CHARTERED
SOCIETY
OF
PHYSIOTHERAPY

Health Education England
Consultation: Facing the Facts, Shaping the Future
A draft health and care workforce strategy for England to 2027

Response from the Chartered Society of Physiotherapy

The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the UK's 57,000 chartered physiotherapists, physiotherapy students and support workers.

Registered physiotherapists are autonomous practitioners, able to independently assess, diagnose and prescribe medicines. The contribution of physiotherapy can be seen at many points of a care pathway as physiotherapists work as clinical leaders and multi-professional team members, to support patients in hospital, home, community work and leisure environments.

Physiotherapy support workers play a vital role as part of the physiotherapy workforce, supporting people to remobilise after injury or illness, providing hands-on care for people with their individual and group exercise programmes, supporting carers and delivering community education.

CSP key messages

- Workforce planning should be based on robust projections of population and system needs and address the needs of the whole health and care economy
- We need an investment in training of the non-medical parts of the workforce (registered and non-registered) to equip them to work at the height of their capabilities and to optimise their contribution to new models service delivery.
- The CSP welcomes the acknowledgement of the need to increase physiotherapy graduates to meet workforce demand
- All available levers to support and maintain HEI market expansion of physiotherapy pre-registration education must be used, including the practice education tariff
- The strategy needs to grow and develop the unregistered parts of the physiotherapy workforce. This includes through structured learning opportunities and apprenticeships
- Training and career progression for support workers who don't want to become registered profession is as important as developing those who aspire to regulated status.
- Transformation requires a shift to prevention, self-care, early intervention and rehabilitation. This will require learning and development across all parts of the workforce
- Support for professional development to enable the deployment of physiotherapists with advanced practice skills as part of the GP team and in A&E departments will provide a sound return on investment
- Excellent management is crucial for high-performing organisations. Investment in the leadership and management skills of service managers is critical
- Education and practice based-learning opportunities should include the role of clinicians in coaching, advising and supporting self-carers, carers and volunteers
- There is a direct relationship between quality employment for all (including support for learning and development), quality services and patient safety in health and social care. This needs to be recognised and acted upon to improve quality services and retain staff.

1.	Do you support the six principles proposed to support better workforce planning; and in particular, aligning financial, policy, best practice and service planning in the future?

1.1 While the CSP agrees with the six principles, we have the following points to make on where we think there are gaps, and where we think the principles need to be strengthened to achieve a genuinely strategic approach to workforce that is grounded in changing needs and context.

Gaps in the principles

1.2 Workforce planning needs to be based on robust projections of population and system needs. Principles from the HEE's Workforce Planning Framework 2015/16 could be helpful to draw upon. There needs to be an overt recognition that this requires workforce capacity to be developed within all parts of the health and social care workforce and professions.

1.3 In line with HEE's responsibility for system-wide workforce planning, the strategy should directly address the plurality of service providers, largely created by government policy. The NHS, military, local authorities, independent sector, charities and research bodies all need a trained health and care workforce. It is welcome that the strategy does recognise the health system beyond the NHS. But the implicit assumption continues to be that it is only the NHS workforce that is in scope – for example in the messages regarding attracting and retaining staff.

1.4 It is a weakness of the strategy that the more strategic approach is only progressed for the parts of the workforce for which HEE commissions education. The strategy needs to consider the workforce as a whole - rather than in disparate elements with different approaches applied in each.

1.5 If there is not a strategic overview of the whole workforce, there is an increasing risk that workforce supply will become increasingly misaligned with workforce demand, existing problems of under-supply will be exacerbated, and there will be a perpetual reliance on short-term arrangements (e.g. agency staff) to meet needs.

1.6 The increasingly diverse ways (commissioned and non-commissioned education routes, capped and uncapped numbers, established and emergent workforce pipelines) in which the future workforce makes workforce planning more complicated than ever. It also makes it all the more important that a strategic approach is taken and this complexity is overtly grappled with.

