Written evidence submitted by The Chartered Society of Physiotherapy (RTR0072)

The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for 63,000 chartered physiotherapists, physiotherapy students and physiotherapy support workers across the UK. More than eight in ten registered physiotherapists are CSP members.

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.

Working under the delegation of a registered health care professional physiotherapy support workers play a vital role as part of the physiotherapy workforce. They support people to regain their mobility after injury or illness, provide hands-on care for people with their individual and group exercise programmes, support carers and deliver education to empower people to manage their health.

Key CSP recommendations

- A fully funded workforce staffing plan with biennial independent workforce projections; Integrated Care Boards (ICBs) level workforce boards including representations from Allied Health Professions (AHPs)
- Relieve service pressures by offering an NHS Band 5 contract to all newly qualified physiotherapists, capitalising on the strong growth in physiotherapy education
- Expand the proportion of non-registered support worker roles and develop these roles to optimise their value
- Set minimum Allied Health Professions (AHP) workforce targets for the next iteration of the People Plan, for both the registered and non-registered workforce
- Support current development of AHP workforce plans at Trust and Integrated Care Systems (ICS) level and make this part of the annual cycle of workforce planning
- Deliver the Long Term Plan commitment to over 5,000 additional physiotherapists with advanced practice skills in First Contact roles to ease pressure on GPs
- Provide sustainable long term funding for continuous professional development of the AHP workforce to enable them to work to the top of their licenses, with an urgent focus on supporting transition to advanced practice roles required by the Long Term Plan, creates a career framework for physiotherapists and other AHPs that retains the workforce, creates more opportunities in the primary and community care sectors, and speeds up the time between registration and working at an advanced practice level

1. What are the main steps that must be taken to recruit extra staff that are needed across the health and social care sectors in the short, medium and long-term?

1.1 A Department of Health and Social Care commissioned study in 2015[1] on future skills and staffing against population need forecast that, by 2035, nurses, AHPs, other non-medical professionals and support workers would need to form a larger proportion of the overall health and care workforce. Enabling AHPs to operate to the full scope of their practice can relieve pressure on doctors, allowing them to focus on those patients who need medical care.

1.2 Similarly investing in rehabilitation professionals and support staff can reduce the demand for social care. This needs the expansion of professions such as physiotherapy and support for the ongoing development of the workforce. Physiotherapy has succeeded in expanding the numbers of clinicians qualifying, providing a clear opportunity to address both vacancies and growth in demand.

1.3 Existing policy commitments in the NHS Long Term Plan and subsequently can only be delivered with an increased physiotherapy workforce. This includes the policies to expand access to rehabilitation as part of respiratory, stroke, cardio and pelvic health pathways, as well as policies on primary care, urgent community response, anticipatory care and discharge to assess. Added to this is now implementation of the Long Covid plan, and clearing the backlog of elective care waiting lists[2]. The lack of workforce targets or guidance for workforce planners on the workforce needed to deliver policy commitments is holding back their implementation.

1.4 There is a healthy supply of registered physiotherapist; since 2012/13 there has been a year on year growth of registered physiotherapists. There has been a 64% increase in student intake since 2015/16. We expect that if pre-registration places remain the same then we can expect an annual growth in physiotherapists in the order of 6-7% per year over the next decade[3]. However, around a third of physiotherapy is delivered outside the NHS. In NHS England September 2019 there were 28,488 advertised vacancies. In Sept 2021 there were 99,460 vacancies[4]. For the NHS to address vacancy rates and growing demand more needs to be done to recruit newly qualified physios into the NHS and to then retain them.

1.5 The CSP believes NHS England should be capitalising on the growth of all physiotherapy graduate numbers and that not doing so is an own goal. One way to achieve this would be to offer a 5 year NHS contract to attract more newly qualified registrants into the NHS, as is being considered for nursing. This would be a measure which could be taken immediately. Ensuring access to ongoing professional development, access to flexible working and fair pay would all help attract and retain more physiotherapists within NHS services.

