Department of Health and Social Care
Integration White Paper: Joining Up Care for People, Places and Populations

The Chartered Society of Physiotherapy Consultation response

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The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for 63,000 chartered physiotherapists, physiotherapy students and physiotherapy support workers across the UK. More than eight in ten registered physiotherapists are CSP members.

1. General feedback

1.1 The CSP supports the goals and content of the Integration White Paper and believes it is essential to improving performance, prevention and personalisation of services and further implementation of the NHS Long Term Plan.

1.2 The Long Term Plan was a major step forward for NHS modernisation. But by organising programmes by condition and sector it has unintentionally reinforced silos. This is inefficient and detrimental to people who need personalised and holistic care. In our answers below we have suggested ways to address this problem through integrated workforce planning, a new integrated rehabilitation offer in communities and building strategic leadership for rehabilitation across sectors at system and national level.

1.3 Making progress on integration is also critical to manage current demands on the health and care system, but only with the funding to expand the workforce where this is needed and taking up opportunities to do this in a timely way.

1.4 A current focus for the NHS is the hospital discharge process. But discharge is not the end of the patient pathway and without action on the next stages of care, readmission or additional social care demands will occur. The CSP and other partners would like to see an *Integrated Rehabilitation Prescription* provided on discharge for all patients who need rehabilitation to maximise their capability to live independently, return to work and manage long term conditions.

1.5 At a national level different Long Term Plan programmes are looking at how to improve access to quality rehabilitation. This is currently being done in silos and it needs to be joined up to support integrated pathways for people to transition from General Practice and hospital to community health services, including rehabilitation and exercise. These are essential to supporting prevention, secondary prevention and supporting self-management of long term conditions. To address this, rehabilitation needs to be adopted as a cross cutting theme, with strategic leadership from the NHSE National Rehabilitation Director.

2. Accountability

2.1 Because rehabilitation crosses sectors and settings, and needs modernisation (as described above) it is important that Integrated Care Boards have a senior responsible officer responsible for rehabilitation. This is already working well in the South West.

2.2 At Place level it makes sense to use Health and Wellbeing Board (HWBs) footprints and (where working effectively) the HWBs themselves, with Primary Care Networks (PCNs) and Community Providers brought into these where they aren't already.

2.3 The integration white paper recommendations need to nurture new leaders and enable capable clinicians, from every professional background, to reach the most senior levels of leadership.

2.4 For physiotherapy and other allied health professions, (AHPs) this is currently not the case. The current lack of requirement to include AHP directors at board levels within trusts or ICSs limits the input of AHPs, who work on the boundary of health and social care, into local workforce strategy and planning. This needs to be addressed in accountability structures. Furthermore, this needs to ensure people with protected characteristics are proportionately represented in senior roles.

3. Financial incentives

3.1 Guidance on pooled budgets would be welcome. Such guidance needs to cover all local NHS budgets, social care funds and GP contract funding.

3.2 Financial incentives are needed for collaborative financial planning, not only in the context of pooled budgets between health and social care. There are other situations where it would be useful to incentivise sharing of costs of staff, training and supervision and avoiding unnecessary transaction costs – for example between community providers and primary care networks in relation to First Contact Physiotherapists (FCPs) and other 'additional roles' in primary care.

3.2 Another area is in relation to community facilities. For example, rehabilitation gym and hydrotherapy pools (for aquatic physiotherapy) can exist within and outside of hospitals. These are essential for many patients' recovery and management of long term conditions. But too often these valuable assets are underused and many have not reopened since the pandemic. Wherever these are located the providers who own them should be incentivised to treat them as shared assets across Places/systems. Guidance on sharing costs and benefits of assets, and on managing insurance issues, would be helpful.

3.3 The CSP supports the transformation of how many hospital-based outpatient services are delivered and accessed, with greater partnership working between health services and local authorities. This includes greater utilisation of community-based venues including gyms and fitness centres to encourage exercise participation in older adults and support rehabilitation for those living with long-term health conditions. This requires discussions between health and local authorities on sharing costs and benefits and guidance on suitability of community-based venues for co-location of rehabilitation services. We would be happy to help facilitate this through the Community Rehabilitation Alliance (CRA), many of whose members (such as UK

Active and Nuffield Health, Macmillan, British Heart Foundation) are leading innovation in this space.

