Written evidence submitted by The Chartered Society of Physiotherapy (CBP0082)

To: Rt Hon Jeremy Hunt MP & Members of the Health & Social Care Select Committee
By email:

The CSP is the professional body and trade union for the UK's 60,000 registered physiotherapists, physiotherapy students and support workers.

The CSP 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-Covid-19 patients' rehabilitation and discharge from hospital. Retired physiotherapists, furloughed & redeployed physiotherapy staff, and physiotherapy students mobilised. Physiotherapy contributes to the health and wellbeing of healthcare workers, unpaid workers and volunteers, and other key workers.

Summary of CSP recommendations

- Clearing the elective care backlog is dependent on building capacity in and improving access to high quality person centred rehabilitation services
- Implement national and local system-level Allied Health Professional workforce planning to ensure we have the right skill mix to transform rehabilitation services and meet the growing backlog
- Amend the Health and Care Bill to ensure that it delivers on national and ICS AHP workforce planning, AHP clinical leadership and mandates a rehab strategy in every ICS to tackle the elective care backlog and drive change to ensure improved access to quality rehabilitation to meet need.
- Invest in community services across the whole of primary and community care beyond GP surgeries to deliver the care required to enable people to manage long term conditions effectively
- Drive transformation of community provision, including implementation of a new integrated model of community rehabilitation for Long Covid and Long-Term Conditions
- Ensure we learn from the pandemic where improved access to remote rehabilitation can build capacity and improve take up of rehabilitation services
- Support a government-led review of current rehabilitation provision

1. Elective care backlog and pent-up demand

1.1 Covid continues to have a severe impact on the anticipated elective treatment waiting list which is at a record 5.45 million and continuing to grow, with trauma and orthopaedics particularly impacted.[1] At the end of June over 300,000 patients have waited more than 52 weeks to receive treatment.[2]

1.2 This includes patients whose medical procedures were initially deemed non-urgent, but whose conditions will have since progressed in severity and face poorer post treatment outcomes as a result. The elective backlog is impacting on GP services as patients on waiting lists seek pain management and their conditions deteriorate.[3] Tackling the backlog by increasing surgical capacity

is important, but relies on increasing the capacity of already overstretched and underfunded community rehabilitation services to optimise medical outcomes.

1.3 Many NHS services including respiratory and cardiology are facing delays to diagnosis and treatment, with disruption to community rehab services. For example, during the peak of the pandemic, expected respiratory appointments taking place reduced by 85%.[4] The Taskforce for Lung Health has highlighted a lack of capacity to see and support all respiratory patients who need care.

2. Clearing the backlog - Community Rehabilitation

2.1 Covid-19 has pushed levels of unmet rehab needs to a crisis point. 70% of patients admitted to hospital with Covid-19 had not yet recovered by March 2021.[5] Long Covid is affecting an estimated 945,000 people as of August 2021,[6] with almost all requiring supported self-management, and an estimated 90% needing to participate in a rehabilitation programme in order to regain their health.[7]

2.2 40% of people are managing a long-term condition[8] and 25% are managing 2 or more, and these figures are rising.[9] Although associated with age, the biggest increase is among working age adults. Musculoskeletal disorders account for 20% of all years lived with disability, and anxiety and depression accounting for 10%.[10] During the pandemic, millions of people with long-term conditions and frailty have deconditioned and deteriorated as a result of lockdown and disruption to services. Many are impacted by the severe backlog in elective procedures affecting their day to day lives. The emotional and psychological distress that patients experienced due to disruption of services and postponement of treatment may also require additional considerations in postoperative recovery.[11]

2.3 Even before Covid, people with long-term conditions already accounted for 55% of all GP appointments, 68% of all outpatients and emergency admissions and 77% of all inpatient bed days.[12] Much of this stems from unmet rehabilitation need forcing people into crisis, and this in turn pushes greater demands onto a struggling social care system.[13]

2.4 The demographic trends in relation to long term conditions mean that rehabilitation services are increasingly not fit for purpose. The need to modernise the system in response to these demographic factors is well known and understood. The Long Term Plan attempts to address this and if implemented will go a long way towards achieving the step change needed, but only if the workforce is developed and grown to deliver this. The experience of the pandemic has made this even more of an imperative.

2.5 The anticipated increase in demand for rehabilitation to manage long-term conditions means that workforce capacity to deliver rehabilitation must increase. The World Health Organisation has recognised this as a global issue[14] and in England even before the pandemic, there were significant areas of unmet need including rehabilitation for stroke survivors and pulmonary rehab (PR).

2.6 Only one third of patients eligible for Early Supported Discharge (ESD), which includes daily visits from a physiotherapists or rehab support worker for six weeks, actually receive it. In addition to ESD, the Stroke Plan now sets out the generalist rehabilitation and support required by stroke survivors for up to 6 months, in order to return to work or other activities.

