Evidence submitted by the Chartered Society of Physiotherapy for the Department of Health on fundamental standards for health and social care providers

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Introduction

The Chartered Society of Physiotherapy (CSP) is the professional, education and trade union body for the physiotherapy profession. The CSP has 52, 000 members, representing 95 per cent of qualified physiotherapists in the UK, as well as physiotherapy support workers and students.

The CSP welcomes the opportunity to respond to the DH consultation on introducing statutory Fundamental Standards of care. Our response is focussed on the areas in which we feel we can most effectively contribute to the debate.

The CSP plays a key role in ensuring high professional standards in the UK physiotherapy profession. It sets out clear expectations of members' professionalism through a Code of Professional Values and Behaviour [1] and Quality Assurance Standards.[2]

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. 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.

As an adaptable, engaged workforce, physiotherapists have the skills to address healthcare priorities, meet individual needs, and to develop and deliver integrated services in clinically and cost-effective ways.

Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity. Physiotherapists work with children, those of working age and older people; across sectors; and in hospital, community and workplace settings. Physiotherapists facilitate early intervention, support self management and promote independence, and help prevent episodes of ill health and disability developing into chronic conditions. Physiotherapy supports people across a wide range of areas including

[1] http://www.csp.org.uk/professional-union/professionalism/csp-expectations-members/code-professional-values-behaviour
[2] http://www.csp.org.uk/publications/quality-assurance-standards

musculoskeletal disorders (MSD); many long-term conditions, such as stroke, MS and Parkinson's disease; cardiac and respiratory rehabilitation; children's disabilities; cancer; women's health; continence; mental health; falls prevention.

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.

Physiotherapists come into direct contact with patients and are well placed to observe the nature of care that patients receive, and the CSP welcomes this opportunity to comment on the proposed introduction of minimum standards or care. In particular, the CSP is championing the focus of the value of physiotherapy in enabling people to 'Live Longer, Live Well'. This has particular emphasis for those who require health and social care services to manage the effects of for example, fractures & falls, dementia and chronic long term physical health conditions which disproportionately affect the elderly population.

1. Do the Fundamental Standards (regulations 4-14) make clear the kind of outcomes we expect providers to meet/avoid?

1.1 The CSP welcomes the opportunity to consider and comment on the actual wording of the draft legislation, whilst recognising that the focus of the CSP is on patient-centered aspects of care, rather than legal analysis. Overall the CSP's view is that the Regulations are welcome in providing a framework from which clear, outcome-focussed legal statements can be made. Some rewording is required to ensure that the outcomes are specifically focused on improving the quality of care. Specifically taking each fundamental standard in turn:

1.1.1 4(3)(a)-(d) These are clear outcomes as they can be evidenced by examination of the clinical record, and the reasonable standards to be expected within each sub-section is further defined by either regulatory or professional standards.

1.1.2 4(3)(e) The phrase *'reasonable adjustment'* is not a clear cut outcome. It may be open to interpretation and challenge, particularly if providers feel adjustments are not reasonable considered in the context of their business model and/or costs. It may be helpful to refer to how this phrase is interpreted in law i.e. by reference to the Equality Act which gives a clearer meaning to this phrase.

1.1.3 4(3)(f) The phrase '*suitable quantities'* is not a precise outcome and leaves open the question of who determines the need, It is not clear whether it is at the practitioner level or the provider level. There is scope for tension when practitioner and provider assess different needs.

1.1.4 5(2)(a) The use of word *'promoting'* is vague and passive and difficult to consistently measure; a better phrase might be *'demonstrating steps to protect....'*

1.1.5 5(2)(b) The phrase *'having due regard'* again is vague and passive; a better phrase might be *'demonstrating compliance with the requirement to respect....'*

1.1.6 7(a) and (b) The word *'appropriate'* needs to be further defined in order to become a valid outcome. Otherwise it is open to challenge as to its

meaning in this context. An alternative phrase might be *'demonstrable steps to reasonably mitigate.... '*

1.1.7 8(2) - Again define the word *'appropriate'* in this context. An alternative phrase *'demonstrable steps...'*

1.1.8 11(1) - Again the words '*appropriately'* and 'appropriate' in this context need to be defined. How a provider believes it '*appropriately'* investigates complaints may be in tension with how a patient believes an appropriate investigation is carried out.

2. Do you think the Fundamental Standards (regulations 4-14) reflect the policy aims we have set out for the Fundamental Standards in Chapter 4

2.1 The overarching policy aims are stated as being a) to introduce fundamental standards b) to make effective and enforceable regulations c) to be outcome focussed and d) to reduce the burden on business.

2.1.1 The CSP supports any move to ensure, enhance and demonstrate safe and effective care, and the need to enshrine such expectations within statutory criminal law where necessary.

