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 the UK’s 49,000 chartered physiotherapists, physiotherapy students and support workers.

The CSP welcomes the opportunity to respond to the proposals published in the White Paper Equity and Excellence: Liberating the NHS. Our response is focussed on the areas in the White Paper on which we feel we can most effectively contribute to the debate.

We would be pleased to supply additional information on any of the points raised in our response at a later stage.

The contribution of physiotherapy

Physiotherapy enables people to move and function as well as they can, maximising quality of life, physical and mental health and well-being.

Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity to support people in managing their own condition, maintaining their independence and preventing future episodes of ill health and disability.

Physiotherapists work with a wide range of population groups (including children, those of working age population and older people); across sectors; and in hospital, community and workplace settings. They facilitate early intervention, support self management and promote independence, and help minimise episodes of ill health developing into chronic conditions. Physiotherapists are involved in public health through the promotion of good health and wellbeing.

Physiotherapy delivers high-quality, innovative services in accessible, responsive, timely ways. It is founded on an increasingly strong evidence base, an evolving scope of practice, clinical leadership and person-centred professionalism.

As an adaptable, engaged workforce, physiotherapy has the skills to address healthcare priorities, meet individual needs, and to develop and deliver services in clinically and cost-effective ways. With a focus on quality and productivity, it puts meeting patient and
population needs, and optimising clinical outcomes, and the patient experience, at the centre of all it does.

1. Overview

1.1 The Chartered Society of Physiotherapy (CSP) would urge the Government to reconsider some of the proposals outlined in the White Paper *Equity and Excellence: Liberating the NHS*. While we welcome the prioritisation of public health, the closer integration of health and social care and an increased focus on patient reported outcomes, we have grave concerns about the scope and speed of the structural changes proposed and the resulting major risks to the quality of patient care and the future of the NHS. We are also deeply concerned that the proposed shift to GP consortia-led commissioning may increase costs, fragment patient care and create an unacceptable postcode lottery of services across the country.

1.2 The CSP is committed to a National Health Service that is free at the point of delivery; based on need; publicly funded, publicly provided and publicly accountable. The CSP believes that collaboration and communication are the best ways to deliver services within the NHS and that an over emphasis on competition between healthcare providers is potentially destructive to patient care. We strongly support service re-design and innovation aimed at improving patient care, but also believe that mainstream NHS services are best delivered by NHS employed staff working within a structure that supports collaboration over competition.

1.3 We believe that the proposals outlined in the White Paper potentially constitute a huge gamble with the NHS – the health of the nation and tax payers’ money. The Government has not yet presented an evidence base to demonstrate that these changes will deliver the stated outcomes. There is a significant risk of patient services becoming fragmented and destabilised, reducing the quality of care and making long-term planning increasingly difficult and the future of the NHS more uncertain. In light of these concerns, the CSP believes that it would be far more productive for the pace of change to be reduced to allow time for pilot studies to be carried out and to ensure that quality of care to patients will not be compromised.

1.4 The current pressure on the Health Service to make substantial efficiency savings of £20 billion will inevitably impact on its ability to introduce what could be the biggest organisational change it has experienced, since its inception in 1948, at the same time.

1.5 It is important to note that the NHS is currently, in many areas, providing a good service, with positive elements that should not be put at risk. There is, and always will be, room for improvement, but we believe that such a radical overhaul is not necessary to make the improvements that need to be made. The CSP is very concerned that fundamental changes to the core structure of the service, as proposed in the White Paper, will create turmoil during the implementation phase which will take staff focus away from providing care, adversely affecting patient outcomes. There have been many restructures and reconfigurations within the NHS over its history, from which its staff have gained extensive experience and expertise in what works and what doesn’t – this must be harnessed in order that we do not have to relearn lessons that have already been learned.
1.6 The title of the White Paper is *Equity and Excellence*, however it is unclear how this equity will be delivered when these proposals could lead to much bigger postcode lotteries than have been experienced before, with patients across the country having access to differing services based on what local GP consortia choose to commission. The CSP believes there is a very real danger that the quality of patient services will be driven down as a result of the combined impact of these fundamental structural changes and the current relentless focus on delivering financial savings.

