APPG Primary Care and Public Health inquiry
Managing demand in primary care: the case for a national strategy

Written evidence from the Chartered Society of Physiotherapy

About the physiotherapy profession

- The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the UK's 56,000 registered physiotherapists, physiotherapy students and support workers
- Physiotherapists are autonomous, regulated practitioners, who don't require supervision or delegation from doctors
- Physiotherapists are qualified to independently assess and diagnose, and to identify and manage risk to patients effectively and safely.
- Physiotherapists are experts in musculoskeletal (MSK) disorders as well as rehabilitation, physical activity and self-management for people with a range of long-term conditions
- Many advanced practice physiotherapists can prescribe medicines, order and interpret imaging (x-rays/ultrasound scans/ MRI) and bloods, provide injection therapy, and provide complex case management
- Increasingly, physiotherapists are working in primary care as General Practice physiotherapists to manage a proportion of the GP caseload.

Summary of CSP recommendations

- To increase ability to self-manage and prevent needs developing, people must have access to expert advice from a wider range of professionals within their General Practice on the basis of the 'Most Appropriate Professional'
- Physiotherapists and GPs are working together to establish successful GP Physiotherapy roles as part of the GP team in many areas
- These successful pilots need national and local support to overcome transactional barriers (including through incentives) to being scaled up and made mainstream
- These roles have focused on musculoskeletal health, an area where significant progress could be made
- These roles also have the potential to go beyond MSK - advanced practice physiotherapists need to deploy their skills as expert generalists to manage a wider range of health conditions and provide public health advice
- Physiotherapists and other members of an expanded General Practice team need to be able to issue Fit Notes as part of their role in supporting people to be fit for work
- To develop the expanded GP team, integrated with other primary and community sector services, there needs to be much more multi-professional training
- For community engagement and service-user participation to happen it needs to be built into the process of service redesign in primary and community care.

1. What needs to happen and who needs to be involved to help assist people in looking after their own minor self-limiting illnesses and long term conditions?

1.1 Physical activity is critical to people's recovery, prevention and management of health. But recent research found that for a third of people with long term conditions, not knowing right activity for them or their condition a barrier to physical activity, and for 28 per cent of them, a fear of hurting themselves was a barrier. (1) To overcome these, people need much easier access than exists presently to expert advice from a wider range of health and care professionals.

1.2 General Practice is the first port of call for most people seeking help with illness or long-term conditions. Widening the General Practice team under the leadership of the GP is required. In many parts of the NHS there is a move towards organising services so that patients can be seen by the 'Most Appropriate Clinician.' This approach needs to be applied to primary care to improve quality of care and effectively support self-management.

1.3 Musculoskeletal (MSK) health is an area where there is significant value in providing early access to advice and support for self-management. MSK health issues account for around 1 in 5 GP consultations (2-4), are the most common cause of repeat appointments (5) and there are high levels of unnecessary medicine prescribing and referrals for investigations and into secondary care. They are also the most common cause of disability, the second biggest cause of sickness absence (6) and a significant factor in the development of co-morbidities.

1.4 Evidence shows that physiotherapists have the most advanced expertise in MSK of all health professionals, with the exception of orthopedic consultants (7) and that physiotherapists can effectively manage 85 per cent of a GP's MSK caseload without the patient needing to see the GP. (8)

1.5 GPs and policy makers are now recognising the potential to utilise physiotherapy expertise through a new role of General Practice Physiotherapist, being piloted by around 40 per cent of Clinical Commissioning Groups (CCGs). (9)

1.6 GP Physiotherapists, commonly with advanced practice skills, provide the same first point of contact service for people with MSK health issues as a GP would. This means that they assess, diagnose and, if necessary, refer for investigation (x-rays, scans etc), or refer to secondary care for ongoing physiotherapy treatment or to see a consultant.

1.7 One of the GP physiotherapy pilots is 'Physiotherapy First', a joint initiative between two NHS providers, Cheshire and Wirral Partnership NHS Foundation Trust and the Countess of Chester Hospital Foundation Trust. Staff within the existing NHS physiotherapy services provide services within 36 GP surgeries in West Cheshire. This provides patients with the choice of seeing a physiotherapist when they first contact a general practice with MSK symptoms. The service is integrated with an existing, successful Clinical Assessment and Treatment (CAT) service within secondary care. For areas that didn't already have such a service, the savings below in relation to secondary care would be far higher.

