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Executive Summary

When planning the primary care workforce of the future we need to have a clear picture in mind of a primary care sector that is responsive to patients' needs, reduces hospital admissions and social care needs, and support people to remain active and independent.

The GP workforce action plan, recently published by NHS England, HEE, the RCGP and BMA, focuses narrowly on addressing current workforce challenges through initiatives focused on the medical profession.

This misses a real opportunity to consider how other parts of the workforce, including physiotherapy and the other allied health professions (AHPs) can contribute to primary care. A transformation in primary care will not be achieved if workforce planning is premised on pre-existing models of workforce supply and service delivery.

To deliver this the NHS must create a new frontline of primary care professionals that makes full use of the talents at its disposal. Physiotherapists and physiotherapy support workers have the skills, knowledge and clinical autonomy to be a central component of this new NHS frontline, working in multi-disciplinary teams to keep people living well and independently. Greater use of physiotherapy workforce within primary care is a cost effective and clinically effective way to reduce the pressure on General Practitioners and deliver the whole-person care required of a modern primary care sector. It is currently an underutilised asset.

Physiotherapists as first point of contact Practitioners
There is strong evidence that Physiotherapists can be the first point of contact in primary care for patients with musculoskeletal disorders, providing a clear and effective alternative to GPs . We need to move away from a 'tunnel vision' view of General Practice to one , where patients are able to access as their first point of contact the most appropriate professional for their needs. As primary contact practitioners in surgeries physiotherapists assess, diagnose and, where needed, treat the 30 per cent of patients each year who visit their GP with a

musculoskeletal condition. There are already examples of GP services developing in this way. (see page 15)

Within primary care we need to use risk stratification tools to direct patients more effectively and efficiently to the treatment pathway that is right for them. (see page 12)

Patient empowerment model

We also must move away from the traditional medical model to one of patient empowerment and develop a culture and service delivery models in primary care to support this.

People with long-term conditions often develop an awareness and understanding of their condition that allows them to know when they need a clinical intervention.

For this growing group one of the biggest frustrations of the current system is that they feel they have to start from beginning each time. This is also the most inefficient way to provide health care. More services in primary care need to be provided on a self-referral basis, so that people can get them when they need them without having to go back to the GP first to seek a referral. The physiotherapy workforce already has extensive experience of delivering self-referral services that triage and prioritise patients. Many of these services have increased further their accessibility by using technology for virtual consultations. We need to learn from the success of these services and make this the norm for a range of conditions.
(See page 12)

Key to a patient empowerment approach is making full use of digital technology and a range of communication means for assessment and follow up advice and support. It also means having shared record-keeping systems between patients and health and social care professionals.

We need to develop our primary care services to integrate with voluntary activity in the community, building on the success of exercise and social prescriptions, and supporting people to lead active lives in the interests of their physical and mental health. The award winning Hope Specialist Service in North East Lincolnshire for people with COPD and older people at risk of falls is an example of an empowering model of service delivery involving patients and volunteers as key partners, reducing hospital admissions and saving money in the process. (See page 10)

Fit for work

Keeping people fit to remain in work and facilitating return to work needs to be a priority for primary care. Musculoskeletal (MSK) conditions are the biggest cause of absence from work in the UK, causing 27% of total days lost to sickness absence and account for 30% of GP appointments. Rapid access to occupational health services, including physiotherapy, gets people back to work quicker and reduces the risk of MSK conditions and stress as they become older. (See page 11)

Multi-disciplinary approach to prescribing
Making the most of the skills and capacity we have in the community requires us to redesign primary care services to make full use of medicine prescribing rights by non-medics, including physiotherapists. It also means reducing the over reliance on medication through providing non-pharmaceutical interventions. (See page10)

Sharing skills and expertise across professions
We need to use the existing expertise in the health and care workforce to raise the standards of care across health and care professionals – for example physiotherapy staff can support other professions to enable patients to be mobile or use screening tools so support early intervention. (see page 16)

Supporting physical activity
Exercise and movement is the one of the cornerstones of physiotherapy practice. This set of skills need to be utilised to give older people and people with long term conditions the confidence to remain active and exercise. (See page 6)

Physiotherapy education and professional development
Pre-registration physiotherapy education is subject to robust regulation and quality assurance arrangements. With low attrition rates it represents value for money and an excellent return on investment.

There are already signs that it is becoming harder to recruit physiotherapists and this needs to be addressed as an imperative, with more training places made available. (See page 19)

Our future workforce is primarily made up of those already in the profession, so greater investment is needed to post qualification to enable the physiotherapy workforce to develop in primary care.

Commissioning models that support integration and transformation
Integration between primary and secondary care, between health and social care and between physical and mental health services is key to the transformation of primary care. The physiotherapy workforce is already playing a central role in this (see page 14). It is essential that commissioning models support this. There is currently a danger that there are instead undermining integration. (See page 17)

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Introduction

With an increasing aging population, living with a greater number of long term conditions, and the requirement for people to remain in work for longer, there are significant challenges for the future in terms of planning a healthcare workforce which is fit for purpose. To be sustainable and fit for the future the health and care system needs to become more preventative, delivered closer to where people are and around their needs. This means transforming primary care.

