19 January 2018

Health Select Committee
Sustainability and Transformation Plans Inquiry

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.

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.

Summary of CSP evidence

- STPs have the potential to deliver game changing improvements through expansion of the General Practice team to include physiotherapy and investment in community based rehabilitation services. This needs to be reflected in delivery plans.
- To engage the public there needs to be a change in the terms of the discussion about transformation as this is currently dominated by fears of services being cut.
- STPs are hamstrung by the continued underfunding of the NHS and social care. The Government needs to commit to a new funding settlement and take responsibility for resolving the debt crisis created by PFI.
- The NHS England Mandate needs to be revised to remove the requirement for Trusts to eliminate their deficits in a short time period. This requirement is risky and unrealistic, and ultimately undermines the potential for STPs to deliver real change.
- All healthcare professions need to be involved in the leadership of STPs – currently this is patchy for physiotherapy and other allied health professions. This needs to be corrected.
- NHS England and the Social Partnership Forum should agree principles as guidance for STPs in strengthening the workforce voice and good employment practice.
- STPs are an opportunity to reform workforce planning that is mapped against future population and service needs across whole health and care economies.
- To deliver plans, STPs need to help address the shortfall in supply of physiotherapy graduates and develop the existing workforce.
- The CSP welcomes the policy intention from NHS England for STPs to move towards effectively removing the provider – purchaser split. The Government needs to support this with necessary legislative changes.

1. What public engagement will be necessary to enable STPs/ACSs to succeed, and how should that engagement be undertaken?

1.1 For the ambitious aims of the STPs and Five Year Forward View to be achieved, a new public consensus needs to be built around what a modern, sustainable health service looks like, the role of the public and the unpaid workforce in this and the relationship between service users, communities and service providers. This includes patient responsibilities as well as right, as highlighted in the House of Lords Long-term Sustainability of the NHS report.[(1)]

1.2 The NHS is still dominated by a narrow medical view that looks at illness as single events, often in isolation from the context of an individual's life. Given this, it is not surprising that the public too view their health as isolated issues that need to be 'fixed' by the professionals.

1.3 Medical intervention and advances are of course vital, but they dominate our current system of care to our detriment. Furthermore, the traditional approach in social care has been to manage and support the existing mental and physical condition of service users. Across health and social care far more priority needs to be given to those services that support, rehabilitate, prevent and maximise people's ability to take responsibility for their health and self-manage ongoing conditions.

1.4 There are many excellent services to learn from, that show how we can work in new ways with communities to improve the quality of care and the health and wellbeing of the population, while being cost effective (see 2).

1.5 Unfortunately, public discussion about change is riven with anxiety about the future of the NHS and fears about withdrawal of services and insufficient funding. At a local level, this is dominated by reduction of acute care provision and closure of hospitals.

1.6 Change needs to focus on, and be clearly presented as, improving local community services. This will reassure the public and build support for transformation. It is not surprising that the public do not see themselves as beneficiaries of transformation given that the priority given to the first STPs has been to cut costs and quickly eliminate deficits built up over years of underfunding. While this remains the dominant focus the public and staff will remain sceptical.

1.7 To engage the public (and staff) positively in STPs requires us to rebuild trust and change the terms of the discussion. At a national level this requires political commitment to ensuring that the NHS will continue to be free at the point of need, paid for out of taxation, as per the House of Lords recommendations on the future of the NHS. There also need to be a commitment to a new funding settlement (see 3). These could potentially be an outcome of a cross party commission on health and social care funding, as proposed by Norman Lamb. [(2)]

2. How will the development of STPs into Accountable Care Systems (ACSs) change the delivery of care in an area?

2.1 The shift in focus from hospitals to the community is an opportunity to improve delivery of care for patients, increase the population's ability to self-manage long-term conditions, and better manage demand on the system.

Building services around GPs

2.2 A major area STPs can bring about improvement is by enabling patients to access expert support and advice from the first point of contact through their GP surgery, by broadening out the GP team to include physiotherapists, pharmacists, mental health workers and others.

2.3 GPs and policy makers are recognising the potential to utilise physiotherapy expertise: the new role of First Contact Physiotherapist in General Practice is being introduced in a number of areas. A recent Freedom of Information (FOI) request by the CSP identified that these roles are now being run in 24 percent of Clinical

Commissioning Groups (CCGs).Over half of these services have already been made permanent.[3]

2.4 First Contact physiotherapists with advanced practice skills provide the same first point of contact service for people with musculoskeletal (MSK) health issues a GP would. They assess, diagnose and, if necessary, refer for investigation (x-rays, scans etc.), or refer to secondary care for ongoing physiotherapy treatment or to see a consultant.

