

## Improving General Practice - A call to action

Evidence submitted to NHS England through online survey

<https://www.engage.england.nhs.uk/survey/improvinggp>

The CSP provided evidence to the Improving General Practice – A call to action consultation by NHS England through an online questionnaire. The key points of our evidence are summarised below, as well as the content of the submission on each theme in the questionnaire.

### Key points

- The CSP believes that the current system of primary care in England needs to change and improve significantly
- Open patient feedback is the best way to shine a light on standards in primary care, and provides the loop necessary for ongoing improvements
- Key to freeing up time and resources in the health system is to ensure people get the right level of input, from the right clinician, at the right time.
- More multi-disciplinary teams in primary care can reverse the rise in emergency admissions; these can be led by GPs, physiotherapists, or other healthcare professionals.
- The central role of GPs should not mean patients having to go back and forth to GPs between every step on the patient pathway. This is frustrating for patients and a costly way of delivering primary care services.
- Self-referral to physiotherapy cuts waiting time, reduces costs in general practice, and put patients in control of their care
- New independent prescribing rights of physiotherapists will provide opportunities for service re-design to reduce waiting times, avoid unnecessary GP appointments and free-up GP time
- Specialist physiotherapists can provide complex case management to support people within their home (for example people with MS).
- Physiotherapy supports patient self-management of conditions through advice, exercise and assessments of home and work environments
- Through the provision of early intervention and assessment physiotherapists and other AHPs can provide GPs with valuable support in helping people get back to work
- Increased use of Information technology has the potential to free up time and resources – there are many successful examples on this in practice in the community already, such as phone triaging for physiotherapy services.
- Quality in general practice should be defined through validated outcome measures: clinical, quality of life and from patient experience data.
- An overreliance on incentives within the GP contract may result in a target driven culture where anything not incentivised is de-prioritised – including MSK conditions.
- Funding should follow patients. The CSP supports the shift over time of resources from acute to primary care, through service reconfiguration, not by cuts in services.

## **1. Do you believe that the current system of primary care in England needs to change and improve?**

1.1 Yes

## **2. Information, Choice and Control**

- 2.1 Consistent Quality of Life measures (QOLs) and patient reported experience measures (PREMs) should be used to collect evidence across all health and care services, including general practice. Audit cycles should incorporate the learning gained.
- 2.2 Virtually no current national data collection captures the impact of the contribution of physiotherapy or other Allied Health Professions (AHPs) to a significant range of patient pathways across health and social care services in the community. The CSP is currently leading a project that is seeking to address this gap. We would be keen to discuss with NHS England how standardised collection of national data on the outcomes from Allied health professionals (AHPs) could be introduced and used to inform general practice.
- 2.3 Vigorous, continuous and open patient feedback is the best way to shine a light on standards in primary care, and provide the evidence necessary for ongoing improvements. Current systems for measuring patient experience (including the Friends and Families Test) are at best blunt instruments (see 11.8) and exemplify the limits of a tick box exercise with no way of contextualising the data collected. Our view is that it should not be the primary source of evidence of patient experience.
- 2.4 The duty of candour needs to apply to organisations delivering services in primary care, including GPs. There needs to be clear reporting systems for poor practice, and care should be taken to ensure that patients are confident that complaining in good faith will not impact negatively on their care.
- 2.5 To stimulate new forms of patient involvement and insight in general practice the CSP advocates an expansion of user groups. The opportunity to give meaningful feedback should become part of the patient experience. All GP surgeries should support the set up of a Patient Participation Group attached to the practice. Use of 'trip advisor' type sites (which already exist) by patients and practitioners should be promoted, as well as the use of facebook and twitter.
- 2.6 Improving information sharing across all health and care services is crucial. Current problems of IT systems not 'talking' to each other, a lack of understanding among health professionals about sharing personal data, and poor coordination between services have acted as barriers to this. Clinical information management systems, with integrated IT (subject to confidentiality safeguards) are key to moving towards one, online (paperless) record system in the health and care service. Effective multi disciplinary team working requires dissemination of clinical information and providing appropriate access to all members of the team.
- 2.7 Linked to this is the work that is needed to ensure patients can easily access their whole records, including through patient held records and online access.