Traditionally the physiotherapy workforce has predominantly delivered services in secondary care and been underused in primary care. So in order to optimise the contribution of this workforce, the NHS must create a new frontline of primary care professionals that patients are able to access as their first point of contact as the most appropriate professional for their needs.

1.0 Responding to Drivers for Future Primary Care Service Demand

1.1 Increasing Complex Needs

The age profile of the population, the prevalence of long-term conditions and medical and technological advances mean that patients will live longer and require greater access to services as a result of increasingly complex needs. Patients with multi-morbidity account for eight in ten primary care consultations.[(1)] Physiotherapists in the primary care setting offers a holistic approach based on high level diagnostic skill and treatment predicated on non-pharmacological modalities. Thus physiotherapy can help avoid the risks and costs associated with polypharmacy including; adverse drug reactions, falls, poor treatment compliance, and medication errors.[(2)]

Pre-registration physiotherapy education prepares physiotherapists for working with patients with complex needs. Physiotherapy students learn how to work with and enable people with long term conditions (LTCs) within academic and a wide range of practice settings. The knowledge and skills required to support patients with LTCs is further developed throughout professional practice, meaning that the profession is excellently placed to meet the increasingly complex demands of the population.

1.2 Growing and aging population

The number of people over 85 in the UK is predicted to double in the next 20 years and nearly treble in the next 30.[(3)] Physiotherapy can improve people quality of life, help to prevent hospital admissions, reduce bed days and individuals' dependence on complex care packages, and decrease the need for residential home placements.

Physiotherapists recognise that this increasing demand on health and social care services is unsustainable in the current financial climate. The profession's high adaptability and skill in

responding to changing patient and population needs has already resulted in service re-design and new ways of working. One example includes collaborative working across three health trusts in a region to improve services for older people and specifically ease pressure on A&E department. The physiotherapy-led service operates seven days a week, 12 hours per day. The service saw 1,015 patients and identified that 584 could be treated at home, rather than needing to be admitted to hospital. This created a saving of £1.6million in 6 months.
An increasingly frail elderly population means that each year, 35 per cent of over-65s experience one or more falls. Based on 2009/10 costs, each hip fracture avoided saves approximately £10,170. Physiotherapy-led falls prevention services increase an individual's confidence to reduce the number of falls and fractures, improve outcomes, keep people living independently and reduce hospital admissions and GP appointments.[4]

1.3 Increasing patient and public expectations of healthcare

Patient and public expectations continue to rise. The exponential increase in availability of healthcare information, particularly through the internet, has meant patients pose questions to healthcare professionals, rather than always being supplicants for information. Patients expect to be offered choice and broad access to services like other service industries. In line with the CSP's quality assurance standards physiotherapists must ensure that; "*Service users are respected as individuals and placed at the centre of service planning and physiotherapy management".*[5] Thus, shared decision making with service users is a key and well established part of physiotherapists practice.

Patients and carers can expect physiotherapy communications to be professional, caring, compassionate and person-centred as this is core to practice. Physiotherapists provide information to service users in a variety of formats. For example, a patient-owned folder of information about treatment and self-management is helping to improve the services of a community neuro-rehabilitation team[6] and expectant mothers can access a video explaining the benefits of physiotherapy for pelvic floor muscle problems.[7]

The physiotherapy profession has been proactive in broadening patient's access to appropriate assessment and treatment. It is possible for patients to self-refer for physiotherapy and also to access support and advice by phone.[8] A breadth of developments such as flexible service hours and seven-day service operation are embedded within physiotherapy to ensure a focus on the requirements of service users. Close attention and responsiveness to user feedback is integral to physiotherapy care. The profession is fully engaged with the importance of delivering services that engage people effectively in decisions about their care and ensure they have the information required to make the choices that work for them.[9]

1.4 Public Health

Although smoking as a risk factor has decreased in recent years, new ones have emerged, most notably obesity. 24.4% of adult men and 25.1% of adult women in England are obese[10] and this is predicted to increase to 60% and 50% respectively by 2050.[11] If these trends are not reversed there will be substantial increases in the number of people diagnosed with associated LTCs.

Physiotherapy in a primary care setting would be ideally placed to prevent and manage obesity. Obesity leads to restriction in movement, affecting engagement in physical activity. Exercise and movement is the cornerstone of physiotherapy practice.[12] Along with a holistic, patient centred, and problem solving approach, physiotherapists have advanced knowledge and skills in:

- anatomical, physiological, and psychosocial mechanisms of health and disease
- assessment and diagnosis
- behaviour change
- biomechanics
- exercise prescription and therapeutic exercise
- management of long-term conditions.

Physiotherapists are therefore ideally suited to address the physical and psychological complexities of obesity.[13] While the importance of being physically active is well recognised, in reality patients often experience difficulties in doing so. An assessment and treatment plan from a physiotherapist will help overcome the barriers to exercise.

Physiotherapists in a general practice role would be well placed to respond to the rising risks and demands of obesity. The existence of the registered list of patients and the knowledge of these patients presents a unique opportunity for illness prevention.[14] This is an area physiotherapists could comfortably lead forward using the knowledge and skill previously detailed.

