The Future of General Practice
Health and Social Care Select Committee Inquiry
Chartered Society of Physiotherapy Consultation response

To: Rt Hon Jeremy Hunt MP & Members of the Health & Social Care Select Committee
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The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the UK's 61,000 chartered physiotherapists, physiotherapy students and support workers.

Physiotherapists form a key function within multidisciplinary primary care teams, reducing demands on General Practitioners (GPs). First contact musculoskeletal (MSK) physiotherapists (FCPs) diagnose and advise patients with MSK conditions. This frees up GPs, speeds up access to expert advice, and saves money in primary and secondary care.

Summary of CSP recommendations

- Continue the roll out of FCPs across England to reach 5000 by 2030 in order to manage approximately half of MSK consultations in General Practice
- Achieve this through creating a pipeline of registered physiotherapists, utilising the growth in graduate numbers and creating a career pathway for staff from being newly qualified onwards
- Fund implementation of the training of physiotherapists to undertake FCP roles through the Health Education England (HEE) FCP Roadmap
- Ensure lessons learned during the initial implementation phases are used to realise the full value of FCPs to General Practice and the wider system through: reducing the average patch size per FCP to 10 000, support FCPs to be part of an integrated MSK pathway and embedded in GP teams through employment of FCPs by the incumbent MSK provider and co-located in GP practices
- Increased focus on integration of primary care and community sectors, with employment and funding mechanisms that support this and include other physiotherapy roles

1. What are the main barriers to accessing general practice and how can these be tackled?

To what extent does the Government and NHS England's plan for improving access for patients and supporting general practice address these barriers?

1.1 MSK health issues are the most common cause of repeat GP appointments.[1] They account for around 1 in 5 of all GP consultations in England[2,3,4] and are estimated to cost the NHS £4.76 billion each year, a figure likely to increase.[5]

1.2 The 2015 Health and Social Care Select Committee Inquiry into Primary Care supported the inclusion of physiotherapists in multidisciplinary teams. The Select Committee recognised the role of physiotherapists in managing this demand, allowing GPs to concentrate on those aspects of care that only they can provide.

1.3 In the last few years FCP roles have been implemented and there are currently believed to be around 800 FCPs (whole time equivalents). These roles have been shown to be clinically and cost effective. FCPs use their advanced practice skills to meet the needs of patients while in primary care. By putting the physiotherapist at the front of the MSK pathway, this provides the patient the expert help they need at the start, increasing self-management, speeding up

access to treatment where needed, reduces GP workload and associated costs, lowers prescription costs and reduces inappropriate referrals to secondary care.[6]

1.4 Physiotherapy management of MSK conditions in primary care leads to fewer referrals to specialist services, compared to GP management.[7] An audit of 40 patients found the FCP service potentially reduced the need for 270 face-to-face consultations with a GP.[8] An FCP hub in Derbyshire found only 2% of patients seen by FCPs were referred to a GP or a Consultant.[9]

1.5 In Lincolnshire an MSK FCP successfully took on 39% of MSK patients, increasing GP capacity. Feedback from patients was 100% positive.[10] The CSP's Phase 2 Evaluation found that "95% patients reported receiving sufficient information on self-care/exercise from the FCP".[11]

1.6 A rural North Wales FCP service found reduced costs compared with a GP providing the same service, less than 1% required GP appointment for same complaint, less than 3% were referred for further investigations and less than 10% of patients seen are referred into secondary care MSK services.[12]

1.7 Early MSK intervention improves outcomes for patients. It keeps people at work or enables them to return to work more quickly. In 2018, MSK problems were the second most common cause of sickness absence, which accounted for 27.8 million days lost in work (19.7% of total sickness absence).[13] FCPs in primary care allow rapid access to access to MSK support which can reduce the amount of time people are off sick.[14] 54% of patients reported less impact of their MSK condition on work performance at 3 months (as measured by the Stanford Presenteeism Scale).[15]

1.8 Addressing GP workload issues through full roll out of FCPs as part of the wider GP team has the potential to attract more doctors to become GPs.

1.9 However, FCPs themselves are currently stretched too thin. There are approximately 800 FTE FCPs, commonly with 1 FCP for a Primary Care Network of 50 thousand population, working across many practices. This level of coverage means that many individual GPs don't experience sufficient difference in workload. This reduces buy-in from GPs, buy-in which is critical to successful implementation.

1.10 For an FCP to manage half of the MSK consultations in General Practice - which equates to roughly 10% of the overall consultations – FCP staffing levels must be increased to 1 FCP per 10, 000 population. To achieve this the People Plan must provide the 5,000 extra MSK FCPs, promised in the interim People Plan.[16] The CSP is disappointed further progress towards this target has not been met and we would urge that efforts are stepped up to ensure that it is met by at least 2030. This would ensure sufficient coverage of FCPs to fully realise their benefits to GPs.

1.11 For the initial implementation of FCPs the contract between the NHS and Primary Care Networks limited PCNs to 1 FCP, and it is this cap that limited the capacity increases needed to genuinely impact on GP demand. This cap was subsequently lifted, but capacity remains constricted due to the lack of a pipeline to support full FCP roll out.

