

The Lord Darzi Review of Health and Care

Evidence from the Chartered Society of Physiotherapy

The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the UK's 57,000 chartered physiotherapists, physiotherapy students and support workers.

Registered physiotherapists are autonomous practitioners, able to independently assess, diagnose and prescribe medicines. 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.

Physiotherapy support workers play a vital role as part of the physiotherapy workforce, supporting people to remobilise after injury or illness, providing hands-on care for people with their individual and group exercise programmes, supporting carers and delivering community education.

Summary of CSP recommendations

- Ongoing commitment to the principles of the NHS, that it is tax-funded and free at the point of use – move the discussion on from options to investing in change
- Develop the health and care system to be more preventative, more rehabilitative, support maximum recovery, reduce health inequalities and empower people
- Continue progress with widening the GP team, including a national roll out of First Contact Physiotherapists linked to General Practice
- Expand multi-disciplinary community teams to support rehabilitation and long-term condition management, integrating health and social care, linked to General Practice.
- Where appropriate, move away from disease-specific rehabilitation programmes to reflect that our ageing population has multi- morbidities
- Provide an immediate increase in funding for the NHS and social care and introduce a formula for Parliament to decide minimum spending levels and annual spending plans
- Target additional funding to rebalance the system by developing primary, community and social care services
- Urgent reform of contracting and payment systems that are acting as a block on improvement and innovation.
- Evaluate the costs of market based commissioning and use this to formulate evidence-based policy on future commissioning
- Remove PFI debts from Trust budgets, and negotiate a payment holiday with companies while debts are reviewed and action decided for how they can be ended.
- Expansion and development of the non-medical registered workforce and the non-registered workforce in health and care.

1. What should our vision for the health and care system be in 2030?

CSP vision for the health and care system in 2030.

- 1.1 One in five people are now living with a disability.⁽¹⁾ The biggest cause of disability in the UK and globally is lower back pain.⁽²⁾
- 1.2 The CSPs vision for the nation's health in 2030 is that we make the same strides in reducing the number of years living with disability as we have in increasing life expectancy, and that we have narrowed inequality in this area.
- 1.3 To achieve this our health and care system will have matured to be more preventative, more rehabilitative, supporting maximum recovery and empowering people to be in charge of their health and wellbeing.
- 1.4 The approach to health and wellbeing among professionals and the public will be a comprehensive one, taking into account the interplay between biological, psychological and social factors.
- 1.5 The NHS will have developed away from a narrow medical model in health that tends to categorise illness as single events in isolation. Social care will have developed away from the traditional approach in social care to manage existing mental and physical conditions. Services will be designed using a social model of care.
- 1.6 By 2030 we hope to see a significant shift away from disease specific rehabilitation programmes to ones that reflect our ageing population has multi- morbidities and are open to all, including people within their own homes and in residential care homes.
- 1.7 Many more common health issues – such as musculoskeletal (MSK) problems, chronic obstructive pulmonary disease (COPD), frailty and falls prevention - that currently result in referrals to secondary care – will be managed more effectively within primary care.
- 1.8 Accompanying this we should expect to see the movement of a sizable part of the workforce out of hospitals out into the community and primary care.
- 1.9 The non-medical workforce within health and care will need to have expanded and developed to work to their potential. This will mean recognition of the value of delegating greater responsibility for unregistered staff (including physiotherapy /allied health profession support workers and health care assistants) and of more registered non-medical staff developing advanced practice skills (including physiotherapists, other allied health professionals, nurses).
- 1.10 Integration between health and social care will have been significantly progressed. The driver for this will be improving patient care, and it will be a major area of investment and development.
- 1.11 The data revolution will mean that people will have more access to their own health care data so will be in a much stronger position to seek more informed, specific and targeted support from the system.
- 1.12 By 2030 the health and care system will need to have become better at educating individuals, their families and carers about health and increasing people's confidence to be in the driving seat of their health and wellbeing.

2. What is the state of quality in the health and care system today?

Progress in primary care

- 2.1 Although driven forward by an immediate crisis of capacity in the face of rising demand, the expansion of the GP team within the GP Forward View has the potential to deliver significant long-term improvements to primary care.
- 2.2 In the last two years, the role of First Contact Physiotherapist has been developed in a growing number of pilots. People coming to their GP surgery with a musculoskeletal issue are offered the option of seeing an advanced practice physiotherapists instead of the GP. Fast access to an MSK expert from the start means patients are receiving a more timely intervention that improves quality and patient outcomes. Patients receive the expert advice they need to manage their issue and if they need further support, are put on the right pathway from the start. This is releasing GP time and reducing unnecessary costs across the system.⁽³⁾
- 2.3 Although focused on MSK health at the moment, First Contact Physiotherapy roles in General Practice have the potential to improve the first line advice and support for other patients – in particular, those with respiratory problems, at risk of falling and frailty.