1.7 The White Paper poses threats to the rights of NHS staff to the national pay, terms and conditions and pensions which are so highly valued by CSP members. There is well established research linking quality employment to quality care which supports our view that changes to these employment rights will have implications for the quality of patient care in the future. National terms and conditions bring a sense of fairness and security to NHS staff and constitute the most efficient way of organising pay and reward in such a complex area of the public sector.

1.8 The CSP is concerned at the lack of vision for NHS staffing in the White Paper proposals. This is a notable absence in light of the fact that staffing is the most important component of effective health care.

1.9 Given the scope and scale of the proposed changes we urge the Government to ensure that all aspects of the White Paper, including the proposed direction of travel, are subject to full public consultation, not just the proposals relating to implementation. Our concerns about equity of access also demonstrate the need for a full equality impact assessment to be undertaken at every appropriate stage.

1.10 The CSP is keen to enter into constructive dialogue and willing to work with the Government to seek solutions to address the significant concerns our membership has around these proposals. Physiotherapists have the skills and ability to deliver high quality, patient-centred care that is extremely cost effective. We are eager to be at the centre of discussions about how the NHS can improve and deliver excellent care to our patients in these times of increased austerity and budget constraints.

2. **Liberating the NHS**

2.1 The CSP broadly welcomes the principles of greater clinical involvement, greater patient and public involvement and increased integration across primary, secondary and social care, that are outlined in the White Paper.

2.2 Physiotherapists provide a clinical and cost effective service that is patient-centred. We welcome moves to break down the barriers between health and social care, where physiotherapy can play a key role.

2.3 The CSP supports the Government’s commitment to reducing health inequalities, but does not believe that the structural approach to the reforms will deliver this. Instead the plurality of commissioning bodies will lead to increased fragmentation of services and postcode lotteries that could serve only to exacerbate the existing health inequalities the country faces.
2.4 We welcome the commitment to the NHS constitution which was developed through partnership working and is an excellent example of what can be achieved using this approach. We hope to see this style of partnership working continue, including the commitment to work closely with NHS trade unions, as without it, patient services will not be joined up and the quality and experience of care will deteriorate.

2.5 As the CSP’s ‘Move for Health’ initiative (see: www.csp.org.uk/moveforhealth) demonstrates, physiotherapy has a key role in improving public health, and we welcome the increased focus on improving health, rehabilitation and reablement. We support the creation of a public health service, in which the physiotherapy profession will need to be a key partner, and look forward to contributing to the consultation on the forthcoming Public Health White Paper. However, it is important to note this approach will only be successful if it is properly funded. The CSP is very concerned by reports of cuts to public health sector roles including specialists appointed to reduce the burden on the NHS caused by alcohol abuse and obesity.

3. Putting patients and the public first

3.1 The CSP welcomes moves to increase patient and public involvement in the NHS. We support the need for an information revolution to ensure people are aware of the services available to them and the benefits and side-effects of different courses of treatment. The availability and access to clear, transparent information will be vital in the implementation of personal health budgets, as to make effective choices about their care, patients will need to be fully appraised of the range of options open to them, with their benefits and risks. This must include access to senior specialist clinicians where appropriate. The CSP would like to see a full evaluation and review of the personal budgets pilots, before this is fully rolled out across the NHS, including a review of the impact of the pilots on healthcare staff both in terms of employment issues and workforce planning.

3.2 Self-referral is a system for patients to make an appointment direct with their local NHS physiotherapy department, without seeing their GP first, which has been proven to reduce costs and time for GPs. Self-referral is readily available throughout the independent sector and private practices and in a limited number of NHS physiotherapy departments. The CSP is concerned that the need to expand and develop effective NHS self-referral schemes could be halted by the adoption of contracting out via the ‘any willing provider’ approach for services that need to be part of integrated physiotherapy pathways. We would urge a greater adoption and roll out of the patient self-referral to physiotherapy scheme, which has proved successful in increasing timely access to physiotherapy services, improving outcomes for patients through early intervention and ultimately preventing onward referral to specialists in secondary care.