2.0 Challenges for Future Primary Care Workforce Supply

The Royal College of General Practitioners (RCGP) estimates that patients have had to wait a week or more on 67million occasions in 2015.[15] This presents a sharp increase on 62.4million in 2014 making it a fourth year running of significant increase. Data from the NHS England GP Patient survey reveals an increase from 9 to 11% of people who have failed to get an appointment. Both these figures suggest growth in unmet need. Compounding the above is the rise in the number of practicing GPs who plan to leave the profession.[16]

The Physiotherapy workforce is one which could rapidly respond to this increasing demand, as is already has the knowledge, skill and diagnostic expertise to work in this environment. Physiotherapists have particular skills and make particular contributions in the areas identified on the following page.

Skills	Service contribution
Assessment, diagnosis and problem-solving	First-contact practitioners, including enabling patient self-referral, leading triage services and integrating independent prescribing into their care of patients (subject to post-registration development/HCPC annotation)
Care planning, implementation and evaluation	Lead and implement integrated care pathways as part of multi-disciplinary/cross-sector team-working
Communication, education, behaviour management and partnership-working	Support individuals to manage and take responsibility for their own health and to promote healthy living and illness prevention
Rehabilitation and enablement	Meet individuals' needs relating to complex, long-term and chronic conditions and lead 'fit for work' initiatives relating to key health care priorities
Physical approaches to care	Enable individuals to optimise their functional ability, health and well-being and quality of life. Build individuals confidence in participating and sustaining higher levels of physical activity and fitness

3.0 Physiotherapy – quality assured and value for money

3.1 Pre-registration education

Pre-registration physiotherapy education in England (as well as the rest of the UK) is subject to robust regulation and quality assurance and enhancement arrangements. Processes ensure that programmes are measured and kept under review against high standards set by the HCPC, CSP, QAA and host higher education institution. The CSP asserts its expectations of UK qualifying physiotherapy programmes through its Learning & Development Principles and accreditation processes. The L&D Principles help programme providers develop learning and teaching opportunities that prepare physiotherapy students for changes in population and patient needs, role and service delivery reconfigurations, and an increasing plurality of providers within health and social care and public health and therefore career development opportunities.

3.2 Value for money

Pre-registration physiotherapy programmes in England represents value for money and an excellent return on investment. Attritions rates form physiotherapy programmes are extremely low - currently at 2.8% across the UK. This is comparable to a 16% attrition rate average across all university courses.[17] There is also a very high translation of physiotherapy graduates into members of the health care professions workforce. This is across an increasing plurality of service providers, but with the majority of physiotherapists continuing to work within the NHS and NHS-funded services.

	Pre-registration training			Post grad training	Totals
	Tuition	Living expenses/ lost production costs	Clinical placement	Tuition and replacement cost	Total investment
Physiotherapist	£25,454	£37,418	£4,603	£44,991*	**£112,446**
Nurse	£24,111	£49,890	£4,603	£42,021**	**£120,625**
GP	£42,964	£59,287	£129,415	£247,455	**£479,121*** **
Consultant	£42,964	£59,287	£129,415	£493,026	**£724,692*** **

* *Physiotherapist post graduate training calculated by:*
Full time MSc = £9,280 (Nottingham advanced practice MSc Leading to an advanced clinical practitioner post)
Backfill for post = 29,759 (mid-point band 6)
On costs = 5952 (20% for pensions/sickness/training etc)
TOTAL = **44991**
** *Nursing post graduate training calculated by:*
Full time MSc = £6,310 (Nottingham Advanced Nursing MSc)
Backfill for post = £29,759 (mid-point band 6)
On costs = £5952 (20% for pensions/sickness etc)
TOTAL= **£42,021**
*** *GP and Consultant calculations & other figures taken taken from:*

(18)

3.3 Post-registration education

Physiotherapists qualify as autonomous practitioners; investment is still needed, In line with the King's Fund *Time to Think Differently* initiative[19], to ensure support is provided to enable the physiotherapy workforce to continue to develop in primary care. Our future workforce will primarily comprise of those already working with in the profession. Sufficient financial support is therefore required to ensure that the workforce remain sufficiently skilled, particularly in the complex multi-specialist area of primary care.

In tight financial times it is essential patients see the right professional at the right time. For example it is less expensive for an advanced physiotherapist in the Locomotor service in Homerton to provide an ultrasound guided steroid injection and two follow up appointments than it is for a GP to provide one blind injection without ultrasound guidance. Not only is this more cost effective, being ultrasound guided increases accuracy and avoids the need for repeat injections based on a suspicion that the original injection was not in the correct place. To enable this kind of efficiency of service the correct support for post graduate training is essential. A typical cost for injection therapy training is £840. When considering the above efficiency savings which could be realised over a long period this presents a sound investment.

Independent Prescribing

Costing on average £1250, independent prescribing courses offer excellent value for money considering the impact the knowledge and skills gained could have on patient care. Physiotherapists being able to prescribe at the point of patient need avoids additional doctors time being spent. Patients quickly get the treatment they need without having to be reassessed by a doctor resulting in a streamlined service. Equipping physiotherapists with this skill in a first point of contact primary care setting could ensure time isn't wasted on having patients return for prescriptions from their GP. To enable this, support is needed to allow physiotherapists to access appropriate training, continued professional development and supervision.