1.7 Transformation requires a shift to prevention, self-care, early intervention and rehabilitation. This will require:

- more expansion of numbers in parts of the workforce, including physiotherapy
- a shift in the balance of the workforce between acute, community and primary care settings
- the development of new or enhanced skills to meet changing needs, for example, to support the growth of first contact practitioner numbers in primary care.

1.8 Across the system, clinical staff tend to become narrower in their fields of expertise as their careers develop. While there continues to be an important role for specialists, there also need to be equal value placed on generalists within each profession, who have a broader depth of knowledge to meet the needs of the population that have increasingly complex and multifactorial in cause.

1.9 While the strategy document acknowledges apprenticeships as a new and increasingly significant pipeline of workforce supply in healthcare, it does not address how this pipeline can be factored into a more strategic approach to workforce planning, development and investment. Neither does it address how apprenticeships further compound the complexities around how the workforce is developed and produced.

1.10 In relation to apprenticeships, the following in particular need to be addressed:
- how HEE can appropriately exercise its national role to have due influence at a regional and local level, via STPs and WLABS on facilitating apprenticeship developments that are responsive to changing priorities
- how employers are supported in making decisions about whether and how they invest their apprenticeship levy in different parts of workforce development
- how strategic issues and challenges relating to the feasibility, finance and logistics of delivering apprenticeships in healthcare are pursued with the Department for Education
- how meaningful progression routes through apprenticeships are created to progess workforce development, opportunities for career progression and recruitment and retention
- how it is ensured that employers' investment in apprenticeships is not confused with the continuing and separate need to invest in the CPD of all parts of the workforce.

Strengthening the principles

1.11 On employment, an important aspect of this principle that needs to be included is the direct relationship between quality employment (including investment in workforce development) and quality services and patient safety. These links need to be overtly acknowledged to achieve sustainable approaches to workforce supply and to address recruitment and retention issues effectively.

1.12 The CSP strongly agrees that service, financial and workforce planning are interdependent. A national workforce strategy needs to take account of service needs as those services are changing. It is important that the workforce strategy clearly sets out how planning at the STP level will inform national workforce planning, development and investment, and vice versa.

1.13 To underpin a more strategic approach to workforce planning and development, concerted efforts are required to improve and make more consistent the quality of data and analysis. Consideration needs to be given to how different data can be appropriately be triangulated, analysed and interpreted. For example, professional regulators operate in very different ways in the data they collect and share, while the electronic staff record (ESR) relates only to the NHS workforce and is recognised to have inaccuracies and imprecisions in capturing workforce trends. A fuller, more standardised approach to data, sustained by a quality assurance framework, is essential to underpin a workforce strategy. The role of professional bodies and trade unions in contributing to workforce data, analysis and interpretation needs more strongly to be recognised and utilised.

Physiotherapy Factsheet (pending)

1.14 The Physiotherapy Factsheet to accompany the strategy recognises that physiotherapy is at risk of being a shortage occupation. The CSP would go further than this and say that this is not a risk but now a reality.

1.15 The analysis and the data used in the Physiotherapy Factsheet has some weaknesses. These reflect our comments on points 1.2 and 1.3 above. There are misplaced assumptions that all physiotherapy graduates are available to work in the NHS. This needs to be replaced with a full understanding of how physiotherapists meet population and patient needs across all parts of the health and care system and in all sectors and settings.

1.16 We hope to have further conversation with HEE in the coming weeks, including to explore how our data and analysis can contribute to a fuller and more informed document, and how we can support and contribute to a more developed approach to intelligence-gathering on workforce supply and demand on an on-going basis. For the future, we believe there is a need for a quality assurance process that enables agreement by professional bodies.

1.17 To understand the dynamics of physiotherapy, it is necessary to understand the whole health economy demand for physiotherapists and the high translation of physiotherapy students into graduates, and graduates into practitioners.

1.18 It also needs to be recognised that not all physiotherapists remain in frontline practice throughout their career. This needs to be positively supported, recognising that these draws on workforce supply are essential for educating an expanding workforce, developing the evidence to support and inform service improvements, and leading and progressing pathway redesign and new models of care.

2. Do you feel measures to secure the staff the system needs for the future can be added to, extended or improved, if so how?