3.3 Early access to physiotherapy, which can be facilitated through self-referral schemes, can help prevent people taking sickness absence from work, and can help people return to work. Musculoskeletal disorders (MSDs) are the most common problems that physiotherapists treat. Early intervention can reduce the amount of time people are off sick and is vital to prevent an acute problem becoming chronic. Up to 60% of people on long term sick leave cite MSDs as the reason and an estimated 9.3 million working days were lost through MSDs in Great
Britain in 2008/9. Research has found that a reduction in welfare benefits expenditure can be achieved through the implementation of workplace-based return-to-work interventions using primary care physiotherapy in the treatment of pain related sickness absence\(^3\). Furthermore, in the management of low back pain, it has been demonstrated that short-term physical intervention is more effective than advice on staying active, leading to more rapid improvement in function, mood, quality of life and general health, with the early timing of intervention delivering psychosocial benefits that are not achieved if treatment is provided later\(^4\).

### 3.4

The CSP would also like to see assurances from the Government that any online communications system(s) for keeping patient records are fully accessible for patients and staff with disabilities such as visual impairments, meet international accessibility standards, and take account of associated issues such as the need to ensure confidentiality and privacy.

### 4. Improving healthcare outcomes

#### 4.1

The CSP supports the principles behind an increased focus on health outcomes and welcomes the use of Patient Reported Outcome Measures (PROMs) as one indicator of the quality of treatment/a service. In many instances, the outcome a patient will want will be something not happening – not being admitted to hospital, not requiring an operation, but things that do not happen cannot be counted. This means that PROMs will become the only way to measure the impact of those interventions that are aimed at preventing a negative health outcome, such as falls prevention, where physiotherapists play a key role. However, it will be critical for the methodology for collecting PROMs to be robust and ensure that right information is collected to give an accurate reflection of the impact of the service provided.

#### 4.2

Physiotherapists have a key role in delivering the health outcomes that patients demand – reducing pain, promoting function and independence and returning working age people to meaningful occupation. Ensuring the NHS provides a comprehensive physiotherapy service, including self-referral with fast access for early intervention, will be vital to meeting patient expectations and delivering these outcome measures.

#### 4.3

The CSP is concerned that there will no longer be any NHS priorities or prioritisation of the outcomes framework. We believe that identifying priority areas for improvement focuses the efforts of the NHS to deliver on key areas. This enables the service to make incremental progress improving one area at a time.

#### 4.4

The CSP would welcome an outcomes framework that measured the impact of the full breadth of interventions of all healthcare staff. In a system that encourages any willing provider, this must mean that all organisations delivering NHS services are subject to the same outcome measures, reflected in their contracts. This is particularly important because organisations tend to deliver on parts of care pathways not on the whole pathway, therefore the data will be meaningless unless all providers supporting a patient along a care pathway input the same standardised data.
4.5 The CSP and its members are willing and able to make an important contribution to the development of the outcomes framework. We would welcome assurances that there will be mechanisms in place to allow this to happen. We also recognise the particular challenges faced by smaller professions in having routes to input the expertise that only they possess and this should also be provided for within these mechanisms.

4.6 The CSP would highlight that a major barrier to the delivery of the outcomes framework is likely to be around the data collection and reporting systems. Currently many professionals, such as Allied Health Professionals, do not have access to integrated systems that are appropriately resourced. There is currently no framework for standardised data collection and even contributing to national data collections, such as the stroke sentinel audit, is fraught with difficulties. At present, most national data collections do not include fields that pick up the rehabilitation element of pathways, and therefore do not include the input of many clinicians within the NHS who are responsible for accelerating discharge and preventing avoidable hospital admissions; however, these services are vital for ensuring efficient and effective care and improving patient experience and outcomes so should be captured.