1.12 In order to realise the additional FCPs required, advanced practice development programmes should be funded and expanded with continued access to the apprenticeship levy. This needs to be sufficiently resourced and aligned to that offered to other professions working in primary care, such as GPs and clinical pharmacists. This includes support to physiotherapists to complete the First Contact Practitioners and Advanced Practitioners in Primary Care: (Musculoskeletal) A Roadmap to Practice.

1.13 Investing in the wider physiotherapy workforce to develop the capabilities required for FCP roles will ensure sustainability moving forward and help to backfill MSK services as experienced practitioners move into FCP roles. Physiotherapy is one of the few professions where there is continued and strong growth in supply, with over 30% growth in graduate

numbers since 2015,[17] and expected ongoing yearly growth of at least 6-7% for the next decade.[18] Workforce plans need to capitalise on this growth, guaranteeing 5-year NHS contracts to newly-qualified physiotherapists who want one. This will create a pipeline of experienced physiotherapists in primary care which is currently being missed by the NHS.

1.14 As well as creating an FCP pipeline, increasing the overall physiotherapy staffing in the NHS is critical to delivering on the rehabilitation and community support commitments in the Long Term Plan. This will also reduce pressures on GPs. 40% of people are managing a long term condition[19] and 25% are managing 2 or more, and these figures are rising.[20] Even before Covid, people with long term conditions already accounted for 55% of all GP appointments,[21] and 29.1m GP appointments are associated with frailty every year.[22] During the pandemic, millions of people with long term conditions and frailty have deconditioned and deteriorated as a result of lockdown and disruption to services. See more under section 3.

What are the impacts when patients are unable to access general practice using their preferred method?

Digital technology

1.15 Covid-19 has accelerated existing changes in Primary Care with GP practices offering a blended offer of in-person and remote consultations as well as access to a wider multidisciplinary team. A 2019 evaluation found that many patients appeared aware of the changing face of primary care and general practice and how FCP sit within the wider general practice team.*[23]*

1.16 Delayed access to GP practices can deter people from accessing healthcare whilst delayed diagnosis, treatment and rehabilitation is a major driver of health inequity. It exacerbates MSK conditions, increases risk of costly related co-morbidities, including diabetes and obesity and according to Versus Arthritis, around 1 in 5 people with arthritis live with depression.[24]

1.17 Offering the option for remote FCP consultations means patients get seen quicker and recover faster. It can help address practical barriers to accessing services, particularly in rural areas, such as the lower access to a car amongst women.[25] Remote consultations must be appropriate and a real choice for the patient. Consideration of multiple interacting factors such as communication needs, resources and digital literacy determines the right type of service delivery at the right time for each individual.

1.18 FCP services must be fully funded to support remote as part of hybrid working practices,[26] provide training and development for the workforce and students, and end the lack of basic technology and interoperability of IT systems. Aligning FCP and General Practice IT systems is essential for optimum working. FCPs working across different GP practices currently deal with several IT systems causing additional stress and wasted time, as outlined in the national NHS England commissioned FCP evaluation study:

> *"The CCG operate from 3 different systems with different passwords to get on the computers. So, I've got six different passwords to get into the 7 clinics. Then I've got another six passwords to get onto their site specific software. So, I've got a diary full of passwords, and it takes me 15 min to get on the system!"*[27]

1.19 Technology enables clinicians to work in virtual multidisciplinary teams (MDTs) across sectors and settings. During the pandemic primary care teams had greater access to specialists, such as neuro-specialists who could attend virtual case conferences without time and travel constraints. This is something that needs to be maintained.

2. What are the main challenges facing general practice in the next 5 years?

How does regional variation shape the challenges facing general practice in different parts of England, including rural areas?

2.1 Further rollout of FCPs can improve access to GP practices in areas to which it has traditionally been hard to recruit GPs.

2.2 Further development and expansion of pre-registration physiotherapy workforce is essential to backfill physiotherapy roles left by FCP recruitment and widen access to GP services, especially in hard to recruit areas such as rural and coastal towns.

2.3 The CSP is working with the profession to diversify physiotherapy student placements and post graduation rotations to increase their early exposure to primary care and support recruitment in hard to recruit areas.

What part should general practice play in the prevention agenda?

2.4 FCPs and community physiotherapists are well placed to support GPs to make a positive impact in public health. Physiotherapists are experts at recognising in their patients any risk factors or social determinants of preventable diseases.

2.5 Integrated pathways which help people transition from General Practice to community health services including rehabilitation and exercise are essential to support prevention, secondary prevention and supported self-management of LTCs.

2.6 General practice are key stakeholders in the transformation of community rehabilitation services. The CSP has co-designed a model of integrated community based rehabilitation with key stakeholders, including the RCGP. Features of the model include hybrid delivery mechanisms, upgrading supported self-management, combining psychological support with physical exercise and education and greater utilisation of the non-registered workforce, including from the voluntary sector and sports and exercise professionals. Importantly it also includes moving more outpatients rehabilitation and into community venues, like gyms or community centres. Insight research commissioned by the CSP suggests that patients would welcome this move to non medical settings. Transformed community based rehabilitation could improve levels of participation and ongoing commitments to physical activity and lifestyle changes. [28]

What can be done to reduce bureaucracy and burnout, and improve morale, in general practice?

