ARMA Health inequalities inquiry response

About the Chartered Society of Physiotherapy (CSP)
The CSP is the professional, educational and trade union body for the UK's 65,000 chartered physiotherapists, physiotherapy students and support workers.

1. What assessment you have made of the causes of inequalities related to deprivation

Current context of Musculoskeletal (MSK) conditions and services

1.1 Nearly one third (32%) of the UK population have a MSK condition. According to the Annual Health Survey for England, almost two in every ten adults (16+) report that their MSK condition is long term. 21% of all years lived with a disability in the UK are accounted for by MSK conditions, the most common of which are back pain, neck pain and osteoarthritis. The prevalence of musculoskeletal conditions is predicted to increase because of the ageing population and growing levels of obesity and physical inactivity. (1)

1.2 This is a driver of health inequality. People who live in the most deprived fifth of society are more likely to report a long-term MSK condition compared to those living in the least deprived fifth. People in the most deprived areas are much more likely to report arthritis than people in equivalent age groups who live in less deprived areas. Furthermore, the prevalence of MSK conditions is greater in some parts of the population than others, for example among women. (1)

1.3 Pain is one of the leading symptoms of MSK conditions. Chronic pain is linked to deprivation. Four in ten people (41%) who live in the most deprived fifth of society in England report chronic pain compared to 3 in 10 (30%) in the least deprived quintile. Furthermore, there is a higher prevalence of MSK conditions among some ethnic minorities compared with white people. Research also shows that MSK pain is more widespread among ethnic minorities and concludes that this may reflect social, cultural and psychological differences. (1)

1.4 The pain and fatigue caused by arthritis and related MSK conditions reduce quality of life. 68% of people surveyed with MSK conditions say the fatigue they experience impacts their daily activities (28% reporting a significant impact). Factors impacting the lives of people with MSK conditions include pain, fatigue, feeling low, difficulty getting out and feeling anxious. Depression is four times more common among people in persistent pain compared to those without pain. (1)

1.5 There is a link between the growing proportion of the population with multiple long-term conditions and the gap in healthy life expectancy. People in the poorest communities are more likely to include Black, Asian and minority ethnic (BAME) and disabled people. (2-3) These groups have a 60% higher chance of being diagnosed with a long-term condition than those in the richest, and it is 30% more likely that their long-term condition will be more severe than those in the richest. (4) By 2035 2/3 adults are expected to be living with multiple health conditions, with 17% expected to have 4 or more conditions. MSK conditions are a common co-morbidity, both contributing and caused by having other long-term conditions. (1) Early support with managing MSK conditions can prevent them from becoming chronic and rehabilitation for long term conditions, including MSK can prevent other conditions from developing or deteriorating. Universal access to rehabilitation and support can prevent a vicious circle, with reduced mobility, increased pain and

associated depression and reliance on medication and reduced ability to be physically, economically, and socially active.

1.6 Among people of working age, the prevalence of MSK conditions in the most deprived areas is more than double that in the least deprived areas. One in ten working-age people in the UK have a long-term MSK condition. 28.4 million working days lost due to MSK conditions in 2019. People with MSK conditions are less likely to be in work than people with no long-term health condition and are more likely to retire early. (1)

Barriers when accessing MSK health services

1.7 MSK health issues account for around 1 in 5 of all GP consultations and are the most common cause of repeat GP appointments. (5-9) Once people have got to see the GP there can be a delay before they can be seen by a clinician who can diagnose, provide expert advice and where needed referred onto the right treatment pathway. Public polling showed strong support for seeing a physiotherapist first instead of a GP for an MSK problem. In some areas this is possible, with MSK First Contact Practitioners (MSK FCPs) attached to GP surgeries. However, many people don't have access to an MSK FCP in their primary care team – either because there isn't one attached to their surgery, or because they are covering large patches and many GP services.

1.8 Long before Covid there have been significant gaps and underdevelopment of rehabilitation services both for MSK and for other long-term conditions. This is particularly outside of hospitals, where there is a lack of visibility, with pathways and services fragmented.

