Long Term Plan Enablers - Workforce
Response from the Chartered Society of Physiotherapy (CSP)

1.	**What is the size and shape of the workforce that we need over the next ten years to help deliver the improvements in the services we would like to see?**

Changing profile of the workforce

1.1 Transforming the system to be more rehabilitative, preventative and empowering of patients and communities is the only realistic way to meet population need. In spite of a growing consensus on this issue, this shift has not so far happened.

1.2 Changing the profile of the workforce is an essential element of this. Work commissioned by the Department of Health from the Centre for Workforce Intelligence, which forecast future skills and staffing needs against population trends, has shown that by 2035 36% more hours of care will be required from the health and care workforce to meet the increase in demand created by growth in long-term physical and mental health conditions.(1)

1.3 This body of work suggests growth is required across all professions, but with the most significant growth among the nursing, physiotherapy and other allied health professions workforce. While growth is required across the workforce, within this the greatest growth needs to be of the non-registered workforce (support workers and health care assistants).

1.4 It is this pattern of growth that will make it feasible for rehabilitation services to be developed to meet population need and transform the system. This would be a significant change in the pattern of growth in the paid health and care workforce compared with the last two decades (of the 1 million additional staff created between 1996 and 2013, 60% were doctors).(1) This change requires adjustments in how the workforce is planned and trained (see 2.8-2.9)

Using the growing registered physiotherapist workforce

1.5 Of the 43,273 registered physiotherapists in England, c. 10k are bands 7 or 8a - These practitioners have advanced practice skills, underpinned by Master's qualifications or equivalent learning, and the capacity to manage complexity, risk and uncertainty.(2) CSP membership figures indicate that 60% work directly for the NHS, and 21% work for private providers or private practice. The remaining 19% - beyond NHS and private practice - is a mix of physiotherapists working in other parts of the public sector, the independent and third sectors and universities. A substantial proportion of those employed in the independent sector are primarily providing NHS services. The ongoing failure to take account of this has been a weakness of workforce planning in England to date.

1.6 For several years there has been a shortfall in the supply of physiotherapists. This is caused by a shortage of university places. This in turn was caused by a combination of insufficient commissions and the bursary system providing insufficient revenue for universities to expand provision to meet the demand.

The UK has a lower number of physiotherapists than most other European countries per head of population. Denmark has 3 times the number of physiotherapists per head of population than the UK. Older people in Denmark living with frailty, regardless of their diagnosis, will generally only need to spend 2 days in hospital and then discharged with a care package and a rehab plan. Anyone applying for social care will be offered rehab first to see if they can postpone needing the extra help. In most parts of Denmark fewer than 2% of the 85's and over live in institutional care, compared to an average of 15-20% in the UK.
Eurostat: Statistics Explained. Practising physiotherapists, 2010 and 2015
Eurostat: Statistics Explained. Very elderly population aged 85 years and over living in an institutional household, by NUTS level 2 region, 2011 (% share of very elderly population)

1.7 However, the registered physiotherapy workforce is now going through a period of expansion. Since the 2015 Comprehensive Spending Review that announced the changes to education funding, there has been an increase in student places of 41.5% (34% increase across the UK). This expansion needs to be supported and utilised in the transformation of rehabilitation pathways and primary care.

More but not more of the same – new roles and skill mix

1.8 Achieving the transformation required, more physiotherapy staff and other rehabilitation professions need to be deployed in the community, in far more integrated community rehabilitation and frailty services and using different models of care and service delivery.

1.9 There is growing awareness of the benefits of organising more services to respond to patients' needs and symptoms, not specific conditions, and a holistic assessment of a patient's mental and physical rehabilitation needs.[3] Currently services are fragmented, not standardised and often operating in condition-specific silos.

1.10 The CSP believes rehabilitation pathways need to be redesigned to take much greater account of the commonality of symptoms across conditions, the interventions to address these and the number of patients with multiple conditions. For example, services could start to be organised around patient symptoms such as breathlessness, pain, muscle weakness/ deconditioning, fatigue, depression and anxiety. This has the potential to improve services and to make the best use of the resources that exist.

1.11 Physiotherapists in first contact practitioner roles in primary care, while focused on MSK, are seeing patients who will have a range of undifferentiated health issues, and need to be able to provide advice, signpost and refer, and spot red flags for patients visiting their General Practice.