2.1 We need to expand the workforce to meet both current and future population needs. The areas of the workforce that need to expand the most are registered professionals other than doctors, - including physiotherapists - and the unregistered workforce - including physiotherapy and AHP support workers.

2.2 Around 8000 of the current physiotherapy workforce qualified overseas, 14% of physiotherapists registered with the HCPC. This is double the estimated vacancy rate in the profession. In the wake of Brexit, and with current visa restrictions that make it difficult to retain overseas physiotherapists for the long-term, the use of overseas recruitment to meet gaps is unlikely to be sustainable. Real effort needs to be made therefore to stimulate additional training within the UK.

Using appropriate levers to increase supply

2.3 The current shortfall in physiotherapists now and projected for the future has been due to insufficient commissioning of university student places over many years. The HEI sector, with the active support of the CSP, is now starting to expand the number of places to meet demand, with an increase of over 15% in 2017/18. Based on information gathered from education providers, the CSP (conservatively) estimates a 21% increase in physiotherapy graduates for three years, each year until 2021.

2.4 This progress has been enabled through band B for funding from the Higher Education Funding Council (HEFCE), in recognition of the higher than average cost of physiotherapy degrees. Now that responsibilities for HEI funding are moving to the Office of Students for physiotherapy workforce growth to be sustainable, this funding needs to continue. The role of the Office of Students needs to be reflected in the workforce strategy.

2.5 A significant proportion of the physiotherapy workforce (20%) is made up of graduates who enter the profession via a Master's pre-registration education programme. This is a valuable supply route for physiotherapy that needs to be nurtured, including through creating certainty regarding funding arrangements both for students and HEIs.

2.6 Return to practice initiatives are an important way to both expand the workforce where there is a shortfall and utilise the experience of senior-level clinicians to support workforce and service transformation. The CSP strongly supports the roll-out of the HEE return to practice initiative for physiotherapists. It is essential that the current pilot is continued to provide sustained return to practice support over time, with due flexibility for individuals to progress through their career paths and for services to draw on available workforce and skills. However, return to practice cannot provide the scale of additional physiotherapists the system needs. It is a supplement to, not an alternative for, more training places.

2.7 The CSP is concerned that recent initiatives by HEE to use the education tariff to increase the supply of nursing will not achieve this objective. It is therefore not a good use of this valuable lever to support growth. In nursing, the underlying cause of a shortfall is the difficulty to attract potential students to train and high attrition rates from courses. Using the

tariff to increase placements does not tackle these issues. Other solutions are necessary in relation to growing the nursing workforce.

2.8 With physiotherapy, there is no shortage of potential students and there are low attrition rates. The potential for growth has been held back by lack of university places, which in part is held back by lack of practice based learning opportunities for students. In this situation the education tariff could successfully act as a lever to stimulate supply.

2.9 The CSP is running a campaign targeting our members to expand and diversify practice based learning for students. This has helped to achieve the growth in physiotherapy places at universities. It has also increased the diversity of practice-based learning opportunities for physiotherapy students, including in primary care settings and the independent and voluntary sectors. We would be happy to share what we have learnt from this work with HEE and others.

2.10 Strategic collaboration between the Department of Health & Social Care and the Department for Education is essential, recognising the strong inter-dependencies between each government department's policy decisions and the risks of a lack of policy integration.

3. Do you have comments on how we ensure the system is effectively training, educating and investing in the new and current workforce?

3.1 There needs to be an investment in training of the unregistered, and registered non-medical parts of the workforce to equip them to work at the height of their capabilities, within both generalist and specialist multi-disciplinary services. Transformative roles need particular investment.

3.2 Transformation requires a shift to prevention, self-care, early intervention and rehabilitation. This will require a workforce to match this need, which has a multi-professional approach to care and the development of new or enhanced skills, and changes to old hierarchies. First contact practitioner posts in primary care are an example of this. In these posts physiotherapists are being deployed to meet population and patient needs in new ways that are more timely and effective.