2.1.2 These standards will only be effective if the CQC has the resources and ability to effectively inspect and bring action against failing providers. Whether the Regulations are enforceable will depend on an analysis of the interdependencies between other sources of legislation. However, where these regulations do make explicit expectations of care, then they will provide patients with a concrete course of redress, rather than relying on either the civil courts, or other legislation such as health and safety law or the Human Rights Act.

2.1.3 Whilst we understand that the policy aim of 'fundamental standards' is not to set standards for specific clinical areas of care, it would be helpful if an overarching policy aim or 'reducing preventable injuries' was set out within the remit of CQC regulation.

3. Are the Fundamental Standards clear enough that they could be used as a basis for enforcement action?

3.1 It is stated that enforcement action will only be taken for serious breaches which, in effect, meet the threshold to be defined as so serious as to constitute *'misconduct'* rather than simply a lack of competence Case law already provides a definition for *misconduct* that may be relevant: *"It is a word of general affect, involving some act or omission which falls short of what would be proper in the circumstance. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a practitioner in the particular circumstances*" [Roylance v General Medical Council (No 2): 1 AC 311 [2001]. Moreover, there is no specific legal threshold that defines when *'sub-standard'* behaviour becomes *'misconduct'*, but it does require a level of seriousness such that it is a *'significant'* breach of expected behaviours. . It would be helpful to further define, within either the Regulations or supporting guidance, the level at which failings will trigger a CQC criminal investigation.

4. Regulation 17 sets out which of the regulations are offences for which CQC will still need to issue a pre-prosecution notice, alongside those that could be prosecuted immediately. Do you think this split reflects our intention (chapter 4) that only breaches related to a harmful outcome can be prosecuted without a pre-prosecution notice being issued in advance?

4.1 In effect, a warning notice is required for alleged breaches of fundamental standards relating to a) patient care (shared decision making, equipment and medicines, b) safe and appropriate care and treatment, c) patient complaints d) governance e) staffing levels and f) fit and proper persons. There is potential for medicines to have harmful outcomes on patients when not given in accordance with the valid direction of the prescriber, or withheld from the patient. Therefore the CSP believes that serious medicines failings should be acted upon promptly without pre-warning.

4.2 It will be helpful to have clarity on how any pre-prosecution notice is reviewed, to ensure that the intended power and impact of the standard is still maintained.

5. Do you agree that CQC's guidance about complying with these regulations should set out criteria for cases in which it would consider bringing a prosecution?

5.1 Criteria must be included that are accurate, clear and concise. They should not use terminology that is open to interpretation or unreasonable challenge. Terms used must be clearly defined in the context in which the CQC will enforce them. Care must be taken that perverse incentives are not created; i.e. providers take the wording of CQC guidance and provide service levels just above the threshold to avoid prosecution.

6. Do you agree that the health and adult social care system should always seek to meet the standards outlines in chapter 4?

6.1 Care must be taken not to discriminate against the levels of care a particular patient group can reasonably expect to receive. ALL patients, regardless of age or care setting have a right to expect the agreed fundamental standards of care.

6.2 The standards themselves need to be broadly worded to reflect the reasonable expectations of all users of health and social care services and please note our comments of where additional standards may be required in answer to Qu7.

7. Do you think any changes are needed to the draft regulations to ensure they reflect the policy aims we have set out in Chapter 4?

7.1 4(3)(d) Needs to include that a valid Advanced Direction is an acceptable means by which a patient can express a wish to refuse treatment prior to losing capacity.

7.2 6(2) Needs to include that a valid Advanced Direction is an acceptable means by which a patient can express a wish to refuse treatment prior to losing capacity.

7.3 7(1) The use of the word '*safe'* implies all treatment is without risk, although it becomes clear that the spirit of this clause is that the risks are properly mitigated. In areas such as physiotherapy rehabilitation, some management programmes will involve challenging a patient. For example, with balance re-education. In some cases this may result in accidental non-negligent injury to patients. The patient, or their relative, may perceive that the treatment was not safe. Paragraph 7(3) goes on to clarify that treatment will be appropriate if conducted in accordance with accepted standards. There perhaps needs to be a distinction between the fundamental expectation that care and treatment should be delivered in safe surroundings and contexts, but that the delivery of the treatment itself cannot truly be without risk, and thus properly 'safe', but must be planned and undertaken with proper consideration and mitigation of the risks involved.

7.4 7 (2) would benefit from the addition of a further subsections to address the potential for inequality in care between service users if this section remains worded as it stands. We recognise the purpose of these Regulations is to address fundamental expectations of care, and not to address specific standards of care in specialist clinical areas. However, there are certain standards that need to be added to ensure that the older population is adequately protected by these standards.