- 2.8 The CSP strongly supports a system of patient choice that puts patients in the driving seat of their care. Patient self-referral to physiotherapy services in the community (see 4.3), the inclusion of self-management information and advice at all stages of care for people with long term conditions, and patient led Health Needs Assessments to identify actions and priorities, are all important elements of this and need to become common features of primary care.

### 3. Clinical leadership and innovation

- 3.1 In the CSP's view the ideal model of clinical leadership is multi-faceted rather than linear. GPs are very well placed to provide leadership in the health service, but of equal importance is the leadership provided or which could potentially be provided among other clinical professionals. It is important that physiotherapists and other AHPs are seen by GPs as equal partners in primary care.
- 3.2 A positive development in recent years has been the beginnings of a reconfiguration of services into multi-disciplinary teams. These can be GP led, physiotherapy-led, mental health specialist led, or led by other allied health professionals. Importantly they cross health and care sectors, supporting integration, reducing hospital admissions and improving health outcomes. Continuing and strengthening this approach and integrating general practice within this, is central to preventing the continued rise in emergency admissions to hospital, a fifth of which could be managed effectively in the community<sup>1</sup>.
- 3.3 The Proactive Care: Long Term Conditions pilot project started in April 2012 in the South Kent Coast CCG. Here patients are supported by a multi-disciplinary team including a GP, community matron, health care assistant, physiotherapist, occupational therapist, pharmacist, health trainer, care manager and mental health professional. Patients are offered a 12 week package of support to improve the management and self-management of their condition. Evidence shows a 15 per cent reduction in A&E attendance, 55 per cent reduction in non-elective admissions and 75 per cent report improvement in functional quality. In March 2013 savings stood at £225, 938<sup>2</sup>.
- 3.4 Another example of multi-disciplinary working in the community is the HOPE Specialist Service at the North East Lincolnshire Care Trust which provides a 'one-stop-shop' for people with Chronic Obstructive Pulmonary Disease (COPD) and older people at risk of falling. The team includes physiotherapists, support worker specialists, volunteer 'rehab buddies' and expert patients. Hospital admissions were reduced (one admission per person attending the pulmonary rehabilitation course), and over four years, the falls and post hip fracture rehabilitation programme has seen an 8 per cent reduction in visits to A&E and a 13 per cent reduction in hospital admissions for people who have fallen<sup>3</sup>.
- 3.5 Robust links between Higher Education Institutes and primary care need to be developed in all areas. This exists in some areas, providing examples to learn from.

<sup>1</sup> *Emergency admissions to hospital: managing the demand*, National Audit Office, 31/10/13

<sup>2</sup> Kent Community Health NHS Trust, March 2013 *The Human Touch, Transforming Community Services in Kent. Service in the spot light: Pro-Active Care: Long Term Conditions*

<sup>3</sup> *Lung Improvement Case Study: Hope for the Future – pulmonary rehabilitation*. NHS Improvement, July 2012

For example in our view the Institute of Primary Care and Health Sciences at Keele University<sup>4</sup> is effective in driving innovation in practice, with established links with GPs and supporting roll out of innovation through effective dissemination and development of tools to support take up.