4. Shared outcomes

4.1 The CSP supports the work to develop a single, shared set of national outcomes.

4.2 We would suggest that national and local outcomes need to include those relating to:

- reducing health inequity and inequity in service provision/access
- diversity of health and care leaders at all levels
- increasing the proportions of patients who leave hospital knowing what happens to them next in terms of their recovery (e.g. rehabilitation prescription, plan for intermediate care)
- reducing unnecessary demands on hospitals, GPs and social care through early access to community services, including rehabilitation
- improving the outcomes for people on waiting lists for elective care and for community services
- personalisation of care
- confidence of patients/service users in managing their health, including long term conditions
- levels of physical activity and mental wellbeing of patients/service users
- ability of patients/service users to stay in or return to work
- degree to which patients/service users feel listened to, respected, involved in decision making, given options
- staff wellbeing and morale
- carers wellbeing and morale

5. Data and digital

5.1 The CSP welcomes the direction on digital and data described in the report. We need easier systems to collect and share data, and better interoperability between systems. National agreements are needed on what data should be collected to allow benchmarking and to identify variation in provision and outcome.

5.2 CRA partners have identified the core data in relation to rehabilitation that needs to be captured and could be, if it was built into the upgrade of the existing community services data set. We provide robust and practical evidence to support a review of the community data set to this end.

5.3 Through analysis of population health data and data collection on provision of services for people with long term conditions, it is possible to target resources to reduce an escalation of needs. This has been shown to be effective in Dorset for example, with work led by the Clinical Commissioning Group there. Front runners like Dorset CCG need to be learnt from and the expertise in this needs to be embedded into ICS structures.

5.4 We have some concerns about how deliverable the targets for roll out of electronic patient records are, based on past experience of the challenges, both contractual and operational terms. For those ICSs without a functioning Electronic Patient Record at this stage, it seems infeasible to go through the procurement, development, implementation and training within the 20 months required to meet the

target 2024. This target is all the more ambitious for the additional target for population health management by 2025.

5.5 While the CSP strongly supports all these ambitions we believe a more realistic timescale. This could be considered based on a digital maturity assessment of systems and by talking to data leaders in those systems furthest along about timescales and critical milestones.

5.6 The data that the CSP has from our members suggests that reliance by systems on paper patient records is between 25-40%[1-3] far greater than the 10 per cent suggested in the white paper. This shows the scale of the challenge.

5.7 The CSP believes that the Digital Technology Assessment Criteria (DTAC) is based on sound principles around patient safety. However we also hear feedback from the innovation and provider community is that it can create barriers to working with the NHS and limit the technology that CSP members can use with their patients. We would like to see the DTAC reviewed so that it can maintain quality and safety, while also speeding up the rate of adoption of new technology.

5.8 The role of digital leadership needs to be addressed in a multi-professional and integrated way. The Chief Nursing Officer, Ruth May, has committed to a Chief Nurse Information Officer in every ICS.[4] We are concerned that AHP digital leadership is not yet recognised in this, and would like to see these roles being open to any health care professional with the skills and knowledge to do their job. In this case leadership and digital skills must trump professional background. Among AHPs there is a pool of talent to draw upon. We are aware that there are growing numbers of physiotherapists ready to take up digital leadership roles, and this should be utilised. The CSP is working to nurture this, as well as promoting physiotherapy services empowered by digital tools and data to demonstrate their impact.

5.9 The CSP supports primary care and community health services to develop hybrid working practices for service delivery that are part of a personalised menu of options that improves access (for example for people in rural areas, people who don't drive or have access to public transport, people who work) and takes into account different communication needs and levels of digital literacy.

5.10 The pandemic has also demonstrated how remote ways of working can be a potential game-changer for integration and team working on service level. For example during the pandemic some primary care and community teams could gain greater access to condition specific experts, such as neuro-specialists, who could attend virtual case conferences without time and travel constraints. In some areas rehabilitation virtual networks of a range of clinicians working in all sectors and settings were established to quickly share learning and develop relationships. These developments need far greater attention in order to fully capitalise on them.

5.11 The CSP recently published guidance gathered over the last 2 years around remote consultations.[5] We are pleased to see the ambition to include digital as part of integration but are still concerned at the challenge of, in places significant, change to current provision given the challenges of demand, workforce and finance affecting large pockets of the profession. Further resources will be published in the coming weeks including guidance to implement these changes for members of the physiotherapy profession and case study examples of those already achieving this.

6. Workforce

6.1 There urgently needs to be a fully funded workforce staffing plan with biennial independent workforce projections. Workforce boards at system level must include representations from Allied Health Professionals and be inclusive of workforce demands for the AHP workforce across sectors and settings.

