House of Lords
Future Sustainability of the NHS inquiry
Written evidence from the CSP

About the physiotherapy profession
The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the UK's 54,000 registered 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

There are ten areas action is required to increase the long-term sustainability of the NHS

1. Giving clear political commitment to health services remaining free at the point of need and use, funded through general taxation
2. Reversing the decline in funding across health and social care
3. Taking national accountability for the 10k workforce expansion target for allied health professions and nurses training places that was indicated from the last CSR
4. Developing and investing in the workforce in line with future need and system transformation objectives and providing fair pay to maintain morale and motivation
5. Utilising all parts of the workforce at the height of their capabilities
6. Redistributing funding to develop out-of-hospital care and services that rehabilitate, prevent, educate and empower self-management and healthy life styles
7. Pursuing integration policies to achieve transformation goals and improving quality of care,
8. Overcoming the transactional barriers to system change, including how services are funded and issues of organisational accountability
9. Building a national consensus on the need for changes to the health and care system and the role of individuals and communities within this
10. Developing IT systems that can provide all parts of the health and care system seamless shared access, communication across boundaries, in a common language with shared standards

1. Resourcing issues – including funding, productivity and demand management

Is the current funding model for the NHS realistic in the long-term? Should new models be considered? Is it time to review exactly what is provided free-at-the-point of use?

1.1 The CSP strongly supports the principles of the NHS, that it is tax funded and free at the point of use, and that individual wealth should not be a barrier to accessing necessary health care services. This is a principle strongly backed by public opinion, with 89 per cent saying that this is what they want their government to support.[1] The CSP also believes that the UKs universal health system is the most realistic system to deliver the changes required to be sustainable in the long-term. The comprehensive review of different funding models by Lord Wanless in 2002 supports this view.[2] "

[1] 2014 British Social Attitudes Survey, undertaken by NatCen Social Research http://www.health.org.uk/publication/public-attitudes-nhs#sthash.jf8DLD2i.dpuf
[2] Securing our Future Health: Taking a Long-Term View" Wanless 2002

1.2 International evidence suggests where charges have been introduced there is a significant decline in access to services, specifically people's use of preventative services, but it has little impact on overall health expenditure.[3]

1.3 Insurance-based systems are not inherently more sustainable, stable or affordable, and the evidence suggests the contrary is the case. A comparison with the insurance-based system in the US is useful, where only one third of the population are covered by publically funded programmes (Medicare and Medicaid). The burden of this system on US taxation is twice that of the universal system in the UK – in 2013 it stood at 17.1 per cent of GDP in the US, while it was 8.8 per cent in the UK. The public cost of health services in the US is higher again when one takes into account the tax exclusion for employer-sponsored health insurance. At the same time, the private cost of health care to individuals in the US far exceeds that of taxpayers in other OECD countries and this cost is the primary reason for personal bankruptcy and mortgage repossession. Conversely, it also leaves public health vulnerable to changes in the economy (e.g. unemployment, wages). This has clear detrimental consequences not just for individuals, but the economy. Furthermore, in spite of high levels of both public and private expenditure, health outcomes in the US do not compare favourably to the UK.[4]

1.4 What is required for the long-term sustainability of the NHS is the modernisation of the health and care system - how services are organised and joined up with attention to the wider determinants of health, the relationships between service users, carers and professionals; the role of individuals and communities in improving public health and the redistribution of resources so that a greater proportion is targeted at prevention, health management and rehabilitation services outside of hospitals.[5] There is already strong consensus among policy makers, political parties, clinical and professional leaders and frontline staff around this transformation agenda.

1.5 This is being undermined by the decline in health and care spending. Spending on social care services for the elderly has fallen by 17 per cent since 2009/10.[6] Overall spending on health has been declining since 2009 as a proportion of gross domestic product, falling to less than both the European and OECD average and as average spending per head of population.[7] [8] Major system change requires investment in time and an adequate level of funding. The policy of transformation and the policy to reduce public spending on health and care are not aligned.

1.6 The productivity agenda sometimes confuses effective and efficient care with rationing of care and can be narrowly focussed on inputs rather than on patient outcomes. It also tends to look at short-term savings, inhibiting the move to more affordable and sustainable models of care. This is seen in physiotherapy where too often the number of physiotherapy sessions that patients receive is the starting point when looking at efficiency. This is crude and means that some patients receive more sessions than they need and others not enough. Getting in front of the problem at an early stage is the way to reduce the number of sessions required.

