Written evidence submitted by The Chartered Society of Physiotherapy (HSC0927)

To: Rt Hon Jeremy Hunt MP & Members of the Health & Social Care Select Committee
Chair of Health & Social Care Select Committee
House of Commons
London
SW1A 0AA

By email:

The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the UK's 60,000 registered physiotherapists, physiotherapy students and support workers.

The profession has played an essential role throughout the Covid19 pandemic. From intensive care through to community rehabilitation, physiotherapists have been providing care for patients most affected by Covid19. Physiotherapists and physiotherapy support workers have been critical in enabling non-Covid19 patients' rehabilitation and discharge from hospital. Retired physiotherapists, furloughed & redeployed physiotherapy staff, and physiotherapy students have mobilised during the pandemic. Physiotherapy contributes to the health and wellbeing of healthcare workers, unpaid workers and volunteers, and other key workers.

CSP Key Points

- We welcome the repeal of section 75 of the Health and Social Care Act 2012 competition regulations representing a move away from competition to a new model of collaboration and integration.
- We support the strengthening of accountability at every level from the Secretary of State and Parliament to NHS bodies that are part of local systems.
- More clarity is required on the make-up, function and interaction of the ICS boards, how ICSs will delegate budgets and decision-making to 'place' level services.
- ICSs must have a duty to increase patient access to address health inequalities.
- All ICSs should be required to have a Rehabilitation Lead at a senior level in order to lead necessary transformation and integration of rehabilitation provision.
- ICSs should also be required to ensure patient voice and representation of staff through their trade unions and professional bodies.
- We strongly welcome the commitment to improve the quality and availability of data across the Health and Social Care Sector including workforce data.
- The proposed reorganisation cannot detract from the urgent need to resolve the significant workforce issues across the NHS and social care or the issue of recovery and rehabilitation from Covid19.

1 Collaboration and integration

1.1 The CSP strongly welcomes the move away from focus on competition towards a new model of collaboration and integration across sectors and settings. Current competition regulations are a costly distraction from the business of improving patient care, public health and making the NHS fit for the future. We agree that this has impeded change and has drawn money away from frontline services.

1.2 In some areas, compulsory tendering has resulted in overly complicated service provision (e.g. seven different MSK providers with different pathways in one area). A population health perspective based on collaboration would be more effective.

1.3 The pandemic has highlighted the impact of poor integration on the people who most need services – for example, resulting in too many people discharged from hospital with inadequate rehabilitation and social care in place.

1.4 The current pandemic has demonstrated how much more effective devolved decision-making can be than national. For example, the ineffectiveness of national temporary workforce and volunteer registers, and the apparently superior results gained from local authorities leading local track and trace in their area than the national system.

1.5 Greater collaboration and integration reflects the current direction of many systems at a local level already and implemented correctly has the potential to benefit many of our patients who live with complex conditions requiring the support of different services and a smooth transition between acute, secondary and primary care.

1.6 The CSP supports the aim of speeding up integration with a place-based approach, as necessary for implementation of the Long Term Plan. This is critical to realising the ambitions of the Long Term Plan for the NHS to focus on early intervention, rehabilitation and recovery; personalisation of care; and rebalancing the system to target resources to primary and community services to prevent and anticipate care needs in the population.

1.7 An issue for the funding of physiotherapy and rehabilitation in the NHS is that their value and impact are often felt in different parts of the system. We therefore welcome the bringing together of funding into one pot and moving away from activity-based tariffs to outcomes-based which has the potential to resolve these issues.

1.8 We support a new 'public value test' which could be a useful criteria tool to guide procurement decisions, prioritising the quality of care, the interests of the public and employment standards. We would welcome the opportunity to help shape this test, along with patients, other professional bodies/unions, charities and the Social Partnership Forum.

2 Accountability

2.1 Strengthening accountability at every level from the Secretary of State and Parliament to NHS bodies that are part of local systems is essential. The last year in particular has shown the need to build public trust in NHS procurement through due process and transparency about funding.

2.2 These proposed changes are an opportunity to set clear expectations of ICSs, joint committees that they establish, and Primary Care Networks (PCNs) that they delegate to. This includes transparency about procurement decisions and spending, including on consultants.

2.3 The NHS Health and Care Act must provide clarity on how the increasing number of bodies including ICSs, Trusts, PCNs, Health and Wellbeing Boards, provider collaboratives and place

level governance structures will work together avoiding confusion and duplication whilst enabling accountability at every level.

2.4 The nature of any powers of direction and intervention given to the Secretary of State must be clarified, and decisions made be subject to the public interest test. We would support the publication of any directions to NHS England. We are concerned that service changes will be slowed if ICSs are constantly answering upwards.

2.5 Clarity in the NHS Bill is critical on the role of the Secretary of State and the role of Parliament. This includes responsibility to provide or secure comprehensive health services, to agree the NHS Mandate and any changes to the constitution, and hold NHSEI and the other arms-length bodies to account.

2.6 More detail is required on proposals on professional regulation. We urge the government to actively engage with the CSP and other Health professional bodies on any future changes to professional regulation.