1.6 However, growing the registered workforce is not enough to meet increased demand and deliver policies to improve access to rehabilitation. Alongside this there needs to be an expansion in the proportion of non-registered staff - physio and rehab support workers that make up the physiotherapy workforce. This can also be done quickly providing there is also planned expansion of the registered physiotherapy workforce to ensure sufficient capacity to ensure delegation practices are safe and effective.

1.7 This will become an increasingly important issue as experienced physiotherapy support workers retire. CSP data shows that approximately 24% of the current physiotherapy support worker workforce are over 55 years of age[5].

1.8 The NHS Long Term Plan[6] highlights a need to nurture new leaders and enable capable clinicians, from every professional background, to reach the most senior levels of leadership. In the physiotherapy workforce this is not currently the case[7] and action needs to be taken by employers to ensure the proportion of the physiotherapy workforce with certain protected characteristics in senior roles should be equivalent to the proportion of those in less senior roles.

1.9 Unlike for doctors and nurses, at present in England, unlike Wales, there is no requirement to include AHP directors at board levels within trusts or ICSs. This creates a glass ceiling for physios and other AHPs and limits the input of AHPs into workforce strategy and planning at a local level.

What is the best way to ensure that current plans for recruitment, training and retention are able to adapt as models for providing future care change?

1.10 The most significant factor that must drive workforce development is the prevalence of long-term conditions 40% of people are managing a long-term condition[8] and 25 % are managing two or more, and these figures are rising. NHS services, especially those that support rehabilitation and

successful management of conditions, are traditionally organised around single episodes and events. They are also focused in and around secondary care. Responding to population needs sustainably will require new models of care and modernization, with a greater focus on secondary prevention and anticipation of needs within primary and community settings.

1,11 New models of care will require a greater proportion of registered physiotherapists to be operating at an advanced practice level in order to assess the needs of patients with multiple conditions and manage demands on the rest of the health care system, including reducing pressures on consultants and GPs.

1.12 The most pressing need for advanced clinical practice roles is in primary and community sectors. This requires the creation of a pipeline of physiotherapists from being new registrants onwards. This will support retention of the workforce in the NHS as well as shorten the timeframe from new graduate to advanced practice from 10-15 years as it is currently to 7 or 8 years.

1.13 As services become more integrated across health and social care contexts, physiotherapy graduates need to be prepared to practice safely, effectively and flexibly across sector boundaries.

1.14 Equipping the growing numbers of newly qualified physios to adapt to a system where care is provided out of hospitals needs education to evolve. Community physiotherapy and rehabilitation teams will need to take on a responsibility to provide students with relevant practice-based learning experiences (commonly known as placements) that reflects the integrated evolution of these services. Currently there is insufficient staffing to manage placement and a concentration on NHS secondary care settings. There needs to be a system wide expectation that all services will take students on placement and support education as an investment in their future workforce.

1.15 Future models of care such as the multi-condition rehabilitation approach championed by the Community Rehab Alliance are based on the use of and upskilling of non registered workers. There is a need to develop this workforce to free up registered clinicians. Funds need to be allocated for training and development for this workforce so that they can adapt and upskill. There would then be scope to develop new education and training programmes for this vital workforce as it expands.

1.16 To achieve the Long Term Plan commitment to over 5,000 additional physiotherapists with advanced practice skills in First Contact roles to ease pressure on GPs and the emerging advanced practice roles needed to deliver existing commitments needs investment in in service training. Currently, funding for ongoing training of AHPs is limited and usually short term. Unlike for medicine there is not always support for clinicians to develop through training. This needs to be addressed if AHPs are to fulfil the roles expected of them in a changing healthcare system. Sustainable long term funding for continuous professional development of the AHP workforce would enable them to work to the top of their licenses, with a focus on supporting transition to advanced practice roles required by the Long Term Plan.

2. What is the correct balance between domestic and international recruitment of health and social care workers in the short, medium and long term?