1.7 Under-resourcing is creating inefficiencies – pushing more service users into the most expensive parts of the health system, insufficient spending on health services pushing up social care costs, and insufficient spending on social care support is resulting in higher demands on health.

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[3] The impact of user fees on access to health services in low- and middle-income countries http://apps.who.int/rhl/effective_practice_and_organizing_care/cd009094_waiswaw_com/en/
[4] http://cohealthinitiative.org/sites/cohealthinitiative.org/files/attachments/warren.pdf
[5] University College London. The Future of Healthcare in Europe. London: University College London. https://www.ucl.ac.uk/european-institute/events-view/reviews/healthcare/FHE_FINAL_online.pdf
[6] NHS in a Nutshell, Kings Fund 2016 http://www.kingsfund.org.uk/projects/nhs-in-a-nutshell
[7] NHS in Numbers, Nuffield Trust 2016 http://www.nuffieldtrust.org.uk/nhs-numbers-0
[8] Staffing matters; funding counts. The Health Foundation, July 2016

2. Workforce – including supply, retention and skills

How can an adequate supply of appropriately trained healthcare professionals be guaranteed? Are enough being trained and how can they be retained? Do staff in the NHS have the right skills for future health care needs?

2.1 In the last Comprehensive Spending Review the government said that the change in student funding would enable an increase in student places for nurses and AHPs by 10 thousand by 2020, which in turn should help address current workforce shortage issues. Predictions of future population needs show the growth areas of need are for caring, rehabilitation and support activity to manage long-term conditions.[9] As well as nurses, the parts of the workforce that need to be grown and developed to meet these needs are support workers and AHPs, including physiotherapists.

2.2 But against evidence of current and future need, the numbers of physiotherapists to be trained in 2016/17 was cut by 6.7 per cent. There is now a shortage of registered physiotherapists, creating difficulties in recruiting to posts. Services are focussed on delivering current contracts with staff shortages, which is a barrier to innovation and service redesign. A survey of practicing CSP members in March 2016 found that 89 per cent of those who responded (440 members) agreed that insufficient posts result in their service being overstretched. There needs to be a minimum increase of 500 physiotherapists being trained every year for at least the next three years to close the gap with growing demand.[10]

2.3 The CSP has supported the removal of bursaries to physiotherapy students on the condition that, if implemented properly it allows for the necessary expansion to happen. Currently there is a lack of clarity over who is responsible and accountable for delivering the 10k nursing and AHP training numbers expansion commitment. This urgently needs to be addressed, and both Health Education England and NHS England mandated by the government to achieve this.

2.4 It is critical that England starts to address sustainable workforce supply through domestic workforce production, rather than the current heavy reliance on overseas-qualified health care staff, particularly now in the context of Brexit and the impact of visa changes.

2.5 The workforce across health and care need to be fully utilised. The OECD earlier this year published a survey of doctors and nurses in 22 countries. This showed that 76 per cent of doctors and 79 per cent of nurses report being over skilled for parts of their work[11]. The UK health workforce reflects this picture, including how physiotherapists and other AHPs are under-utilised.

2.6 Enabling all parts of the health workforce to work to the height of their capabilities and scope of practice means: registered physiotherapists and other AHPs not doing tasks that can be performed just as adequately by support workers; support workers not doing the tasks that carers or volunteers could do; and doctors not doing tasks that can be done just as well – or in many situations better – by an advanced practice physiotherapist or nurse. Taking this approach across the whole workforce frees up staff to concentrate on doing what only they can do.

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[9] Future Demand for Skills – initial results. Horizon 2035, Centre for Workforce Intelligence. August 2015 URL: http://www.cfwi.org.uk/publications/horizon-2035-future-demand-for-skills-initial-results

[10] The Chartered Society of Physiotherapy. Workforce data modelling tool. London: The Chartered Society of Physiotherapy; 2015. URL: http://www.csp.org.uk/professional-union/practice/evidence-base/workforce-data-model

[11] Health Workforce Policies in OECD Countries: Right Jobs, Right Skills, Right Places, Ch 6 Skills use and skills mismatch in the health sector: What do we know and what can be done?http://www.oecd.org/publications/health-workforce-policies-in-oecd-countries-9789264239517-en.htm

