NHS England Urgent and Emergency Care Review

To: NHS England Urgent and Emergency Care Review
Via online survey

1-4. Respondent details

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4. Providing response as an organisation

5. If you are responding on behalf of an organisation which organisation is it

5.1 The Chartered Society of Physiotherapy (CSP). The CSP is the professional, educational and trade union body for the UK's 51,000 qualified physiotherapists, physiotherapy students and support workers. 97 per cent of qualified physiotherapists are CSP members. Our members work across all sectors and health and care settings.

6. Which of the following areas of health care are you representing?

- Acute services
- Mental Health services
- Primary Care services
- Community based care
- Other (specify) Intermediate Care Services

7. Do you believe that the current system of urgent and emergency care in England needs to change and improve?

Yes

8. Have you read the full Urgent and Emergency Care Review evidence-base?

Yes

9. Do you agree with the evidence-base presented for self-care and self-management?

Partly

10. Do you agree with the evidence-base presented for telephone care?

Mostly

11. Do you agree with the evidence-base presented for face to face care?

Partly

12. Do you agree with the evidence-base presented for 999 emergency services, accident and emergency departments, and access to back up services?

Mostly

13. Do you agree with the evidence-base presented for emergency admissions?

Partly

14. Do you agree with the evidence-base presented for the urgent and emergency care workforce?

Partly

15. Do you agree with the evidence-base presented for urgent and emergency care networks?

Mostly

16. Do you have any other comments on the evidence base, or is there any further evidence that you would like to support improving the urgent and emergency care system in England?

16.1 In the CSP's view there are insufficient community based services for the treatment and management of long term conditions, and where these do exist, there is a lack of integration between services in community and acute settings, resulting in fragmented transitions from one to the other which can slow or limit an individual's recovery. There is a wealth of evidence demonstrating the clinical and cost effectiveness of physiotherapy in community based and intermediary services, including reducing Accident and Emergency (A&E) attendance and avoidable hospital admissions for people with long term conditions.

16.2 In Portsmouth three health trusts are working together to 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 treated at home rather than taking up a hospital bed and stay until suitable arrangements can be made to move them to community care. 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. (http://www.portsmouth.co.uk/news/health/local-health/community-lounge-hailed-success-to-avoid-a-e-stays-1-5189911)

16.3 Chronic obstructive pulmonary disease (COPD) is the fifth biggest killer in the UK, and the second most common cause of emergency admissions in the UK, being responsible for one in eight (130,000) acute adult medical admissions. NICE estimates that the direct cost of providing care in the NHS for people with COPD is almost £500 million a year. More than half this cost relates to the provision of care in hospital (*Physiotherapy works: COPD.* CSP, January 2012)

16.4 Respiratory physiotherapists support self-management and admission avoidance by helping patients to control the disease. They provide advice on appropriate positioning and teach specialist breathing techniques to manage hyperventilation, breathlessness and difficultly in clearing retained sputum from their chest (all of which can lead to A&E attendance and hospital admission). Physiotherapists will also provide advice on how to pace activities, and help patients to improve their ability to carry out daily activities, such as washing and dressing. In addition, those physiotherapists who have undertaken the required training are also able to act as supplementary prescribers, prescribing medicines to COPD patients in line with a clinical management plan that is agreed and signed off by a designated medical practitioner. They can prescribe patients with antibiotics, cortico-steroids and inhalers, supporting management in the community and reducing admission to A&E. Pulmonary rehabilitation programmes for people with COPD are proven to reduce the length of hospital stay and reduce the number of hospital re-admissions, and for this reason is recommended by National Institute for Health and Care Excellence (NICE) for all appropriate patients with COPD. (*Physiotherapy works: COPD.* CSP, January 2012)

16.5 The HOPE Specialist Service at the North East Lincolnshire Care Trust provides a 'one-stop-shop' for people with Chronic Obstructive Pulmonary Disease (COPD) and older people at risk of falling. The team includes physiotherapists, support worker specialists, volunteer 'rehab buddies' and expert patients. Hospital admissions were reduced (one admission per person attending the pulmonary rehabilitation course), and over four years, 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. (Lung *Improvement Case Study: Hope for the Future – pulmonary rehabilitation*. NHS Improvement, July 2012)

16.6 As highlighted in the evidence review, good management of the transition to community or primary care after discharge is a significant factor in preventing hospital re-admissions. Research conducted by the CSP and the Stroke Association in 2010 found that more than a third of stroke survivors felt that there

was a delay in receiving community based physiotherapy after discharge from hospital, and a quarter of stroke survivors had to wait longer than one month after discharge. Furthermore, fewer than half (44 per cent) of hospitals have access to early supported discharge teams, and 45 per cent of stroke services do not have access to specialist community rehabilitation teams. Northumbria Healthcare NHS Foundation Trust established an Early Support Discharge team to support stroke survivors in the community. This multi-disciplinary team including physiotherapists has resulted in the average length of stay in hospital being reduced to half the national average and savings of around £500,000 (*Physiotherapy works: Stroke.* CSP, January 2012).

