Age Proofing the UK: Realising the Potential of an Ageing Society

Evidence submitted by the Chartered Society of Physiotherapy to the Liberal Democrat Policy Consultation on consultation paper 116

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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 97 per cent of qualified physiotherapists, as well as physiotherapy support workers and students. CSP members work across all sectors and settings in health and social care.
- Physiotherapy works. It increases the numbers of people who are living longer and living well.
- The physiotherapy workforce uses manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity.
- The profession is at the forefront of innovative practices in integration and multi-disciplinary working that keep people out of hospital and maximises independence.
- The CSP also represents members in the workplace and recently contributed to the UK-wide Working Longer Review, to address needs of older workers so that they can remain in the workforce.
- The CSP welcomes the opportunity to take part in this discussion. Our contribution is drawn from experiences as a professional and representative body.

Understanding ageing

1.1 The overarching message in *Age Proofing the UK* that an ageing society is a cause for celebration is refreshing and extremely welcome.

1.2 How we as a society respond and change in the face of the fact that we are living longer is a vitally important question. There is a tendency in the current narrative around ageing to suggest that older people are a burden and that there is an intergenerational conflict of interest. This is not materially accurate, and neither is it helpful for good policy-making or wider public discourse. Appointing an independent commissioner for older people could be instrumental in changing this narrative.

The economics of ageing

2.1 The current health and social care system should do far more to support older people both to be economically active and to be active in their communities on retirement.

2.2 Cancer treatment is a clear example of how redesigned services could help achieve this. An aging population mean that many more people are now living with or living after cancer, and the number is predicted to reach 3 million by 2030[1]. Of the 300, 000 people diagnosed with cancer each year, half are of working age and they are 40 per cent more likely to be unemployed than the overall population[2]. Where rehabilitative exercise is incorporated into treatment there is an 87 per cent increased likelihood of returning to work[3].

2.3 There are many conditions that result from having cancer or treatment for cancer, such as poor shoulder mobility among survivors of breast cancer, muscle wasting, weight gain, and osteoporosis, which increases the risk of fragility fractures. All of these can have a negative impact on the ability of people who have survived cancer being able to lead active lives, in the workplace and the community. Physiotherapy and physiotherapy-led exercise treatment supports cancer survivors to recover their mobility and fitness, reduces the risk of falls and improves mental wellbeing and quality of life. Most importantly physical exercise among cancer survivors significantly reduces the risk of cancer reoccurring and increases survival rates[4].

2.4 An example of good practice in this area is the breast cancer rehabilitation service at Bart's Hospital, where patients are assessed by a specialist physiotherapist in the post operative phase of treatment. Ongoing physiotherapy care includes manual treatment, exercise and advice on self-management and returning to work.

2.5 As the age profile of the workforce changes, then far more is needed in terms of changes in work to provide a fair deal for older workers to enter and remain in employment. MSK conditions are the biggest cause of sickness absence from work in the UK, accounting for 27 per cent of total days lost due to sickness absence. Stress accounts for 10 per cent of sickness absence overall, and is the number one reason for long term absence[5]. The interplay between MSKs and stress/depression is well established, with chronic pain and contributing to stress and depression and vise versa.

2.6 Key to tackling this is to ensure that more employees have rapid access to occupational health services throughout their working lives. Good occupational health services get people back to work quicker and reduce the risk of both MSK conditions and stress as they become older[6]. Many employers have found this significantly reduces sickness levels and saves money. For example, the Royal Mails national occupational support and therapy programme cut absence by 25 per cent in 3 years, and provided a return on investment of 5: 1[7].

2.7 In the same way as savings in the public sector have been achieved through sharing back office facilities, there is potential to increase the number of employees with access to occupational health services through sharing facilities - for example Hospital Trusts with occupational health services could generate income through agreements to provide services to other public sector workforces.

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[1] Physiotherapy works. Cancer Survivorship. Chartered Society of Physiotherapy November 2012
[2] ibid
[3] ibid
[4] ibid
[5] Sickness Absence in the Labour Market. April 2012. ONS 15 May 2012
[6] Rapid access to treatment and rehabilitation for NHS staff, NHS Employers July 2012
[7] Fitness Profits. CSP Oct 2011

2.8 For many small and medium sized enterprises (SMEs), who employ 59 per cent of employees[8], occupational health services will not be affordable. For these employees improving access to appropriate services in the community will be the main route to improving the health and wellbeing of employees.