1.12 Across all parts of the physiotherapy workforce, there will need to be a greater breadth of expertise and experience of supporting people with multiple long term conditions with a range of symptoms.

1.13 A greater proportion of physiotherapy and other non-medical professions need to be working at an advanced practice level. For example, physiotherapists in FCP roles in primary care and in emergency settings are taking on some tasks that might previously have been performed by doctors. This requires the development of capabilities to manage higher levels of complexity and risk, in addition to qualified skills such as medicines prescribing, ordering and analysing x-rays and scans, and providing injection therapy.

1.14 Physiotherapy and AHP support worker roles are increasingly taking on greater degrees of responsibility for hands on patient care and exercise classes. These higher level support worker roles need to be invested in, recognised and standardised in line with the Nurse Associate role, with the necessary input from all the relevant professional bodies.

1.15 Non-medical clinical leadership roles, such as specialist leads within acute departments and Community Matrons, will continue to grow in importance to support care planning and case-load management. While traditionally these sorts of roles are filled by nurses, in many circumstances the capabilities required fit that of an advanced practice physiotherapist or other allied health professional. To make the best use of the skills and expertise across the workforce, all job roles like these need to be updated so that they are explicitly based on capabilities (such as the Advanced Clinical Practice Framework) and the needs of the service, and not by profession.

1.16 Physiotherapy and AHP support worker roles are increasingly taking on greater degrees of responsibility for hands on patient care and exercise classes for patients who are frail, need support to manage a long term condition, or who need rehabilitation following an acute episode. This trend will need to continue to increase capacity to meet population need. This will require a growth in support worker numbers, and a larger proportion of these need to be higher level support worker roles. It is also important that plans do not conflate the roles of non-regulated staff providing care and those providing rehabilitation. These are distinct roles that require different skills and capabilities.

2. How should we support staff to deliver the changes and ensure the NHS can attract and retain the staff we need?

Attracting and retaining registered physiotherapists to work in primary and community settings

2.1 There is no shortage of people wanting to join the physiotherapy profession, with high competition for university places. Drop-out rates from education and the profession are very low. The attrition rate for all physiotherapy students in 2016/17 was 1.9% (for nursing it is around 15%)[4], meaning that almost all individuals who embark on physiotherapy education finish the course, qualify and practice.

2.2 To maximise the potential for the physiotherapy workforce to be a workforce solution, including moving larger parts of the workforce within the community and primary care sectors there needs to be investment in training and development.

2.3 Traditionally, most advanced practice roles for physiotherapy have been concentrated in acute care, and in particular the orthopaedic and rheumatism departments in hospitals. This has perpetuated a professional culture – found across all health professions - that tends to view community-based roles as lower in status than those based within a hospital setting. This needs to change if we want the system to be better at supporting better outcomes for people with respiratory and cardiovascular diseases, and reduce the demand on the acute sector as a result.

2.4 The existing physiotherapy workforce need to be able to develop the skills and experience to take up new roles in community and primary care, including the first contact roles described above. Areas for skills development are assessment and diagnosis skills to provide expert advice, use of healthcare technologies, and evaluating the value and impact of services to support service improvement.

2.5 Roles should be developed in line with the capabilities that the population and system needs, rather than along professional lines. So, the FCP roles in primary care are mostly physiotherapists, but can could be delivered by other professionals who can meet the requirements of the MSK FCP capability framework. More professional development opportunities also needs to start to be delivered on a multi-professional basis, with a focus on ensuring that investment in workforce development is more equitable such that patient and service delivery needs are met. A meaningful approach to ensuring workforce supply matches workforce demand can only be progressed only if workforce planning and investment is predicated on population, patient and service delivery needs and looks at the workforce as a whole, rather than treating parts of the workforce differently or in isolation

Develop more support workers as part of the physiotherapy workforce

2.6 Far more is needed to develop the unregistered part of the physiotherapy support workforce, and for this to expand alongside the expansion of the registered physiotherapy workforce. Currently there is a lack of common standards, particularly across the higher level (band 4 and above) support worker roles, including Assistant Practitioners.