1.9 Community MSK services have become even more overstretched since the pandemic because of the backlog of patients. (10-11) Evidence shows a reduction in physical activity with specific groups most negatively impacted such as people from BAME backgrounds, people with disability and long-term conditions (12). Often patients' with MSK conditions are more chronic and complicated by multimorbidity as a consequence of delays to care caused by Covid.

1.10 MSK services were slow to be restored after the disruption of Covid, with ongoing problems in regaining therapy space that was repurposed during Covid. This includes many services in areas of deprivation. The loss of suitable rehabilitation space means physiotherapy staff struggle to provide the quality and quantity of rehabilitation patients need, longer waiting times and poorer outcomes. Following the recent House of Lords debate on rehabilitation, the Government is writing to all NHS chief executives to urge them to restore rehabilitation facilities that were converted into overspill wards, storage rooms and other spaces during the pandemic.

1.11 Research from Kings Fund and Healthwatch England in 2021 showed that people living in the most deprived areas such as BAME and disabled people in England are nearly twice as likely to experience a wait of over one year for elective hospital care than those in the most affluent. Most of the elective care backlog is knee and hip replacements. Nearly one in five people in the study eventually paid to have their treatment privately. For many people this will have meant going into debt. 47% of respondents who had their treatment delayed said they simply couldn't afford it. As well as being critical to the outcomes of post operatively, the research recognises the importance of people waiting for knee and hip replacements to have access to physiotherapy. (13)

1.12 The long elective care waiting lists impacts on demand for MSK physiotherapy whilst waiting. NHS England recently published Community health services waiting lists that show in January 2023 more than a quarter of a million adults were on waiting lists for musculoskeletal services, with 35 815 waiting between 6 months and one year. (14) This is worse in some deprived areas such as in Birmingham combined with Solihull, which has 15,694 people on the waiting list.

1.13 Older women are particularly at risk of falls related injuries which can lead to death, disability or dependency. The cost of falls to the NHS is estimated to be more than £2.3 billion per year. Multifactorial falls risk assessment reduces falls by 24% and should be offered to all older people who have fallen or are at risk of falls. Yet the availability of falls prevention services is patchy across the UK. Women also wait an average of 2 years longer than men for a diagnosis of axial spondyloarthritis (axial SpA). This shows further evidence of inequality faced by women. (15)

Staffing level issues

1.14 New surgical hubs for hip and knee replacements are being established in England to speed up the rate of operations and reduce the waiting list. For operations to be as successful as possible pre and post operative physiotherapy and rehabilitation are an essential part of treatment. However, the physiotherapy workforce to match the increased surgical workforce to staff surgical hubs are not being factored into their planning.

1.15 Within primary care teams in England there are currently 1278 MSK FCPs (full time equivalents (FTE)), in Wales: 92 FCPs (FTE) Scotland there are 180 (headcount) and Northern Ireland there are 60 (headcount). This level of staffing means they are stretched too thin to fulfill their potential for the population, GPs and system, and is creating inequality of provision in primary care. In England the Interim People Plan 2019 committed to 5000 MSK FCPs, which meets the minimum staffing level recommended by The Chartered Society of Physiotherapy of 1 FCP (FTE) per 10 000 adult population and this staffing level is also being implemented in the roll out of FCPs in primary care teams in Northern Ireland. In England this means that there is a shortfall in the necessary MSK FCPs of 3722 (FTE). In England only a quarter of the population is staffed by FCPs at this recommended level.

2. What actions have you taken to address this and why you chose these

Championing better access to MSK services in primary care and community

2.1 Addressing MSK service in primary and community care is critical to addressing health inequalities. Accessing GPs is harder in more deprived communities. (16) Evidence from NASS shows long delays in diagnosis particularly affecting women, so enabling more expert MSK assessments in primary care is important to addressing sex-based inequality. To improve access to assessment and care of MSK conditions in primary care the CSP developed and championed the MSK FCP role. MSK FCP roles are now well established as part of MSK pathways across the UK.