2.5 The evidence from First Contact physiotherapy pilots show that they achieve savings and reduce waste across the system – in particular reducing demand for GP appointments, reducing unnecessary orthopedic, MRI and x-ray referrals and reducing waiting times for MSK patients who do need referrals to secondary care. They are also achieving high levels of patient satisfaction.[4]

2.6 One of these pilots is 'Physiotherapy First', a joint initiative between two NHS providers, Cheshire and Wirral Partnership NHS Foundation Trust and the Countess of Chester Hospital Foundation Trust. 36 GP surgeries in the West Cheshire STP now provide their patients with the choice of seeing a physiotherapist when they first contact the practice with MSK symptoms. They see around 1000 patients per month – roughly a quarter of the GPs MSK caseload. Just under 3 per cent are referred back to the GP for medication review or for non-MSK conditions, while over 60 per cent are discharged after one appointment. This service was set up in addition to an already successful orthopaedic and pain triage/clinical assessment and treatment service (CATS). Areas with no such provision are likely to see more dramatic pathway changes and savings from reducing unnecessary referrals. The service has:

- Saved GP /locum time – 84 per cent of patients seen by the physiotherapist would have been seen by the GP – value £540k / year
- Decreased plain x-ray referrals 5.9 per cent - value £28k / year
- Decreased MRI referrals 4.9 per cent - value £83k / year
- Decreased orthopaedic referrals by 2 per cent - value £70k / year
- Reduced referrals to physiotherapy services by 3 per cent - after a year-on-year increase of 12 per cent over the previous 5 years
- High patient satisfaction – 99 per cent rated the service good or excellent, 97 per cent had their issues addressed.
- High GP satisfaction - 91 per cent rated the service as being 8 or over for how beneficial they felt the service is to their practice, 45 per cent scoring 10 out of 10.[5]

2.7 While the pilots have concentrated on MSK health, physiotherapists in these roles also bring a level of expertise in relation to a range of other conditions that would be of significant value in a GP setting – falls prevention, respiratory and cardiac rehabilitation, exercise advice for people with long-term conditions and disabilities.

2.8 The Director of Primary Care for NHS England, Dr Arvind Madan used his speech at the annual conference of the Royal College of General Practitioners (RCGP) to make a statement about his ambition to roll out First Contact physiotherapy roles in General Practices in 2018.[6] The CSP is now working with NHS England to develop commissioning guidance and to get the system ready for large scale implementation.

2.9 The development of more First Contact physiotherapy services needs to be reflected in STP delivery plans. NHS England should be directing STPs and Accountable Care

Systems to enhance local patient services and improve cost effectiveness through rapid adoption of such initiatives.

Community rehabilitation

2.11 Another area where STPs could drive improvements in patient care is in rehabilitation services outside of hospital. This is both specialist rehabilitation to support early discharge into the community (for example for older people with respiratory diseases, those who've had a stroke or a hip fracture) and the generalist, community rehabilitation that should follow to maximise return to health and minimise disability.

2.12 Given the strategic direction being taken, it is surprising that most STPs are not being appropriately transforming rehabilitation services. This must be rectified and rehabilitation emphasised in transformation plans.[7]

2.13 A good example of how services can be improved is the Hope Specialist Service, a social enterprise in Grimsby, which provides rehabilitation and support for patients with Chronic Obstructive Pulmonary Disease (COPD) and older people at risk of falls. Taking two hospital based rehabilitation services for COPD and falls, a new single service was created, in the heart of the community. The physiotherapy led, multi-disciplinary rehabilitation team includes 80 volunteers. The volunteers are former patients and carers, who act as motivators, role models and community educators – for example, giving talks to local residents groups. When the service was established it took over Hope Street Medical Centre, a run-down GP surgery in an area of high deprivation. The centre was 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, outdoor exercise facilities, a garden and a café – with gardening forming part of people's rehabilitation 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. Together they have: prevented hospital admissions (one per patient on the programme saving £2600 each); reduced numbers of hip fractures, 62% higher quit rate than the national average in their smoking cessation classes; patients report significantly reduced levels of anxiety and depression with higher confidence and ability to undertake daily activity; and created a valued community asset.[4]

Supporting the Implementation of Change

2.14 Bringing together providers and commissioners has the potential to remove the transactional barriers to integration and service redesign. The move towards single commissioning and financial bodies for STP areas and Accountable Care Systems is positive.

2.15 The barriers to implementation of an expanded GP team to date have been transactional in nature, and the result of systems that support silo working, with separate budgets across a patient's pathway and different financial levers and incentives. Under current arrangements, savings from transformation often not realised in the budget of the entity needing to fund change. Commissioners are not incentivised to look at more streamlined, and cost-effective ways of delivering services across a whole pathway. A measure of the success of STPs and Accountable Care Systems will be how successful they are in dismantling these barriers to change.