3.3 There needs to be a shared approach to workforce development across the whole workforce, with the development of common language and processes. The HEE's recent report on postgraduate medical education and training highlights the level of investment made without necessarily there being confidence in the quality of the education delivered and its value and impact for meeting workforce, service and patient needs. Most of the workforce for 10 years time the existing workforce (Kings Fund 2013). It is essential then that retraining and redeveloping roles across the whole workforce. Realistically, it is difficult to see how the necessary investment in training for the non-medical workforce can take place without a review of how training resources are distributed, and how employers are currently incentivised.

Advanced practice physiotherapy roles

3.4 There is a need for investment in professional development to enable the deployment of physiotherapists with advanced practice skills as part of the GP team and in A&E departments, as a first point of contact. A priority for implementation is increasing the numbers of physiotherapists with advanced practice skills and with experience of working in a GP setting.

3.5 In the last two years, there has been the development of First Contact Physiotherapists with advanced practice skills, working within General Practice. (CSP 2017)

> In West Cheshire for example, the FCP pilot now delivers for 36 practices. Advanced practice physiotherapists see 11 000 patients per year. This is 25% of total GPs MSK caseload. There is scope to increase this.
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> - 84% patients would have been seen by the GP – value £540k pa.
> - 20% less referrals to MSK physio services – after 12% increase p/a for 5 years prior, reducing waiting times.
> - 4% less MRI imaging – saving £11495 in 1 yr – savings higher still against predicted spend (20% increase p/a for 2 years prior)
> - 5.9% less X-rays - saving £28k pa 2% less orthopaedic refs, value £70k pa.
> - 99% patients rated service good or excellent and happy to use again
> - 91% GPs rated service 8+ for over how beneficial service is to their practice with 45% scoring a 10/10

3.6 The CSP values the leadership role of Health Education England in relation to this development, which has been critical nationally and locally. This includes HEEs role in working with NHS England to support implementation of these roles in General Practice.

3.7 This development supports not only management of demand into secondary care, but key objectives for GP Forward View, including the target of 5000 clinicians in addition to GPs. The CSP believes the development of FCPs should be explicitly included in workforce strategy and planning to help reach this target.

3.8 To support registered physiotherapists working in advanced practice roles as the first point of contact, there is a need to invest in continuing professional development (CPD) to develop skills in:

- Accountability for managing high levels of complexity (including co-morbidities), risk and uncertainty
- Specific advanced practice skills such as prescribing, injecting, ordering and analysing diagnostics
- Use of assessment and diagnosis skills to provide expert advice (including self-management and return to work) and referrals.

3.9 There is the potential to use the Advanced Clinical Practice apprenticeship to enable workforce development in this area. The CSP is actively pursuing this, including to ensure education providers' responsiveness to changing workforce and service delivery needs

Physiotherapy/AHP support worker roles

3.10 There needs to be more structured development opportunities for unregistered parts of the workforce whose hands-on care and day-to-day contact with patients and their families have significantly increased in recent years. This needs to be supported. There is a significant opportunity to develop support worker roles as part of the multi-disciplinary team in primary care and public health. Priorities for CPD for support workers include:

- Physiotherapy rehabilitation and exercise
- Coaching patient self-management and behaviour change
- Community education and support for carers and volunteers
- Use of healthcare technologies.

3.11 The support worker and registered workforce are interdependent. Support workers can enable registered professionals to operate more to the top of their capabilities, and at the same time require support and supervision from registered professionals. The registered workforce has a key role to play in developing the areas of work appropriate for support workers, supervising clinical elements of work and ensuring safe delegation.

Broader skills development in the non-medical workforce

3.12 Excellent management is crucial for high performing organisations. Investment in the leadership and management skills of service managers is critical, in particular those on Agenda for Change bands 6 – 8a, or their equivalent.

3.13 A priority should be to increasing the on evaluating value and impact of services across the whole system and applying insight to lead improvement.

3.14 More opportunities for all healthcare professionals to engage in research activity as an integral part of their job roles and career development should be progressed – both within clinical and clinical academic roles. This has value for enhancing patient care, service improvement and workforce development. Currently this is common place for doctors, but not for other parts of the workforce. For physiotherapists this includes the opportunity to engage with HEE's new advanced clinical practice framework.