4.7 Where data is collected the systems are sometimes paper-based as organisations are not able to fund the necessary IT infrastructure that allows collection and reporting. There are currently no national mandatory data collections for Allied Health Professionals, although we understand that one may be launched later this year. The CSP is currently developing some data sets that it will promote to members to support the standardised collection of data according to some agreed standard definitions, but we would welcome Government support to implement this work.

4.8 We believe it will be important to ensure that the outcomes framework does not perpetuate the focus of the NHS as an illness service rather than one concentrating on the health of the population – care must be given to making sure the outcomes are not only focused on hospital based activity and will give information back to the NHS Commissioning Board regarding the significant activity that happens outside of hospital care.

4.9 The design principles for the outcome measures must include public health and social care interventions. The CSP would argue that if the NHS is to be successful it must have an integrated approach for patient pathways to be designed appropriately, and delivered effectively.

5. Autonomy, accountability and democratic legitimacy

Public health and tackling inequalities

5.1 The CSP welcomes the new and enhanced role for local councils in relation to health improvement and prevention activity. In principle, devolving decision making closer to patients is a good idea. Strengthening local accountability by placing more power in the hands of elected members of local authorities will give patients more influence over health decisions in their area. We agree that giving local councils the power to lead joint strategic needs assessments (JSNA) makes sense, but to be
effective these JSNA’s must be based on up to date appropriate data and information, and involve all relevant healthcare professionals.

5.2 The CSP strongly believes that health promotion and well-being are crucial to improving health outcomes in the future. Improving health equality and preventing ill-health is still a major challenge. Despite significant investment and improvements in care, the gap in life expectancy between the most deprived and least deprived areas has widened, regardless of improvements in life expectancy in the most deprived areas. There is an opportunity now to place greater emphasis on assessing local needs, and prioritising investments to deliver long term health outcomes. The commissioning of health and social care services should be pivotal in reducing health inequalities; supporting the shift from treatment and diagnosis to prevention and the promotion of well-being.

5.3 The CSP is concerned that because of the short term focus on achieving significant ‘efficiencies’ in the NHS and financial savings in public services, alongside the fragmentation of services and proliferation of providers, commissioners will not be able to end the inequalities in health outcomes. The CSP is particularly concerned about the growing numbers of adults and children who are overweight or obese, and the worrying numbers who take insufficient exercise. Physiotherapists are well placed to encourage and promote healthy lifestyles, including the benefits of regular physical activity. The focus of commissioning has, to date, been primarily on the provision or improvement of acute and community-based health treatment services. The CSP therefore welcomes the Government’s proposal to develop a more strategic focus on improving public health, tackling health inequalities and reforming adult social care. Physiotherapists can make a key contribution as public health responsibilities transfer to local authorities.

5.4 The CSP supports the proposal to establish a statutory health and wellbeing board within a local authority, to promote integration and partnership working between the NHS, social care, public health and other local services. We would like to see greater clarity on how this health and wellbeing board would be able to influence commissioning. Given the important role of Allied Health Professionals in integrating care and the key contribution that physiotherapy can make to improving public health and well-being, we would like to see Allied Health Professionals represented on the proposed new health and well-being boards.

5.5 We also welcome the assurance that staff engagement and partnership working will be promoted throughout the NHS and that the Boorman Review recommendations on staff health and well-being will be implemented. Physiotherapy has a key role in realising the increased productivity gains outlined in the Boorman Review and the profession is keen to support the roll out of the recommendations which call for all NHS organisations to provide staff health and well-being services that are centred on prevention (of both work-related and lifestyle-influenced ill-health), are fully aligned with wider public health policies and initiatives, and are seen as a real and tangible benefit of working in the NHS. However, we have concerns around how this will be implemented with the encouragement of any willing provider and the plans for the NHS to commission but not provide services, and would like to see a commitment to the Boorman recommendations written into all local provider contracts.
Commissioning

5.6 The CSP welcomes the principle of greater clinical involvement in the planning and commissioning of services, and will be looking to ensure that final plans honour the assertion made by the Secretary of State that GPs will involve a range of health professionals, including physiotherapists, in planning and decision-making through the consortia groups. Equally, the new NHS Commissioning Board will need input and advice from physiotherapists and other Allied Health Professionals to ensure that it has access to that expertise in its decision making and specialist commissioning.

