Department of Health

October - November 2015

Consultation response form

Setting the mandate to NHS England for 2016 to 2017

Consultation Questions

1) Do you agree with our aims for the mandate to NHS England?

The Chartered Society of Physiotherapy (CSP) agrees with the aims set out in the draft mandate.

The physiotherapy profession has an essential role to play in improving public health, preventing deterioration of health and the onset of disability, reversing loss of function and mobility, increasing independence and supporting people to be fit for work.

2) Is there anything else we should be considering in producing the mandate to NHS England?

In securing an affordable and sustainable system of health and care that better meets modern population needs workforce transformation will be critical.

For the next decade this will be predominantly the existing health and care workforce. We therefore suggest that two further critical factors that need to be reflected in the aims and priorities are positive staff engagement and culture change across health and care.

The best way to achieve the transformation that needs to take place is positive engagement with the full range of health and care staff, including the physiotherapy workforce to harness their insight and expertise on how to achieve the priorities in the mandate.

The Mandate needs to overtly encourage better coordination across the priorities between NHSE and the other arm's length bodies, including Health Education England and Public Health England. This is essential to achieve policy cohesion in the context of the Five Year Forward View.

For example we need to ensure that education and training resources are used to support the existing workforce to deliver transformation - including the transformation of out of hospital care and greater integration. This requires greater alignment between policy implementation in relation to service delivery models and service commissioning on the one hand, and how workforce planning, development and investment are progressed to meet new service needs on the other. At the moment, this alignment isn't apparent, so full opportunities for achieving change are at risk of being lost, for example in relation to primary care.

3) What views do you have on our overarching objective of improving outcomes and reducing health inequalities, including by using new measures of comparative quality for local CCG populations to complement the national outcomes measures in the NHS Outcomes Framework?

The CSP agrees with the overarching objective of improving outcomes and reducing health inequalities. It will be important that new measures are able to capture data in relation to musculoskeletal (MSK) disorders. MSK disorders are the greatest cause of disability in the UK, has the third greatest impact on health of UK population is the number one cause of sickness absence in the UK. It has a major impact on mental health. Depression is four times more likely among people with persistent pain and two thirds of people with osteoarthritis report periods of depression. All of these factors contribute significantly to health, social and income inequality. It is also an area where there is a potential to achieve significant improvements using the current workforce. Access to early and appropriate intervention within a primary care setting varies considerable and if made more consistent would reduce levels of disability, pain and barriers to the workplace and improve overall health and wellbeing.

4) What views do you have on our priorities for the health and care system?

The CSP agrees with the priorities set out in the draft Mandate. In relation to seven day services in hospitals and general practice the CSP agrees that this should be the goal for the NHS. However it is important that it is does not become an end in itself, but determined on a case by case basis by evidence on impact in relation to patient outcomes and patient access to services. Without additional resources there is a risk for some services that stretching the same resources for five days over seven could be detrimental to quality and waiting times.

There are two gaps in the priorities that we believe need to be addressed:

There is growing consensus among health professionals and NHS leaders of the need to extend the core GP team and the wider primary care team. Currently this is not clearly reflected in the priorities. This needs to be a key feature of new ways of working in General Practice - both to meet the current capacity issues in General Practice and to make the health and care system both more effective and more sustainable in the long term.

The other gap is around patient empowerment. The Mandate describes an intention to enable patients to have more power and control over their care. In order to make progress in this area this intention needs to be reflected in the priorities and objectives to be developed beneath these. Allowing patients to self-refer to appropriate services, including physiotherapy, within primary care, would be a major contribution to this end. (see 5)

5) What views do you have on how we set objectives for NHS England to reflect their contribution to achieving our priorities?

There are 30 million appointments made with GPs every year for MSK disorders - accounting for up to 30% of the caseload. Many of these are repeat appointments, before

eventually being referred to physiotherapy. There is significant variation in referral rates to specialist consultants – the King's Fund found referral rates within a single area vary ten-fold between individual GPs. A significant proportion (around a quarter) of orthopaedic referrals by GPs are judged by orthopaedic specialists to be unnecessary. A measure of the quality of referrals is the proportion that result in surgery. GP practices that provide physiotherapy services as the first point of contact substantially improve performance and efficiency in this area.

Allowing patients to self-refer to physiotherapy reduces GP appointments, reduces unnecessary tests and imaging, and reduces orthopaedic referrals. Through cutting waste and improving efficiency in this way considerable cost savings are achieved. The evidence base for self-referral to physiotherapy is also robust in showing this does not lead to any increase in demand and is both safe and clinically effective.

Many GPs, including in areas where they are having problems recruiting GPs, are now bringing in physiotherapists to be part of their core teams. There are also examples of this development in a number of Vanguard sites (such as South Hampshire and West Cheshire). With this new way of working, patients booking an appointment with the practice with MSK symptoms are offered the choice of an appointment with physiotherapist instead of the GP. This is quick and convenient for patients. This saves GP appointments, and has been shown in practice to increase the proportion of patients who are treated effectively through advice, exercises and support to self-manage, without the need for follow up or onward referrals.

Part of the transformation of out of hospital care needs to be improving access to specialist rehabilitation and prevention services. Patients who make great progress through intensive physiotherapy as part of their rehabilitation in hospital, for example, see their progress reversed owing to long waiting times for rehabilitation services in the community, if they receive them at all. Research led by Professor Timothy Briggs for the British Orthopaedic Association published this year looked at orthopaedic services across England and found that of all the hip fracture patients treated by the NHS half are left with a permanent disability, which often could have been prevented with better access to rehabilitation services out of hospital.

Far more needs to be done to identify those at risk of falling and providing appropriate intervention. There are simple established tests that could easily be carried out in General Practice by any member of the team. Those at risk should then be referred for appropriate intervention - whether this be a medication review by a pharmacist or physiotherapy to support people to build strength and balance. If everyone aged 65+ who was identified at risk of falling were referred to physiotherapy, for example, 205,132 falls would be prevented that would otherwise result in A&E attendance.

This would save the NHS £279,443,871 every year. Every £1 spent on physiotherapy for those at risk of falling produces a £2.27 return on investment.

Working with patients and service users to maximise their mobility and function needs to be a shared goal of all health and care staff. Currently in many hospital and residential care settings patients and service users are debilitated needlessly because supporting

physical activity is not seen as the role of all health and care staff and is sometimes actively discouraged. Furthermore patients are often required to stay longer than they need to in residential care longer than they need to be because of a lack of access to rehabilitation services.

To support the priorities outlined the CSP recommends objectives which encourage:

1) Stepping up of support for patients to self-manage MSK conditions

2) Reducing referral of MSK patients for unnecessary tests and consultant referrals from General Practice

3) Reducing the time off work caused by MSK conditions - which would be a major boost to productivity in the NHS and the wider workforce

4) Increased provision of multi-disciplinary specialist prevention and rehabilitation services in within primary care.

5) Routine identification in primary care of those at risk of falling and access to falls prevention interventions for those identified as at risk

6) The role of all health and care staff to support patients and service users to maximise mobility and function