2.7 We agree that legislation can only ever be part of the picture and we therefore call for a duty on ICSs to increase patient access to services like rehabilitation to address health inequalities. This should run alongside a cross governmental strategy to tackle wider health inequalities.

3 Integrated Care Systems

3.1 We would urge clear requirements on the governance structures of ICSs. This is because the rebalancing within the system through improvements in community and primary care provision needs to be fully realised in governance arrangements within ICSs.

3.2 Clarity is required on the relationship between the NHS ICS and the ICS Health and Care Partnership; as well as who will be on the boards, how they will operate or handle disagreements between the boards.

3.3 There is a risk that the NHS ICS Body becomes narrowly focused on the NHS if the ICS Health and Care Partnership lacks the powers to drive change. Tackling wider health inequality and ensuring true integration of health and social care requires ICSs to consider wider services such as social care, housing and keeping people in work. The role

3.4 As well as ensuring sufficient weight within ICS structures for local authorities, community and primary care, there needs to be a voice for rehabilitation. Rehabilitation is critical to the rebalanced system envisaged in the Long Term Plan and commonly takes place at the interface between different parts of health and social care. However, it commonly lacks visibility in the system and it's value and potential are not always understood by system leaders.

3.5 We believe that improving quality and access to rehabilitation should be recognised as core to NHS business and a cross cutting theme of Long Term Plan implementation. NHSEI has drafted guidance for rehabilitation for providers and commissioners including proposals for each ICS to appoint a Rehabilitation Lead to drive transformation of rehabilitation. All ICSs should be required to have a rehabilitation lead at a senior level.

3.6 The legislative changes proposed in the White Paper will require amendments to the NHS Constitution. At the same time the NHS Constitution should be amended to include a commitment to meeting rehabilitation needs as a core function of the NHS, along with enabling prevention and public health. With putting ICSs onto a statutory footing, it needs to be clear that ICS accountability includes delivery of the NHS Mandate and upholding the rights set out in the NHS Constitution.

3.7 We also ask that the statutory requirement that only doctors and nurses can become Medical and Nursing Directors in Foundation Trust Boards be revised to be inclusive of physiotherapists and other Allied Health Profession (AHP) leaders. We suggest that there is an AHP Director who is an AHP, and they have responsibility for AHPs and rehabilitation. Given the role of AHPs in delivering transformation and integration in practice, this overdue modernisation will support delivery of the Long Term Plan.

3.8 Each ICS needs to have a clear structure and requirement for staff and patient engagement, including through representation from trade unions and professional bodies. Currently some ICSs do this well and others not at all. We suggest that the Social Partnership Forum be involved in developing requirements in relation to this.

3.9 Any changes to the current CQC regime must be robust and responsive to ensure effective regulation in all domains, including the well-led domain and the focus within this on workplace cultures.

4 Workforce

4.1 The CSP notes that key issues of workforce shortages and future supply to meet demand remain unaddressed in the White Paper.

4.2 At present there is no clear line of accountability for the workforce, which has led to a failure to address urgent challenges. The proposed changes must result in greater accountability for workforce planning and development.

4.3 Workforce issues that need to be addressed include vacancy rates, a growth in demand due to covid19/long covid and delayed elective surgery, systematic health inequality and a growing need for recovery time for the workforce post pandemic.

4.4 We therefore call for a national workforce strategy for the NHS and social care and clear transparent arrangements for reporting progress.

4.5 We support the extending of the statutory triple aim for NHS bodies and ICSs to be quadruple aim, with a fourth aim to develop the workforce, including support workers, to deliver patient care. We believe this duty should be extended to all organisations providing services to the NHS, including independent providers from the private and voluntary sector.

4.6 The Committee should be mindful of the timeline for implementing these measures and the additional strain this may place on staff who are already facing stress and burnout. The workforce and patients must receive assurance that the reforms in the NHS Bill will not lead to overnight restructuring of frontline services at a time when services are already struggling to meet current demand, and that any future changes will genuinely be in service of better health and not just change for change's sake.

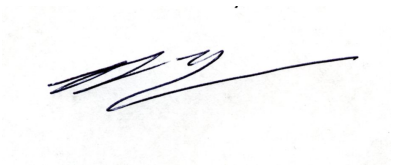
4.7 Any additional costs of redesigning services and expanding the workforce should be fully funded to ensure that the proposed reorganisation does not impact on care or staff performance.

5. Social care

5.1 The CSP is concerned about the omission of long overdue social care funding and reform in the White Paper. Whilst we welcome the proposal to award proper legal standing to a formal collaboration between the NHS and local authorities we are concerned that integration is problematic whilst the NHS and social care are funded and organised on a totally different basis. We look forward to further detail on the reforms promised later this year as a matter of urgency.

5.2 We strongly support a new legal framework for a 'Discharge to Assess' model in principle and believe this is in the long-term interests of patients. However, it is essential that this be managed well. There must be sufficient staffing and resources for the Discharge to Access team and in rehabilitation and social care to enable timely patient access to services. Particularly in the current context, it is essential that this significant change is fully resourced and the best practice is employed in supporting and engaging physiotherapy staff in its implementation.

The CSP would welcome the opportunity to meet with committee members to discuss any of this further.



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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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