CHARTERED SOCIETY OF PHYSIOTHERAPY

Anticipatory Care Specification

Consultation response from the Chartered Society of Physiotherapy 15/01/20

NHS England has consulted on 5 new service specifications which contain important changes to how primary and community services will be expected to deliver from April 2020, and implications for physiotherapy.

This is how the CSP replied to questions on the *Anticipatory Care* specification.

1. Is there anything else that we should consider for inclusion as a requirement in this service? For example, are there approaches that have delivered benefits in your area that you think we should consider for inclusion?

1.1 Meeting the different rehabilitation needs of people with complex and multiple long term conditions is key to anticipatory care – supporting independence, reducing levels of disability, maximising mobility and function, maintaining health and slowing down deterioration, as well as reducing the pressure on carers.

1.2 Delivery of the Anticipatory Care services to the specification is dependent on Community Rehabilitation MDTs as part of community services working in partnership with PCNs.

1.3 Currently Anticipatory Care needs for working age adults is missing. The specification will not meet the needs of the working age population with complex needs. This is a gap that needs to be addressed, with vocational rehabilitation added to the list of requirements.

1.4 Physiotherapists and the non-registered physiotherapy workforce (support workers) are central to this in terms of providing leadership, personalised assessment of rehabilitation needs and identification of patient goals and an individualised care plan (including for people with multiple long term conditions), delivery of rehabilitation exercise programmes and supporting integration with other parts of the pathway.

1.5 Rapid response teams and early supported discharge teams should be part of Community Rehabilitation services to deliver continuity of care, and this need to be clear in the specification.

1.6 Community Providers also need to be directed through the Standard Contract to ensure that there is sufficient capacity in Community Rehabilitation MDTs to meet increasing
demand, including through delivery of the Anticipatory Care services.

1.7 As well as ensuring appropriate staffing levels, this entails new ways of working. New ways of working should include: provision of more group-based exercise(1); increased numbers of higher-level physiotherapy/AHP support workers, greater partnership-working with voluntary sector and sports and exercise services as integral to the

rehabilitation workforce, and enabling care home staff to support people to be more physically active.

1.8 Community Rehabilitation leaders and managers are most commonly AHPs, often advanced practice physiotherapists. These may also be in Community Matron roles. They will have a critical role to play in implementing new ways of working and redesigning Community Rehabilitation services to support delivery of the specification in partnership with PCNs and will be a key stakeholder. This also needs to be identified on the specification.

1.9 Community Rehabilitation teams need to be able to support people living with multiple long term conditions who have rehabilitation needs, for example rehabilitation related to cardiovascular, neurological, respiratory conditions, pelvic health and cancer.

1.10 At certain points specialist rehabilitation may be required. This could be pelvic health physiotherapists, neuro rehabilitation teams, oncology rehabilitation teams, pulmonary and cardio rehabilitation. These services are commonly within secondary care outpatients and can be provided by both acute and community trusts.

1.11 In the specification document, page 21 part 12 should be amended to be clear that PCNs will be expected to establish clear referral routes and information sharing arrangements with Community Rehabilitation services. It should in addition be clear that there is an expectation of Community Services that their Community Rehabilitation Services have these referral routes and information sharing links in place with specialist rehabilitation teams and services.

1.12 The specification requirements from Community Providers need to include promotion of the RightCare Community Rehabilitation toolkit, due for imminent publication, which is fully aligned with the Anticipatory Care model and the points above.

1.13 The advanced practice MSK physiotherapists delivering First Contact Physiotherapy (FCP) roles would have a role to play in delivering the PCN responsibilities in relation to the Anticipatory Care model, and already work with the people who have multiple long-term conditions. They are also critical to the work to improve system-level approaches to population health management, helping to build links and integration across the system. The role of the FCP in system transformation and integration is strongest where the FCP is working across primary and community sectors and employed by the MSK service provider.

1.14 Full roll out of FCPs will also be critical to freeing up GP time to lead in delivery of services.

2. Are there any aspects of the service requirement that are confusing or could be better clarifies?

2.1 The reference to 0.5 WTE physiotherapist per PCN within Additional Roles in paragraph 1.12 is confusing.

2.2 The CSP supports NHS England's ambition for full roll out of FCP roles by 2023. FCP staffing of 1 WTE for every 10 thousand population is required for the FCP to manage 50% of a GPs MSK caseload and appointments, rather than the GP. This would free up GP time considerably, including to enable GPs to deliver key elements of the specifications.

2.3 We ask that the indicative illustration in 1.12 is removed. Local areas will have different starting points, rending the illustration meaningless. Further, it confuses the specific intention to deploy additional roles (including FCP) within practice teams (with the purpose of freeing up GP time), with the significant opportunity offered by these five specifications that requires work from a range of clinicians, requiring other specific workforce consideration.

2.4 Clarification within the Anticipatory Care specification is required on how the complex needs /needs arising from multiple long-term conditions among working age adults will be met.

3. What other practical implementation support could CCGs and Integrated Care Systems provide to help support delivery of the service requirements?

3.1 The Rightcare Community Rehabilitation Toolkit (due for publication) sets out an integrated
approach to rehabilitation that should be adopted by community providers and reflected in referral routes across sectors.

