Primary care in the Long Term Plan for the NHS
Response from the Chartered Society of Physiotherapy (CSP)

Key messages

- The populations' musculoskeletal (MSK) needs are not being met. At the same time there is significant over testing and unnecessary referrals. Most MSK needs should be being met within primary care, without the need for referral for secondary care services
- First Contact Physiotherapists (FCP) need to be available to patients from all GP surgeries. The learning from the current NHS England FCP High Impact Intervention programme should be used to ensure full implementation can be delivered as part of the NHS Long Term Plan
- FCP roles, while primarily focussed on MSK, need to include a greater role in supporting the older frail population in primary care, and providing physical activity advice for people with diagnosed long-term conditions
- Transforming primary care requires the systemic and capacity issues of community based rehabilitation services to be addressed, including the referral routes between General Practice and community services
- The policy advice from the Department of Work and Pensions about the use of the AHP Fitness for Work Advisory Report as the equivalent to the GP Fit Note must be communicated across and by Government departments – this is a quick win.

1. How can the NHS help and support patients to stay healthy and manage their own minor, short-term illnesses and long-term health conditions?

1.1 The urgency of improving musculoskeletal (MSK) health care in primary care is clear. It is the biggest single cause of disability[(1)] and second biggest reason for sickness absence[(2)] from work. It is also a common co-morbidity with other long-term conditions, for example where a condition has reduced a level of mobility or is a barrier to physical activity. It is an area where patients are being failed in spite of high levels of NHS spending and variation in spending between localities.

1.2 A priority for primary care transformation in the NHS Long Term Plan must be to ensure that the majority of patients MSK issues are dealt with effectively entirely within primary care; establishing advanced practice physiotherapists working in primary care as the first point of contact for patients with MSK issues will facilitate this.

1.3 Physiotherapists are working in first contact practitioner roles within primary care. They have demonstrated their impact and value in supporting patients to manage their MSK health. By providing a higher level of expertise at the start of the patient's journey, they are improving the quality of care while streamlining the pathway, saving money, reducing waste and reducing pressure on other parts of the system.

1.4 Providing this easy route via General Practice for people with MSK issues to get advice and support from an advanced practice physiotherapist removes the need for most MSK patients to be referred into secondary care for further treatment, assessment or investigation. For those who do need further tests, treatment or consultant assessment, FCPs have the expertise to expedite this.

1.5 This successful initiative is ready to become part of the mainstream primary care landscape and identified as a high impact intervention by NHS England. From June 2018 large implementation sites have been identified in each STP area for large-scale piloting, and national evaluation is being carried out 2018/19. The plan for national roll out from mid-2019 onwards needs to be taken forward as part of the NHS England Long Term plan and NHS planning guidance.

1.6 Financial systems and commissioning practices need to be developed that enable full roll out of FCPs. The issues that need to be resolved are common in other areas of primary care transformation. FCPs can be a useful test ground for these. The key aspects of this are:

- financial systems that have the flexibility to enable savings delivered by FCPs for elective care services in acute and community to be drawn down to fund FCPs, and can be directed to fund FCPs
- incentives for General Practice through Quality and Outcomes Framework to improve MSK care and for multi-disciplinary working
- contractual arrangements that allow GP federations and networks to deliver primary care contracts with deployment of FCPs employed by community and acute providers.

1.7 The FCP role should start to be developed beyond MSK, to make full use of physiotherapy advanced clinical practice in relation to people with frailty, people at risk of falling and people with other diagnosed long-term conditions who need physical activity advice to support self-care.

1.8 The FCP role should be fully utilised within General Practice to provide support for people flagged with frailty risk in the electronic frailty index. This includes those who are at risk of falling and provide tailored advice on strength and balance exercises, as a preventative measure to build patients' resilience and reduce and reverse escalations from mild frailty, through moderate, to severe.

1.9 FCPs can also help provide for onward referral of those with a mild frailty risk and mild rehabilitation needs to services provided by the fitness industry and the voluntary sector, and for those with moderate to severe frailty risk and rehabilitation needs to multi-disciplinary teams integrated in a community hub model.