#### 4. Freeing up time and resources

- 4.1 It is important that practice teams do not view their work in isolation, but rather adopt an inclusive service model with a multi-disciplinary team working approach, including medical, physiotherapists and other AHPs, nurse, social services and support workers. Furthermore, teams should be working in partnership with service users and carers evaluating services, identifying innovative solutions and problem solving.
- 4.2 Key to freeing up time and resources in general practice, and elsewhere in the health system is to make sure that people get the right level of input, from the right clinician, at the right time. The Stepped Care Model with appropriate risk stratification screening tools is one method to help with this that can help GPs and others decide what level of care is needed at different points. The 'Start Back' questionnaire for back pain is a good example of a screening tool that has been used in this way. This tool helps primary care clinicians (GPs, physiotherapists etc) to group patients into categories of risk of poor outcome and target interventions for each sub-group. This was trialled and as well as achieving health benefits, it showed an average saving to health services of £35 per patient and societal savings of £697 per patient<sup>5</sup>.
- 4.3 Commonly GPs will be the initial point of assessment of patient's needs. However, for patients with conditions like musculoskeletal disorders, and in some cases of respiratory illnesses, physiotherapists are likely to be best placed to make the initial assessment, reducing waiting times and freeing up GP appointments.
- 4.4 Self-referral to physiotherapy has been demonstrated to be particularly effective as a means to target resources more effectively, by providing early intervention, and allowing patients to self-manage their conditions. It reduces unnecessary time spent by GPs on appointments and referrals (including sometimes inappropriate referrals into secondary care) and reduces unnecessary demands on health and care services. Following a rigorous quality assurance process, patient self-referral was endorsed as part of the Quality, Innovation, Productivity and Prevention (QIPP) process for musculoskeletal disorders<sup>6</sup>. This showed a significant fall in waiting times (from 14.2 weeks to 8.4 weeks) and in patient absence from work (from 7 days to 4.1 days)<sup>7</sup>. Compared with traditional GP referral for musculoskeletal physiotherapy which costs £133, GP suggested self referral costs 11 per cent less at £118, and patient self-referral costs 25 per cent less at £100<sup>8</sup>. In Cambridge self referral to physiotherapy has given an average saving of £12 000 per annum per

<sup>4</sup> <http://www.keele.ac.uk/pchs/disseminatingourresearch/>

<sup>5</sup> *Comparison of stratified primary care management for low back pain with current best practice (STarT Back): a randomised controlled trial*. The Lancet 29 September 2011

<sup>6</sup> *Guidelines in Practice*, Ruth Tenhove, CSP October 2013

<sup>7</sup> *NHS evidence*, Nice 2012

<sup>8</sup> *NHS evidence*, Nice 2012

<sup>8</sup> *NHS 2010-2011 reference costs publications*. Department of Health. 2011

GP<sup>9</sup>. In spite of overwhelming evidence of its cost and clinical effectiveness access to the the self-referral model of physiotherapy services remains patchy.

- 4.5 The new independent prescribing rights for physiotherapists<sup>10</sup> is a world first that has the potential to significantly reduce bureaucracy, reduce the pressure on general practice, and improve patient care. Utilisation in general practice of physiotherapy advanced practitioners, including new independent prescribers to enable early assessment and treatment of patients with acute / acute-on-chronic conditions reduces waiting and freeing up GP time.
- 4.6 Utilising expert physiotherapists or other AHP practitioners as lead clinician in complex case management can also avoid unnecessary admissions and readmissions. This includes proactive support of people with complex conditions (e.g. multiple sclerosis, COPD) in their own homes.
- 4.7 At the heart of physiotherapy is support for patient self management of conditions, through advice, exercise, assessments of home and work environments. For example the Enabling Self-management and Coping for Arthritic Pain through Exercise (ESCAPE-pain) programme developed at Physiotherapy Outpatient Department at Sevenoaks Hospital integrates patient education, coping strategies and a challenging exercise regimen through group classes<sup>11</sup>, the programme targeting patients who would normally likely to seek help from their GP. The programme has been commended by NICE and the Royal College of Physicians as an example of good practice<sup>12</sup>. Developing programmes like these in primary care would free up considerable resources as well as empower patients.
- 4.8 Musculoskeletal (MSK) disorders are the biggest cause of sickness absence in the UK, accounting for 27 per cent of all days lost. Sickness absence in the UK costs the UK around £15 billion annually in lost economic output and £13 billion on health related state benefits.<sup>13</sup> Rapid access to physiotherapy has been shown to dramatically cut sickness rates. For most employers (99 per cent of whom are SMEs) will not be able to provide occupational health services and rely on employees being able to quickly access physiotherapy in the community. In a survey of employers 39 per cent said that some sickness absence was as a direct result of members of staff being unable to work to full capacity while they have waited for medical treatment<sup>14</sup>.
- 4.9 The Government is expecting GPs to support employers and employees by providing a Statement of Fitness for Work report, which should include advice on what actions employers can take to make an early return to work/or staying in work possible. However most GPs do not feel equipped to provide this. A survey of GPs and employees in April 2010 found that 65 per cent of GPs of 200 surveyed felt ill equipped to provide fit notes, and out of 1000 employees canvassed 57 per cent did

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<sup>9</sup> *Physiotherapy works. Musculoskeletal disorders*. CSP January 2012.