2.7 This can be seen very clearly in the care of musculoskeletal health in General Practice. Physiotherapists are autonomous, regulated practitioners. They have the same high safety record as GPs, and considerably lower levels of complaint. They don't require supervision or delegation from medical colleagues or others. Many physiotherapists have advanced practice skills, and can independently prescribe and carry out injection therapy. An advanced practice physiotherapist costs £54.11 per hour, a GP £130.71,[12]

2.8 Musculoskeletal (MSK) health problems are the biggest cause of disability in the UK, are the most common cause of repeat appointments and account for between 20 and 30 per cent of the GP caseload, yet it is an area GPs commonly say they are not confident in managing.[13] MSK problems are the most common cause of sickness absence from work and are a major barrier to physical activity. Physiotherapists have the most advanced expertise in MSK of all health professionals with the exception of orthopaedic consultants, and they can safely and effectively manage 85 per cent of a GPs MSK caseload.

2.9 GPs and policy makers are recognising the potential to utilise this expertise and the new role of General Practice Physiotherapists is being piloted in a number areas. Physiotherapists with advanced practice skills are contracted to provide the same first point of contact service for MSK patients as a GP would. The evidence from these pilots show high patient satisfaction, reduced costs and reduced pressure on GPs and secondary care – in particular significantly reducing unnecessary orthopaedic, MRI and xray referrals. In the longer term it could improve musculoskeletal care in communities, with significant benefits to public health and supporting people to be fit for work.

2.10 One of these 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 footprint 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 percent are referred back to the GP for medication review or for non-MSK conditions, while over 60 per cent are discharged after one appointment with the General Practice physiotherapists. This service was set up in addition to an already successful orthopaedic and pain triage/CATS service. Therefore areas with no such provision are likely to see more dramatic pathway changes and savings from reducing unnecessary referrals. The service has achieved all of their objectives:

- 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 12 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 with 45 per cent scoring them a maximum 10. Dr Chris Steere, GP at Neston Medical Centre told the CSP *'Physiotherapy First really complements how our GP's work in practice. Patients with MSK problems no longer need to see a GP first. Our patients are very impressed with the quick access and very few need a re-referral to see a GP.'*

[12] Chartered Society of Physiotherapy. Physiotherapy Cost Calculator. London: The Chartered Society of Physiotherapy. 2016. URL: http://www.csp.org.uk/professional-union/practice/evidence-base/physiotherapy-cost-calculator

[13] Goff I, Wise E, Coady D, Walker D. Musculoskeletal training: are GP trainees exposed to the right case mix for independent practice? Clinical Rheumatology 2014;Sept 6 (Epub). http://www.ncbi.nlm.nih.gov/pubmed/25190366

2.11 There needs to be a rebalancing of investment in the training and development of the existing workforce. Approximately 60 per cent of the NHS's training budget is spent on just 12 per cent of the workforce (doctors) and there is no national training budget for support workers. What is required is an inclusive approach to workforce development and investment. This must be in line with changing patient, service and workforce needs and support advanced practice development across professions, optimise the contribution of support workers, and enable strengthened skill mix and inter-professional and cross-sector/-agency working.

2.12 A sustainable health system requires staff to receive fair pay for the work they do in order to maintain morale and motivation. Since 2010 £4.3 billion has been cut from the salaries of NHS staff by the government restraining of public sector workforce pay below inflation[14]. The CSP supports the UK pay framework as set out in the Agenda for Change agreement and believes a Pay Review Body, independent from Government, is the most appropriate way of delivering this.

3. Models of service delivery and integration

How can the move be made to an integrated National Health and Care Service? How can organisations in health and social care be incentivised to work together?

3.1 The experience from the Vanguard sites suggests that the barriers for scaling up new models of care are not the workforce but transactional issues relating to contracts, organisational accountability and sharing of risk, coupled with lack of time for service development.

3.2 The current payment systems create perverse incentives and act as a barrier to a better use of resources overall – for example, activity-based payment in the acute sector that discourages a shift of care outside of hospital settings.[15] This is only exacerbated by the current financial circumstances of providers. The bringing together of commissioners and providers into common partnerships (the STPs, devolved authorities) and the efforts to reform funding (towards capitation funding and commissioning for outcomes) offer a major opportunity. However, if these partnerships are principally presiding over cuts to services to balance the books in the short term, they are less able to lead the transformation of the system needed for long-term sustainability.

3.3 Community rehabilitation reduces the number of people becoming needlessly disabled and minimises restrictions in their leading active lives. It is essential for people to manage long-term conditions successfully. Teams are multi-disciplinary – integrating care around patient needs, as they move from one sector or setting to another, working in partnership with service-users to achieve the goals that are important to them.