16.7 Falling is frequent and serious in people aged 65 and above. Each year 35 per cent of over 65's experience one or more falls, about 45 per cent of people over 80 who live in the community fall each year. Half of all people who have a fall will fall again in the next 12 months. Among the over 75's injury from falls is the leading cause of mortality. Recurrent falls are associated with increased mortality, increased rates of hospitalisation and institutionalisation. Costing the NHS over £4.6 million each day, adding up to £1.7 billion per year, falls in later life represent a major burden on the health and social care systems. Based on 2009/10 costs each hip fracture avoided would save approximately £10,170. (*Physiotherapy works. Fragility, fractures and falls*. CSP, January 2012)

16.8 NICE guidelines require all older people with recurrent falls or an increased risk of falling to be considered for individualised multi-factorial intervention, including strength and balance training and home hazard assessment. Community based falls prevention programmes can be cost saving, with the savings from reduced hospital admissions significantly exceeding the cost of intervention. (*Physiotherapy works. Fragility, fractures and falls*. CSP, January 2012)

16.9 The physiotherapy-led Glasgow Falls Prevention Programme sees nearly 175 patients a month in their homes to assess risk factors and intervene to modify these. Between 1998 and 2008 there was a reduction in admissions due to falls in the home of 32 per cent, falls in residential institutions of 27 per cent and falls in the street of nearly 40 per cent. Over the same period, the number of admissions for hip fractures decreased by 3.6 per cent (compared with an increase of nearly 2 per cent in England in the same period). (*Physiotherapy works. Fragility, fractures and falls*. CSP, January 2012)

17. Have you read the full Urgent and Emergency Care Review emerging principles?

Yes

18. Do you agree that any improvements and changes to the urgent and emergency care system need to be based on the emerging principles?

Yes

19. Do the system design objectives outlined allow the emerging principles for the future delivery of urgent and emergency care to be met?

Partly

20. Do you support the identified possible implementation solutions?

Partly

21. What types of things would help implementing the possible solutions?

- Improved IT and information sharing
- Increased focus on clinical outcomes
- Urgent and emergency care networks
- Closer working across organizations
- Closer working between GPs and secondary care clinicians
- Wider range of skills and increased training
- Other

21.1 There is a need to increase provision of physiotherapy within A&E and acute medical departments. Frontloading physiotherapy in the acute and emergency departments, across seven-day and evenings, not only supports effective and safe admission avoidance, but also prevents deterioration after admission and facilitates early discharge. The Quality, Innovation, Productivity and Prevention (QIPP) process in England has endorsed such extended day and seven-day physiotherapy service in acute medicine (evidence provided by Cardiff and Vale University Health Board).

21.2 New ways of working, including seven day working, should be used as an opportunity to help ensure that working patterns and careers are sustainable (implementation option for System Design Objective 5).

21.3 To be introduced successfully seven day physiotherapy services require the following key conditions to have been met: Staffing levels and skill levels need to match the demands of the service required over the seven day period. Staff must be consulted on and have an input into how changes to working hours are organised, and consensus reached on now new working patterns will be implemented and operated. Staff should receive pay enhancements to compensate for working at the weekend or in the evening. There needs to be levels of flexibility agreed between employer and employee to address both the requirements of the standards set by the Improving Working Lives programme and changes to service demand.

21.4 Physiotherapy specialists and other allied health professionals need to be involved in service redesign from the start.

21.5 Redesigned services and new ways of working need to be properly resourced and staffed, and introduced in partnership with staff in those services.

21.6 There is an urgent need for investment in physiotherapy-led multi disciplinary teams that act as a bridge between hospital and community, including early discharge models, preoperative preparation which can reduce the dependence on post operative care, post operative rehabilitation (in particular among frail elderly patients following falls), and respiratory critical care.

21.7 Commissioners need to give priority to integration of services, and consider the benefits to patients and the long term value for money of integration over and above the value for money of individual services.

22. What types of things might prevent implementation of the possible solutions?

- Incompatible IT systems/data sharing issues
- Culture of silo working – not owning the whole pathway
- Lack of secondary care support for GPs
- Lack of awareness of how GPs can contribute to their patients care in hospital
- Focus on process rather than outcomes
- Insufficient skill mix across workforce
- Other

22.1 If physiotherapists and other AHPs are not adequately represented in the new structures of the health services – including Clinical Commissioning Groups and Clinical Senates – it will be harder to design and implement effective solutions. There is a tendency for smaller professions to be overlooked which means that valuable experience in multi disciplinary working, prevention and reablement across acute and community health settings can be lost.