7.4.1 7(2)(e) taking appropriate steps to reduce the risk of reasonably foreseeable accidental injuries sustained in a care setting

7.4.2 7(2)(f) taking appropriate steps to reduce the risk of falls and fractures sustained in a care setting.

7.4.3 7(2)(g) taking appropriate steps to ensure safe moving and handling of patients in health and care settings

7.4.4 7(2)h taking appropriate steps to manage and identify the effects and impact of dementia experienced by patients receiving care

7.5 11(2) It may be helpful to state that any investigation should be 'impartial' and 'independent' to enhance to requirement for openness and transparency.

7.6 13(c) This needs redrafting to read *'where such persons are health and social care professionals registered with the HCPC, or *other medical and health professionals registered with their relevant and appropriate regulator, they are enabled to provide evidence to their professional regulator demonstrating.....'** It must be clearly understood that it is registration with the '*regulator'* that is a condition of practice, not registration with a *'*professional body'**. This section must also apply to ALL registered health professional, including doctors, nurses and pharmacists, and not just those AHP's and social workers registered with the HCPC.

7.7 14(1)(a) A definition of '*good character'* for the purposes of this Regulation needs to be added to the Section 2 – Interpretation. It also needs to be

clear how this will be demonstrated. This could be, for example, *' by the production of a DBS certificate dated within x weeks of commencing employment'*.

7.8 14(4) The word '*professional'* needs to be replaced with the word 'regulatory'. There is a clear distinction in law between a '*regulatory'* body for health professionals and a '*professional body'*. The purpose of this section is to make explicit that registration with the relevant regulator is a mandatory requirement to practise. Membership of a professional body, while highly valued and desirable (including for the purposes of promoting and supporting professionalism, and including through peer networking and review), is not a statutory condition of practice.

7.9 14(5)(a) and (b) Can be consolidated into one subsection as '*informing the relevant regulator where such persons are health and social care professionals registered with the HCPC, or other medical and health professionals registered with their appropriate regulator.'*

8. Do you have any other comments about the draft regulations?

8.1 We recognise the logic of having a single set of fundamental standards. We are also away that there are due to be higher level standards that service providers will be measured against. This raises questions about how the overall set of standards will present a cohesive whole and be implemented in a co-ordinated way.

8.2 Strong links need to be made between the CQC's regulation of providers and professional regulators' oversight of registrants' practice

8.3 The requirements relating to staffing numbers, skill mix and support for staff members' development need to be genuinely inclusive of all staff (qualified and non-qualified, all professions, and in all sectors and settings, etc.). Furthermore, they should be focused on outcomes for patients and the quality and effectiveness of care (taking account of all factors relating to patients, environment and staffing), not just issues to do with caseload management, patient throughput and fulfilment of targets. They also need to factor in issues relating to the sustainability and integration of services as a key component of ensuring patient safety and quality of care.

8.4 We strongly welcome the acknowledgement that access to appropriate supervision, support and appraisal is a fundamental aspect of delivery effective care. Again, it will be necessary to ensure that future requirements relating to this standard reflect the need for all staff groups to be included, including to ensure that the development needs of the support worker workforce are also addressed to ensure that high-quality patient care can be assured and upheld. .

8.5 The importance of *'proper persons'* being employed must be linked to the above issues, and again is to be welcomed. This should include ensuring that decisions made about the staffing numbers, skill mix and team delivery of care are predicated on a sound understanding of who is best placed to deliver high-quality, effective care. Again, decisions should not be based on how a service can be delivered most cheaply in the short-term. This can risk patient safety/quality of care and fail to deliver long-term benefits/clinical effectiveness for patients or cost-effective service

delivery (including in relation to reducing hospital admissions and re-admissions).

8.6 We welcome the introduction of these Regulations as a response to some of the findings of the Francis report. However, regulation still remains separated into 'professional regulation' and 'organisational regulation'. There is the risk that regulation will remain uncoordinated and/or inconsistent, and fails to uphold patient safety and quality of care. We would like to see clarity of how these fundamental standards will sit alongside the proposed 'enhanced standards' that are in development, and how strengthened arrangements for organisational regulation will sit alongside strengthened ones for professional regulation (including in light of the publication of the Law Commission report on regulating health and social care professionals).

9. Do you have any concerns about the impact of the proposed regulations on people sharing protected characteristics as listed in the Equality Act 2010?

9.1 We note that, as worded, older people and those at greater risk of preventable injury in care settings (such as those with existing disease or disability) may not benefit from the same level of protection from these standards as others in the population. The standards need minor expansion in Section 7 to ensure that older people are protected from risks and care matters that disproportionately affect this population group.

10. Do you have any comments about the estimated costs and benefits of these regulations, as set out in the draft impact assessment?

We have no specific comments to make on this question.

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