1.10 The joint health and work unit has advised that AHP Fitness for Work advisory reports, that provide advice to employers and employees can be used in exactly the same way as a GP Fit Note i.e. evidence for employers for Statutory Sick Pay (SSP). However, this has not been communicated yet by Government to employers, to the public, to GP teams, or across their departments (for example, Inland Revenue who audit employers accounts, including records for SSP). This is an easy win that needs to be immediately actioned so that issuing AHP Fitness for Work reports can become part of the FCP role.

1.11 A priority for physiotherapy workforce development is to increase the numbers of the existing workforce with advanced practice skills – including post-graduate training to

be medicine prescribers, trained to provide injection therapy and order and interpret relevant diagnostics and investigations. Training for FCPs in responding to mental wellbeing (i.e. CBT, motivational interviewing/coaching techniques) will also add value given the link between MSK, pain, anxiety and depression.

1.12 Undergraduate training needs to be developed so that students need to gain experience of working in a primary care setting and the capabilities to develop advanced practice skills applied to an undifferentiated patient group and the complexity and risks that this involves.

1.13 Many of the training needs for first contact physiotherapists are shared by other professions who are forming part of the widening GP team, and would benefit from being organised on a cross professional basis. Community Education Provider Networks could play an important role in developing this.

2. How could services like GPs and pharmacy, work with other services like hospital services to better identify & meet the urgent and long-term needs of patients?

2.1 To deliver their full value, FCP provision needs to be both connected to general practice and GP networks and integrated within physiotherapy MSK teams as part of existing service provision.

2.2 In practice there are significant benefits if physiotherapists are deployed as FCPs in primary care for only part of their week, and continue to be part of wider physiotherapy and rehabilitation teams within community and acute settings. Benefits include improving patient flow, reducing duplication, staff development and retention, system flexibility and continuity of care for patients.

2.3 Making FCPs part of an integrated contract for MSK, operating across sectors, provides for the greater flow of resources required to primary care and General Practice and support better links between general practice and rehabilitation staff within the acute and community sector.

2.4 The wider GP team (including physiotherapists) must also be able to more easily refer people identified as frail on the Electronic Frailty Index or with long term conditions (including all the clinical priorities in the Long Term Plan) to community rehabilitation teams.

2.6 CGA and rehabilitation assessments (whether provided in acute, primary or community sectors) should form part of the patients records accessible to patients, GP teams and community rehabilitation MTDs.

2.8 Currently community rehabilitation services are fragmented, organised in condition specific silos, developed in a piecemeal fashion and hard to access. This is a systemic problem regarding lack of visibility in data used to commission and the systems of commissioning and payments, which has contributed to insufficient resources.

2.9 Community rehabilitation and frailty services need to be viewed as a whole, so that gaps and duplications can be identified. The CSP believes that integrating services in a community hub model should be explored, based on need – either physically co-located or better networked. These should be organised around GP networks and federations.

2.10 We also believe that many services could increase their capacity by greater utilization of the unregistered support worker workforce, and through exploring potential to reorganize some services based on common symptoms, common interventions to address and co-morbidities.

2.11 Community-based rehabilitation services have experienced disinvestment over many years – in spite of irrefutable evidence of value to patients and the rest of the system, and in spite of growing need. This year half of all community providers report that they are managing real term cuts in their budgets).[3] As a result community services apply stringent inclusion and exclusion criteria in an attempt to manage demand. This creates a barrier to effective handover from acute settings and referral routes in from primary care.

2.12 As NHS payment and commissioning systems are developed they need to be able to properly identify the activities and staffing required to meet rehabilitation needs in the population – addressing the lack of clarity about what rehabilitation activity is included within payment for episodes of care and who pays for community–based rehabilitation activity. Currently rehabilitation activity is not specified within units of provision in enough detail, and can be assumed by commissioners to be included within funding of episodes of care, when the reality provision is limited and nowhere near meets patient need. The new best value tariffs for COPD and for hip fracture both illustrate this.