2.7 Increased FCP service capacity and presence within GP surgeries will optimise the success of the FCP model. Current numbers of FCPs positively influence GP's work experience by reducing workload through reallocating MSK appointments, reduced prescription costs,[29] and gaining in-house MSK expertise. However, their full value to GPs will only be realised with the additional 5,000 FCPs promised in the interim People Plan.

2.8 It is important that in general practice the lessons of reducing staff burnout are learned and applied to the wider primary care team. FCP consultation space and appropriate appointment times (20 minutes is often reported as a minimum requirement) must be protected. FCPs have reported a loss of consultation space during Covid-19 with some practices taking the opportunity to offer remote FCP services to free up GP space. In a recent survey the CSP found that 88% of physiotherapists surveyed said that loss of space and services had affected staff negatively. Many also reported 'burn-out', 'anxiety' and other mental health issues as a consequence of not being able to carry out face to face assessments where it would deliver the best care for their patients.[30]

2.9 The benefits of a co-located model, where the FCP is based in the GP practice include improved communication and support, consistency of messaging to the inpatient population, enhanced confidence among the clinical and support staff within the practice, and a perception of decreased clinical risk.[31]

2.10 Appropriate job planning and coordination is essential to delivering the FCP roadmap. Implementation of the HEE roadmap is needed to provide a framework for FCPs in training posts should include guidance in relation to the content, workload, amount of training, supervision and mentorship and the standards of training and practice. This is important when considering future expansion for the sustainability of these roles.[32]

2.11 The employment model described below (3.1) enables physiotherapists to undertake split roles, part of the time deployed as an FCP and part of the time in the main MSK service, which increases levels of peer support and reduces the risk of the burn-out experienced by many GPs.

3. How can the current model of general practice be improved to make it more sustainable in the long term?

Do the current contracting and payment systems in general practice encourage proactive, personalised, coordinated and integrated care?

3.1 The CSP and NHSE[33] recommends FCPs are employed by the incumbent MSK service providers and embedded in the GP practices. Evidence from the FCP rollout is this improves pathway integration, reduces administrative burden on GPs, and provides peer support to reduce feelings of burnout and isolation.[34]

3.2 This approach also enhances patient experience as there is consistency throughout the MSK pathway and FCPs will have good knowledge of the whole pathway, referring people to the most suitable service in the area.

3.3 To enable Primary Care Networks to commission FCPs from MSK providers, those MSK providers must not subcontract or add steep on-costs. This is creating a financial disincentive for PCNs to contract with MSK providers to provide FCPs.

3.4 We would support an exploration of joint funding of PCNs and community services for FCP roles, as has been explored in mental health. This has the potential to increase levels of integration, and incentivises all parties to maximizing the value of FCPs and additional physiotherapy roles across the system.

3.5 Formal supervision and support for FCPs must be available from within the practice. This ensures the practice and patients will appreciate the full benefits of having an FCP within the team whilst also supporting the FCP's wellbeing.[34]

Has the development of Primary Care Networks improved the delivery of proactive, personalised, coordinated and integrated care and reduced the administrative burden on GPs?

To what extent has general practice been able to work in effective partnerships with other Professions within primary care and beyond to free more GP time for patient care?

3.6 As described above (3.1) if PCNs can be enabled to commission FCPs from the existing MSK provider it not only helps integration but also significantly reduces the burden on GPs in relation to sickness cover and responsibilities as a direct employer.

3.7 The future of primary care needs to be one of integration with community services and the rest of the health and care system. This is currently significantly underdeveloped. An important element of this is the need to increase access to rehabilitation from general practice. New roles are required to lead this transformation in community and primary care, including Advanced Clinical Practitioners for Long Term Conditions. This will further free up GPs' time as well as delivering the anticipatory care model, and integration of out of hospital services, envisaged in the Long Term Plan.

3.8 Primary Care Networks must work together across Integrated Care Systems to support sustainable FCP implementation. NHS England's Best MSK Health, launched in February 2021, aims to improve and sustain delivery of evidence informed, personalised, high quality, integrated MSK healthcare.[35] It is a positive driver for MSK services to achieve quality improvements. Some FCP teams are also developing systems to improve communication

with secondary care services through developing shadowing opportunities for secondary care colleagues.

3.9 MSK service transformation should be supported through investment and Quality Improvement support from NHSEI regions community service. Waits would be better managed, reducing the number of patients who go to the GP particularly where self-referral to MSK community services is available.

3.10 Within wider GP teams, there is evidence that FCPs increase the quality of service for MSK patients by the whole team, with GPs in some practices with an FCP reporting that this has improved the quality of their own referrals of MSK patients to secondary care.

3.11 As roll out of all of the Additional Roles continues, it will be important that they work together as a team to improve the overall quality of primary care services. This is also key to making the necessary progress in the integration of primary and community services.

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