5.7 It is unclear from the proposals outlined in the White Paper whether the Department of Health will seek the views of NHS staff via the annual staff survey as part of the assessment of providers. We believe it is important that the NHS staff survey is continued and that in future it needs to be extended to include staff working for alternative providers of NHS services. Both clinical and non-clinical staff have a major contribution to make in identifying where and how efficiency savings can be made and patient services improved.

5.8 The CSP has concerns over the inevitable increase in postcode lotteries of care as the number of bodies commissioning services increases from 150 PCTs to an undetermined number of much smaller GP consortia. This seems to be in conflict with the assertion in paragraph 1.10 of the White Paper which outlines the Government’s desire for the NHS to become less fragmented and insular, a desire that the CSP and its members share.

5.9 The CSP is concerned over the indication in the White Paper that all the mechanisms to manage or influence the NHS’s expenditure of £110 billion of taxpayers’ money are being removed very rapidly. This includes the Secretary of State giving up his statutory powers, the Department of Health being reduced to public health, plus the abolition of the SHAs and PCTs. The replacement of any management of the system by only one regulator, the NHS Commissioning Board, seems to be a major risk of fragmentation and postcode lottery. We would ask the Government to rethink the extent and consequences of this reform.

5.10 While we recognise the argument that local people will make decisions based on the needs of the local population, this will lead to differences in provision from one area to another. Strong monitoring and accountability processes will be needed to ensure that an unacceptable variation in levels of care across the country is avoided. The CSP seeks assurances that the new NHS Commissioning Board with its regional arms will be properly resourced to carry out this role on a par with the current provision from SHAs and PCTs. Moreover, the production of the NICE quality standards will not be completed until 2015, by which time the structural changes and new commissioning arrangements will have been in place for at least two years. Consideration must be given to how unacceptable variations in the provision and quality of care are avoided in those areas of healthcare that do not have NICE quality standards by the time the new commissioning arrangements come into being. The CSP would, therefore, urge the Government to delay the implementation of the structural changes in commissioning to enable NICE to complete its work first.
Furthermore, we are sceptical that an increase in the number of commissioning organisations across the country will provide the reductions in management costs that the Government is seeking to realise. We are concerned that administering a large number of GP consortia will prove to increase the NHS management budget in the long-term, diverting resources from patient care. In addition to this, we are concerned about the financial management of the NHS budget once it has been devolved to the local GP consortia.

The 26 August 2010 edition of the Health Service Journal (HSJ) reported that existing GP consortia had overspent their budgets by 2.5%, which would result in up to £3 billion of overspend if this were repeated by all consortia in the new system, placing huge pressure on the NHS as a whole and individual GP practices. Although these figures have been challenged, this article demonstrates the real probability of future deficits in the NHS budget.

**Competition and the ‘Any Willing Provider’ approach**

The CSP is firmly of the view that collaboration is the best way of providing quality healthcare and that competition, which pits NHS organisations and staff against each other, is destructive to patient care, making pathways of treatment that cross healthcare sectors or providers increasingly disjointed and harder to manage. We urge the Government to rethink their policy of extending the principle of competition in the NHS.

The CSP is also concerned about the impact of competition between NHS and other service providers on the principle of innovation and sharing best practice to improve patient care. Private companies will see innovations and good practice as areas of competitive advantage so others will not be able to learn from this to develop their service and improve patient outcomes.

The CSP is concerned about the conflict of interest that may arise from private companies being awarded contracts to undertake local needs mapping and commissioning activities when they are also competing to provide the commissioned services to the NHS. There must be clear and transparent rules introduced to ensure that no company or individual with an interest in running NHS services can be involved in any way in the process of commissioning or subsequent performance management of contracts.

Decent and fair workforce standards as enshrined in the NHS Staff Passport must be incorporated into all contracts. Potential new providers should be assessed on the basis of their track record in this area along with a system to monitor performance of all providers on an ongoing basis.