Multi-professional development

3.15 The CSP welcomes the development of multi-professional capability frameworks as a way of enabling a review of skill mix when developing staff, strengthening MDT working and redesigning services. While we are actively supporting their development, we have some concerns that frameworks are not being consistently developed, applied and evaluated.

3.16 Innovation can be driven by greater cross-fertilisation of expertise between disciplines and specialties. As well as cultural and service delivery changes, this requires changes in education. The work that HEE and some of the CEPNs are developing in relation to training the whole GP team is an excellent example of this. At the same time, the approach taken needs to be genuinely inclusive in taking a multi-disciplinary approach, and actively to progress the recommendations of the Roland Commission.

3.17 Professional bodies play an important role in defining multi-professional capabilities and progressing an outcomes-based approach to professional development, including through contributing to consensus-building on progressing a genuinely collaborative approach that can support skill mix review, strengthened team-working and new models of service delivery. The new multi-professional MSK first-contact practitioner framework is a good example of this.

3.18 In addition, it is essential that a genuinely collaborative, inter-professional approach is taken to exploring the development and implementation of credentialing schemes. The contribution of different professions and professional bodies needs to be recognised, such that the best elements of tried and test approaches to learning and development processes can be drawn upon to support workforce development and new models of service delivery.

Workforce development and regulation

3.19 It is essential that professional regulatory arrangements support and enable workforce development – to meet changing population, patient and service delivery needs – while obviously upholding public interest and patient safety. Any reform of professional regulation needs to avoid arrangements becoming more restrictive and cumbersome, while ensuring that professional and systems regulation more strongly align.

3.20 We would be concerned if physiotherapists in advanced practice roles were to become subject to separate regulation from other members of the profession. If advanced practitioners were required to hold dual recognition (as mooted in the recent medical associate consultation), this would undermine their accountability for how they draw on their profession-specific knowledge and skills, create confusion regarding regulatory arrangements and accountability, and work against workforce development in line with changing needs. It would also have the effect of significantly undermining the identity of

individual professions, implying that advanced practice takes practitioners away from their profession, rather than its being a natural trajectory in practising their profession.

3.21 We believe that existing forms of regulation appropriately cover advanced practice roles, with the potential for their development and refinement, subject to full appraisal and consultation. There is a clear logic to individual advanced practitioners being subject to the same regulator and regulatory requirements in enacting their role as other registrants (including in terms of working within their personal scope of practice and competence), with due responsibility and accountability for their decisions, actions and omissions. This includes in how they manage complexity, uncertainty and risk as key components of advanced practice activity.

3.22 At the same time, we recognise that there is a need to build stronger awareness, understanding and confidence in regulatory arrangements. This includes understanding how these sit with other governance requirements (including at an employer level) in relation to individuals' professional and role development. This is essential for enabling the workforce to respond to changing population/patient and service needs in flexible ways and enhance individual practitioners' knowledge, skills and professionalism.

4. What more can be done to ensure all staff, starting from the lowest paid, see a valid and attractive career in the NHS, with identifiable paths and multiple points of entry and choice?

4.1 To support transformation and improvements to the quality of patient care the health and care workforce needs to be able to work at the height of their capabilities, with clear career routes across settings and sectors.

4.2 Developing skills to undertake advanced practice roles and unregistered roles can both be part of a ladder of progression within the physiotherapy profession. Unregistered support roles also provide an entry point and way of earning an income while studying for registered roles.

4.3 The training and career progression of those support workers who don't want to become registered profession is as important as developing those who aspire to regulated status. Many employers have withdrawn funding for training and development for support staff in response to the apprenticeship levy. This risks significant staff turnover, particularly as the demographic profile of this section of the workforce becomes younger. Younger workers are increasingly valuing employers who offer development opportunities.

4.4 The CSP is keen to work with HEE to grow and develop the unregistered parts of the physiotherapy workforce, including through apprenticeships.

5. Do you have any comments on how to better ensure opportunities to; and meets the needs and aspirations of all communities in England?