3.4 However, too often people might receive intensive rehabilitation in hospital but then have long waits for rehabilitation in the community[16], if it is available at all. While patients wait their recovery is halted and can reverse – often causing lasting disability and deterioration of health. This impacts terribly on people's lives and drives up costs in both health and social care.

3.5 To stop this, a patient's rehabilitation should be continued from hospital to home. This is both a question of expanding rehab services in the community and integrating them with the rest of out of hospital care (including GPs).

[14] Forthcoming submission by health unions to the pay review body for 2017/18
[15] NHS payment research report, Nuffield Trust 2014
http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140220_nhs_payment_research_report.pdf
[16] The Chartered Society of Physiotherapy. Unpublished data from a freedom of information request on community rehabilitation services. London: The Chartered Society of Physiotherapy: 2016

3.6 Furthermore the model of access needs to be modernised. Requiring people to either go to see their GP or go back to secondary care for a referral builds in delays and duplication. A modern and more efficient model of care within communities puts more power into the hands of individual service users with long-term conditions to refer themselves to see the right professional at the right time.

3.7 Allowing patients direct access to physiotherapy is tried and tested. It cuts costs by up to 25 per cent compared to a GP referral.[17] It has been evaluated fully and recommended by NICE for musculoskeletal patients, but in spite of this is only available in 3 in 10 CCG areas in England[18]. In trials in 2014/15 it was actively marketed to 10 000 adults registered in the intervention practices. There was no increase in referral to physiotherapy or waiting times and the number of inappropriate referrals was slightly lower among the self-referrers than it was among those referred by the GP.[19] The Health Select Committee report into primary care recommended a timetable for the implementation of self-referral to physiotherapy as an urgent immediate reform.

3.8 There is also undoubted waste and inefficiency caused by duplication of care and delays across health and social care. Local evaluations of integrated approaches show the potential to reduce costs. For example, the NHS Greenwich Integration Pioneer brings together teams of nurses, social workers, occupational therapists and physiotherapists to provide a multidisciplinary response to emergencies they are alerted to within the community at care homes, A&E and through GP surgeries. They handle those that can be dealt with through treatment at home or through short-term residential care. In two and a half years over 2,000 patient admissions were avoided due to immediate intervention from the Joint Emergency Team; there were no delayed discharges for patients over 65 and over £1m was saved from the social care budget.[20]

3.9 However, evidence from integration initiatives overall suggests that integration may not achieve short-term savings. On the contrary, the experience of CSP members suggests that the current pressures to achieve efficiencies and squeezing of budgets is undermining the success of integration. The March 2016 survey of CSP members found that 75 per cent of members agreed that lack of funding was a barrier to successful integration. Their experience echoes the evaluation of the Better Care Fund by the Public Accounts Committee in 2015. [21]

3.11 In the long term, care costs may be reduced (or at least the rise in care costs mitigated) if the health and care system was better able to support patients and carers to be more actively involved in their care and reducing levels of need.[22] This requires an approach to integration that goes beyond integration at the level of organisations and an approach to care that goes beyond the limited medical model that dominates the health system.

3.12 The CSP is concerned that there has been a narrowing of focus in the implementation of integration policies as a means of achieving short-term savings. As well as doubting this as a means to save money, our concern is that decoupling integration from the longer-term goals on quality and the transformation agenda for long-term sustainability serves to

[17] Holdsworth L, Webster V, McFadyen A. What are the costs to NHS Scotland of self-referral to physiotherapy? Results of a national trial. Physiotherapy. 2007;93(1):3-11.
[18] Chartered Society of Physiotherapy. Physio Works: self-referral. London: Chartered Society of Physiotherapy. 2015. URL: http://www.csp.org.uk/professional-union/practice/your-business/evidence-base/physiotherapy-works/self-referral
[19] Keele University 2014/15. Awaiting publication
[20] Department of Health. Integration pioneers leading the way for health and care reform. 2013. URL: https://www.gov.uk/government/news/integration-pioneers-leading-the-way-for-health-and-care-reform--2
[21] Planning for the Better Care Fund report, Public Accounts Committee 2015 http://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news/report-planning-for-the-better-care-fund
[22] Hibbard JH, Peters E, Dixon A, Tusler M. Consumer competencies and the use of comparative quality information: it isn't just about literacy. Med Care Res Rev. US: Sage Periodicals Press. Aug 2007; 64(4):379-94.

undermine these aims. Successful integration requires a significant investment of time and resources in IT systems, system changes, cultural change, developmental work to provide services in different ways and the training and education of the workforce.