3. What other kinds of professionals could play a role in primary care, what services might they be able to deliver which are currently delivered elsewhere and how might they be supported to do so?

3.1 The expansion of mental health therapists in General Practice, through Improving Access to Psychological Therapies is extremely welcome. In many areas this has played a significant role providing frontline mental health support and signposting to other services, and in training other healthcare professionals. In General Practice this has the potential to ensure mental health is considered within all consultations. There is a particular synergy with physiotherapy and the role of FCPs, because of the interplay between mental health, MSK and pain.

3.2 It is important that exercise prescription and physical activity pathways through to leisure and voluntary sector services is part and parcel of consultations with all members of the GP team, including FCPs. A good example of this in practice is Sheffield Physical Activity Referral Scheme.

3.3 Social prescribers have an important role to play as part of the GP team both to directly provide support to patients and in building the capacity of the GP team to provide this advice within consultations.

3.4 The co-location of primary care professionals with each other, and within used community-resources should be part of onward transformation of primary and community care services.

4. How could prevention and pro-active strategies of population health management be built more strongly into primary care?

4.1 Meeting the minimum physical activity guidelines is key to people successfully managing long-term conditions. It is effective as a means of managing pain, enabling

and maintaining function, and improving quality of life. That now includes advice on maintaining strength and balance through life.[4]

4.2 People with long-term conditions however experience additional barriers to being physically active. This includes pain, fear of further injury, and a lack of confidence as a result of their condition. This group needs expert advice from a health professional who understands these barriers and how to overcome them.[5, 6]

4.3 All people who seek advice or treatment in primary care for physical or mental health issues should be provided with bespoke physical activity advice to support ongoing self-care and meeting physical activity guidelines.

4.4 Recent research by the Richmond Group of charities into co-morbidities,[7] has shown that mobility is the main factor for people with long term conditions in determining their quality of life, their likelihood of developing health issues and in inequality. All healthcare professionals in primary care (and across the NHS and social care) therefore need to be working to a shared goal of supporting patients to become and remain mobile, and equipped with the training and expertise needed to support this.

4.5 Physical activity, including strength and balance exercise are core components of physiotherapy. Advanced practice physiotherapists have a significant role to play as part of the wider GP team in being this trusted source of expertise for patients, and working in collaboration with other members of the wider team, and increasing confidence of colleagues to give physical exercise advice to people with long-term conditions and disabilities.

4.6 The roll out of FCPs as part of the NHS Long Term plan needs should include the development of digital resources for patients and clinicians to give tailored exercise advice and monitor progress, which could be linked to patient records and online booking and triage systems. A number of FCP pilots provide online advice and booking, and are currently exploring apps to compliment this.

The West Cheshire FCP pilot operates across 36 practices. The capacity of the service stands at: 11,000 patients per year, which is 25% of total GPs' MSK caseload. There is a scope to increase the capacity of the service further. The service was developed with a successful clinical triage assessment and treatment service already in place.

Outcomes:

- More than 60% of self-referred patients discharged after the first appointment.
- Quick access to advice provides rapid return to function and no need for further treatment.
- Less than 3% of self-referred patients needed to see the GP for medication reviews or non MSK conditions etc.
- High patient satisfaction: 99% rated the service good or excellent and happy to use again (1897 patients)
- High GP satisfaction : 91% rated service 8+ for how beneficial service is to their practice with 45% scoring a 10/10
- 20% fewer referrals to MSK physio services (after 5 years of an annual 12% increase) resulting in a reduction in waiting times
- Savings: 84% patients would have seen the GP saving
  - £540k a year, 4.0% less MSK imaging saving £11,495 a year, 5.9% fewer X-rays saving £28k a year, 2.0% and fewer orthopaedic referrals saving £70k a year.
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(Source: CSP case study data base and used in the (soon to be published) NHS England FCP HII guidance)

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