Memorandum of evidence submitted by the Chartered Society of Physiotherapy for the House of Commons Committee stage of the Care Bill

To: Public Bill Committee
Email: scrutiny@parliament.uk

Introduction

The Chartered Society of Physiotherapy (CSP) is the professional, education and trade union body for the physiotherapy profession. The CSP has 52, 000 members, representing 95 per cent of qualified physiotherapists, as well as physiotherapy support workers and students.

Physiotherapy enables people to move and function as well as they can, maximising quality of life, physical and mental wellbeing. Physiotherapists work across sectors and care pathways, providing the 'bridge' between hospital, primary and community care, and across health and social care. Alongside other allied health professionals (AHPs), physiotherapists and support staff are central to the delivery of integrated care and keeping people out of hospital.

Physiotherapists and physiotherapy support staff work with a wide range of population groups, facilitating early intervention, supporting self-management of conditions and disabilities, promoting independence and helping prevent episodes of ill health and disability developing into chronic conditions, minimising or delaying substantial health and care needs.

Physiotherapy supports people in range of need areas, including musculoskeletal disorders; many long term conditions, such as stroke, multiple sclerosis and Parkinson's Disease; cardiac and respiratory rehabilitation; children's disabilities; women's health; continence; mental health; and falls prevention among older people.

The CSP would be happy to provide any additional information or clarification on the issues raised in the evidence we present here.

Summary of CSP recommendations

- Support the amendment to Clause 13 from Paul Burstow on eligibility criteria, making it clear that moderate care needs should be met
- Strengthen the Care Bill to support fundamental reform of commissioning practices, to raise standards of care and employment
- Supports the three amendments from Paul Burstow to clauses 88 and 89 that are intended to restore the powers of the Care Quality Commission (CQC) to review or investigate local authority social care provision or commissioning without first securing Ministerial approval.
- Signal a sea change in practice for social care commissioning, making it clear on the face of the Bill that forthcoming statutory guidance on commissioning will

include time allocation to care, rates of pay, conditions and contracts of staff, and staff engagement, including through recognised trade unions

- Clarify Clause 80 to ensure that duties on openness and transparency will apply equally to non NHS providers and to social care providers in the same way
- Oppose the opposition amendment to apply the Duty to Candour to health and care professionals
- Delete the 'Lewisham Clause' (Clause 118) and amend the Bill to ensure that the duties of commissioners to involve and consult patients includes recommendations of Trust Special Administrators
- Amend Clause 99 to require Health Education England (HEE) to have regard for national need for services regardless of the sector they are delivered, meeting the demands of future service redesign and adopting a consistent approach to all groups of health professionals
- Reinstate the clause previously included that allows the HEE to arrange national provision or direct one or more Local Education and Training Boards (LETBs) to do so on its behalf.
- Amend Clause 102 to add a requirement that how individual LETBS are organised and structured is transparent, and that it is clearly communicated publically how stakeholders and patients can engage with them
- Amend Clause 102 and 104 to specify that Local Education and Training Boards (LETBs) must have regard to the need for and contribution of allied health professionals (AHPs) in all their strategic planning activities and that AHPs are involved in LETB decision making structures

PART ONE – CARE AND SUPPORT

1. Setting the threshold for social care to support prevention and independence

1.1 The Care Bill sets out a welcome vision for social care, putting prevention, early intervention and wellbeing centre stage (Clause 2). However the framework for eligibility, coupled with chronic underfunding, seriously undermines the possibility of achieving this.

1.2 Local authorities have been limiting social care to people with substantial care needs only, with only a handful left who provide to people with moderate care needs. As a result the numbers of people receiving social care are falling, with many basic needs not being met. 97,000 fewer disabled people have been in receipt of social care since 2008, and among older people the figure is 250, 000[1] and 4 in 10 of working-age disabled people who receive social care say that it does not meet their basic needs, including eating, washing, dressing and getting out of the house[2]. This should be recognised as a failure of our current system.

1.3 Guidance to the Bill suggests that the current eligibility criteria in the Care Bill assume a threshold of critical or substantial care needs, so effectively putting current practice on a statutory footing. The CSP believes that this is taking us in the wrong direction.

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[1] *Changes in the Patterns of Social Care Provision in England: 2005/6 to 2012/13*, Personal Social Services Research Unit, London School of Economics and University of Kent, December 2013

[2] The Other Care Crisis, Scope, Mencap, National Autistic Society, Sense, Leonard Cheshire Disability, January 2013

1.4 Not providing services for people with moderate needs is short-sighted. New research[3] commissioned by the Care and Support Alliance found that one in three working aged disabled people say cuts in social care have prevented them from working or volunteering. Limiting access to health and care services in the community increases dependency on more intensive and expensive health and social care services further down the line.