3.2 There are rehabilitation needs assessment tools, which are currently used to assess suitability for intermediate care, these could be tested out in community services. One such tool has been developed by the UK Rehabilitation Outcomes Collaborative and is included in the Rightcare Community Rehabiltiation toolkit.

3.3 CCGs and ICSs can support implementation of the Anticipatory Care service in line with the specification through endorsement and use of the Rightcare Community Rehabilitation toolkit.

3.4 Community Rehabilitation is a core area of Community Services critical to delivery. AHP leaders and managers need to be part of the partnership discussions from the earliest stage about the Anticipatory Care specification. This could mean for example engagement with Health Education England regional AHP workforce leads and regional AHP Council's.

3.5 The key role of physiotherapists and physiotherapy support workers across the 5 PCN specifications needs to be within ICS's workforce growth and development plans.

3.6 There is strong growth in numbers of registered physiotherapists with physiotherapy pre- registration courses continuing to be over-subscribed, with high quality candidates and strong completion rates. This growth needs to be supported, and furthermore, translated into staffing to meet needs.

3.7 In relation to developing the existing physiotherapy workforce the priorities for local workforce plans are:

- increasing numbers of physiotherapists with advanced practice capabilities (including prescribing and FCP specific modules)
- supporting development of and access to tailored advanced practice modules within multi-professional ACP programmes/ apprenticeship
- developing the non-registered physiotherapy /AHP support worker workforce, in particular to develop more higher level support worker roles and
- supporting development training opportunities for physiotherapy/AHP support workers (e.g. exercise prescribing) including as part of multi-professional non registered apprenticeships

4.	**To what extent do you think that the proposed approach to phasing service requirements is manageable in your area?**

4.1 The contribution of the physiotherapy workforce to deliver across the 5 PCN specifications, both from primary care and community services in line with the schedules set out is dependent on continued workforce growth, translation of workforce growth into staffing and the training and development of the physiotherapy workforce.

4.2 This includes full roll out of FCPs that is critical to freeing up GP time (see answer to Q3). It also includes the development of physiotherapy/AHP support workers working in more advanced roles, which is critical to having sufficient community rehabilitation capacity.

4.3 In paragraph 1.21 it states that where PCNs are struggling to recruit, CCGs and systems should take action to support them.

4.4 The current NHS England and NHS Improvement suggestion is for PCNs who have not spent all of the Additional Roles Reimbursement Scheme (ARRS) funding should be redistributed to neighbouring PCNs.

4.5 The CSP believes that the funding should ideally be used for the population that it is intended for. The CSP therefore suggests that the DES contract specify that CCGs' supporting activity expected here (including workforce training and development) can in part be financed by ARRS underspend. This would support the scheduling as set out.

5.	**Do you have any examples of good practice that you can share with other sites to assist with delivering the suggested service requirements?**

5.1 In Frome a particular feature of service redesign has been the partnership between community services and primary care, relevant to this specification. Frome Community Hospital East Mendip Integrated Services includes rehabilitation/therapies, older people's mental health and district nursing teams. They are working in partnership with Frome Medical Practice to drive a more integrated approach to community mental and physical health services. Key clinicians involved are physiotherapist Angela Lloyd into the Community Hospital Matron role at the From Community Hospital, and Dr Helen Kingston at Frome Medical Practice, who established the Mendip Health Connections initiative, and leads community MDT 'Complex Care Meetings' in a more integrated approach to the care of local patients with complex needs.[(2)]

6.	**Referring to the 'proposed metrics' section of each of the services described in this document, which measures do you feel are the most important in monitoring the delivery of the specification?**

6.1 The CSP proposes that in addition to the metrics listed, there needs to be measures that capture quality of life, reducing personal care needs (e.g. care package costings and hours), return to work, numbers of personalised care plans that include goals around physical activity, and preventable admissions.

6.2 The partnership working between PCNs and community services highlights the importance of multi-professional access to systems and the development,

improvement and procurement of any new primary care electronic systems, across all of the service specifications.

6.3 The following data challenges need to be addressed to ensure quality data is collected in relation to Anticipatory Care:

- Improve access to systems by staff in community rehabilitation services
- Address the issues of interoperability between the different systems in play throughout health and social care. As well as poor data sharing, the current limited interoperability means time and resource is lost to duplication of data entry.
- Improve connectivity so that clinicians can collect data away from their central base, and provide comprehensive access to appropriate hardware, including mobile hardware with appropriate access to necessary systems
- Address the challenges of standardisation of data collection. Although the Community Services Dataset (CSDS) has been mandated by NHSE for a number of years it is far from comprehensively submitted. There is an opportunity in this work to add importance to the collection of national standardised data for community rehabilitation services.
- Although there are some standards published by the Professional Records Standards Body, implanting these on all national systems has not happened yet. Until it does there is the risk of incomplete data sharing and therefore decisions made without the benefit of full intelligence around the patient.

References:

1. Kendrick D, Kumar A, Carpenter H, et al. Exercise for reducing fear of falling in older people living in the community. Cochrane Database Syst Rev. 2014(11):CD009848.

2. The Chartered Society of Physiotherapy. Information drawn from an unpublished case study developed from a series of CSP service visits in 2019. More information available on request. . London: The Chartered Society of Physiotherapy; 2019.