<sup>10</sup> Introduced by Parliament in England in 2013

<sup>11</sup> Arthritis Today, 1 January 2008 <http://www.arthritisresearchuk.org/arthritis-information/arthritis-today-magazine/139-winter-2008/exercise-is-effective-for-older-people-with-knee-pain.aspx#sthash.SEOtKdcZ.dpuf>

<sup>12</sup> *OSTEOARTHRITIS National clinical guideline for care and management in adults*, NICE and Royal Collage of Physicians 2008 p94

<sup>13</sup> *Health at work – an independent review of sickness absence*. Black C, Frost D. Department of Work and Pensions, 2011.

<sup>14</sup> *The Sixth Aviva Health of the Workplace Report*. Aviva. Autumn 2012



not think their GP was in a position to say whether or not they could return to work<sup>15</sup>.

- 4.10 Physiotherapists and other AHPs working in the community can provide GPs with valuable support in this respect, providing expertise and reducing the input required by GPs. The Allied Health Professions Federation, which includes the CSP, has developed an AHP Advisory Fitness for Work Report. This is completed by AHPs and is an effective tool to support employers, employees and GPs in helping people to remain in or return to work. It can also be used by GPs and consultants to support their completion of a Fit Note. It provides information on whether a patient should refrain from work for a stated period of time, or whether they are fit to work, including advice on the patient's limitations or adaptations that may be required to facilitate their remaining in or returning to work. The DWP will accept it as evidence for payment of sick pay. The report is part of the assessment process and incurs no additional charge.<sup>16</sup>
- 4.11 Information technology has the potential to free up time and resources, improve patient access, and target resources in general practice. There are many examples in community based services of this already working:
- 4.12 Physio Direct phone triage has been introduced in several areas of the UK as a cost effective way of improving patient access and reducing waiting times without compromising health outcomes<sup>17</sup>. In 2001 Huntingdon, Cambs and Gloucestershire each independently pioneered a new system for telephone assessments. In Huntingdon algorithms were developed by the physiotherapy service leads and converted into computerized screening tools by an IT specialist. Patients were then assessed over the phone using the software. In Cheltenham robust structured assessment tools were developed. The Huntingdon model was runners up in the Health and Care Awards in 2003, and PhysioDirect has since been taken up in other areas, including the whole of South Cambridgeshire, Cambridge, and Gloucestershire.
- 4.13 Another example is the National Mobile Health Worker project<sup>18</sup> where community-based health workers are given the technical resources to access and input to patients information systems while they were with patients in the community, removing the need to travel to and from the clinic to do this. Evaluation of the project has shown that this resulted in significant increases in both productivity and time spent with patients, and reduced costs in time and travel. Most importantly the report described patient confidence and engagement in the new system, which made it possible for example for them to see the availability of follow up appointments, and view patient information on screen e.g. choices of equipment.
- 4.14 The CSP would like to see further development of Apps to to promote health and wellbeing, support self management/ exercise strategies and treatment concordance to reduce exacerbation of conditions and flare ups.

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<sup>15</sup> *The Fourth Aviva Health of the Workplace report* p9. Aviva October 2010

<sup>16</sup> *Allied Health Professions Fitness for Work Advisory Report*, Allied Health Professions Federation 2012

<sup>17</sup> *A pragmatic randomised controlled trial of the effectiveness and cost-effectiveness of 'PhysioDirect' telephone assessment and advice services for physiotherapy* Health Technology Assessment Programme, NICE 2013 <http://www.hta.ac.uk/execsumm/summ1702.shtml>

<sup>18</sup> *National Mobile Health Worker project. Final report*. Department of Health, January 2013

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213313/mhwp\\_final\\_report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213313/mhwp_final_report.pdf)

- 4.15 Becoming fully digital in appointment making also has the potential to free up resources, for example through online booking systems, appointment reminder texting. However it is essential that the non-digital route to services is properly protected. 16 million people in the UK aged 15 and above don't have basic online skills<sup>19</sup> and it is well documented that these numbers are concentrated among older people, and among people in disadvantaged areas on the lowest incomes. It is not acceptable for people who cannot access services digitally to have to wait longer for services that they need, or be denied advice and care. We are aware that this is happening in some areas. For example the EMIS online booking system which in one practice in Lambeth offered appointments eight days earlier than those booking appointments by phone<sup>20</sup>. In the CSP's view this undermines policy priorities on early intervention to improve outcomes and reducing health inequalities.