2.1 There is a limited potential for recruiting physiotherapists from overseas given the differences in education and scope in many countries, and the shortages in counties where we have traditionally recruited from including Ireland and New Zealand. 14 % of[1] overseas qualified physiotherapists make an important contribution to healthcare in the UK. They should be welcomed and supported.

[1] Exact data on foreign nationals who practice in the UK is not available as; the Home office does not separately record visas issued to physios and the regulator does not provide nationality data. Overseas qualification, overseas student status and estimates based on CSP membership are therefore the best available data.

2.2 There has long been international mobility amongst physiotherapists. This has enabled physiotherapists to work across the world and has encouraged the sharing of best practice internationally. However, it is important that current registration standards are maintained to ensure patient safety. We would, for example, be concerned if future trade deals allowed for automatic recognition of overseas qualified physiotherapists. The scope of practice for physiotherapists and level of clinical autonomy varies worldwide. For example, a UK registered physio is expected to be able to give lifesaving support for respiratory patients without supervision. Respiratory therapy is not, however, part of physiotherapy in all counties.

2.3 The CSP supports World Confederation for Physical Therapy (WCPT)) and World Health Organisation (WHO) approach which is to protect developing healthcare systems from large-scale recruitment of healthcare professionals by developed healthcare economies. the NHS in England should aim to reduce its dependence on international workforce supply by focussing on domestic supply and by creating more Band 5 roles in the NHS and then enabling them to progress.

2.4 We believe the UK has a responsibility to support physiotherapy education in developing health systems and to train overseas physiotherapists in the UK. Whilst the UK continues to rely on overseas physiotherapy staff, it is especially important that we support the development of physiotherapy internationally.

What can the Government do to make it easier for staff to be recruited from countries from which it is ethically acceptable to recruit, with trusted training programmes?

2.5 The CSP welcomes government's decision to include physiotherapists on the shortage occupation list in March 2021 [9] However, there is potential to enable overseas physiotherapists who do not meet UK registration requirements to work as support workers whilst upskilling to UK standards. This would need physio support workers to be added to the shortage occupation list.

2.6 Our members who have trained outside the UK report a barrier to working in the NHS as a chartered physiotherapist once registered is an employer requirement for previous NHS or UK experience. This results in some overseas qualified physiotherapists having to work initially as support workers despite being registered physiotherapists or overseas qualified professionals rejecting he NHS as a place to work. Removing such unnecessary criteria should be a priority for the NHS.

2.7 The CSP would wish to see more support for overseas registered physiotherapists who are UK residents, including refugees, being supported through the UK registration programme including help with return to practice placements or education to meet UK requirements. We are exploring this with HEE and other bodies.

3. What changes could be made to the initial and ongoing training of staff in the health and social care sectors in order to help increase the number of staff working in these sectors?

To what extent is there an adequate system for determining how many doctors, nurses and allied health professionals should be trained to meet long-term need?

3.1 The system for workforce planning is inadequate, particularly for AHPs for whom there is no current workforce plan or target for either NHS physiotherapy or whole system need.

3.2 Currently Health Education England have provided Trusts short term funding for AHP leaders to develop local AHP plans. This is a welcome step and long overdue. It is critical that these are implemented and made a regular part of workforce planning at Trust and ICS/People Board level.

However, the physiotherapy labour market is a UK wide one and local planning alone will not ensure enough staff are trained and recruited.

3.3 We need a fully funded workforce staffing plan with biennial independent workforce projections; Integrated Care Boards (ICBs) level workforce boards including representations from Allied Health Professions (AHPs).

Do curriculums for training doctors, nurses and allied health professionals need updating to ensure that staff have the right mix of skills?

3.4 The CSP is currently leading a Physiotherapy Education Review in order to refresh pre-registration physiotherapy education guidance and its appropriateness to prepare a physiotherapy workforce fit for the future. The impact of the COVID-19 pandemic on physiotherapy education has accelerated digital and simulated learning as well as innovation in practice-based learning . The review is an opportunity to evaluate these changes; findings of the review will be published in March 2022.