Having been able to independently prescribe since 2014, the first large scale evaluation of physiotherapy and podiatry independent prescribing is currently underway at the University of Surrey. For more information on the project please visit: http://www.surrey.ac.uk/fhms/research/healthcarepractice/evaluation_of_physiotherapy.htm

4.0 Current quality primary care services – examples of excellence

4.1 Long term conditions

An estimated 18.1 million people in the UK have at least one long-term condition. The UK currently spends £19 billion on people with three or more long-term conditions. This is projected to rise to £26 billion by 2016. Physiotherapy reduces these costs through prevention, early intervention and rehabilitation and at £34 per session, provides excellent value for money. [20-22]

The Hope Specialist Service in North East Lincolnshire is an award-winning integrated primary care based one stop shop service for people with COPD and older people at risk of falls. In 2005 a local primary care survey found that COPD services in the area lacked integration and importantly lacked capacity. This allied with a significantly high incidence of COPD highlighted by the Lincolnshire Public Health Report meant that change was needed. With input from local patients a specialist physiotherapy led initiative was developed – The Hope Service.

Fundamental to the services success was the introduction of Pulmonary Rehab Buddies. These are expert patients, whose role is to motivate and encourage patients, provide peer/emotional support and help in the running of the programme. In combination with specialist physiotherapists, nurses and physiotherapy assistants, an atmosphere was created where patients felt free to express their concerns and their ideas for improvement. The programme continues to show dramatic life changing outcomes for patients, in both their physical capabilities and quality of life. Furthermore it has been found that the programme saves on average one hospital admission per patient, resulting in an average saving of more than £2600 per patient.

The innovative Bradford teaching hospitals NHS Foundation Trust Early Supported Discharge (ESD) pathway helps people regain their independence and function following hip fracture or

other orthopaedic problems. The ESD team of physiotherapists, OT's and therapy assistants provide a direct link between acute and community services, delivering intensive post discharge rehabilitation immediately patients return home. The team undertakes home visits twice a day for an average of 5 days focusing on setting individual goals to promote independence and optimise recovery. Liaison with other agencies helps ensure people receive the help they need to return to their normal lifestyle.

Between 2011 -2013 the service saved the Trust a total of 2,698 orthopaedic bed days equating to an estimated cost savings of more than £600,000. Readmission rates fell from 10-12% to 5-6%. Other outcomes included a reduction in falls risk and standard measures evidenced clinical improvements of between 25-50%.[(23)]

These examples show how physiotherapists can lead change in the primary care setting whilst integrating with other professions, build confidence in patients to better self manage and support and develop volunteers.

4.2 Working age population

Occupational Health

Keeping people fit to remain in work and facilitating return to work is a priority. Musculoskeletal (MSK) conditions are the biggest cause of absence from work in the UK, causing 27% of total days lost to sickness absence.[(24)] Rapid access to occupational health services, including physiotherapy, gets people back to work more quickly and reduces the risk of MSK conditions and stress as they become older. York Teaching Hospital Foundation Trust was losing 5.5% of total working time due to sickness absence. This amounted to an annual cost of £3.7 million. The Trust started a project in 2008 to tackle this. By 2011 the Trust had invested £160,000 in a multidisciplinary team (MDT) including occupational health physiotherapists. This team worked in partnership with hospital managers and trade unions to help sick or injured employees return to work. By January 2011 absence rates were down to 3.8% and by November 2011 had reduced further to 3%. Long term absence has fallen by 72% for those off for four weeks or longer and 77% for those absent for three months.

Measured on a full-time equivalent basis there are now 54 more staff available to work with direct savings in pay costs of almost £1.2 million per year from a reduced need for bank and agency staff.

The above is a good example where physiotherapists are already the first point of contact for patients. With an increase in the physiotherapy workforce capacity, primary care based physiotherapy interventions such as the above could be more widely adopted. If more widely adopted this could have a significant impact on the burden to GPs.

Self-referral

The Quality, Innovation, Productivity and Prevention (QIPP) process in England has endorsed self-referral for MSDs to allow easier access to treatment. It has been shown to not increase

demand for physiotherapy in the long term and also reduces patient related costs; such as prescribing, X-rays, MRI and more expensive medical consultations. Holdsworth et al demonstrated that in Scotland, an episode of GP prompted self referral costs 10% less and full patient self referral costs 25% less than traditional GP referral for physiotherapy, resulting in savings of £25,207 per 100,00 population.[25] The English pilot showed 41% of referrals came from the traditional GP route, 35.4% came from prompted self referral and 23.6% were full self referral. This shows the potential for greater cost savings for three quarters of patients with MSDs if full self referral were properly promoted.[26]

Risk Stratification

Within the UK each year, up to 9% of adults see their GP about back pain. Some patients have a simple ache which will correct itself whilst others will have a long standing pain. The evolution of 'risk stratification', where patients are screened to identify the risks which may affect their treatment outcome, allows patients to be directed to the treatment pathway that is right for them rather than applying a one size fits all approach.