## **5. Defining practice accountabilities for high quality**

- 5.1 High quality general practice and its responsibilities and accountabilities should be defined through robust clinical and Quality of Life outcome measures, and patient experience data. The same measures should be adopted across all health and care services in the community.
- 5.2 In the CSP's view, services should be focused on the best patient care and while the GP should retain overall responsibility for care in practice, optimal care may often be achieved by having another health professional as lead clinician, especially for patients with long term conditions.
- 5.3 Improving primary care requires better coordination between a range of professions and services. GPs having a central role should not mean patients having to go back and forth to GPs before every step on the patient pathway. This is frustrating for patients and a costly way of delivering primary care services. As other health care professions develop and grow their competency framework, more support can be provided to GPs, freeing up more GP time for people who really need to see their GP, as well as the additional demands of their new commissioning role.
- 5.4 Physiotherapists work across all health care settings and conditions and are well placed to be part of a person centred integrated multi-disciplinary team enabling the individual to be seen by the right clinician at the right time in the right environment. In many instances it is appropriate for physiotherapists to be the lead clinician.
- 5.5 In defining practice accountabilities, general practice needs to build upon the positive experiences of multi-disciplinary team working in the community. Sometimes such teams are GP led, but equally may be led by a physiotherapist, community matron, or another health professional. The main issue is not which profession takes the lead, but the use of cooperation and coordination between different professionals within a team, with a lead individual taking a case management role.
- 5.6 An example of this is the development of 'virtual wards' in a number of areas since

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<sup>19</sup> Race Online, IPC Media website <http://www.ipcmedia.com/raceonline>

<sup>20</sup> As of late August 2013

2006. Croydon is an award winning<sup>21</sup> example of this, where there are now 10 virtual wards with capacity to care for 1000 high risk patients. Their virtual wards are led by community matrons, and other staff including physiotherapists and occupational therapists and social workers. They used a Combined Predictive Model to identify patients with high risk of hospitalisation in the future who would benefit from multi-speciality case management.

- 5.7 In Croydon the virtual ward team works closely with GPs in the area. In other areas that have developed virtual wards also using a predictive risk tool, GPs are part of the team, for example in Torbay and South Devon where virtual wards are hosted in GP surgeries.
- 5.8 Full evaluation of virtual wards has yet to be published (expected from the Nuffield Trust later in 2013, evaluating virtual wards in Croydon, Devon and Wandsworth). Evidence to date suggests that in Torbay and South Devon there has been a reduction in admissions to hospital and residential care homes, and greater partnership working between health care professionals and carers<sup>22</sup>. In Croydon, although the causal link is not established it is notable that a year after virtual wards opened, Croydon PCT spent £1 million less on acute admission services at the local hospital. Furthermore, the virtual wards were very popular with GPs in Croydon who lobbied for a further eight virtual wards to be opened after the experience of the initial two<sup>23</sup>.
- 5.9 Other good examples of multi-disciplinary working include community-based falls prevention programmes. The physiotherapy-led Glasgow Falls Prevention Programme sees nearly 175 patients a month in their homes to assess risk factors and intervene to modify these. Between 1998 and 2008 there was a reduction in hospital admissions due to falls in the home of 32 per cent, falls in residential institutions of 27 per cent and falls in the street of nearly 40 per cent. Over the same period, the number of admissions for hip fractures decreased by 3.6 per cent (compared with an increase of nearly 2 per cent in England in the same period)<sup>24</sup>.