Advances needed in community rehabilitation

- 2.4 Medical advances have meant significant advances in the treatment of many serious diseases, including several cancers and stroke. This needs to continue so that everyone can benefit from these, and development of specialist centres of excellence has an important role to play in this.⁽⁴⁾
- 2.5 These advances mean that many more people are surviving life-threatening events, and the potential for recovery of health is significantly increased.
- 2.6 However, the quality and availability of services that support people to recover and maintain their health have been declining, just when the need for them is increasing. Many people are left needlessly disabled or in failing health as a result.
- 2.7 Although known to improve outcomes, 50% of people who have had a hip fracture are not offered rehabilitation services when they leave hospital.⁽⁵⁾ Already a vulnerable population, people who have had a hip fracture are at risk from further falls, chest infections, pressure sores and depression. For those who receive rehabilitation, the average wait in England and Wales is 15 days, but some patients have to wait for up to 80 days. The amount of rehabilitation patients receives varies greatly, with some patients getting less than 1 hour per week. 1 in 5 services are able to provide continuity of rehabilitation from hospital to home, enabling individuals to regain mobile and return to independent living.⁽⁶⁾
- 2.8 45% of people who have had a stroke feel abandoned when they leave hospital. Many people have to wait for six weeks for physiotherapy rehabilitation after they've left hospital to start.⁽⁷⁾
- 2.9 For a person with cancer, support to move and exercise is critical to recovery and reduced risk of relapse in just the same way as chemo or radiotherapy. But 1/3 of Macmillan GPs say there is no focus on support after treatment.⁽⁸⁾
- 2.10 People with COPD who attend pulmonary rehab classes spend 50% less time in hospital, are 26% less likely to be readmitted and have lower levels of related anxiety

and depression. Only 34% of people in need of pulmonary rehab are referred, and of those 37% wait longer than three months.⁽⁹⁾⁽¹⁰⁾

- 2.11 If people are immobile at home and not confident to move, they are also at risk of other complications associated with an increased re-admission rate, length of hospital stay, A&E attendance and use of GP time, as well as social isolation and loss of daily living skills.
- 2.12 This picture is in contrast with the aims of Five Year Forward View and STPs.

Widening inequality

- 2.13 There is a direct link between poverty and disability. Half of all people living in poverty are either disabled or living in a household with someone who is disabled.⁽¹¹⁾
- 2.14 In the UK people in wealthier areas are enjoying some of the best health in the world, but in deprived areas in the UK, people are dying before their time and spending more years in poor health.⁽²⁾
- 2.14 Key to tackling this are radically improving access to a range of expertise within primary care and expanding services that support people with rehabilitation. Preventing treatable problems from becoming chronic and supporting people to reverse damage and regain function and mobility will reduce levels of disability.

3. What can we do to drive innovation in the health and care system?

More tailored health care

- 3.1 Service planning and decisions about medicines and health interventions provided to individuals by the health and care system are rightly based on broad population data. Far greater use also needs to be made of the level of detail now available through testing about individuals' health and wellbeing, that allow for more sophisticated treatment options, tailored for individuals.

Learning across disciplines and professions

- 3.2 Innovation can be driven by greater cross-fertilisation of expertise between disciplines and specialties. This requires cultural change (greater levels of trust and communication), service delivery changes (multi-disciplinary team working in all parts of health and care services), and changes in education (multi-professional programmes for workforce development and clinical pre and post registration training).

Working in partnership with the public

- 3.3 The public need to be empowered to be actively involved as experts in their own health and make informed choices about their care. The UK's overly medicalised model of health has encouraged a passive view of our own individual health as isolated issues that need to be 'fixed' by the professionals, and often discouraged people from taking ownership of their health. Changing this mindset will allow us to harness the potential created by the increase in person health data that can be available to individuals.

Digital technology

- 3.4 Digital technology has an important role to play in addressing this. AHP Suffolk, has run a successful self-referral service in primary care for the past eight years. Central to its success is an online portal, which 85% of patients use to self-refer and provide information for the physiotherapists ahead of consultation. After feedback from

patients, the service has gone further in using digital technology to support self-management by developing an exercise app. After their appointment, patients can receive a video on their handheld device showing how to do their exercises, sends reminders and invites them to record what they have done. The results are automatically put on their records. The purpose of the app is to reduce the number of appointments patients need and help people to get better quicker. ⁽³⁾

Shared IT systems

- 3.5 Innovation in pathway redesign is still hampered by a lack of investment in the technology and systems to provide seamless shared access, communication across boundaries, in a common language with shared standards. This is a priority for action.