1.5 Providing health and care support for people with moderate needs helps people to maintain independence and stay healthy, and saves money. For example, evidence shows that for every £1 invested in care for disabled people with moderate needs generates a saving of £1.30, and supporting people with moderate needs so that they can be independent, and in the case of working age people, work - £700 million saving to central Government through an increase in tax revenue and reduction in welfare spending[4].

1.6 The LSE suggestions an additional £2.8 billion would be required for councils to set eligibility at moderate care needs. This should be set in context of an overall budget spend for health and social care of £120 billion. **The CSP urges Committee to accept the amendment from Paul Burstow to Clause 13 to define eligibility criteria.**

PART TWO – CARE STANDARDS

2. Improving standards through better commissioning

2.2 The social care sector is too often characterised by poor standards, exemplified by 15 minute visits, with poor pay and conditions for those working in social care – with more than 307 000 people (20 per cent of the social care workforce) employed on zero hours contracts[5], typically for the minimum wage, and (as pointed out in the Cavendish Review) frequently less than the minimum wage when travel time in between visits is factored in.

2.3 While the Government has given public assurance that the Care Bill will eliminate 15 minute visits, where these are inappropriate, through the requirement for council's to focus on an individual's wellbeing, the CSP is not assured that this will be the case in reality unless it is built into the regulatory framework.

2.4 Evidence from Francis and related reviews demonstrated two points that need to be better reflected in the Care Bill. First is the role played by the focus on financially driven targets in undermining the quality of patient care. Second is the link between conditions of employment and care, with quality employment as a key underpinning for delivering high quality care, including good staff engagement, the health and wellbeing of staff, trade union representation, and safe staffing levels. Notably, the Keogh review discovered a relationship between mortality rates and levels of trade union organisation among staff.

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[3] *Changes in the Patterns of Social Care Provision in England: 2005/6 to 2012/13*, Personal Social Services Research Unit, London School of Economics and University of Kent, December 2013

[4] *Economic Impact of Social Care Services. Assessment of the Outcomes for Disabled Adults with Moderate Care Needs. Final Report.* Deloitte, May 2013

[5] Written reply to the House of Commons by Care Minister Norman Lamb 20 June 2013

2.5 **The CSP asks the Committee supports the three amendments from Paul Burstow to clauses 88 and 89 that are intended to restore the powers of the Care Quality Commission (CQC) to review or investigate local authority social care provision or commissioning without first securing Ministerial approval.**

2.6 However we believe that MPs need to go further than to instigate the sea change in commissioning that is required. As it stands it is largely reactive. The Government has agreed to statutory guidance on commissioning practices in relation to care. **The CSP welcomes this commitment and asks Committee to make it clear on the face of the Bill that the guidance will include time allocation to care, rates of pay, conditions and contracts of staff, and staff engagement, including through recognised trade unions.**

3. The Duty of Candour

3.1 The CSP welcomes the duty of Candour (clause 80) on provider organisations, and making it a criminal offence to give false or misleading information (clauses 90-92), and the overall approach to the Duty of Candour taken by the government.

3.2 To be effective this clause must apply to all providers. **The CSP asks Committee to clarify Clause 80 to ensure that duties on openness and transparency will apply equally to non NHS providers and to social care providers in the same way**.

3.3 We ask that Committee opposes the opposition amendment to apply the Duty to Candour to health and care professionals, rather than working with professional bodies to incorporate into professional standards. In our view this amendment works against the goal of making health and care organisations places where staff can be encouraged to learn and raise issues of concern.

4. New powers for the Trust Administator – the Lewisham Clause (Clause 118)

4.1 **Clause 118 allows that the Trust Special Administrator can decide to close a hospital that is financially viable in the interests of the 'wider health economy.' The CSP would urge the committee to delete this.**

4.2 The Care Bill also says that duties of commissioners to involve and consult patients doesn't include a duty to consult on recommendations of Trust Special Administrators. **The CSP asks that the committee amend this to say that they must consult.**

4.3 The background to both these elements in the Bill is the case of Lewisham hospital, which the Trust Special Administrator sought to close because of the financial difficulty in a neighbouring trust, and was overwhelmingly opposed by the local community, health commissioners and political leaders across the political spectrum in Lewisham. If the 'Lewisham Clause' had been in place then, Lewisham hospital would have closed in spite of this. In the CSP's view this is undemocratic and runs contrary to the Government's commitment to localism and participation in health and care, including in the new NHS five year strategy[6].