6.2 The lack of integration in workforce targets, even solely within the NHS, has resulted in unintended consequences which have been detrimental to progressing the reform of services and patient care.

6.3 For example, the NHS and Government committed to 5000 FCPs [6] in order to manage half of all GP appointments for musculoskeletal issues (10 per cent of all GP consultations). From implementation so far (1000 FCPs) it is evident that meeting this target will significantly relieve pressures on GPs as well as benefitting patients and reducing demands on secondary care. However this is being hampered by the lack of workforce targets for community services, because it means insufficient numbers overall, with the knock on effect of having an insufficient pipeline of physiotherapists gaining the experience and develop the advanced practice skills needed to be FCPs of the future.

6.4 Having a more integrated approach to workforce planning would enable the NHS to utilise growth in supply of parts of the workforce needed to deliver better services and reduce demand on the most expensive parts of health and care. This includes physiotherapy, with at least 7% annual growth in physiotherapy graduates until the end of the decade and a strong desire by the profession to expand the roles of unregistered professionals and support staff within rehabilitation services. Although international comparisons of different systems should be treated with caution, it is worrying how close to the bottom the UK is of OECD and European countries in relation to physiotherapy numbers per population.[7, 8] We have an opportunity to bring us more in line with countries with comparable advanced health care systems.

6.5 Service contracts, models of employment and implementation of flexible working policies should enable portfolio careers and sharing of staff (and staff costs) across employers and sectors.

6.6 As the white paper describes, the driver for integration is to meet population needs, and the increasing numbers with multiple long term conditions. For example, people with chronic obstructive pulmonary disease are twice as likely to suffer from depression and over a third have osteoporosis. A third of people with heart disease have arthritis and joint pain, and there is a strong association with anxiety. Almost everyone who has a stroke has at least one other long term condition.

6.7 Rehabilitation is critical to meeting these needs, and is the interface between sectors and settings. But it is currently siloed by medical condition and sector. This is inefficient and results in a confusing system that is ultimately bad for patients who need personalised and holistic care that is easy to access. It results in rehabilitation located in hospital department out-patients when it doesn't need to be and inconsistency in quality standards.

6.8 The poor integration of rehabilitation and lack of consistent access is a driver of health inequality. There is a strong relationship between levels of deprivation and

populations with protected characteristics, the development of multiple long term conditions and poor mobility.[9]

6.9 The CSP works with 55 national charities and professional bodies in the CRA specifically to address this. The broad membership includes stakeholders from different parts of the NHS and social care, the fitness sector and the voluntary sector. It has developed an integrated, community based rehabilitation approach which we are waiting to hear if NHSE will pilot. The CRA is also currently co-designing community rehabilitation standards. We would be pleased to share with you our work on integrated approaches to rehabilitation service delivery and standards

6.10 The CSP and CRA partners have also supported work by Health Education England to develop the capabilities and training for a new Advanced Clinical Practice role to lead implementation of this integrated rehabilitation approach at Place level. These could be physiotherapists, other allied health professionals or nurses. They would have a critical role to play in developing multi-disciplinary teams working across sectors, including greater use of the wider workforce in rehabilitation services, such as Health Coaches and Sports and Exercise professionals. These roles would also lead greater utilisation of digital assets and brokering partnerships for appropriate use of gym space and community centres for the co-location of community based rehabilitation services.

6.11 The CSP is working with the profession to diversify physiotherapy student placements and post-graduation rotations to increase their early exposure to a range of health and care settings. Implementation of the recommendations from the white paper need to support this approach.

7. Implementation

7.1 While the need to progress integration is growing, we need to be mindful that these proposals come at a time when the NHS and social care workforce is tired and in many cases burnt out. This is shown in the growing problem of retention of NHS staff, with leaver rates of physiotherapists and other AHPs now exceeding that of nursing and high vacancy levels. This is why we have suggested shared national outcomes should include outcomes in relation to staff wellbeing and morale.

7.2 Social partnership working between employers and trade unions will be key to delivering these changes and using the expertise and commitment of staff.

7.3 Good practice in implementation of the measures in the white paper needs to include consistent and early engagement with staff and their unions in the process of change, protecting conditions of employment, best practice in negotiation of changes to staff terms and conditions, including consistent use of equality impact assessments and risk assessments. Social Partnership Forum nationally and regionally will be an important partner in driving good practice in this respect.

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