2.9 The quickest and most accessible physiotherapy services in the community are by self-referral, where people can refer themselves to an NHS physiotherapy service without seeing a GP or other healthcare professional first. In spite of being clinically and cost effective, and supporting self-management of long term conditions, and recommended by NICE, self-referral physiotherapy remains patchy[9]. In an aging society this is a feature of health services in the community that will need to change.

2.10 Rapid access to treatment and rehabilitation supports an assisted return to the workplace, as well as improving long term prospects for health and wellbeing[10]. There is scope for employers to utilise expertise within the health system so that they can better support health and wellbeing among employees. For example, the Allied Health Professions Federation has developed a tool to support employers, employees and GPs. The AHP Fitness for Work Advisory Report is completed by allied health professionals and includes advice on capabilities and adaptations required to facilitate remaining in or returning to work[11]. The CSP expects to use this experience to support the Government's Health and Work Service as it is rolled out.

2.11 Employers should be encouraged to have a strategic approach to the health and wellbeing of all their staff. Evidence from the NHS suggests that the most effective organisational strategies to improve employee health are based on an audit of health and wellbeing, which involves staff in the process[12].

2.12 Age-proofing the workforce will require a commitment to change from both the workforce and employers. The NHS is the UK's largest employer and needs to lead by example. In recognition of this the NHS is working to review how the increase in the age of retirement will impact on service provision, employers and employees. The NHS Council Working Longer Review Group[13] has identified key actions in the areas of data collection, working practices, culture change, pension flexibilities and occupational health services to support employers and employees to adapt to an older workforce. The review found that some older workers are supported in continuing to work in the NHS, but that this is piecemeal, largely driven by individual line managers. It concluded that far more should be done at a corporate and policy level within Trusts. Positive strategies for supporting older people to continue to work need to be accompanied by operational advice for managers. Developing policies to age-proof the UK should take account of the work that is already being done in the public sector and support the implementation of its findings.

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[8] Small business and the UK economy. Chris Rodes, Economic Policy and Statistics, House of Commons Library, last updated 19 December 2012

[9] *Musculoskeletal Physiotherapy; Patient self-referral. Quality and Productivity Proven Casestudy (QUIPP),* NHS Evidence, Nice February 2012 (first published February 2011).

[10] Rapid access to treatment and rehabilitation for NHS staff, NHS Employers July 2012.

[11] *Allied Health Professions Fitness for Work Advisory Report*, Allied Health Professions Federation. 2012

[12] *Health and wellbeing in healthcare settings*. NHS Partnership for Occupational Safety and Health in Healthcare. October 2012

[13] This is a tripartite partnership between NHS employers, the Department of Health and recognised health unions and professional bodies

2.13 CSP members report that health is a key factor in their decisions to retire, the majority citing MSK injuries/conditions making it difficult to continue to work. Many of these injuries are acquired over a period of time in manipulating and treating patients, for example arthritis of the thumbs. For staff involved in any physically demanding work a new type of risk assessment framework is needed that identifies what sorts of roles risk injury over the long term, and to identify solutions to enable continued working.

2.14 In implementing the statutory right of employees to carers leave we need to learn from the experience of maternity rights. This means having clear enforcement routes and rights for employees to take action on discrimination because of their caring responsibilities.

2.15 Employees rights to request part time working, job sharing and flexible hours need to be strengthened and publicised. The CSP agrees with the Age UK proposal that all jobs should be 'flexible by default' and mainstreamed in the labour market[14]. We would add that it is important be clear about what flexible working means. Some of the poorest conditions of employment (such as zero hours contracts) are regularly promoted as flexible working.

2.16 There is a clear gender dimension to the issue of poverty among older people in the workplace. Women are more likely to be in low paid work – two thirds of those living below the living wage are women[15]. Evidence suggests this particularly affects older women – with the majority of women aged over fifty earn less than £10 000 per year and that many struggle to access training opportunities that would help them to progress out of low paid work[16].

2.17 Caring responsibilities (along with poor health) are one of the main factors that push older people out of the labour market[17]. This primarily affects women. Older women often face a multitude of pressures caring for older, sick or disabled relatives, caring for grandchildren, and being in paid employment. The CSP supports the introduction of five to ten days paid carers leave each year and unpaid leave entitlement for grandparents, on a par with parental leave to help address this. Such measures would support women to juggle responsibilities and remain in the workforce, impacting positively on both their current income and future pension income.

Housing

3.1 In all settings where frail older people receive care – in the home, in residential care and in hospital - there can be a tension between the goal of supporting them to be more physically active, and providing care as quickly and efficiently as possible. In the short term caring for someone who is less mobile can be easier for nursing and support staff to manage. Maximising individual mobility needs to become a shared goal of all health and care professionals, with patients and service users.