3.5 Apprenticeships relating to the development of both the non registered workforce and at post registration level are most useful when they are designed to be multidisciplinary and multi professional, with profession specific modules and options. This is because of the very real issues of economies of scale and viability of provision. It is also in line with the direction of travel in terms of how population and patient needs are met, service delivery models and individuals' preparation for job roles. This is currently not how many apprenticeship programmes are designed.

3.6 The Physiotherapist Degree Apprenticeship provides a useful additional route for individuals, including existing support workers, to enter the physiotherapy profession. Providing that it is delivered in ways that uphold the high education and professional standards of the physiotherapy profession this has the potential to contribute to workforce growth and widen participation to the profession and improve the diversity of the registered workforce. This is an area of growth within pre-registration education delivery. There are currently eight BSc degree apprenticeship programmes with a total of 115 enrolled apprentices.

Should the cap on the number of medical places offered to international and domestic students be removed?

3.7 The CSP would support a properly funded expansion of medical training. However unless adequate funding is provided there is a significant risk that removing the cap on medical places could lead to funding cuts to the already underfunded provision for AHP and nursing training.

4. What are the principal factors driving staff to leave the health and social care sectors and what could be done to address them?

4.1 Most (almost 60%) of CSP members employed by the NHS in England, Wales and Northern Ireland report that they have considered or pursued non-NHS employment over the last 12 months, and 20 % have actively sought to move out of the NHS[10]. For physiotherapists there are a range of alternative employment opportunities with around a third of CSP members working primarily outside the NHS including for; large independent providers, occupational health services, hospices, charities, social care or as self-employed or private practitioners.

4.2 Most recently it has been reported that more than 27,000 people voluntarily resigned from the NHS from July to September last year, the highest number on record[11]. Pay and other financial considerations rank highly among the primary motivations causing CSP members to consider working outside the NHS. Among those respondents that stated they had at least considered non-

NHS employment or early retirement, 66 % indicated the value of their take home pay factored into their thinking. Issues with workloads and workplace stress – both impacted by understaffing and poor staff retention – also featured highly[12].

4.3 NHSE data on retention suggests that around 7% of physiotherapists who work for the NHS leave to carry on practicing in other sectors and that for most of these it is of clinicians early in their career (aged 25-29). The CSP believes that this is due to a lack of opportunities, inflexibility in working arrangements, lack of training opportunities, frustration at rationing of care and a lack of progression opportunities. In some cases the experience of racism, ableism, sexism or homophobia are also factors[13].

4.4 The CSP supports greater flexible working which would benefit staff health, wellbeing and stress levels. We strongly support the new flexible working arrangements that have been agreed for the NHS contract from 2021. This needs to be followed through by action at Trust level to bring their policies and guidance documents in line with the new national arrangements.

4.5 We also support measures to address racism and other forms of discrimination and disadvantage faced by some of our members within the NHS.

5. Are there specific roles and/or geographical locations, where recruitment and retention are a particular problem and what could be done to address this?

5.1 First Contact Practitioners (FCPs) have proven to be safe and effective in providing the first line of clinical input for people with MSK issues in primary care, reducing demand on GPs and secondary care.

5.2 Currently most FCPs are covering areas of 30-50k populations. Stretching coverage to this extent reduces the benefit to individual GPs and hampers successful implementation and embeddedness in GP services. To achieve the full value from FCPs their needs to be 1 FCP per 10 000 population, to manage approximately half of all MSK consultations in General Practice. This would require approximately 4000 additional FCPs.

5.3 It is clear to the CSP that the main barrier to increasing FCP numbers in primary care is insufficient investment to upskill more physiotherapists to demonstrate that they meet the event advanced practice standard and to backfill vacancies created as staff do become FCPs.

5.4 In some areas services are also experiencing difficulties recruiting established (Band 6) physiotherapists. The CSP believes that this is largely due to failure to establish a necessary pipeline by investing in accelerating development of longer standing Band 5s and recruiting more newly qualified staff than previously to ensure backfill for the resulting B5 vacancies which accelerated development to B6 will create.