Keele University demonstrated that the STarT Back Tool for neck and back patients was clinically and cost effective. Significantly improved outcomes at four months and a £34.39 saving per patient was shown when comparing the STarT Back intervention group with those who received usual care.[27]

The STarT Back method asks patients to fill out a questionnaire with the GP or physiotherapist. This identifies whether the risks that may affect the treatment outcome are low, medium or high. The STarT Back questionnaire takes into account the patient's symptoms, their perception of their pain as well as how it is affecting their life. Patients can then be directed to an appropriate treatment pathway based on this assessment. The pathway may include greater emphasis on self management for low risk patients or greater management of psychological distress for high risk patients.[27]

Accident and emergency

In 2012-13, 18.3million people attended A&E units; 43% were under 30 years old, 24% were aged 60 or over, 21% were admitted to hospital and almost 21% attended for joint, muscle, tendon, ligament and soft tissue injuries.[28]

Physiotherapists work either as frontline emergency physiotherapy practitioners (EPP) or as part of the multidisciplinary therapy team in A&E and medical admission units (MAU) to reduce delays and inefficiencies, prevent unnecessary admissions and enable timely discharge of patients to home or community settings.

EPP's see patients with, mainly, musculoskeletal (MSK) problems independently of medical staff, undertaking activities including expert assessment, requesting and interpreting investigations, managing wounds, soft tissue injuries and fractures, providing advice and treatment freeing doctors up to manage more complex conditions and improving patient

flow.[29, 30] Physiotherapists managing MSK injuries have equivalent clinical outcomes and lower direct costs than doctors or emergency nurse practitioners.[31-33]

Salford Royal NHS Foundation Trust treats 88,500 Accident and Emergency patients per year. An advanced physiotherapy practitioner post was established in 2010 for people attending A&E with musculoskeletal injuries. Evaluation has shown increased service efficiency and care quality. Patients are provided with immediate access to expert physiotherapy advice and treatment, and waiting times have been lowered. A reduced requirement for more expensive medical staff has resulted in cost savings of £32 per patient - a 60% reduction. Patient flow through A&E has been improved and staff have reported better knowledge sharing between members of the multi-disciplinary team.[1]

Through stronger support of post-graduate training and career development these advanced roles could be expanded across primary care. If the service model demonstrated above were widely adopted this could be a huge saving for the NHS and a significant improvement in the quality of patient care, including decreased waiting times for accident and emergency primary care.

4.3 Frail and Elderly

Costing the NHS over £4.6 million each day (= £1.7 billion per year), falls in later life represent a major burden on the health and social care systems.[34] Prevention is better than cure. Physiotherapy led Falls prevention programmes are proven to prevent falls, reduce hospital admissions and restore independence. NICE guidance requires all older people with recurrent falls, or at increased risk of falling, to be considered for an individualised intervention including evidence based strength and balance training.

The Westminster Falls Service ran in the community by a team of physiotherapists' offers risks assessment and intervention for clients referred following a fall or who are at risk of falling. After assessment clients are receive either 1:1 physiotherapy and/or attend a12 week strength and balance programme designed to increase physical capability and confidence, improve balance, and reduce fear of falling. On completion of the programme clients continue falls prevention exercise via 'Steady and Stable' classes in partnership with a voluntary organisation. Clients followed up a year later reported a 60% fewer falls, 55% fewer fractures, 92% fewer A&E admissions, and a 80% reduction in GP appointments compared to the year prior to intervention.

The CSP has published a falls prevention economic model[35] which demonstrates how investment in physiotherapy in primary care produces cost savings across other parts of the health economy. The tool brings together data from high-quality sources including the Cochrane Collaboration and the Office of National Statistics to provide intelligence based on local populations. This is in line with the CSPs ambition to support services to be commissioned based on patient and population need. For example the tool demonstrates that in England preventative physiotherapy in the community for older people could lead to 187,462 fewer falls resulting in £274,998,720 cost savings.

4.4 Mental Health

750,000 people in the UK live with dementia. Two thirds live in their own homes & one-third in care homes.[36] Thus this presents a considerable challenge for primary care. Physiotherapists, as autonomous practitioners, can undertake detailed, individually tailored assessments of the impairments, activity restrictions and participatory limitations faced by people with dementia.

Physiotherapists work as part of a multi-disciplinary team ensuring the delivery of high quality, effective care, in line with the NICE Quality Standards for people with dementia.[37]
This standard advocates provision of assessment and ongoing personalised care plans, addressing individual needs. NICE[38] and SIGN [39] guidelines recommend physiotherapy for promoting and maintaining independence for this client group. As well as treating this client group in the community and therefore essentially in primary care; physiotherapists acting as first point of contact practitioners would be well placed to identify the needs of this patient group.

4.5 Integrators of care

Physiotherapy staff work across sectors and have a long experience of working in multi disciplinary teams, building strong working relationships with other professionals. The review of the Primary Care workforce needs to be informed by the experiences of integrated health and care services.