[14] *A means to many ends*. Age UK. 2013
[15] *Below the Bottom Line*, Resolution Foundation, January 2013
[16] *Age Immaterial: women over 50 in the workplace, a TUC report*. TUC, February 2014
[17] *Unfinished Business: Barriers and Opportunities for older workers*, Giselle Cory, Resolution Foundation 2012.

3.2 Assessments of health and care needs must take into account the whole of a person's circumstances, including their housing. Furthermore, rehabilitation needs to be central to assessment of need. Too often assessments following discharge from hospital will focus on immediate limitations to mobility. Physiotherapy professionals on the other hand carry out assessments that focus on the potential, and work with service users to achieve goals. For example, physiotherapy staff will work with an elderly person to increase mobility, improve balance and reduce the risk of falls in the home. While physiotherapists advise on adaptations, the focus on progress will mean for example working with an individual so that they can manage the stairs in their home rather than installing a stair lift.

3.3 Homes that are damp and cold contribute to poor health among older people. It is a contributory factor in Chronic Obstructive Pulmonary Disease, one of the main causes of unplanned hospital admissions and readmissions among older people (see below)[18]. Action on housing conditions and fuel poverty among older people needs to be a priority. Health and social care professionals should be identifying where housing and living conditions are a contributory cause of respiratory conditions.

3.4 The needs of an ageing population should be considered fully in all aspects of planning and design of housing and communities. Purpose built housing is part of this. It is important to learn from the experience of social housing, where much purpose built housing for older people was unpopular and became difficult to let. One of the lessons from this is that purpose built housing needs to be desirable, a place to go and live and be active in, and invite your friends and family to, in mixed communities. These lessons need to be reflected in the design, size and planning of purpose built housing.

Active ageing

4.1 We need health and care services that enable us to live longer and live well. In addition to people in the workplace (see above) older people in retirement need to supported be as physically active as possible. This is an essential prerequisite to participation, and maintaining important friendships and support networks, as well as feeling in control, all key facets of overall health and wellbeing.

4.2 This means redesigning health and care services to put rehabilitation and reablement in the community at the forefront, maximising physical activity, keeping people out of hospital and reducing the need for residential care.

4.3 Too commonly, while older people receive intensive physiotherapy as part of their rehabilitation when they are in hospital (for example after a stroke, a heart attack, a fracture or a joint replacement), on discharge they have a long wait for services and the access to services is limited[19] [20].

[18] *Focus on preventable admissions*. Ian Blunt. Nuffield Trust October 2013

[19] Research found that a quarter of stroke survivors had to wait longer than one month after discharge for physiotherapy. *Moving On. A vision for community based physiotherapy after stroke.* CSP and The Stroke Association, 2010

[20] Further work revealed a third of patients are not being referred for physiotherapy, a third waiting for more than one year, and just one in ten waited less than one month. *RA and Physiotherapy : a national survey.* CSP and National Rheumatoid Arthritis Society 2011

4.4 In Bradford the early supported discharge service works to support patients to regain independence, increase mobility, improve their ability to integrate themselves within their community and reduce the need for ongoing care. It forms a direct link between acute care and the community services, providing intensive physiotherapy and occupational therapy delivered by staff working both in the hospital and in the community. In the last year the service saved the trust an estimated 2315 bed days, reduced the risks of falls from moderate to low, and reduced readmission rates for patients who have fallen by 50 per cent[21].

4.5 North Devon Healthcare Trust reconfigured their stroke therapy team to support early discharge by integrating acute, rehabilitation and community services. Team operates across two sites, one being community based. As well as enhancing patient, carer and staff experience, the service has reduced length of stay by six days from 22 days, saving £833, 700, reduced hospital readmissions from six per cent to three per cent, and 13 per cent more patients were able to return home rather than move to a care home, saving over £75,000 per person[22].

4.6 Chronic Obstructive Pulmonary Disease (COPD) is one of the primary causes (top three) of older people having unplanned admissions to hospital[23] and is the second highest of any disease area, resulting in more than one million bed days in hospital. One in three of these will be readmitted within 28 days. Pulmonary rehabilitation services, which include physiotherapy-led exercise and personalised self-management advice, reduces unplanned COPD hospitalisations by 9 per cent[24], cut in half time the spent in hospital once people are admitted[25], and reduces readmissions by 26 per cent[26]. These figures represent vast potential savings for the NHS, yet around half of people with COPD are not referred to a pulmonary rehabilitation programme either by their GPs or hospital[27].