4. What are the current and future funding requirements of the health and care system?

New funding settlement

- 4.1 There is not sufficient money within the NHS or social care system. Overall spending on health has been declining since 2009 as a proportion of gross domestic product, falling to less than both the European and OECD average and as average spending per head of population. Spending on social care services has reduced overall, and for the elderly has fallen by 17% since 2009/10. ⁽¹²⁾ The recent National Audit Office review of local government spending has found that despite growing demand, spending on social care still fell by 3% from 2010/11 to 2016/17. It also found that most local authorities with social care responsibilities relied on their reserves in 2016/17 and that for 10% of these if this continues they will have less than three years of reserves left. ⁽¹³⁾
- 4.2 An increase in funding for the NHS and social care is urgently required, to bring the UK in line with European and OECD counterparts and bringing average spending per head back up to levels in 2007/8.
- 4.3 To achieve the transformative changes required to the health and care system, there needs to be a public consensus around what a modern, sustainable health and care system looks like. Concerns about funding gets in the way of this new consensus being built. An agreed formula to decide minimum spending levels and annual health and care spending plans agreed by Parliament could rebuild public confidence and provide stability to NHS and social care finances.

Funding to rebalance the system

- 4.4 Underfunding is particularly evident in the community sector of the NHS, resulting from a concentration of efforts and resources on care that takes place within hospitals. 57% of delayed transfers from hospital are due to a lack of community NHS services. ⁽¹⁴⁾ While there is a desire from system leaders to improve the care outside of hospitals to reduce admissions/support earlier discharge, but isn't reflected in redistribution of resources
- 4.5 Additional funding needs to be used to rebalance the system, and achieve the development of primary, community and social care services required to stem the growing demand on secondary and emergency care services. This will require reforms to the current system of payment.

5. What are the future funding options for the health and care system?

Tax funded, free at the point of use, inclusive access

- 5.1 The CSP supports the principles of the NHS, that it is tax funded and free at the point of use, and that individual wealth should not be a barrier to accessing necessary health care services.
- 5.2 This is a principle strongly backed by public opinion, with 89% saying that this is what they want their government to support.⁽¹⁵⁾ Two thirds of people are believed to support paying more tax if it means that the quality of the NHS improves (polls by Britain Thinks⁽¹⁶⁾ and Ipsos Mori⁽¹⁷⁾ in 2017 both showing 66%). Given that for many people, paying higher taxes does appear to be conditional on what it is spent on, increasing National Insurance contributions and ring fencing this to the NHS, social care and public health could be one option.
- 5.3 The CSP believes that the UK's universal health system is the most realistic system to deliver the changes required to be sustainable in the long-term. The comprehensive review of different funding models by Lord Wanless in 2002⁽¹⁸⁾ and the House of Lords Inquiry in the Future Sustainability of the NHS in 2016⁽¹⁹⁾, both supports this view.

New charges or insurance-based schemes are not the answer

- 5.4 International evidence suggests where charges have been introduced there is little impact on overall health expenditure, but there is a decline in access to services, specifically people's use of preventative services.⁽²⁰⁾
- 5.5 US health care is insurance based. A third of the US population are covered by publically funded schemes (Medicare and Medicaid). The burden of this on US taxation is twice that of the universal system in the UK – in 2013 it stood at 17.1 % of GDP in the US, while it was 8.8 % in the UK. The public cost is higher again when one takes into account the tax exclusion for employer-sponsored health insurance.⁽²¹⁾ The private cost of health care to individuals in the US far exceeds that of taxpayers in the UK (and other OECD countries)⁽²¹⁾ and this cost is the primary reason for personal bankruptcy and mortgage repossession⁽²²⁾. It leaves public health vulnerable to changes in the economy (e.g. unemployment, wages). This has clear detrimental consequences not just for individuals, but the economy. In spite of high levels of both public and private expenditure, health outcomes in the US do not compare favourably to the UK.⁽²³⁾
- 5.6 Discussion among policy makers needs to move on from worn-out debates about different ways to fund health. This would allow a focus on the changes needed to transform care to properly meet modern population needs, and do so sustainably.

6. What changes to care models should be undertaken post Five Year Forward View?

Prioritising integrated care models in the community

- 6.1 To achieve the goals of the Five Year Forward View and build on these, we need to significantly enhance primary, community and social care services.
- 6.2 Widening the GP team needs to continue, supporting a national roll out of First Contact Physiotherapists linked to General Practice.
- 6.3 There needs to be expansion of multi-disciplinary community teams to support rehabilitation and long-term condition management within communities. These need to integrate health and social care, and community teams with General Practice.