The CSP also has concerns that an increased plurality of providers will lead to fragmentation of healthcare services, with private companies opting to provide the most profitable services and leaving the NHS to cope with the most complex and resource-intensive work. This happened as a result of GP fund holding, so there is a precedent for this outcome. Safeguards will need to be put in place to ensure that this situation is avoided: a challenge that the CSP believes the Government must be prepared to face.
5.18 Any decisions on future organisational structures at local level should be preceded by meaningful consultation with all relevant stakeholders including NHS staff and their representatives. This should be in the spirit of full and effective partnership working and should comply with the NHS Constitution. The CSP actively encourages our members to participate in this process. Where members conclude that a different model of service delivery is genuinely in the best interests of the users of the services, and of the staff employed within them, the CSP will support members in their choice. However, there must be a demonstrable evidence base to show that the changes will result in better care; and genuine choices between alternative providers and NHS services must be offered.

Stability of the service

5.19 The NHS has had a poor record in workforce planning in recent years, as highlighted by past Health Select Committee reports. Increased fragmentation and plurality of providers will worsen this, creating uncertainty for future healthcare provision, which could result in real shortages or a cycle of boom and bust in the availability of appropriately trained healthcare staff. The CSP is very interested to hear from the Government how it plans to tackle this problem. It is our opinion that it will not be possible to ensure that the correct numbers of health professionals are trained and available to meet the healthcare needs of the population in the future, without national level workforce planning and regional level bodies (currently Strategic Health Authorities) commissioning training places with universities. We welcome the commitment the Government has shown to improving workforce planning in the NHS by supporting the work of the Centre for Workforce Intelligence (CfWI) which states, in its recent report on physiotherapy student intakes into universities, that "If the number of training places commissioned significantly decreases any further, CfWI supply forecasts suggest the NHS physiotherapy workforce will decline in numbers from 2012 ... As such, the likely future demand for physiotherapy services needs to be strongly considered in commissioning decisions."

5.20 The CSP would like to see alternative providers of healthcare services taking their fair share of responsibility for student placements, for the funding of both undergraduate training costs and CPD, and for providing rotation posts for newly qualified staff to ensure that, if implemented, the policy of ‘any willing provider’ is truly based on a level playing field.

5.21 With regard to the proposals for all NHS Trusts to become Foundation Trusts by 2013-14, we would highlight the risk of there being some rapid financial cutbacks or vacancy freezes in NHS Trusts as they strive to ensure their finances are in order to meet the deadline for becoming Foundation Trusts. This move to Foundation status will be a significant change for a number of Trusts, which will have only a short time to make this transition. The CSP is also concerned about the financial stability of new Foundation Trusts and the risk of these organisations potentially going bankrupt. With the understanding that the Government will not bail out Trusts which end up in this situation, measures will need to be put in place to ensure quality healthcare services continue to be provided in the locality and also to avoid valuable public assets, the NHS Estate – such as hospital buildings, being sold to meet debts in the future, which will further destabilise the service.
5.22 The move towards establishment of social enterprise companies (SECs) raises serious concerns particularly about their long term viability and the implications for staff should they fail financially. Our experience to date is that the drive towards the establishment of SECs has led to staff being pressurised to support this change. Where staff have been fully and comprehensively consulted about such proposed changes they have, in the main, been overwhelmingly rejected.

5.23 The CSP believes that maintaining a stable, quality NHS workforce is crucial to ensuring high quality care for patients. The impact of these proposals on staff, in terms of morale, concerns about job security and future impact of potential changes to their pay, pensions and terms and conditions of employment, should not be underestimated, particularly in light of pre-election promises that there would be no top down reorganisation of the NHS, which was understandably interpreted to mean there would be no reorganisation of NHS structures. Significant, rapid change could divert resources and time from patient services if staff feel demoralised and uncertain about their future.

5.24 Paragraph 1.21 in the White Paper refers to large cuts in administrative costs, but does not make clear where or how these duties will be covered. The CSP is already aware that vacant posts are not being filled in many areas and hard pressed staff are having to cover the work of absent colleagues. It is important to recognise that an increase in the burden on clinical staff, caused by a reduction in the workforce and any transfer of administrative duties to clinical staff caused by the loss of management or admin support staff would further impact on the efficiency and effectiveness of staff resulting in an adverse impact on patient care.