[6] *Everyone Counts: Planning for Patient's 2014/15 to 2018-19*, NHS England, December 2013

SCHEDULE 5 – HEALTH EDUCATION ENGLAND AND SCHEDULE 6 LOCAL EDUCATION AND TRAINING BOARDS

5. Health Education England and Local Education and Training Boards

5.1 The CSP welcomes the clauses in the Bill placing Health Education England (HEE) and Local Education and Training Boards (LETBs) on a statutory footing, and the role to provide sector-wide leadership and oversight of workforce planning, education and training.

5.2 We have some concern that there are different approaches to workforce planning being taken by HEE in relation to different groups of health workers, with some considered nationally and others on an area by area basis. This lack of consistency poses a particular risk to smaller health professions (including physiotherapy), where a series of local decisions taken without regard to the national picture can have significant unintended consequences for professions.

5.4 Furthermore, current workforce planning looks only at NHS services, and does not look at future needs across all sectors. Given the move to a more mixed health economy this approach urgently needs to be revised.

5.5 The other aspect of Workforce Planning that is critical is to move to planning based on how we want service to look in the future, considering the skill mix and approach necessary to deliver innovative and integrated services.

5.6 The CSP and others have raised these concerns with HEE. We welcome HEE's recognition in its national workforce plan (December 2013) of the importance of adopting a consistent and strategic approach to workforce planning for all professional health groups, rather than perpetuating the current situation where national decision making predominates for some and local arrangements for others, including taking account of professions forming national mobile workforces and the impact of mobility throughout the UK and across national boundaries. It also recognises that forecasts of need must look at need for staff across all sectors, and that there is a gap in the evidence to do this which must be rectified.

5.7 **The CSP asks Committee to amend Clause 99 to require HEE to take account of all these factors; the national need for all types of health service; needs across all sectors delivering services; meeting the demands of future service redesign**

5.8 **Previously the Bill included a Clause *'where HEE considers that it would be better for the provision of certain education and training to be made on a national basis, it may arrange for that provision accordingly or direct one or more LETBs to do so on it's behalf'.* This clause no longer appears to be in the Bill. The CSP asks Committee to reinstate this clause.**

5.9 Because of the large degree of autonomy in how they are organised and structured, it is our understanding that the structure and make-up of LETBs varies considerably. Our sense is that this is having the unintentional consequence of creating a lack of clarity and transparency about how LETBs are operating, gaining local information and representation and making decisions. **The CSP asks Committee to amend Clause 102 by adding a requirement that how individual**

LETBS are organised and structured is transparent, and that it is clearly communicated publically how stakeholders and patients can engage with them.

5.10 Allied health professions are a cornerstone of effective reablement, rehabilitation and health prevention – for example the role played by physiotherapists, occupational health therapists and speech and language therapists in supporting people to be discharged as early as possible from hospital, prevent further health conditions, and regain independence. AHPs are also leaders in innovation, integration and service redesign, commonly working in multi-disciplinary teams and across sectors. It is essential that allied health professions have a voice in the new structures for workforce planning, education and research so that they can be informed by this experience. Some LETBs recognise this, and have elected to have an AHP representative on the core group and/or have established an AHP sub group to feed in. However other LETBs have not done so and physiotherapists and other allied health professions have little or no involvement in them to date. **The CSP asks Committee to amend Clause 101 and 102 to require LETBs to consider the need for allied health professionals' involvement in their strategic planning and decision making.**

6. The future of social care

6.1 The Care Bill has not taken the opportunity to address the current crisis in care.

6.2 The social care system has been chronically underfunded for decades. This now compounded by 33 per cent cuts in local authority budgets by 2014. Over the past three years, £2.68 billion has been cut from adult social care budgets, 20 per cent of net spending. At the same time the number of working-age disabled people needing care is projected to rise by 9.2 per cent and the number of older people needing care will rise by 21 per cent between 2010 and 2020.

6.3 To prevent people from needlessly requiring hospital or residential care, helping people to get out of hospital sooner, and preventing readmission people need access to integrated health and care services in the community. This includes services that support rehabilitation, reablement and prevention, help people stay out of hospital and get people home from hospital without needless and costly delays.

6.4 While the requirement to carry out social care assessments of care needs is positive, without established services in communities to refer to they are not meaningful and there is a risk that they are just another administrative burden on local authorities.

6.5 Integration needs to be properly funded and is not fully achievable by moving existing NHS financial resources to social care, or visa versa. Access to integrated care services needs to be based on NHS principals – funded through taxation and free at the point of delivery, based on need and not the ability to pay.

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