The physiotherapists see around 1000 patients per month – a quarter of the GPs' MSK caseload. Under 3 percent are referred back to the GP, for a medication review, a fit note or for non-MSK conditions. Over 60 per cent can be discharged after one appointment with the GP physiotherapist. The service has:

- Saved GP /locum time – 84 per cent of patients seen by the physiotherapist would have been seen by the GP – value £540k / year
- Decreased plain x-ray referrals 5.9 per cent - value £28k / year
- Decreased MRI referrals 4.9 per cent - value £83k / year
- Decreased orthopedic referrals by 12 per cent - value £70k / year
- Reduced referrals to physiotherapy services by 3 per cent - after a year-on-year increase of 12 per cent over the previous 5 years
- High patient satisfaction – 99 per cent rated the service good or excellent, 97 per cent had their issues addressed.
- High GP satisfaction - 91 per cent rated the service as being 8 or over for how beneficial they felt the service is to their practice with 45 per cent scoring them a maximum ten. (10)

1.8 The evidence from GP physiotherapy pilots shows that the majority of patients accessing GP Physiotherapy support can be discharged with advice and exercise to self-manage, there is high patient satisfaction and patient understanding of how to self-manage.

1.9 Allowing people to directly refer themselves to physiotherapy does not increase demand. In a randomised controlled trial the 10 000 people registered to the GPs where self-referral was being offered received direct marketing of the service. This found no increase in the number of people referring themselves to the service, no increase in inappropriate referrals, and no increase in risk. (11)

1.10 General Practice Physiotherapy roles have so far focussed on MSK health. However, physiotherapists in these roles also bring a level of expertise in relation to a range of other conditions that would be of significant value in a GP setting in reducing demand and supporting public capacity to self-care. This includes older people at risk of falling, people managing their Chronic Obstructive Pulmonary Disease and Cardiovascular Disease.

1.11 Fear of falling and fear of exacerbating respiratory and heart conditions, prevents people from being physically active. We know that this increases the risk of falling and condition deterioration. Many physiotherapists work in, and often lead, falls prevention teams, and pulmonary and cardiovascular rehabilitation exercise programmes. However, people generally do not have access to these services until they have had an acute episode. Physiotherapists as first point of contact posts in General Practice can provide expert advice and support before people have reached that stage. GP physiotherapy roles therefore have the potential to go beyond MSK, and deploy skills as expert generalists to support people to manage a wider range of health conditions.

2. Is it necessary to commission self-care and how can this be done effectively?

2.1 All health and care professionals have a responsibility to empower patients to manage their health. Work by the Royal Society of Public Health and Public Health England showed that for the public, physiotherapists and other allied health professionals are a trusted source of advice on healthy living and already see an important part of their role is to prevent ill health, have healthy conversations built into their everyday practice. (12)

2.2 Expanding the range of services that a patient can access either directly at their local surgery, or through other agencies within primary care better linked up with GPs is

key to this – including exercise programmes run by AHP support workers under the direction of registered physiotherapists and other AHPs or nursing staff.

3. What training is necessary to support primary care staff in educating people to look after themselves and who is providing this training?

3.1 There would be significant value in investing in multi-professional education to optimise approaches to educating people to look after themselves. This needs to build on work being progressed by NHSE and HEE to define the mulit-professional competences required to support patient self-management and behaviour change in effective, integrated ways.

3.2 Implementation of this work needs to ensure that all parts of the workforce are supported in being enabled to access and engage in learning opportunities on an equitable basis, recognising that such equity does not yet exist in other areas of skills and professional development. In addition, delivery of learning needs to enable all parts of the workforce to learn on a collaborative basis, such that they can share their insights and expertise with one another.

3.3 Expanding the GP team and better integrating GP services with wider primary and community services should support inter-professional sharing of expertise in supporting self-care. For example, many physiotherapists are trained by mental health professionals in cognitive behavioural therapy (CBT). They use CBT techniques when motivating patients to be physically active. Similarly, physiotherapists can share their expertise with colleagues in how people with long-term conditions can exercise safely.

3.4 More broadly, there is a need to ensure that workforce development and investment are progressed in ways that support the progression and implementation of new models of service delivery and multi-disciplinary team (MDT) working.

3.5 This needs to include opening up opportunities for developing workforce capacity through the Community Education Provider Networks (CEPNs) beyond GPs to physiotherapists and other members of expanded GP team. Work also needs to be progressed to open up the infrastructure for postgraduate medical education and training to the wider workforce to support changing service delivery models, MDT working, and enable all parts of the workforce to work to the height of their capabilities.

4. How can local health expertise such as pharmacy, health coaches, patient groups and charities be incorporated into the system to help manage demand?

4.1 As services in primary care are redesigned, there is an opportunity to build into design involvement of service users and carers that empowers, improves services and strengthens communities.