The Integration Pioneers contain many useful models for delivery of primary care services in the future. For example:

- In Greenwich, multi disciplinary teams based around a hub of GP practices respond to emergencies within the community and in care homes. The teams include physiotherapists, occupational therapists and social workers.
- In Southend on Sea there are community level multi-disciplinary teams that span across primary, community and social care and include GPs, physiotherapists, district nurses and community matrons. The model provides one route of access for all unplanned care and specialist teams in the community to prevent A&E admissions and support early discharge.

In Worcestershire the Well Connected Programme includes a clustering of services around GP hubs, and includes virtual wards with multi disciplinary team case management for older people, facilitative discharge to provide intensive packages of care and rehabilitation to support the return home. The programme focuses on provision of services in the community for people with long term conditions, including tele-health to support self-management and a defined role for the voluntary sector.

The Locomotor pain service in Homerton is another fantastic example of how integrated services using the expertise of multiple professions can have a real impact on patient outcome.

The service integrates psychologists, physiotherapists including extended scope practitioners with independent prescribing rights and sonography qualifications, pain consultants, pain nurse and occupational therapists. The success of the service has resulted in a number of benefits including; reduced GP appointments, decreased need for MRI referral, and decreased reliance on spinal injections. These all have significant associated cost savings. Patient satisfaction and outcomes have also been outstanding.

4.6 Further information

For further evidenced based briefings on how physiotherapy can help a multitude of patient populations please visit: http://www.csp.org.uk/professional-union/practice/your-business/evidence-base/physiotherapy-works

5.0 New approaches to using traditional skills

5.1 First point of contact practitioners

It is estimated that 30% of all general practitioner consultations are for musculoskeletal (MSK) conditions.[40] They are also the most common reason for repeat appointments in primary care.[24] With an aging population[3] and rising public expectations; the demand for musculoskeletal services in primary is set to significantly increase. These statistics coupled with the evident shortfall in the general practitioner workforce presents a real challenge to providing care for the population and an opportunity to do things differently.[41]

Physiotherapists have the ability to provide a first point of contact service to patients in the primary care setting easing the burden on GPs and providing a solution to growing demand for MSK services. One NHS vanguard site in West Wakefield is doing just that for MSK patients. Up-skilled reception staff use a set criteria to select appropriate patients for the service. Therapists have 15 minute appointments to assess, advise and signpost. Procedures are in place to ensure that investigations, medication or referrals required do not create unnecessary follow-up appointments with GPs. Patient feedback has been excellent with high satisfaction and low rates of return to the GP. With the appropriate post-graduate training these physiotherapists could take further responsibility by independently prescribing and ordering further investigations. This is an area where HEE could provide greater support.

A similar first point of contact service has developed in Nottingham. The service which initially started in 2 GP practices was quickly expanded across 26 practices due to its early success. In addition to having high patient satisfaction the service is proving cost effective by saving more costly GP time.

Physiotherapists are specifically trained, skilled and knowledgeable in the management of MSK conditions. The interventions physiotherapists provide align neatly with best evidence guidelines for the care of MSK conditions including exercise programmes, manual therapy and acupuncture.[42] Physiotherapists have also proven themselves to be effective in triaging and

providing appropriate onward referral, particularly in the orthopaedic setting.[43] Research has also shown health professionals such as physiotherapists are equally as able to identify serious pathology as general practitioners.[44]

As well as providing a safe and effective service, self-referral to physiotherapy has significant opportunity for cost savings. As previously mentioned in this document, physiotherapists have been early adopters of stratified care for patients with low back pain. Not only has this been shown to be more cost effective, it is also more effective for patient outcomes. There are greater economic savings are also to be had by having physiotherapists as first point of contact practitioners. This is backed by research which shows early access to physiotherapy reduces time patients are off sick and prevents acute problems becoming chronic.[45]

Leading care pathways
Working with nine GP surgeries and a total patient list of over 77,000, Connect, an independent NHS provider of MSK healthcare has led an innovative reform of their local MSK services in Newcastle. A community MSK Clinical Assessment and Treatment Service (CATs) was developed. General practitioners referred all MSK patients to the community service, leaving the decision to access secondary care to the MSK CAT service. With new physiotherapy services sited in numerous GP practices to improve access and reduce wait times, every referral was coordinated via a specialised 'call referral management' centre. This resulted in patients being dealt with promptly and efficiently.

Telephone triage was introduced so patients could receive immediate guidance from the comfort of their own home. In six months of operation the service had saved the NHS £42,000 whilst also improving patient satisfaction with 96% of patients rating the care they received as "excellent" or "very good". The service also had widespread GP support with 97% of GP's rating the reformed service as "better" or "much better".

If physiotherapists were the first point of contact in the above scenario the patient pathway could be even further streamlined. Resultantly, patient satisfaction would likely improve secondary to having a single point of access as well as greater continuity of care. Furthermore, it is likely further cost savings would be attained by avoiding the use of costly GP time.