5.25 The CSP has gathered evidence to show the impact that our members are already experiencing with current staff shortages. In August 2010, the CSP undertook a survey of NHS physiotherapy service managers to obtain information about the impact of cuts to budgets that are being imposed in the current financial year. We received responses from over 100 organisations in England. Among the key findings:

- 41% of managers agreed that inadequate physiotherapy staffing levels were obstructing them from redesigning and modernising their service.
- Nearly 90% of physiotherapy service managers are having to make cuts to their budgets this year, with some required to make cuts of up to 20%. Nearly 60% of managers thought that these cuts were certain or very likely to lead to cuts in staffing numbers. The majority were facing significant delays in filling vacant posts due to vacancy control procedures put in place by employers which are adding to the workload of existing staff.
- Nearly three quarters of managers reported significantly increased workloads for their staff over the past year with a corresponding rise in staff stress levels reported by 69%. In addition demand for physiotherapy services was expected to rise over the coming year by nearly 9 in 10 managers and most (70%) did not expect to have sufficient resources to meet this rise in demand. The result of this will be increases in hospital in-patient stays and outpatient waiting times which impact on patient outcomes.

5.26 A move to the ‘any willing provider’ approach will have an impact on the career development and employment of staff currently working in the NHS. Measures must be put in place to ensure that clear career pathways for physiotherapists and support workers are assured to ensure the future provision and stability of the
service. This is key to ensuring that high quality patient care will be maintained in the future. A lack of clear career progression would deter people from training into the profession and lead to disillusionment among those already working in the health service, resulting in staff shortages and longer waiting lists and hospital in-patient stays for patients in the future.

**NHS staff terms and conditions**

5.27 The increase in outsourcing of services signalled in the White Paper has huge implications for NHS staff. Although staff who transfer over to new employers have their terms and conditions protected at the point of transfer, they will have no rights to future improvements to NHS terms and conditions and pay. The right of staff to remain within the NHS pension scheme will be compromised if they have to take on non-NHS work. This situation will be worsened if the Cabinet Office code on workforce matters, designed to prevent two-tier workforce conditions, is abolished. We believe the emergence of a two-tier workforce delivering NHS care with different employment conditions will have a direct negative impact on staff morale, flexibility and the quality of patient care.

5.28 The CSP fully recognises that any NHS pension scheme must be sustainable and affordable in the long term; fair to both the public service workforce and the taxpayer; and flexible enough to meet the fiscal challenges ahead. The current NHS Pension Scheme was introduced in April 2008 following four years of intensive negotiations. This resulted in significant changes including increased member contributions and an increase in the normal pension age. These reforms have been introduced to ensure that the scheme remains sustainable. We believe the NHS Pension Scheme is a very effective recruitment and retention tool for NHS staff and must, therefore, be maintained, with all staff working to provide contracted out NHS services having an equal right to be members of the NHS Scheme. This avoids two-tier arrangements which are damaging to staff morale and flexibility as outlined above. The CSP has taken the opportunity to comment on the review of public sector pensions\(^\text{10}\). The National Audit Office\(^\text{11}\) found that one quarter of NHS pensions are less than £40 per week and are not the unaffordable gold platted standard many would imply.

5.29 The future role of the Pay Review Body (PRB) is unclear in the White Paper proposals. The PRB is highly valued by CSP members and regarded as a fair and independent process. Development of different pay rates and terms and conditions in different regions and organisations will lead to disparities in pay for staff undertaking similar roles providing NHS care, with similar levels of responsibility, experience and skills. It could also lead to pay discrimination undermining the principle of equal pay for work of equal value which the *Agenda for Change* agreement has been shown to have implemented. It is likely that Foundation Trusts in better financial shape will pay more than those in poorer financial shape leaving the latter unable to retain staff and resulting in unacceptable variation in quality of care across the health service, characterised by a postcode lottery.