4. Prevention and public engagement

How can people be motivated to take greater responsibility for their own health? How can people be kept healthier for longer?

4.1 Motivating people to take greater responsibility for their health requires a shift in all our thinking about what health and care services should be prioritised and how they should be delivered. The NHS is 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.

4.2 Medical intervention and advances are of course vital. But far more attention needs to be given to those services that support, rehabilitate, prevent and educate people to manage conditions and lead healthy lives, and support carers to do the vitally important work that they already do. This is currently not the case for most areas.

4.3 Furthermore, the traditional approach in social care has been to manage and support the existing mental and physical condition of services users. What is required is a far more rehabilitative and preventative approach to care that empowers and enables people to manage themselves, and maximises their abilities to do so.

4.4 Falls prevention is a good example of preventative health care services. Half of all people who suffer a hip fracture are left with a permanent disability and can no longer live independently. Group exercise programmes reduce falls by 29 per cent and individual exercise programmes by 32 per cent. Every year 160 000 serious falls would be prevented if everyone 65+ at risk of falling was referred to physiotherapy, which would save the NHS £252 million.

4.5 There are many excellent services that empower service-users and build social capital by reconnecting with communities. For example, the Hope Specialist Service in Grimsby is part of social enterprise, Care Plus, and provides rehab programmes and support for patients with COPD and older people at risk of falls. The team is made up of physiotherapists, occupational therapists, generic technical instructors, rehabiliation assistants and 80 volunteers – made up of former patients and carers, who act as motivators, role models and community educators. When the service was established it took over Hope Street Medical Centre, a GP surgery in an area of high deprivation. The centre was run down and used to be 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. Results from the service include: One hospital admission prevented per patient on the 8-week programme – saving £2600 per patient; hip fractures have been substantially reduced; volunteer led smoking cessation courses have a 62 per cent higher quit rate than the national average; patients report significantly reduced levels of anxiety and depression with higher confidence and ability to undertake daily activity; and a valued community asset has been created

4.6 Furthermore, a new public consensus needs to be built around what a modern, sustainable health service could look like, the role of the public and the unpaid workforce in this and the relationship between service users, communities and service providers. Services like Hope have a great deal to tell us about how we can go about this.

4.7 However, building this consensus is dependent on the public being able to trust that the NHS is going to continue to be free at the point of need and that adequate funding of health out of general taxation will continue to be a priority for whoever is in government.

5. Digitisation, big data and informatics

How can new technology be used to ensure sustainability of the NHS?

5.1 A major barrier to integration at a service level is the lack of investment in technology and systems to provide seamless shared access, communication across boundaries, in a common language with shared standards. This is required for example for booking and record keeping systems. The March 2016 CSP member survey found that 85% per cent of CSP members agreed that different IT systems are a barrier to integration in their experience. One member in the South West summed this up: "*Fundamentally our IT services are all completely different: The acute trust, community trust, social services, mental health trust and GP practices all have systems that don't talk to each other. This wastes so much time, effort and money!"*

5.2 Digital technology has a rapidly increasing role to play in supporting people to self-manage conditions and motivate behaviour change, as well as modernising how patients access services. AHP Suffolk, a social enterprise, has run a successful self-referral service in primary care for the past seven years. It has driven down waiting times to 1-2 weeks for most patients and reduced secondary care referral rates by 20 per cent. Central to its success is an online portal, which 85 per cent of patients use to self-refer. This has significantly increased capacity by reducing triaging time by the physiotherapist to three minutes and freeing up time at the first appointment. It scores 97 per cent on the friends and family test and 88 per cent on patient satisfaction. West Suffolk CCG is now working with AHP Suffolk to pilot GP Physiotherapists in two GP surgeries, with a view to rolling this out to 22, in order to reduce orthopaedic referrals and save GP time. After consulting with patients, the service has gone further in using digital technology to support self-management by developing an exercise app. As well as receiving a tailored exercise sheet, patients will receive a video on their handheld device that shows how to do their exercises, sends reminders and invites them to record what they have done. The results are automatically put on their records. The purpose of the app is to reduce the number of appointments patients need and help people to get better quicker.

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