22.2 In line with emerging principle three it is essential to recognise that not all urgent and emergency situations require a doctor. There are many health professionals who have the skills and expertise to prevent admission and contribute to care, and in doing so, reduce the overall pressure on the urgent and emergency care system. There is a danger that lack of awareness of the specialist role of physiotherapists will prevent implementation of possible solutions.

22.3 As the research identifies, currently the array of services and access points is confusing and inconsistent. Without a significant improvement in public communications and a push for greater consistency around what services are called, how to access them and when they should be accessed this will hamper solutions being implemented successfully.

22.4 Related to this there is a danger of services becoming fragmented and harder to navigate from the patients' point of view, with the introduction of competitive tendering and the Any Qualified Provider model.

22.5 If there are cuts in funding taking place at the same time as possible solutions being implemented there is a real risk that opportunities to improve care which could result in savings in the long-term, will be lost. In 2011, the CSP carried out an audit of physiotherapy services in England through a Freedom of Information request to all primary care trusts in England and two surveys of physiotherapy managers. More than half (57 per cent) of physiotherapy managers reported cuts to patient

services, nearly 60 per cent said that these cuts had or would reduce the number of treatment sessions a patient could receive.

22.6 If an increase in activity levels and demand for physiotherapy resulting from an introduction of a seven day service is not supported with additional funding and workforce hours, it will not achieve the desired improvements in patient care.

23. Do you have any further comments about the emerging principles, system design objectives, or implementation solutions, or are there other suggestions you would like to make?

23.1 The physiotherapy profession supports patients and their families/carers to manage their health in a number of ways, with a focus on early detection, personal goals, exercise and consideration of the patient's external environment in the round.

23.2 Self-management of long term conditions is essential to improve health and wellbeing and reducing the need for emergency interventions. For self-management to be viewed positively by patients it needs to be provided as an element of hands on care and not an alternative to it.

23.3 The Locomotor Service is a community physiotherapy service, which is part of Homerton University NHS Trust and manages 89 per cent of musculoskeletal patients in the community. The Locomotor service has a chronic pain interdisciplinary service within it, allowing a smooth pathway from initial physiotherapy assessment to interdisciplinary management. The Locomotor service sets goals with patients with chronic pain, to achieve personal function and quality of life goals. Patients are taught to manage persistent pain and flare-ups, and as a result visit A&E and their GPs with pain less frequently. Patients are also taught how to manage their medicines (*Homerton University NHS Trust website).*

23.4 The Proactive Care: Long Term Conditions pilot project started in April 2012 in the South Kent Coast CCG. 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. Savings to date are £225,938 (*The Human Touch, Transforming Community Services in Kent*. Kent Community Health NHS Trust. March 2013).

23.5 Frail older people tend to have the longest length of stay and the highest rate of in-patient complications. This is in part related to the nature of illness in this population e.g. the presence of multiple co-morbidities, polypharmacy and cognitive impairment. Another factor which increases attendance rates, admission rates and length of stay is the diagnostic uncertainly in this patient group, who frequently present non-specifically. Therefore approaches which target frail older people early in the pathway and deliver comprehensive assessment resulting in early diagnoses and problem-solving, are increasingly required.

23.6 Targeted comprehensive geriatric assessment services are required to address frail older people presenting as emergencies. Examples of these models can be found in Leicester and Bournemouth and a model is currently being developed in Cardiff and Vale UHB. The vision is for a Frail Older Persons Assessment and Liaison team, consisting of a consultant geriatrician(s), senior geriatric assessment liaison nurse, a physiotherapist and occupational therapist, senior nurse sessions specifically linked with community resource teams, a mental health link and social services link. The team works within a Frailty Clinical Decisions Unit, however, in addition to these A&E based assessments, the team should also be able to provide an outreach service, taking a presenting patient back to their home for a community based assessment, and where admission can be avoided, ensure that appropriate community services are wrapped around the patient.

23.7 Older people and the frail elderly are also particularly vulnerable to 'social' admissions and re-admissions. Lack of community service support and rapid social care assessment and provision often results in GPs having no choice but to advise A&E attendance to support the safety and wellbeing of a vulnerable patient who is unable to remain in their own homes safely with their current level of support. There is a clear need to develop rapid community assessment services where allied health professionals or specialist nurses provide rapid assessment and, together with the GP, determine whether the patient requires medical admission or could be supported more safely in the community setting through provision of enhanced social care. These services should offer self-referral and carer-referral in addition to GP referral.