5.1 Student funding is a key factor in widening participation. The additional cost to physiotherapy students, and course requirements make it very difficult for them to also undertake paid work. A review of the impact of the changes to student finance needs to be carried out to look at the impact on widening participation. Physiotherapy and other health students need additional financial support to pay for travel and, if necessary, accommodation related to placements.

5.2 Education and practice-based learning opportunities should include the role of clinicians in coaching, advising and supporting self-carers, carers and volunteers. These skills will be increasingly needed in new models of service provision, such as the Hope service (below).

The Hope Specialist Service in Grimsby demonstrates the value of this in quality service provision. The team at Hope provide rehabilitation and support for people with chronic obstructive pulmonary disease (COPD) and older people at risk of falling. The multi-disciplinary team includes physios, OTs, technical instructors, rehab assistants. It also includes 80 former patients and carers who volunteer as motivators, role models and community educators, and on the board of the fundraising arm of the social enterprise provider.

The ethos of the service is of empowering service-users and being part of the local community. They turned a run-down former medical centre that was a target for vandalism into a modern rehabilitation centre, with a gym, a garden and a café run by volunteers.

Their impact includes reduction in COPD hospitalisations, reductions in hip fractures in the local population, high success rates in volunteer led smoking cessation courses, and reduced levels of anxiety and depression among service users alongside an increase in confidence and ability to undertake daily activity. (CSP 2017)

6. What does being a modern, model employer mean to you and how can we ensure the NHS meets those ambitions?

6.1 It is welcome that the strategy recognises the importance of developing career pathways and professional development for the non-medical workforce. This needs to be broadened-out beyond nursing to all parts of the workforce. Career pathways need to be developed for physiotherapists, other allied health professionals and support workers, outside hospital settings. To deliver the workforce we need for the future recognising and properly incentivising generalism as much as specialism will be critical.

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6.2 Flexibility for employers and interest of staff need to be balanced. The CSP agrees with Simon Stevens that changes to how staff are deployed need to be ‘de-risked’ for the workforce (NHS England 2017).

6.3 Pilots of FCPs in General Practice are an example of this issue in practice. The physiotherapists in the new roles continue to be employed by the NHS provider. The physiotherapists in the new roles usually continue to be employed by the NHS provider. This provides security for the FCP and access to appropriate clinical supervision with the wider physiotherapy service.

6.4 Good employment practices and T&Cs aid recruitment and retention. All health and care employers need to be good employers. The CSP is concerned about the levels of staff reporting lower satisfaction with the quality of the work and care they are able to deliver and those feeling unwell due to work related stress (NHS staff survey 2018). There is a direct link between the quality of employment and the quality of patient care.

7. Do you have any comments on how we can ensure that our NHS staff make the greatest possible difference to delivering excellent care for people in England?

7.1 The goals of Five Year Forward View rely on the whole system becoming more preventative and more rehabilitative, with a rebalancing of resources to invest in primary care and community services. These shifts require workforce change.

7.2 This needs to include the development of new roles (such as first contact roles for advanced practice physiotherapists) and structured development opportunities for

physiotherapy/AHP support workers, who increasingly have a greater hands on role and day to day contact with patients and their families.

7.3 Involving the public and patients in workforce development initiatives is critical. There are successful initiatives regarding patient/public involvement in the design of pre-registration education programmes to learn from. Similarly, having public communication plans in place regarding new roles or deployment of roles in different ways.

8. What policy options could most effectively address the current and future challenges for the adult social care workforce?

8.1 Social care is a significant gap in the workforce strategy. Given the Ministerial announcement about the need for a new 10 year integrated health and care workforce strategy, this will also need to be addressed within *Facing the Facts*.

8.2 Convergence in working conditions is needed to support integration. As health and social care services become more integrated the differences in staffing arrangements, training and reward are likely to become barriers to closer working. This is especially an issue for the large parts of the social care sector where provisions is outside local authorities and other public agencies.

8.2 The adult social care workforce experience significantly worse conditions in relation to training, professional development, pay, pensions and security than in health. The most effective way to address the current and future challenges of the adult social care workforce is to start to level up this inequality.

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