2.2 National evaluation of MSK FCP roles shows they save GP time. 95% of people seen by an FCP did not need a GP follow-up and 80% had not seen their GP for the same problem. They also reduce demands on secondary care, with a 24% decrease in referrals to orthopaedic services. (17)

2.3 But most importantly, FCPs have improved the outcomes for patients, which is highly significant for people living in areas of high deprivation where prevalence of MSK conditions is higher. Improved outcomes from FCP roles have reduced the impact of MSK on people's ability to work. 54% of patients reported less impact of their MSK condition on work performance at 3 months (as measured by the Stanford Presenteeism Scale). Patients who have consulted an FCP have overwhelmingly found them effective – reporting high confidence in the FCPs competency to assess the problem, would recommend to family and friends, and received sufficient information, exercise and advice for self-management of their MSK condition. (27)

2.4 In addition, 44% of MSK patients who would have received a drug prescription from a GP were not given one by the FCP, rising to 84% for repeat drug prescription and instead 43% of MSK patients

are prescribed exercise by the MSK FCP. (28) Given the disproportionate level of prescribing in areas of higher deprivation, this is also pertinent to reducing health inequity.

2.5 For example, MSK FCP role was successfully established in Lincolnshire in 2019, covering 420 neighborhoods that are some of the most deprived in England. They have taken responsibility for 39% of GPs MSK patients, increasing GP capacity. Feedback from patients seen by the FCP has been 100% positive (18).

2.6 MSK FCPs are part of MSK pathways. CSP has created a set of standards to measure what good MSK services should be. These CSP evidence-based standards set out what 'good' MSK services look like in 8 domains including personalised care, supported self-management and integrated pathways. The standards are focused on the delivery of physiotherapy for any services managing MSK conditions within MSK pathways. They are intended as a tool for services to demonstrate the value of MSK physiotherapy services with the aim to drive continuous quality improvement. Key audiences for the resources include the physiotherapy workforce, people with MSK conditions and health boards. (19)

2.7 As specialists in MSK health, physiotherapists can support employees to return to, or remain in work, where there might otherwise be significant employment consequences. There is potential for physiotherapists to have an increasing role in helping employees of all ages to maintain their fitness for work. The CSP believes that all people who require support to stay in work should be supported to do so by their employers where this is reasonably practicable. FCPs have an important role to support this. Some MSK conditions are more present amongst women, so access to occupational health physiotherapy services and professional ergonomic advice, tailored to the needs of working women, is also a key part of preventing women's ill health.

2.8 1 in 6 Fit Notes are for an MSK condition. (1) Fit notes are used predominantly as 'sick notes'. The CSP has long argued for the value of physiotherapists issuing fit notes to drive a cultural shift to use fit notes to enable people to return to or remain in work through necessary adjustments. Physiotherapists are now able to certify and issue fit notes, and help ensure that good quality conversations about work and health is routine and embedded in MSK care.

2.9 The CSP founded, co-chairs, convenes and supports alliances in the four nations, including the Community Rehabilitation Alliance (CRA) in England, The Community Rehabilitation Alliance Northern Ireland, the Right to Rehab Coalition in Scotland and the Right to Rehab Campaign in Wales. These bring together national charities and professional bodies with a shared concern about the lack of universal access and under-development of rehabilitation services outside of the acute hospital setting and the resultant widening inequality in healthy life expectancy.

2.10 With the support of alliance partners across the UK the CSP produced a report in 2022: Rehabilitation, recovery and reducing health inequity: Easing the Pain which brought together evidence relating to the issues with rehabilitation provision and its link with driving health inequity. (20)

2.11 Alliance partners have co-developed Community Rehabilitation Best Practice Standards, published in England in 2022 and tailored editions of this are shortly to be published with the support of alliance partners in Scotland, Wales and Northern Ireland. Through promoting these standards and supporting their implementation we are seeking to address the inconsistency and gaps in provision which sees millions who need rehabilitation missing out. (21)