4.7 The Hope Specialist Service at the North East Lincolnshire Care Trust provides a one stop shop for older people at risk of falling and people with COPD. The team includes physiotherapists, support workers, volunteer rehab buddies and expert patients. In a four year period hospital admissions for COPD have been reduced – for each person attending a pulmonary rehabilitation course there is one less admission to hospital. In the same period the falls and post hip fracture rehabilitation programme has seen an 8 per cent reduction in visits to A&E and a 13 per cent reduction in hospital admissions for people who have fallen[28].

4.8 In Portsmouth three health trusts are working together to improve services for older people and ease pressure on Queen Alexandra Hospital's casualty department. The physiotherapy-led Community Assessment Lounge was set up in December 2012 and is open seven days a week from 9am till 9pm. Patients aged 65 and over, who go to the A&E department are assessed in the lounge, to see if they can be

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[21] http://www.csp.org.uk/frontline/article/home-goal
[22] http://www.northdevonhealth.nhs.uk/2013/07/stroke-therapy-team-wins-top-national-award-for-helping-patients-recover/
[23] ibid
[24] Eaton 2009
[25] *Results at 1 year of outpatient multidisciplinary pulmonary rehabilitation:a randomised controlled trial* Griffiths TL, Burr et al (2000) Lancet 2000; (355 (9201): 362 – 368
[26] Seymour 2010
[27] *Ready for Home*. British Lung Foundation and the British Thoracic Society. December 2010
[28] *Lung Improvement Case study. Hope for the Future – pulmonary rehabilitation*. NHS Improvement , July 2012

treated at home rather than taking up a hospital bed and stay in the lounge until suitable arrangements are made for them to return to the community with appropriate support in place. Between December 12, 2012, and May 31, 2013, 1,015 patients were seen in the lounge – with 584 of them being treated outside the hospital – creating a saving of £1.6m[29].

4.9 In Torbay, integrated health and care teams, which include physiotherapists, provide integrated care. It has reduced the use of hospital beds, delays in transfer of care from hospital to the community and rates of emergency admissions and readmissions to acute hospitals. It has also reduced the use of residential care, increasing use of home care services, with greater use of direct payments in social care[30].

4.10 Greenview intermediate care unit, a multi-agency project commissioned by NHS Harrow offers rehabilitation to people with dementia and delirium. Patients are provided with physiotherapy five days week, following an assessment, and home visits are conducted to assess risk factors prior to discharge. 58 per cent of patients return home, and physiotherapists make follow up home visits to evaluate progress and liaise with other agencies to ensure the patient remains safe in the home. The service has reduced time spent in hospital by people suffering from dementia and delirium, with enormous benefits to their wellbeing as well as reducing costs[31].

4.11 Another aspect of an aging society is the rise in numbers of people living with one or (increasingly) more than one long term condition. In Kent Proactive Care: Long Term Conditions pilot started in April 2012. Patients are supported by a multi-disciplinary team including a GP, community matron, health care assistant, physiotherapist, occupational therapist, pharmacist, health trainer, care manager and mental health professional. Patients are offered a 12 week package of support to improve the management and self-management of their condition. Evidence shows a 15 per cent reduction in A&E attendance, 55 per cent reduction in non-elective admissions and 75 per cent report improvement in functional quality. Overall savings in the first year were £225, 938[32].

4.12 The latest innovation in practice demonstrate a shift away from a medical model of intervention, towards an approach that considers an individual's circumstances in the round and putting individuals in the driving seat in planning their care. This is core to the values and practice of physiotherapy, which relies on working in partnership with individuals to reach goals based on their individual circumstances and own priorities.

4.13 Further learning can be gained from anti poverty campaigners in the UK and in international development. There are well developed models for community development that take an asset based approach, rather than a deficit model of unmet need[33]. This approach could be usefully applied in care planning.

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[29] http://www.portsmouth.co.uk/news/health/local-health/community-lounge-hailed-success-to-avoid-a-e-stays-1-5189911

[30] *Integrated Care. What is it? Does it work? What does it mean for the NHS?* Chris Ham and Natasha Curry, Kings Fund 2011

[31] *Physiotherapy works. Dementia care*. CSP January 2012

[32] *The Human Touch, Transforming Community Services in Kent. Service in the spot light: Pro-Active Care: Long Term Conditions.* Kent Community Health NHS Trust, March 2013

[33] *The Sustainable Livelihoods Handbook: An asset based approach to poverty*, Oxfam GB and Church Action on Poverty, 1 November 2009

4.14 Significant features of all of these examples are the shift of resources from acute to community settings, integrated working across different health settings and social care, and supporting self-management including exercise. Physiotherapists are well-placed to lead such service redesign, enabling people to live well and live longer.

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