- 6.4 There are some excellent examples of community rehabilitation services to learn from. The Hope Specialist Service in Grimsby provide rehabilitation and support for people with COPD and older people at risk of falling. The multi-disciplinary team includes former patients and carers who volunteer as motivators, role models and community educators. The ethos of the service is of empowering service-users and building social capital within the local community. With the help of some Neighbourhood Renewal funding they turned a run-down former medical centre that was a target for vandalism into a modern rehabilitation centre, with a gym, a garden and a café run by volunteers. Their impact includes reduction in COPD hospitalisations, reductions in hip fractures in the local population, high success rates in volunteer led smoking cessation courses, and reduced levels of anxiety and depression among service users alongside an increase in confidence and ability to undertake daily activity. ⁽³⁾
- 6.5 Excellent services are often part of local initiatives introduced to cope with secondary and acute sector pressures. These tend to be partial, small scale, not looking at the whole health system. This is a priority for the post Five Year Forward View period.

7. What reform to the system is needed to enable these changes to take place?

Reforms to payments and commissioning

- 7.1 Funding should be reformed. Tariffs, levels, and flow of funding are all in need of changes. The CSP believes we need to move to having much more flexible pathway funding, that follows the patients. Currently, commissioning practices do not allow the flexibility required in the system to develop new ways of working. There are a lack of incentives for services to move out of hospitals and into the community.
- 7.2 For example, First Contact Physiotherapists in General Practice deliver savings and improvements to services across the system – for example reducing need for GP locum time, reducing unnecessary orthopaedic referrals, reducing imaging costs. In spite of the success of pilots, these new roles will not be sustainable if they are not able to draw down these savings from multiple budgets. This is a major barrier to change that needs to be resolved.
- 7.3 The hip fracture tariff is another illustration of why reform is necessary. Currently this tariff only includes care provided in hospitals, and does not include the vital services involved in supporting an individual to recover following a hip fracture.
- 7.4 Reforms must support integration between health and social care. The CSP is aware the NHS physiotherapy services do not routinely provide rehabilitation services for people in care homes. CSP members report that though some care homes commission rehab services independent physiotherapy sector, this is only for people funded through Continuing Healthcare. This is inequitable and unfair on individuals whose health and wellbeing suffers as a result. It is also costly, increasing social care needs.
- 7.5 Care outside of hospitals has suffered from a lack of visibility for decades in the data collected about health care. Health services continue to focus on waiting times for secondary care rather than measuring impact. The CSP is actively supporting the introduction of the new Community Data Set by NHS Digital, which will start to make activity outside of hospitals more visible and quantifiable. This needs to be reflected in tariff payments. The CSP welcomes the development of Community Currencies to enhance resource allocation in response to patient need.

- 7.6 Five years on from the Health and Care Act 2012, the CSP recommends that the costs of market-based commissioning in the NHS be reviewed. Direct spending on commissioning and maintaining the infrastructure around this, is a major proportion of the NHS budget that is not spent on providing health care services. We all need to be confident that this is public money well spent. If it is of poor value, then we need to make comprehensive changes to how services are commissioned and paid for.

Managing PFI debts

- 7.7 Considerable debt has been allowed to build up in the NHS because of the Private Finance Initiatives (PFIs) brought in by successive governments.⁽²⁴⁾ The recent National Audit Office report on PFI and PFI2 in the NHS have been at a high cost and low benefit to tax payers.⁽²⁵⁾
- 7.8 Effort to transform health and care services is being undermined by insufficient funding and the drive to make short-term savings to deal with debts. Given the recent issues with Carillion and other companies involved in PFI, the Government needs to take national action on this. This needs to provide a long term plan to get rid of the debt and short term action to alleviate the pressures the debt is creating, such as negotiating a payment holiday.

Developing the workforce required to change the system

- 7.9 Expansion is needed across the workforce, including a need for more GPs. But by 2031 to meet population need the greatest growth will need to have taken place among the non-medical registered workforce (physiotherapists and other allied health professionals, nurses), and the non-registered workforce (AHP support workers, health care assistants, health coaches etc).
- 7.10 The CSP believes there should be a particular focus on developing the non-medical workforce within health and care should be developed to work to their potential. Within physiotherapy, and other parts of the non-medical workforce, there is a particular need to develop support workers and physiotherapists in relation to advanced practice skills.
- 7.11 In our existing system, clinical staff become narrower in their fields of expertise as their careers develop. While there continues to be an important role for specialists, there also need to be equal value placed on generalists, with a broader depth of knowledge, to meet the needs of the population that have increasingly complex and multifactorial in cause.
- 7.12 Enabling more of the physiotherapy workforce to move out of hospital settings, increase the value placed in generalist skills, developing support worker and advanced practice roles, require reforms to how staff are trained and how training resources are distributed.



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