5.2 Educators and enablers of others in delivering care

Core skills of physiotherapists are being able to support patients in self-managing their condition through education and facilitate behavioural change to optimise their health and well-being. Commonly people worry if they're doing the right thing in the context of their condition. Physiotherapists are skilled at helping people to develop the confidence needed to safely engage in physical activity. Within primary care settings, the profession could make a strengthened and considerable contribution to promoting and supporting the health and well-being of local populations through enabling them to be more active.[46]

As experts in movement, including manual handling, physiotherapists have an increasingly important role to play in supporting carers and the invaluable role that they play in patient

care. There are already twice as many unpaid carers—nearly 6.4 million—as there are paid staff in the health and social care systems combined.[47] One physiotherapy service in Leeds noticed that residents in a local care home were not able to mobilise or sit comfortably due to the care staff not being confident in manual handling. A training programme was therefore developed; physiotherapists taught the healthcare assistants appropriate ways of moving and handling, thus enabling ongoing care and better quality of life for the residents. This type of programme has significant scope to expand across primary care. The Stoke Association noticed this opportunity and has approached the service to discuss using the programme.

Physiotherapists are also excellently placed to educate their healthcare professional colleagues. Progressing risk stratification approaches to ensure patients receive the right care is given at the right time, and that staff and other resources are most appropriately deployed to meet specific needs, is one example where physiotherapists have worked with GPs to adopt innovative practice. Physiotherapists commonly support nurses to ensure ongoing care for patients is optimised. Furthermore, physiotherapists educate and work alongside unregistered physiotherapy assistants. Assistants are an invaluable resource. When supported, including through appraisal and structured opportunities for learning and development, they can vastly improve the timeliness, access and sustainability of care and therefore the quality of patients' experience and outcomes. [48]

6.0 Barriers to implementation of new models of care

6.1 Commissioning Models

Commissioning models such as Any Qualified Provider, Prime Provider and Alliance Contracts have recently come to the fore in an attempt to drive more transformational service integration. The CSP is concerned these models, which use multiple providers, in fact risk working against the shared aim of better integration across healthcare. The CSP believes this could lead to fragmentation of care; a plethora of different standards against which the quality of care is judged; and poor monitoring of non-NHS providers and a wide variation in employment conditions and pay. It is essential that these risks are mitigated in the interests of clinically- and cost-effective care for patients.

The Any Qualified Provider (AQP) model of commissioning is one such example where service development has been limited by the commissioning model. In Cornwall, an MSK self-referral pathway under AQP was stopped due to fears of increasing cost. If the CCG had understood the demand on the service before introducing AQP, this may have identified the latent need within the local community and enabled planning for subsequent rise in demand for physiotherapy. Research shows that patients do refer themselves appropriately. By stopping the self-referral service GPs would have had to pick up those patients who would have originally gone through a more cost-effective and efficient self-referral route.

6.2 Workforce Development

While physiotherapy and other allied health professions (AHPs) can make a strong contribution now to primary care, the benefits of their input to service delivery can be increased through role reconfiguration/substitution, as well as service re-design and integration. Their full potential could be realised further through an increased commitment to workforce development and investment for the professions.

It is also essential that the potential for skill mix review and role re-configuration /extension/development/substitution is considered broadly within how care is led and delivered in primary care settings, rather than there being a narrow focus on particular parts of the workforce that have traditionally practised in these settings. The real benefits of strengthened inter-professional team working and stronger collaboration within and across sectors and services need to be achieved to ensure that the care that patients can access and achieve is thoroughly integrated and sensitive to their individual needs.[(49)]

We see the physiotherapy workforce as being excellently placed to engage in and contribute to workforce transformation to strengthen primary care. However, we believe that the full potential for meeting patient care needs differently and more effectively and efficiently hinges on consideration being given to the following workforce development issues:

- A more supportive structure for post-registration/postgraduate education and development for AHPs that aligns with changing job roles and optimising the professions' potential; we would see the proposals recently published by HEE and the Nursing & Midwifery Council for developing an infrastructure for career development for nurses as providing a valuable model for a broader range of professions.[(50)]
- Stronger structures for professional leadership and peer review, particularly in the context of increasingly fragmented service delivery and the imperatives of more inter-professional team working and more collaborative working across sectors and settings (to achieve care that is genuinely integrated and person-centred)
- As part of the above, we see robust models for peer review and supported professional development and leadership (within and across professions and in ways that can foster genuine collaboration within multi-disciplinary teams) as being central to creating a sustainable, affordable model for the primary care workforce and that optimises the contributions of each profession and occupational group
- Related to the all above, we see it as essential that the workforce, across the professions and including physiotherapy, is supported in making shifts from practice from one setting and service design to another (including from acute to primary care settings and from 5- to 7-day service delivery models), including so that the development and implementation of their knowledge and skills can be optimised and the needs of patients can most effectively be met
- Again, we see it as essential that attention is given to developing supported opportunities for individuals across the workforce to return to practice after a career break (as is now

being done within nursing and for GPs) - as recognised for these other professions, this is a key way in which the expertise and experience held by individual practitioners can be tapped into to meet patient need and for them not to be lost as a valuable component of workforce supply (we are keen to explore with HEE how such an initiative could be progressed, including in ways that ensure appropriate economies of scale to make delivery of return to practice schemes (in line with HCPC requirements) feasible