## 6. GP contract: incentives for outcomes

- 6.1 The CSP is concerned to make sure there is not an overreliance on incentives within the GP contract. There is a risk that this can build in perverse incentives for practitioners or the perception of perverse incentives among patients. There is also the danger of focusing attention on easily measured issues, to the exclusion of other important features of care – including ones that may be the patient's priority (such as levels of pain or other quality of life issues), and significant public health issues, such as musculoskeletal conditions which are not currently included in QOF.

<sup>21</sup> The scheme won four prizes at the HSJ Wards in 2006 and overall winner of the Guardian's Public Service Awards in 2007.

<sup>22</sup> *Co-ordinated care for people with complex chronic conditions. South Devon and Torbay Proactive case management using the community virtual ward and the Devon Predictive Model* Kings Fund 2013

<sup>23</sup> *Predictive Modeling in Action: How 'Virtual Wards' Help High-Risk Patients Receive Hospital Care at Home*, The Commonwealth Fund, August 2010

<sup>24</sup> *Physiotherapy works: Fragility Fractures and Falls* CSP January 2012



- 6.2 The CSP welcomes the focus on culture proposed by the Francis and Berwick reports. In our view development of the GP contract needs to take into account impact on organisational culture and the development of a culture of care in general practice.
- 6.3 We suggest that rather than introducing more incentives for working collaboratively with other health and social care providers, this could be achieved by breaking down the barriers between hospital and primary care, working to 'whole care pathways' and adopting a multi-disciplinary approach, while developing clear validated outcomes measures linked to these.
- 6.4 Compliance with a clear set of validated outcomes should be considered as part of the GP contract and should reflect and encourage quality of care for people with co-morbidities and complex health and care problems. To support this, completion of Health Needs Assessments by patients, and provision of training and support to self manage, should both be an integrated part of assessment and care throughout the patient journey.

## **7. Safe, controlled investment**

- 7.1 The robust and transparent management of conflict of interest issues is essential to maintaining and building community confidence in services, in particular in the advent of greater plurality and competition, and the GP commissioning role.

## **8. Market management**

- 8.1 To incorporate the best examples of integrated health and care within the community it is essential that the design and development of 'primary care plus' contracts fully involves allied health professionals.
- 8.2 Co-commissioning between CCGs and those commissioning primary care has the potential to produce conflicts of interest. Furthermore, smaller professions are often not represented at CCG level, and their significant value as a partner in improving primary care can be overlooked. It is essential that AHPs are fully involved in service redesign and contract development within primary care.

## **9. Workforce development**

- 9.1 In view of the aging population and increasing prevalence of long term conditions emphasis needs to change from a 'find it and fix it' (medical) model to a biopsychosocial (whole person) model. This model recognises social, economic, environmental and psychological influences on health and wellbeing, and is at the heart of physiotherapy. This should be reflected in the education and ongoing training of all health care professions, including GPs.
- 9.2 All health and care staff training should support multi-disciplinary working. Education and training of all healthcare professions needs to reflect this.
- 9.3 Time out for training and continuous professional development IS important for all health care staff across all health and care settings.

## 10. Specific issues and questions

- 10.1 The CSP supports the shift over time of the resources from acute to out of hospital care. It is important that this shift happens over time, as services are reconfigured, and responsibility to deliver certain services is transferred, rather than funded through blanket cuts to acute services, which would be counterproductive.
- 10.2 Many excellent services operating in the community that support independence and wellbeing, reducing admissions and preventing readmissions are funded by providers of acute services. An example of this is the North Devon Healthcare Trust. They reconfigured their stroke therapy team to support early discharge by integrating acute, rehabilitation and community services, and operating the team operates across two sites, one being community based. As well as enhancing patient, carer and staff experience, the service has reduced length of stay by six days from 22 days, saving £833, 700, reduced hospital readmissions from six per cent to three per cent, and 13 per cent more patients were able to return home rather than move to a care home, saving over £75,000 per person.
- 10.3 Where funding is transferred it is essential that this is to the primary care sector, and not solely into general practice. There is a danger that channelling funding into general practice will be a move away from the innovative, integrated approaches that have been shown to be better for patients and save money and involve health care professions beyond general practice.
- 10.4 In the CSP's view, resources should follow the patient to enable the person to be seen by the most appropriate professional at a time and place that is accessible, safe and convenient. Community provision should not be regarded as a 'cheap' option but should be adequately resourced to enable quality care, which delivers overall savings in the long term.
- 10.5 The CSP supports the suggestion of lead GPs for many cases. We would add that advanced physiotherapy practitioners may be well placed to be the lead clinician for a patient with a long term condition affecting actions for daily living, mobility, respiratory or neurological function. In other cases it may be appropriate for a mental health specialist in the community to be the lead clinician. The most important issue is not which professional leads, but working as equal partners in a multi-disciplinary team.