5.5 Grow your own strategies that attract, retain and develop the physiotherapy workforce from registration or encourage support staff into pre-registration apprenticeships, should be adopted.

5.6 More broadly the CSP believes NHS Trusts in these areas should operate as anchor institutions and work in collaboration with local communities, schools, FE colleges and HEIs to attract and train local people into a career in health and social care and support ongoing career progression. This is particularly critical for non-registered roles. In addition, while there is no shortage of people wanting to train to become physiotherapists nation-wide, NHS Trusts playing this role would support recruitment in areas of shortage and help ensure that the profession reflects the diversity of the populations it services.

6. What should be in the next iteration of the NHS People Plan, and a people plan for the social care sector, to address the recruitment, training and retention of staff?

6.1 There are national targets for nurses and doctors but no targets for growing the AHP workforce; AHP targets are urgently needed. This includes physiotherapy, where (as described in previous sections) there is strong supply, a clear need, but not yet a translation into staffing numbers. We urgently need to set minimum AHP workforce targets for the next iteration of the People Plan, for both the registered and non-registered workforce.

6.2 A national AHP workforce target and plan should be aggregated from local (Trust and ICS level) AHP workforce plans that are currently in development, but triangulated against known system commitment such as the Long Term Plan. Unless the national direction of travel is factored into workforce planning we will continue to underestimate demand as local services ted to focus on historic service models rather than transformational requirements. Targets will also need to factor in non-NHS workforce demand and not assume 100% of newly qualified clinicians will work in the NHS.

6.3 There is an urgent need to create a career pathway for both registered and non-registered physiotherapy staff. This would create the pipeline for roles required by the system which is currently missing as well as optimising the value of the workforce. It would also reduce the high volume of registered physiotherapists who leave the NHS in the early phase of their career due to a lack of opportunities to progress.

7. To what extent are the contractual and employment models used in the health and social care sectors fit for the purpose of attracting, training and retaining the right numbers of staff with the right skills?

7.1 The CSP strongly supports moving more services from hospital to community settings where this supports better and less inequitable health outcomes for people.

7.2 Decisions about moving services out of hospital needs to be driven by the evidence of what is best for individual patients/service users. This includes the implementation of policies to support patient flow, such as 'discharge to assess' in England and the movement out into the community of rehab services currently provided in hospital outpatients.

7.3 When changes to service delivery are being undertaken, there must always be a meaningful consultation process with all groups of staff affected by the proposals.

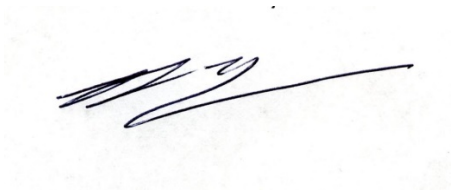
8. What is the role of integrated care systems in ensuring that local health and care organisations attract and retain staff with the right mix of skills?

8.1 ICSs provide an important opportunity to improve workforce planning and development. We believe every ICS should have a workforce board to plan workforce needs across the local health and care system, including non NHS demands. Workforce Boards should include representation of the professions and unions as well as all sectors of health and care.

8.2 There are some specific areas of integration where there is a particular need for more joined up approaches. The anticipated increase in demand for rehabilitation to manage long-term conditions means that workforce capacity to deliver rehabilitation must increase. The WHO has recognised this as a global issue[14] and in England there are currently significant areas of unmet need.

8.2 Rehabilitation is a critical element of many different condition pathways, with services in multiple sectors and settings and critical to patient flow. Currently it is largely considered in condition

specific silos and requires modernisation. Doing this requires a whole system, integrated approach. As a result, there is no joined up approach to defining, recruiting and developing the rehabilitation workforce across the multiple providers, from multiple sectors involved. Potentially ICSs could provide a vehicle for greater joint planning and development of this key workforce in different localities or areas.



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For further information on anything contained in this response or any aspect of the Chartered Society of Physiotherapy's work, please contact:

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