- We are concerned that the Talent for Care strategy is implemented in ways that are genuinely inclusive of all parts of the support worker workforce (including those who work with the AHPs), such that learning and development opportunities available to individuals align with and support changing job roles and optimise how care can be delivered in accessible, timely ways (including in ways that facilitate patients' increased access to care in primary care settings)[(48)]
- We are likewise concerned that our members have strengthened access to support for research-related and service evaluation activity, including in line with the HEE strategies on research and innovation and library and information services. Ensuring that all members of primary care teams have access to information and research resources and opportunities (including those relating to research collaborations and standardised data collection) are essential for developing and using the evidence base to underpin continuous improvement in service delivery and design.[(48)]

6.3 Workforce Capacity

The physiotherapy workforce is showing signs of entering shortfall. Managers are reporting increasing difficulty in recruiting physiotherapists. The CSP's manager survey completed in March 2015 demonstrated that of 167 responses from England 46% reported severe difficulty in recruiting band 6 physiotherapists and 39% reported moderate difficulty. Similarly, 71% of managers reported moderate or severe difficulty in recruiting experienced band 5 physiotherapists. In addition graduate employment rates have significantly increased. This indicates that there is high demand for newly-qualified staff, with supply not keeping pace with demand (figure 1).

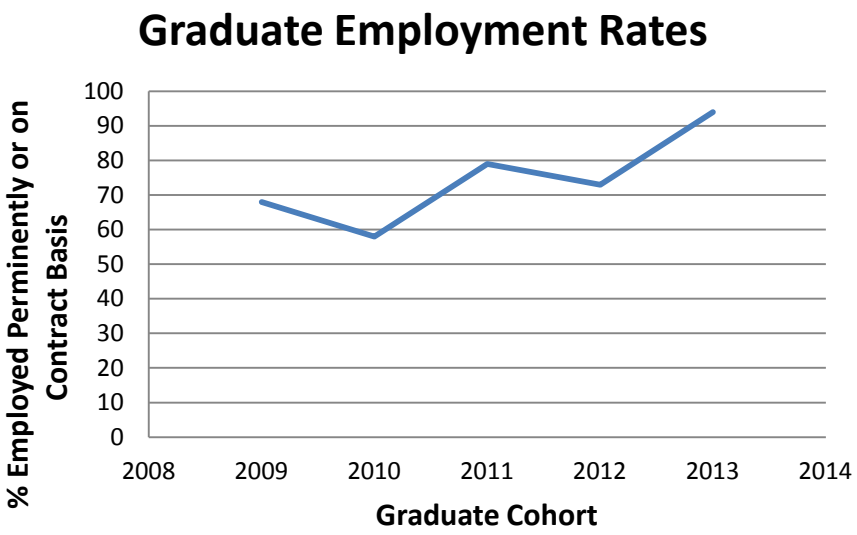

Figure 1. (Based on the CSP's annual graduate survey)

In line with our previous submissions to HEE and our on-going work to develop a workforce data modelling tool, we are concerned that physiotherapy workforce supply is fully predicated on projections of areas of changing and increased patient need. This is essential for ensuring that the full potential for meeting needs in clinically- and cost-effective ways is achieved, that the risk of under-supply of the workforce is averted, and that workforce transformation can genuinely be achieved.

As indicated above, additional ways in which workforce supply could be bolstered would be to provide stronger support for individuals both to return to practice after a career break and to make career shifts, including to meet changing patient needs and to deliver care within changing service models. Again, we would see replicating the models that are being implemented for the nursing and GP workforces as key for maximising workforce support, including through enabling those with high-level knowledge, skills and experience to return to the workforce and meet service/patient need.

6.4 Optimising service delivery models, including through multi-specialty community providers

We strongly support an approach to workforce planning, development and investment that appraises workforce supply need from the perspective of changing population and patient needs and taking different approaches to service design and delivery. This should enable more lateral considerations to be taken of how workforce demand can be met in responsive, clinically- and cost-effective ways, rather than workforce planning being premised on pre-existing models of workforce supply and service delivery.

We are concerned that the GP workforce action plan, recently published by NHS England, HEE, the RCGP and BMA, focuses narrowly on addressing current workforce challenges through initiatives focused on the medical profession. This misses a real opportunity to consider how

other parts of the workforce, including physiotherapy and the other AHPs can contribute to primary care in significant, clinically- and cost-effective ways[49]. We are keen to contribute to exploring how a more lateral, strategic approach to addressing current needs – with fulfilling patient needs in safe, effective affordable ways brought to the fore – can be progressed to achieve the kinds of workforce transformation required.

We believe that the physiotherapy workforce can play a key role in leading, integrating and delivering services in primary care settings, including through new models such as MCPs and across service delivery sectors (including health and social care; the public, independent, private and third sectors; and across illness prevention, health and well-being).
A further potential barrier to implementation of a physiotherapy primary care workforce could be if investment is heavily placed into new unregulated professions such as physician associates. We would consider investment would be better placed in developing the physiotherapy workforce. As an autonomous profession that is regulated and able to independently prescribe, physiotherapists are excellently placed to take on stronger roles in leading and managing whole packages of patient care, as outlined in this submission.

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