## 11. Analytical pack

- 11.1 MSK conditions are the greatest cause of disability in the UK<sup>25</sup>, they are a significant long term condition and their prevalence is a significant factor in the demands for GP health services. Yet MSK conditions are not mentioned in the analytical pack, or included on the list of prevalent long term conditions (on page 13).
- 11.2 This is a significant omission. Research for Arthritis Research UK found that in a 'typical' GP practice of 10 000 registered patients, musculoskeletal disorders make up the third biggest number of consultations by single problem (12 per cent, coming

<sup>25</sup> *UK health performance: findings of the Global Burden of Disease Study 2010*. Murray CJL et al. The Lancet, 5 March 2013

after respiratory at 16 per cent and circulatory at 14 per cent). For adults aged fifty plus the proportion of consultations for MSK conditions is nearly one third (31 per cent), compared to 29 per cent with a respiratory illness and 39 per cent with a circulatory problem.<sup>26</sup>

- 11.3 In addition long term musculoskeletal conditions and chronic or persistent pain (often linked to MSK but also a complex condition in its own right) can have a severe impact on mental wellbeing resulting in increased depression, anxiety and stress.
- 11.4 Evidence suggests that exercise is key to the management of these conditions and physiotherapists working in many fields including pain management, MSK therapy and mental health have the skills and competencies to facilitate and support individuals to introduce or increase activity and exercise resulting in improved physical and mental wellbeing.
- 11.5 This is a vital area for general practice to develop. It is well established that early intervention through physiotherapy services in the community is effective in enabling people with long term MSK conditions to manage these, and to prevent acute MSK conditions from becoming chronic<sup>27</sup>. Yet there is a shortage of MSK services in the community. Back pain for example is in the top ten conditions that GPs say they find more difficult to refer on for specialist treatment<sup>28</sup>.
- 11.6 Developing general practice and setting priorities for general practice that will have the largest positive impact on health outcomes must include improving services for people with MSK conditions.
- 11.7 The fact that MSK is not included in the evidence pack effectively underlines the risk of the incentives approach, as focus is on conditions measured by QOF to the exclusion of those that are not.
- 11.8 The CSP would also suggest that the evidence in the analytical pack on patient experience of GP services appears too good to be true. For example, the 87 per cent of people describing their experience of the GP surgery as good, with a range of only 19 from 74 per cent to 93 per cent. This calls into question the nature of the current audit of patient experience, and highlights the need to move away from a tick boxing culture to more meaningful measures of patient experience.
- 11.9 The analytical pack describes the different types of A&E departments as it examines the increasing emergency pressures on them. We suggest that the Type 3 descriptor would be improved by including the multi-professional nature of clinical teams in these settings, including the role of physiotherapists and other AHPs located both within A&E and within the community who play a significant role to play in supporting early discharge and preventing readmissions.

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<sup>26</sup> Arthritis Research UK National Primary Care Centre, Keele University. *Musculoskeletal Matters: what do general practitioners see?* Bulletin 1, October 2009, [www.keele.ac.uk/media/keeleuniversity/ri/primarycare/bulletins/MusculoskeletalMatters1.pdf](http://www.keele.ac.uk/media/keeleuniversity/ri/primarycare/bulletins/MusculoskeletalMatters1.pdf)

<sup>27</sup> *Physiotherapy works. Musculoskeletal disorders.* CSP January 2012

<sup>28</sup> *Doctors' Orders in a changing environment. The tenth Aviva Health of the National Index.* Aviva. July 2011

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