practice physiotherapist or nurse.
- 6.4 For example, in a number of pilot sites, patients are now able to access advanced practice physiotherapists rather than a GP in General Practices, and are assessed, offered diagnosis and tailored management plans. This new service is affordable, because it reduces costs while also improving the quality of care. If MSK services were redesigned so that all GPs could offer this to their patients, the level of disability, worklessness and social care needs caused by MSK conditions would be reduced.
- 6.5 As well as working flexibly, to the height of their own capabilities, the health and care workforce also need to share their expertise across professions to raise standards. In Leeds, for example, a group of physiotherapist volunteers formed a Care Skills Group to develop and deliver training for care staff to better support residents to be mobile and in less pain²⁴. They have made this freely available to other physiotherapists.²⁵ These sorts of initiatives need to be encouraged and built into policies for integration.



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²⁴ Millett R. Are you sitting comfortably? Frontline. London: Chartered Society of Physiotherapy. November 2013. URL: <http://www.csp.org.uk/frontline/article/are-you-sitting-comfortably-1>

²⁵ Millett R. Physiotherapy Care Skills Group launches free online training package. London: Chartered Society of Physiotherapy. June 2014. URL: <http://www.csp.org.uk/news/2014/05/29/physiotherapy-care-skills-group-launches-free-online-training-package>