2.16 The CSP welcomes the policy intention made explicit in the Five Year Forward View Next Steps report for this to signal an effective removal of the provider – purchaser

split. This should not be a political football, but a question of what works and is best value.

2.17 The Department of Health should signal a willingness to propose new legislation if integration without legislation proves challenging.

3. What do the available evidence, and experience so far, tell us about the deliverability of STP plans given the financial and workforce pressures across the NHS and local government? Are the demands being made of STP plans through the NHS Mandate and the NHS Shared Planning Guidance deliverable, and can STPs ensure the fulfilment of the requirements of the NHS Constitution?

3.1 The goals for long term change mean that STPs need to be genuinely transformative, which requires investment, and current Government policies are not aligned to allow this to happen. Fundamentally there isn't enough money in the system. There is growing demand coupled with the decline in real terms in health and care spending (per head of population).[8, 9]

3.3 Under-resourcing is creating inefficiencies – pushing more service users into the most expensive parts of the health system as insufficient spending on health services pushes up social care costs, and insufficient spending on social care support is resulting in higher demands on health. Pump priming of transformation is required to deliver greater medium term cost effectiveness.

3.4 We need to invest in changes to how services are organised, in the workforce to deliver them and in society's future health. A priority for us all needs to be a radical improvement and redesign of health and care services outside hospital – including the expansion of the General Practice team and community rehabilitation, as part of integrated pathways from prevention to recovery. This is essential to meet the test set by NHS England for reducing bed capacity in the acute sector and to build public confidence.

3.6 Inadequate funding is the main driver of Trust deficits.[10] The CSP agrees with the concerns of Jim Mackey, former NHS Improvement Chief Executive that requiring Trusts to eliminate deficits in such a short period of time is extremely risky.[11] We fear that it is undermining STPs. What little transformation funding is available is being directed to pay for this. The Government should remove this from the NHS England mandate.[12]

3.7 For a number of Trusts, the debt created by PFI is a significant factor in the deficit. In 2014 the majority of trusts (67%) with a deficit of more than £25 million had a PFI scheme.[13] More generally PFI debate has helped drive behaviour by Trusts to prioritise tariff revenue above patient outcomes – behaviour that STPs are now seeking to change. The Government should seek to resolve the debt crisis created by PFI and historically low public sector borrowing costs.

4. What governance, management and leadership arrangements need to be created to enable STP planning and implementation to be carried out effectively? Are additional, or different, arrangements required for areas which are developing ACSs?

4.1 Most STPs have not published their structures and governance arrangements on their websites or in their plan. This lack of transparency sends the wrong message

and hinders wider engagement. The requirements in the FYFV Next Steps Paper for some greater consistency is welcome.[14]

4.2 STPs will need to be proactive in utilising the leadership of all parts of the health and care workforce. Currently most STPs lack involvement of physiotherapists and other allied health professionals in their leadership. Given the significance of this part of the workforce to rehabilitation and keeping people out of hospital, this is a significant gap. The CSP would be happy to work with NHS England and the STPs to help address this, as they did with the RCGP in relation to GPs.

4.3 There needs to be a much stronger workforce voice in STPs, through formal involvement within structures of representative bodies and through consistent staff engagement. The Social Partnership Forum (SPF) brings together NHS employers and health unions. The SPF has issued guidance agreed with the NHS Five Year Forward View and New Models Programme Team to promote best practice for partnership working to support system transformation and a positive constructive approach.[15]

4.4 There are some isolated examples of good practice where this is happening, to a certain extent: In the Greater Manchester STP, involvement of the unions and employers happens through a workforce board and wider workforce forum, as well as through the North West regional SPF. This appears to be working effectively, achieving a memoranda agreement about workforce signed up to by all the unions involved and the Greater Manchester Combined Authority, and providing a way of working through employment issues arising from integration.

4.5 The Five Year Forward View Next Steps report usefully highlights the importance of involving unions in STPs and stresses the need to 'de risk' service redesign for staff – such as the concept of NHS staff retaining employment with their existing employer but being 'passported' to work with other employers.[14]

4.6 To take this forward it would be helpful if the National SPF could agree some broad principles that would facilitate change where necessary, whilst recognizing the importance of ensuring that there are no adverse employment implications for staff.

4.7 STPs should have clear patient and community engagement approaches, including formal representation in governance either directly or through locally elected bodies, such as local mayors or councils. Anecdotally the evidence is that community engagement has been stronger where local authorities play a key role in STP partnerships.