4.2 An example of this in practice is the Hope Specialist Service in Grimsby, part of social enterprise, Care Plus. Hope provides rehab programmes and support for patients with COPD and older people at risk of falls. The team is made up of physiotherapists, occupational therapists, generic technical instructors, rehabilitation assistants and most importantly 80 volunteers. The volunteers are all former patients and carers, who act as motivators, role models and community educators – linking up with residents' organisations and patients groups and running quit smoking classes.

Using Neighbourhood Renewal Funding, the service turned a vandalized former GP surgery it into a modern rehab centre and a valued community asset. They raised money locally to develop a gym, outdoor exercise facilities, a garden and a café – with gardening forming part of people's rehabilitation and produce from the garden is used in the café. In order to fundraise, they established a charity The Hope Street Trust, with volunteers on the board. Results from the service include: One hospital admission prevented per patient on the 8-week programme (saving £2600 per patient); hip fractures substantially reduced; volunteer led smoking cessation courses with a 62 per cent higher quit rate than the national average; patients report significantly reduced levels of anxiety and depression with higher confidence and ability to undertake daily activity. (13)

5. What else has to happen to improve joint working locally to engage people in their health and wellbeing and so reduce service demand?

5.1 A significant area for joint working locally to engage people in their health and wellbeing is between employees, employers, DWP and health staff. MSK health issues are the most common reason for a person to be off sick from work, and the most common cause of disability. As well as having a social and economic impact, this creates a significant demand for GP appointments from patients in order to obtain a fit note.

5.2 As well as increasing demands on GP time, there are also inherent weaknesses in the current reliance on GPs to provide Fit Notes for MSK health issues, which acts as a barrier to joint working. GPs can offer fitness for work information, but as well as having significant time pressures, are often not expert in MSK health issues. The section '*may be fit for work subject to the following advice'* which can assist employees and employers to make necessary adjustments to work, is rarely completed by GPs. (14) Evidence also suggests that GPs feel ill-equipped to provide this advice and often patients are not confident in their GP's ability to judge or advise on return to work. (15)

5.3 The current Health and Work Green Paper from the DoH and DWP recognises the potential for physiotherapy to improve MSK care in primary care and to reduce sickness absence. (14)

5.4 The DoH and DWP are also actively considering whether to extend those professionals who can issue fit notes to physiotherapists and other health professionals. (14) Offering return-to-work advice is part of what physiotherapists do on a day-to-day basis. Physiotherapists routinely also include a patient's work in their functional outcome measures and have 'healthy conversations' about work.

5.5 The British Medical Association (BMA) and the CSP, have called for this reform to be introduced as soon as possible. (16)

6. What impact have Government policies such as the FYFV and GPFV had in managing demand and how can we move towards that much sought after whole-systems NHS?

6.1 Experience from the NHS England new models of care vanguard sites suggests that the barriers to scaling up new models of care, using a whole systems approach, are generally transactional ones (i.e. relating to contracts, budgets, organisational accountability, and how risks are shared across organisations), rather than more fundamental ones.

6.2 While the direction of health policy is to address this (e.g. through STPs) the reality of practice on the ground now is that silo working by budget-holders, the combination of different financial levers and incentives, and separate budgets across a patient's pathway of care, are acting as barriers to manage demand better across the system.

6.3 This point is well illustrated by General Practice physiotherapy. Evaluations of pilots have shown that putting experienced physiotherapists at the front end of a patient's journey from General Practice reduces demand and waste across the system, as well as improving care.

6.4 Because of the number of areas using the GP Access Fund to pilot these posts, General Practice physiotherapy was chosen as one of six areas to focus on in a 'deep dive' exercise by Mott MacDonald, the independent evaluators commissioned by NHSE. This will be published later in 2017. Early findings show that both patients and GPs are seeing the benefit of having more rapid access to physiotherapy services within primary care.

6.5 But in spite of demonstrable impact, and support from GPs, the Royal College of General Practice (RCGP) and the BMA, successful pilots are struggling to secure mainstream funding to replace the GP Access Fund.

6.6 To achieve delivery of its General Practice Forward View plan in relation to the expanded GP team, NHS England need to provide more support for commissioners, providers and clinicians to overcome the transactional barriers that exist locally. They also need to incentivise local budget-holders to look at more streamlined, and cost-effective ways of delivering services across whole pathways. One area that may be useful to look at is the potential for a QOF payment for multi-disciplinary working.

Professor Karen Middleton CBE FCSP MA
Chief Executive
Chartered Society of Physiotherapy
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For further information on this response or any aspect of the CSP's work please contact:

Alice Sorby, Policy and Research Officer
The Chartered Society of Physiotherapy
14 Bedford Row, London WC1R 4ED
Telephone: 020 7306 6625
Email: sorbya@csp.org.uk
Website: www.csp.org.uk

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