Supporting ongoing innovation in MSK provision

2.12 Physical activity is vital to good MSK health both for prevention and management of

MSK conditions. Physiotherapists have expertise in supporting patients to increase levels of physical activity, as both as part of *Making Every Contact Count* approaches and as part of management plans for MSK conditions. (22)

2.13 CSP has also developed various resources such as [Stronger My Way hub] to support physiotherapy staff and other clinicians to incorporate promotion of physical activity into their practice. (23)

2.14 CSP has [supported the use a wider MSK workforce] to ensure the rehabilitation needs of patients with MSK conditions, with physiotherapy staff working alongside exercise professionals in shared rehabilitation spaces or with strong links between their services. (24) This increases accessibility and supports appropriate transition of patients from the NHS to other services for ongoing fitness and support ongoing management of long-term conditions.

2.15 This approach has been used by services to address health inequity and make their services more accessible. For example, this is what [Connect in Tyneside] did, using the CSPs Stronger My Way resources. (25)

2.16 The Good Boost programme is another example of health and leisure services working in partnership. Their partners include ukactive, NHS physiotherapists and local authorities. They pool financial and workforce resources to provide physio-led rehabilitation and self-management of MSK conditions in community gyms and pools, with certified training for non-clinicians to understand how to deliver sessions for people with MSK conditions effectively in leisure centre venues. The CSP has worked with ukactive to promote these to NHS England and the Department of Health and Social Care to make it easier for these partnerships to be formed.

2.17 The Good Boost model can help address the needs of people in the most deprived areas. For example, Good Boost in Southwark, where over a third of the population live in the most deprived neighbourhoods in England. The Good Boost partnership with Kings College NHS Trust in Southwark demonstrated the value of this approach to tackling health inequality, with high uptake among BAME communities, people from areas of deprivation, people with multiple conditions, and people who were not physically active before the programme. (20)

Addressing workforce issues

2.18 The CSP has been evidencing why and how to expand the physiotherapy workforce, with the priority being community and primary care services. CSP proposals for the physiotherapy workforce include better utilization of the growth in graduate numbers by the NHS in England, expanding supply in Scotland through changes to physiotherapy workforce planning and increased commissions in Northern Ireland and Wales.

2.19 Our proposals would also help create a pipeline of registered physiotherapy roles, including MSK FCPs and advanced clinical practice roles for long term conditions and expanding workforce capacity by increasing the proportion of non-registered support worker roles within physiotherapy services and developing non-registered roles to optimize their value to patients.

2.20 People from marginalised communities often report poor experience of accessing health services and worse outcomes, compounding health inequality. For example, people from BAME backgrounds are more likely than the white British population to report poor treatment when visiting their GP surgery and experience insufficient support from local services. (26) They also have poorer outcomes. Building trust between clinician and patient, and the provision of culturally competent services are essential to overcome barriers to accessing MSK services. Cultural attitudes to pain, illness and drugs, language needs, along with health seeking behaviours are all acknowledged as factors affecting disparities in experience and outcomes of services. It is also

important to ensure that people with MSK conditions should be offered personalised and timely physiotherapy with equal access and tailored to their individual needs, preference and goal.

2.21 The CSP strategy for 2023-27 reflects the need for transformation in how we approach ill health to tackle health inequalities. In order to support members with this the CSP is designing a web-based resource of information which aims to:

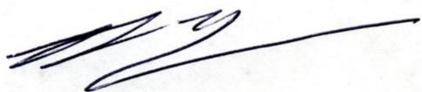
I) Provide an introduction on health inequality aimed at clinicians and service managers.
II) Provide basic information on how to access data on protected characteristics and population health.
III) Raise awareness of the relevance of health inequality to physiotherapy services and practice.

In addition, as part of the annual quality monitoring process for pre-registration physiotherapy education, higher education institutions will be asked to demonstrate how health inequality is being addressed within the curriculum.

3. Any evaluation of effectiveness of your interventions or how you plan to evaluate

3.1 The MSK and Community Rehabilitation Best Practice have audit tools. This audit tool has been created to support MSK physiotherapy services to examine the quality of their service and identify areas for quality improvement.