5. What legislative, policy and/or other barriers are there to effective STP and ACS governance and implementation, and what needs to be done by national bodies and national leaders in the NHS to support the implementation of STPs and ACSs?

5.1 A significant barrier to implementation is workforce supply and development**.** Nationally workforce planning continues to be carried out based only the status quo and commissioning practices only on the workforce needs of NHS providers. This is out of step with STP goals. The development of STPs is an opportunity to move to an approach that looks across the health and care economy, is based on mapping future population and service needs and aligns with how NHS-funded services are currently contracted and commissioned. STPs must be supported in a coordinated way by NHS England, NHS Improvement and Health Education England. The CSP

welcomed the recent publication of Health Education England's draft NHS Workforce Strategy to 2027[16] and will formally respond to the consultation.

5.3 One of the casualties of poor workforce planning historically has been the failure to provide sufficient numbers of physiotherapy graduates to meet supply, creating problems across all sectors in recruiting to vacant posts. For example, the Milton Keynes, Bedfordshire and Luton STP identifies that they have a 13 per cent vacancy rate in physiotherapy posts.[17] This is a problem more widely across geographical areas and across sectors. There is no shortage of the numbers of people who want to train to become physiotherapists and there has been a 15 percent increase in physiotherapy student places for 2017/18 following the recent funding changes. The dropout rate from physiotherapy programmes (unlike other professions) is negligible,[18] while we know there is a very high translation of new physiotherapy graduates into registration and professional practice. All these factors indicate the problem is one of supply not meeting demand.

5.4 The physiotherapy profession is critical to getting people out of hospital and keeping them out of hospital. Ensuring that we grow the workforce is therefore essential to the implementation of STPs. Following the growth in student places, the CSP is working with employers and education providers to increase practice-based learning capacity to support and sustain further growth in the number of programmes and their cohort size. The CSP is keen to work with STPs and the national arm's length bodies in this, so that the physiotherapy workforce can be grown as a priority.

5.5 Creating more opportunities for inter-professional learning (at pre-registration and to develop the existing workforce) would support implementation. This needs to include investment in workforce development on a multi-disciplinary basis, for all members of the extended GP team, in line with the recommendations of the Roland Commission in 2015.[19] The CSP is currently contributing to activity with Health Education England, and other professional bodies, to support workforce development in ways that ensure responsiveness to changing patient and service delivery needs. This includes the development of multi-professional capability frameworks that can be used for skill mix review and to optimise how all members of the workforce are deployed to deliver safe, effective care in timely, sustainable ways.

5.6 Efforts to increase workforce numbers will take time to deliver. Far more attention needs to be given by STPs to how to make the most out of the existing workforce. The shift into the community requires different skills – for example, upskilling staff to work at the height of their capability (e.g. the development of advanced practice physiotherapy roles), increase in skills as generalists able to support patients with multiple conditions, skills in more multi-disciplinary working and flexibility between professions, coaching and educating patients. It is also essential that practitioners are supported in returning to practice after a career break, and that employers are enabled to facilitate return to practice to meet their workforce needs. We support the AHP return to practice initiative announced in August 2017,[20] with the caveat that it needs to be sustained in ways that parallel initiatives have been progressed for nursing and GPs.

6. How effective have STPs been in joining up health and social care across their footprints, and in engaging parts of the system outside the acute healthcare sector, for example primary care, local authorities, public health, mental health and voluntary sector partners? How effectively are they engaging local communities and their representatives?

6.1 Many of the STPs are new partnerships, which haven't necessarily worked together before – partly because of how the systems work, and partly because of how the boundaries for STPs have been worked out geographically.

6.2 The process of the STPs has worked against involvement of all the necessary partners from the start. The timescales have inhibited involving the necessary stakeholders, let alone the relationship building necessary for these to be lasting partnerships.

6.3 Another consequence of the priority given to clearing Trust deficits is the domination of the acute sector, to the detriment of involvement of other partners.

7. Looking across all STPs, are there any major areas where the content of the plans needs to be tested for credibility and realism? Are there any major gaps? For example, are proposals in some plans to reduce bed capacity credible? Are the NHS efficiency estimates in STPs robust? Is the workforce available to enable the implementation of STPs? Or is the timescale for the changes proposed in STPs realistic?

7.1 The CSP does have concerns about the credibility of the savings / efficiency estimates. In most STPs it is not possible to see how these figures have been arrived at. We also note that most of the plans are dependent on bids for transformation funding, far surpassing the total amount actually available.[21]

7.2 We suggest that delivery plans need to detail how they will be achieved, and revised to be more realistic in many cases.

7.3 This includes the length of time that it will take to expand the workforce where there are shortages (including physiotherapists) as well as the training and development of the existing workforce (see 5).

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