5.30 The CSP’s experience of local pay bargaining in the NHS in the 1990s was of management and staff side trade union reps spending a great deal of time negotiating pay and conditions, which effectively took time away from treating patients. In reality, the final agreements varied little from Trust to Trust, despite the huge amount of time taken up in the process. National pay bargaining is an agreed,
highly efficient, non-legalistic way of determining reward and we would strongly argue for its retention.

5.31 The CSP rejects the imposition of the two year pay freeze on NHS staff earning in excess of £21,000 per year which affects the majority of our members.

6. Cutting bureaucracy and improving efficiency

6.1 It is unclear from the White Paper whether the desired ‘more than 45%’ cuts in management will include cuts in clinical leader positions – these senior clinicians have a key role in planning the delivery of patient care and any reductions would reduce the clinical input into commissioning. Great caution must be exercised in the use of the terms “frontline” and “non frontline” staff. As our members are aware in practice there is no clear separation as they are interdependent and an intrinsic aspect of the team-working that is absolutely fundamental to the provision of high quality care. A major risk is that remaining staff will have to take on more administrative tasks, cutting into patient contact time and adding to workloads which will inevitably take time away from patient care, ultimately increasing the length of hospital in-patient stays and out-patient waiting times. To suggest that huge savings can be made in “non frontline” jobs without impacting on “frontline” jobs is untenable.

6.2 Physiotherapy management posts are often key people who have the experience and skills to innovate and lead improvements to patient services, identify where efficiency savings can be made and ensure that the profession is able to input into organisations’ strategic plans. They have a very important role in managing complex services in often very large organisations and the constant denigration of service managers is damaging to both the morale of NHS staff and to patient care.

7. Conclusion

7.1 The Chartered Society of Physiotherapy (CSP) is concerned about the speed and direction with which these reforms are being implemented and we would urge further consideration over a number of the proposals as highlighted in our response above.

7.2 The scope and speed of the structural changes proposed needs to be reviewed to allow these to be phased in more gradually, on a timeline that will allow for pilot schemes to be introduced and assessed. This will help to ensure that the proposed changes will work and that the fundamental principles contained in the White Paper are properly assessed before wholesale reforms are implemented. We also urge the Government to ensure that all aspects of the White Paper are subject to full and meaningful public consultation and for equality impact assessments to be undertaken at every appropriate stage.

7.3 The CSP urges the Government to rethink their policy of extending the principle of competition in the NHS. We firmly believe this will lead to fragmentation of services which will create barriers to co-operation and collaboration and ultimately be to the detriment of patients and quality of care.
7.4 The CSP calls for the introduction of clear and transparent rules to ensure those running or seeking to run NHS services cannot also be involved in the commissioning or performance management of services.

7.5 The retention of national pay, terms and conditions and pension rights is of major importance to our members and is the most efficient way of organising pay and reward in an organisation the size of the NHS. We also call for the Pay Review Body to be retained in its current role as it is seen by our members as a fair and independent process.

7.6 We will also be submitting a response to the associated consultation documents:
- Commissioning for patients
- Local democratic legitimacy in healthy
- Freeing providers and economic regulation
- NHS outcomes framework

7.7 We hope that our contribution is helpful in the development and implementation of the proposed structural and procedural changes. We look forward to ongoing constructive dialogue with the Government over these plans for the future of the NHS.

Phil Gray
Chief Executive
The Chartered Society of Physiotherapy
4 October 2010

- ends -

For further information on anything contained in this response or any aspect of The Chartered Society of Physiotherapy’s work, please contact:

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References:
1 Campbell, D (2010) Doctors and nurses among 1,700 staff sacked at Department of Health
Guardian Online (20 September 2010); London.
http://www.guardian.co.uk/society/2010/sep/20/doctors-nurses-sacked-nhs
2 Department of Health (2008) Self-referral pilots to musculoskeletal physiotherapy and the implications for improving access to other AHP services. DH; London.


Centre for Workforce Intelligence (2010) Physiotherapy Workforce Review.