3.2 National phase 1 and 2 evaluation of FCP model shows.



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References:

1. Versus Arthritis. The State of Musculoskeletal Health 2021: Arthritis and other musculoskeletal conditions in numbers. London: Versus Arthritis; 2021.

2. Institute of Race Relations. BME statistics on poverty and housing and employment. London: Institute of Race Relations; 2021.

3. SCOPE. Disability facts and figures. London: SCOPE; 2021.

4. King's Fund. Long-term conditions and multi-morbidity. London: King's Fund; 2018.

5. Department of Health. Musculoskeletal services framework: a joint responsibility: doing it differently. London: Department of Health; 2006.

6. Arthritis Research UK National Primary Care Centre. What do general practitioners see? Musculoskeletal Matters. Bulletin no.1. Keele: Keele University; 2009.

7. Jordan K, Clarke AM, Symmons DP, et al. Measuring disease prevalence: a comparison of musculoskeletal disease using four general practice consultation databases. Br J Gen Pract. 2007;57(534):7-14.

8. Royal College of General Practitioners Birmingham Research Unit. Weekly returns service annual prevalence report 2007. London: Royal College of General Practitioners; 200

9. Keavey R. The prevalence of musculoskeletal presentations in general practice: an epidemiological study. British J of General Practice. 2020, Jun Suppl.1

10. Opinium. Strikes: polling of CSP members London: The Chartered Society of Physiotherapy; 2022.

11. NHS England. An improvement framework to reduce community musculoskeletal waits while delivering best outcomes and experience. London: NHS England; 2023.

12. Sport England. The impact of coronavirus on activity levels revealed. London: Sport England; 2021.

13. King's Fund. People living in the poorest areas waiting longer for hospital treatment: The King's Fund and Healthwatch England share new analysis. London: King's Fund; 2021.

14. NHS England. Community health services waiting lists. London: NHS England.

15. National Axial Spondyloarthritis Society. What do patients value and need in the diagnosis, treatment and care of axial spondyloarthritis? London: National Axial Spondyloarthritis; 2022.

16. The Health Foundation. Who gets in? What does the 2020 GP patient survey tell us about access to general practice? London: The Health Foundation; 2020.

17. Stynes, S. Goodwin, R. Bishop, A. National Evaluation of First Contact Practitioner (FCP) model of primary care: patient characteristics, outcomes and qualitative evaluation. London: The Chartered Society of Physiotherapy; n.d.

18. NHS England. Transforming musculoskeletal and orthopaedic elective care services. London: NHS England, 2017.

19. The Chartered Society of Physiotherapy. Musculoskeletal physiotherapy service standards. London: The Chartered Society of Physiotherapy; 2022.

20. Newton R, Owusu N. Rehabilitation, recovery and reducing health inequity: easing the pain. London: The Chartered Society of Physiotherapy; 2022.

21. The Chartered Society of Physiotherapy. Community Rehabilitation Best Practice Standards. London: The Chartered Society of Physiotherapy 2022.

22. The Chartered Society of Physiotherapy. Developing and evidence based Making Every Contact Count (MECC) model of practice. London: The Chartered Society of Physiotherapy; 2018.

23. The Chartered Society of Physiotherapy. Stronger my way: how a service understood and adapted to local need. London: The Chartered Society of Physiotherapy; 2022.

24. The Chartered Society of Physiotherapy. I want to feel stronger. London: The Chartered Society of Physiotherapy; 2022.

25. The Chartered Society of Physiotherapy. Stronger my way: how a service understood and adapted to local need. London: The Chartered Society of Physiotherapy; 2022.

26. Kapadia D. Zhang J. Salway S. Ethnic Inequalities in Healthcare: A Rapid Evidence Review. London: NHS Race & Health Observatory.

27. NHS England. Phase 3 national FCP evaluation. London: NHS England; 2020

28. NHS England. Phase 1&2 national FCP evaluation. London: NHS England; 2019