Enhanced Health in Care Homes 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 *Enhanced Health in Care Homes* 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 Delivery of Enhanced Health in Care Homes is dependent on Community Rehabilitation MDTs as part of community services working in partnership with PCNs. Physiotherapists and the non-registered physiotherapy workforce (support workers) are central to this. They provide leadership, personalised assessments of rehabilitation needs and an individualised care plan, delivery of rehabilitation exercise programmes and support integration across pathways.

1.2 Community Providers therefore 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 Enhanced Health in Care Homes.

1.3 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.

1.4 In the list of clinicians required from Community Services (page 19, section 8), physiotherapists and physiotherapy/ AHP support workers need to be added. This is because of their central role in relation to keeping people living in care homes mobile, and in relation to the list their key role in falls prevention, advice, strength and balance training and first line of support for continence assessment and care (pelvic rehabilitation).

1.5 Physiotherapy staff in Community Rehabilitation teams have a particular role to play to build confidence among care home staff to enable residents to be more physically active, and counter the tendencies to a risk averse culture. For example, falls prevention strength and balance training enable people to feel more confident about movement and less likely to hurt themselves seriously (ie have a fracture) if they do fall. It should never be about restricting mobility to avoid falls. Physiotherapist and

physiotherapy /AHP support workers have a key role to play in upskilling care home staff and co-producing resources and information with them to embed this approach within all areas of care within care homes.

1.6 Physiotherapists also have a role to play in supporting care homes staff to routinely carry out multi-factorial falls assessments for all residents and annual reviews.[2] This would identify those residents who would benefit from a specific rehabilitation programme, alongside increased physical activity within the home.

1.7 Community Rehabilitation leaders and managers are most commonly Allied Health Professionals, often physiotherapists. They will have a critical role to play in redesigning Community Rehabilitation services and pathways 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.

1.8 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.

1.9 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.

1.10 In the specification document, on 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 also 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.

1.11 The advanced practice MSK physiotherapists delivering First Contact Physiotherapy roles in the Additional Roles Reimbursement Scheme (ARRS) are critical to freeing up GP time to deliver the Specification for Enhanced Health in Care Homes.

1.12 The CSP does not recommend that FCPs would be directly carrying out the PCN elements of delivery within the Enhanced Health in Care Homes specification, such as ward round visits. To achieve their full value, including in freeing up GP time, FCPs need to focus being the frontline for MSK health presentations.

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 We suggest that the supply, development and role of FCPs in freeing up GP time in relation to the PCN responsibility within all of the Enhanced Health in Care Homes specifications needs to be made clear.

2.5 The CSP has been made aware by its members and members of public, that care home residents do not access anything like the same levels of rehabilitation as someone in their own home. A common example of this, for example is the rehabilitation needed surgical fixation of hip fracture. This appears to relate to the difference in access dependent on whether or not an individual's residential care is funded by 'continuing healthcare'.

2.6 It is welcome therefore that the scope of the specification is very clear that it is for all people who live permanently in care homes, regardless of how that persons care is funded.

2.7 However it remains to be clarified what access to rehabilitation services there should be for people living temporarily in care homes. In these situations, if rehabilitation support is not made available, then some people, for example, following a fall during a temporary stay in a care home, will be delayed from returning to their home. Their temporary stay may in the most serious cases become permanent. This has implications for social care costs as well as individual wellbeing and quality of life. The specification is an opportunity to clarify this issue so that all people in a care home setting can access rehabilitation support that meets their needs.

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

3.1 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 Enhanced Health in Care Homes specification. This could mean for example engagement with Health Education England regional AHP workforce leads and regional AHP Council's. CCGs and ICSs need to support this to happen.

3.2 CCGs and ICSs can support implementation of Enhanced Health in Care Homes services in line with the specification through endorsement and use of the Rightcare Community Rehabilitation toolkit.

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

3.4 There is strong growth in numbers of registered physiotherapists. Physiotherapy pre-registration courses continue 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.

3.5 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 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. This includes full roll out of FCPs that is critical to freeing up GP time (see answer to Q3).

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

4.3 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.

4.4 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 The award winning Community Rehabilitation and Falls Service in Guy's and St Thomas' NHS Foundation Trust, which increased capacity of the community falls service, including through physiotherapists training non-registered staff to deliver an innovative referral and triage process, run strength and balanced classes as well as provide one-to-one treatment.[(3)]

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 the metrics listed there needs to be measures that capture Quality of Life, levels of mobility and numbers of personalised care plans that include goals around physical activity, proportion of residents who have had multi-factorial falls risk assessment 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.

6.2 The following data challenges need to be addressed to ensure quality data is collected in relation to Enhanced Health in Care homes:

- 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. With private and public provision of care homes this is likely to result in even more systems in play so duplication of entry is a real fear for staff.
- 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. Though the Community Services Dataset (CSDS) has been mandated by NHSE 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 of Systematic Reviews; 2014(11).

2. Hopewell S, Adedire O, Copsey BJ, et al. Multifactorial and multiple component interventions for preventing falls in older people living in the community. Cochrane Database Syst Rev. 2018;7:CD012221.

3. The Chartered Society of Physiotherapy. Physiotherapy Works. Falls: a community approach. 2nd ed. London: The Chartered Society of Physiotherapy; 2019.

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