23.8 There is a need to carefully consider the ways in which hospitals define an “admission” (i.e. whether a patient is deemed to be admitted while on the medical assessment unit pending a decision as to their clinical needs) and the social care responses to this admission. The CSP is aware that social care provision is often terminated when a patient is admitted to hospital and that once terminated it is usually not possible to restart the package of care for a number of days. As such, once a patient is admitted, regardless of clinical need it is likely that they will be held in hospital for a number of days. During this time, deterioration in physical functioning and a sense of dependence can occur, especially where access to physiotherapy and occupational therapy is insufficient.

23.9 It is clear that a high proportion of patients attending A&E departments are likely to require assessment, investigation and treatment of their presenting complaint, with some also requiring hospital admission. However, a number of patients attending emergency department can be effectively and efficiently sign-posted and navigated to other community and out-patient services, as clinically appropriate.

23.10 North Manchester Accident and Emergency Department has developed a ‘navigator’ service offered from 9am to 9pm seven days a week. The Navigators are either allied health professionals or senior nurses. They support emergency staff, actively seeking, sign-posting and coordinating speedy referrals for patients deemed appropriate, to alternative community and out-patient services. These provide intermediate and social care resources for patients who are medically fit to be discharged, but unable to return home due to further nursing needs, support requirement or awaiting rehabilitation (e.g. intermediate care, falls rehabilitation, pulmonary rehabilitation). The navigator service is also looking to extend through

accepting referrals from community, and ambulance services to avoid the need for A&E attendance.

23.11 North Manchester is also developing a 'Crisis Response' pilot, which will be accepting attendance avoidance referrals from GPs and step down referrals from Urgent Care to avoid acute admission. There is the potential for such crisis response services to be extended to accepting referrals from the ambulance service. Similar excellent models can be found in Salford.

23.12 In addition to providing access to seven day community, mental health and hospital nurse specialists, an implementation solution for System Design Objective 2 (related to self-care) is the provision of seven day community physiotherapy for services where physiotherapists are best placed to support self-care. Examples include access to specialist respiratory physiotherapy for patients experiencing an acute exacerbation of their COPD (see 16.2) or musculoskeletal physiotherapists providing same day physiotherapy musculoskeletal assessments within walk-in-centers and GP practices, to reduce the need for A&E attendance and support self-management from the outset.

23.13 It is important to consider the referral route into these services. Self-referral to physiotherapy has been demonstrated to be particularly effective as a community-based service and alternative to GP or A&E attendance. The Quality, Innovation, Productivity and Prevention (QIPP) process in England has endorsed self-referral for musculoskeletal disorders to allow easier access to treatment. (*NHS evidence* 2012). It has been shown to not increase demand for physiotherapy in the long term and also reduces patient related costs; such as prescribing, X-rays, MRI and more expensive medical consultations. (*Self referral to musculoskeletal physiotherapy pilots*. Department of Health 2008). In Cambridge, self referral to musculoskeletal outpatient services has reduced costs due to less GP use of prescribing and diagnostic tests, and 75 per cent of patients who self-referred not requiring a prescription for medicines, giving an average saving of £12,000 per GP practice. We recommend that this model be developed at the same time as the introduction of seven day working, as an implementation to support patients to self-manage conditions (*Physiotherapy works. Musculoskeletal disorders*. CSP, January 2012).

23.14 In addition to developing the range of community based A&E ‘deflection’ services, there is a need for ambulance services to have clearer local guidelines, criteria and pathways in accessing these services. This could increase the number of emergency calls which result in referral to a deflection service rather than an ambulance call out and A&E attendance.

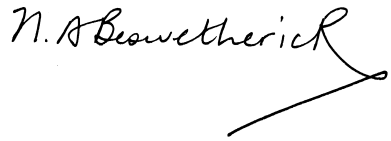
23.15 Suitably trained advanced practice physiotherapists are now able to independently prescribe medicines, relevant to their area of expertise, without a doctor authorising their decision. Consideration needs to be given as to how the urgent and emergency care system can support the implementation of independent prescribing and the potential it offers for reducing the need for GP and consultant involvement in routine cases, the pressure on A&E and hospital admissions.

23.16 As highlighted in the evidence review, good management of the transition to community or primary care after discharge is a significant factor in preventing hospital re-admissions. There is an urgent need for investment in physiotherapy-led multi disciplinary teams that act as a bridge between hospital and community,

including early discharge models, preoperative preparation which can reduce the dependence on post operative care, post operative rehabilitation (in particular among frail elderly patients following falls), and respiratory critical care.

24. Would you like to be involved in further work relating to the review?

Yes



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For further information on anything contained in this response or any aspect of the Chartered Society of Physiotherapy's work, please contact:

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