2.7 NICE guidance says 1.15 million people with COPD every year should be referred for pulmonary rehabilitation (PR) but only 15% are referred.[15] Of those referred a significant proportion (31%) do not attend assessment for treatment.[16] This doesn't include new needs resulting from Covid. The Long Term Plan is for 100% of eligible patients to be referred. A programme of PR delivers a 36.4% reduction in exacerbations and admissions and demonstrates cost effectiveness. The effectiveness of PR is endorsed in The Respiratory Medicine GIRFT Programme National Specialty Report published earlier this year, which highlighted serious gaps in provision as well as an additional backlog of an estimated 8000 people.[17] The report calls for detailed workforce planning in respiratory physiotherapy, including advanced practice.

Develop the physiotherapy workforce to meet the backlog

2.8 To achieve transformation in rehabilitation services as well as meeting the growing backlog, we need more physiotherapists and physio support workers with the right skill mix to meet current vacancies, new demands and population pressures.

2.9 Physiotherapy is one of the few professions where there is continued and strong growth in supply. To take full advantage of this national and local Allied Health Professional (AHP) workforce plans are needed to translate the growth in physio supply into more physiotherapists working in the NHS. This should include guaranteeing 5-year NHS contracts to newly-qualified physios who want one.

Invest in advance practice

2.10 To reduce pressure on GPs and consultants in secondary care, investment is needed in advanced practice and consultant physiotherapy. This will allow physios to take on the extended roles needed to meet changing healthcare needs. This includes roles such as First Contact MSK Practitioners (FCPs) and community rehab advanced practitioners alongside expansion of pre-registration training to backfill roles. Every person should be able to access an MSK FCP via their GP surgery. This existing role frees up GPs, speeds up access to expert advice, and saves money by keeping patients out of hospitals and reducing unnecessary referrals to secondary care. New roles of Long Term Condition Advanced Clinical Practitioners are required in the community to lead the service transformation required to meet modern population needs.

Expand the support workforce, as a proportion of the physiotherapy workforce

2.11 Workforce plans should include recruitment of more support workers alongside expanding the registered physiotherapist numbers. Higher-level role development should be implemented for therapy support workers, including in supporting clinical education, exercise prescription and coaching/motivational interviewing.

2.12 The Assistant Practitioner apprenticeship for therapies should be developed and promoted. This will widen access, including in hard to recruit areas such as rural and coastal towns. The CSP supports a reform of visa arrangements so that physio support workers become eligible for Health and Care visas.

Impact of Covid on the physio workforce

2.13 Physio staff have played an essential role throughout the pandemic and recovery. However, re-deployment, cancelled leave, heavy workloads and the emotional impact of Covid has taken its toll. Healthcare staff working in communities report experiencing patchy access to support compared

with those working in hospitals.[18] Going forward there is an urgent need to strengthen their resilience and prevent staff leaving the NHS by tackling the root causes of workplace burnout.

3. Positive lessons to be learned from healthcare service redesigned during the pandemic

Integrated rehabilitation

3.1 NHS services are traditionally crisis driven, organised around single episodes and events. Support for people with long-term conditions continues to be located in and around secondary care, shaped by narrow targets on admission avoidance or discharge. They are also organised in condition-specific medical silos, that don't yet respond effectively to the needs of people with multiple long-term conditions.

3.2 Primary care funding traditionally focuses on GPs services. However, redistributing NHS resources to invest in multi-disciplinary community teams would reduce costs to GPs and improve access to high quality person centered community services.

3.3 We need to reimagine rehabilitation in order to meet demographic changes and population needs, address the backlog in elective care, and reduce demands on GPs, social care and secondary care. We need to provide a new offer of rehabilitation that provides improved supported self-management/advice, personalisation and integrated approach including psychological support.

3.4 Dealing with an unknown condition with a virus that attacks multiple systems in the body during the pandemic has taught healthcare workers to take a personalised approach to each patient, tailoring treatments to individual needs. Going forward rehabilitation services must build around the needs of the individual person, not necessarily based on single conditions, because people present with a whole range of different needs, often both physical and psychological.

Improving access to rehabilitation

3.5 Having multiple long-term conditions is closely associated with income, age, ethnicity, gender, sexuality and disability. Any levelling up agenda must include improved access to rehabilitation. There is a clear link between lack of universal access to rehab for people with Long-Term Conditions and health inequity – i.e. those who can afford to pay do so, those who can't do without and bear the long term consequences of this. This is a vicious cycle, as poor access to appropriate rehabilitation is driving unnecessary disability, loss of income, and loss of independence.