2.7 Insight work carried out by the CSP in 2017/18 shows that physiotherapy support workers (defined as undertaking physio duties under the oversight of a registered health or care professional are taking on greater levels of responsibility and developing higher-level skills in educating and advising others, and that this is welcomed by both support workers and registered physiotherapists. It also shows that physiotherapy support workers want greater recognition for progression and CPD opportunities. Supporting this is a priority for the CSP.[5, 6]

2.8 Higher level support worker roles need to be invested in, recognised and standardised in line with the Nurse Associate role, with the necessary input from all the relevant professional bodies and the Professional Standards Authority, and the CSP is currently reviewing the options for CSP policy and future role in this.

2.9 For support workers this requires the development of skills relating to patient self-management and behaviour change. For registered physiotherapists and other AHPS it requires the development of skills in delegating and overseeing activities performed by others.

Making funding for training and development more equally distributed

2.10 For changes to the profile of the workforce to happen there needs to be a major rebalancing of investment in the training and development of the existing workforce. 60% of the NHS's training budget is spent on just 12% of the workforce (doctors) and there is no national training budget for support workers. Cuts to CPD budgets have been a backwards step that needs to be rectified. Employers' investment in skills development via their use of the apprenticeship levy should not be confused with investment in CPD; the two are fundamentally different and meet different workforce development needs

2.11 The inequities of approach, infrastructure and funding for workforce development across professions/all parts of the workforce and at all levels must be addressed – the Kings Fund paper in 2014 highlighted the gross inequities in funding, that have probably now been exacerbated by subsequent public funding decisions.

2.12 More specifically, the 10 year plan must actively look at the perverse incentives wrapped up in the funding for employers attached to postgraduate medical education and training. This is not an issue that can be avoided for much longer.

2.13 The CSP is concerned that the current major workforce development initiatives (nurse associate roles, apprenticeships, education tariff) are overly focussed on solving nurse supply issues.

2.14 Of course the nurse staffing crisis needs to be resolved. However, these initiatives will not address the underlying issues for nursing (lack of people wanting to study to be nurses, high attrition rates, poor retention in the workforce). With this misdirection of resources there is a risk of an unintended failure to invest in the training and development of the physio staff where there is growth and potential to be deployed in new ways.

2.15 Similarly, introducing staffing levels legislation will do nothing to resolve the difficulties in part of the workforce to recruit and retain staff, and risk introducing new perverse incentives and distractions.

2.16 In the next 10 years we need to be looking at workforce supply and demand across health and social care (all sectors) on a UK- wide basis to achieve a strategic approach. Workforce planning needs to be based on a clearer understanding of workforce pipelines and the dynamics in workforce supply at a national, regional and local level (informed by what's state-driven, employer-driven, university-driven, what is down to individual motivation, etc.).

Sharing expertise

2.17 All health and social care professionals need to be working to the goal of supporting patients to become and remain mobile. Evidence shows that early mobilisation in older patients in hospitals reduces the length of stay by reducing deconditioning. The physiotherapy workforce has an important part to play in sharing expertise to build confidence and awareness of their colleagues across the health and care system.

2.18 Because of the fragmented nature of provision, models of integration so far have not focused sufficiently on sharing teams and skill operationally across boundaries in a 'place-based' approach. This is one of the areas that Integrated Care Systems could play a role in redressing.

3. What more could the NHS do to boost staff health and well-being and demonstrate how employers can help create a healthier country?

3.1 Many parts of the health and care system are seriously under resourced. There has been a year on year disinvestment from community services, which is where most rehabilitation services sit within the system. Over half of all community providers in a survey by NHS Providers said that this year they were managing real term cuts to their budgets.

3.2 As well as impacting on people's health and disability, and driving demand to the most expensive parts of the health and care system, under-resourcing is leading to significant stress in the workforce. A recent survey by the CSP of its members found that 84% of physio staff are stressed at work, and 3/4s of those who work for the NHS do unpaid overtime, because of work demands, and 4 out of 10 of them don't have the equipment, resources or supplies they need to do their jobs.

3.3 Musculoskeletal health issues are the second biggest cause of sickness absence, and is linked with stress and depression, which is the biggest cause. All NHS employers should be providing direct access to occupational physiotherapy for their employees who have MSK health issues. This is proven to reduce sickness absence.

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