3.6 Options of more local or remote rehabilitation, as part of a blended offer of remote and in person services, could help address practical barriers to accessing services such as the lower access to a car amongst women.[19] Recent patient insight research carried out for the CSP suggests that people would find rehabilitation more accessible if more of it took place outside of medical settings,[20] and there is potential that such a shift to community assets, like gyms or community centres, could improve levels of participation and ongoing commitments to physical activity and lifestyle changes. [21]

3.7 Rehabilitation services also need to be flexible in their approach to improve take up. For example including carers in planning and attending sessions, would make services accessible to people with learning disabilities (among other groups). People with learning disabilities have difficulties accessing health services and have significantly worse health outcomes than the rest of the

population.[22] Studies into cardiovascular rehabilitation programmes have suggested that higher take-up among South Asian women could be achieved through providing same sex groups and using same ethnicity advocates.[23]

3.8 The CSPs supports the Community Rehabilitation Alliance's joint call for a government-led review of current rehabilitation provision. This would bring together evidence of the cost effectiveness of rehabilitation in the health and care system and its wider economic benefits and cross-departmental value, consider international and domestic best practice. It would also capitalise on the current learning and momentum to improve the rehabilitation offer, and implement lessons learnt through the pandemic.

3.9 Rehab services need to provide a step change in supported self-management. Physiotherapists are viewed as a trusted source of advice on strength and balance and this should be capitalised on to support public engagement in exercise and in rehabilitation to manage long-term conditions.[24]

Digital technology

3.10 Covid response has highlighted the urgent need to mainstream remote rehabilitation as part of a blended service offer along with face to face, improving access (particularly in rural areas) and helping to develop a system that is resilient to future pandemics. Remote provision enables clinicians to work in virtual multidisciplinary teams (MDTs) across sectors and settings. During the pandemic community teams had greater access to specialists including neuro-specialists who could attend virtual case conferences without time and travel constraints.

3.11 The impact of remote provision must not be to reduce quality or access to rehabilitation services, but to build capacity and break down barriers to take up. Rehabilitation services must be fully funded to support remote or hybrid working practices,[25] provide training and development for the workforce and students, and end the lack of basic technology and interoperability of systems.

Data and health inequities

3.12 Existing healthcare data highlights the inequity in the rehabilitation offered to and taken up particularly by women and marginalised communities. Better data, which moves beyond activity data to include need and outcome, is critical to understanding the extent of this. Improvements to national audits of rehabilitation provision and routine data collection across primary care, community and social care, and linking up these data sets, is urgently needed. A greater ability to understand population health needs through data and design services to address inequities in provision and outcome.

4. Reforming NHS and care services to deal with the backlog

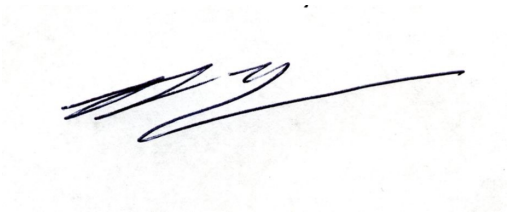
4.1 We are not starting from scratch. A new Long-Term Conditions integrated rehab model is expected to be piloted by Academic Health Science Networks (AHSNS) and supported by NHSE. In the first year these two year pilots would focus on long covid rehab, and in year two be broadened out to all long term conditions. This builds on work by the Chartered Society of Physiotherapy, Royal College of Occupational Therapists and other members of the Community Rehabilitation Alliance and the Royal College of General Practitioners. It also builds on many exemplary services that already exist e.g. Sandwell Rehabilitation Centre,[26] and Greater Manchester's Prehab4Cancer service.[27]

4.2 To modernise community rehabilitation we support wider changes to workforce planning. We therefore support the amendment to the Health and Care Bill requiring the Secretary of State to publish a report on assessing and meeting the workforce need annually. The Bill needs to go further and include AHPs, who as the third largest clinical staff group, are critical to many of the developments outlined in the Long Term Plan which ICSs will be seeking to deliver. They are also the clinicians working on the boundaries between health and social care therefore crucial to delivering integration.

4.3 To ensure that ICSs benefit from strategic AHP clinical leadership and deliver integration the Bill should be amended to ensure every Integrated Care Board (ICB) has an AHP member. We would also support an AHP director at Trust level to put AHP clinical leaders on the same footing as medical and nursing leaders at board level within NHS organisations.

4.4 The Department of Health & Social Care should provide guidance for ICSs and Trusts to produce AHP workforce and rehabilitation plans covering the provision of rehabilitation services. Rehabilitation is the forgotten fourth pillar of healthcare; after nursing, medicine and surgery. It is key to integrating heath and care services and critical for clearing the current backlog, improving patient outcomes and reducing health, social care and personal costs.

4.5 Organisations are nervous about the proposed change in the system. Integration is key but this must lead to improved access and not an exercise in rationing or further under-resourcing. Rehabilitation in particular is woefully underdeveloped and an area in need of greatest innovation. It is also the area with the greatest potential to drastically improve a patient's quality of life by allowing them to retain as much of their independence as possible. On top of this, from a financial standpoint, it reduces demand on the most expensive parts of the NHS and social care systems.



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