Life Long Loans
Department for Education consultation
Chartered Society of Physiotherapy response

About the Chartered Society of Physiotherapy (CSP)

The CSP is the professional, educational and trade union body for the UK's 63,000 chartered physiotherapists, physiotherapy students and support workers, representing 81% of registered physiotherapists.

All registered physiotherapists are educated to degree level, with a significant minority educated to post degree level. Physiotherapy support workers work under the delegation and supervision of statutory registered healthcare professionals, including physiotherapists. They do not hold a professional registration but have relevant qualifications at level 2, 3, 4 and 5 that enable them to work safely and effectively in their roles.

Key recommendations:

- Partnership working between Education providers for all health and care courses and local health care employers should be strengthened to ensure learners are adequately prepared for a career in healthcare.
- Aligned with this, provision funded by LLE must be driven by national standards and expectations set by independent bodies such as regulators or professional bodies.
- The Government must ensure that the LLE doesn't have the unintended consequence of reducing employer support for Apprenticeships.
- All four year physiotherapy and health care programmes, including physiotherapy, must be included for LLE funding. This must include the level 7 pre-registration programmes that are currently funded through HESF.
- With the introduction of the LLE, it is essential that pre-registration healthcare programmes continue to be funded for their entirety, not modular components, to avoid compromising the already high quality of the provision, with implications for patient care.

1. How can we best ensure that, compared to the current student finance system, the LLE will better support learners to train, retrain or upskill throughout their lifetime?

1.1 Physiotherapy /allied health profession (AHP) support workers play a crucial role in the physiotherapy workforce, providing high quality patient care and releasing capacity of registered staff. As well as an essential role in itself, support workers are an important supply route to the profession. A significant proportion of registered physiotherapists were originally in Support Worker roles, and in 2019 a large survey of physiotherapy support workers showed a third aspired to become registered physiotherapists. The training and development of physiotherapy /AHP support workers is a priority for the health system, being progressed through the Health Education England Support Worker Optimisation Programme.

1.2 Improved access to education at levels 4-5 that the LLE affords will likely stimulate expansion of courses aimed at healthcare support workers or those seeking to become a support worker.

1.3 While this is welcome, there is a risk that without a means of quality control, providers will rush to meet the market. This could result in the very thing that the Government says it

wants to reduce – the spread of courses that don't provide the knowledge and skills local healthcare employers need, or enable leaners to succeed properly.

1.4 It is essential that the Government doesn't allow this to happen, and that providers and local employers are required to work together in partnership to deliver strong outcomes for learners as well as deliver value for money. This provision must not only focus on local need but be in keeping with national workforce needs.

1.5 Established apprenticeships must remain the key route for support workers to progress in their careers, paid for from the employer levy (see 5A.2).

1.6 Given that healthcare professions are mandated by the regulator to learn throughout the lifetime of their career, clarity is needed on whether the LLE could be drawn down by registered physiotherapists to pay for training that would contribute to advanced level practice, such as using population health data or prescribing medicines. The CSP would urge this to be considered and funding available be increased to recognise that a model of 3+1 would only leave those learners with one year's worth of funding

1.7 All healthcare pre-registration programmes that are currently funded through the Education and Skills Funding Agency must continue to be funded, including those at level 7. As we have already successfully argued to secure that funding any removal of this risks decimated workforce supply chain overnight. Just under 40% of the physiotherapy pre-registration intake is achieved through this route each year.

2. What barriers might learners face in accessing/drawing on their LLE and how could these barriers be overcome?

2.1 A full EIA should be undertaken.

3. What information and guidance should be displayed in a lifelong learning account to support learners to understand their options for using their LLE?

3.1 The different career destinations and career pathways available to them.

3.2 The different types of training that the LLE be used to pay for. This should include clear information on where it would not be appropriate to accrue a selection of modules explicitly designed to be part of a pre-registration course that leads to registration with a healthcare regulator.

3.3 It should also indicate where an Apprenticeship, paid for by the employer levy, would be an alternative (see 5A.2).

4. How can we best ensure that the LLE will enable learners to access technical as well as academic courses at levels 4 to 6?

4.1 See 5A.2 – to not be in competition with, or seek to replace other routes that might offer learners more financial security

5A How can we best ensure that the LLE will encourage FE and HE providers across the country to offer provision that closes the current skills gap and supports future upskilling?

5A.1 The LLE proposals for levels 4-6 provide greater options for existing support workers, particularly those who may want to pursue different careers in healthcare (e.g. operational management).

5A.2 However, apprenticeships remain the key route for support workers to progress in their careers. The LLE should not affect apprenticeships, as this is supported through the employer levy. However, there may be unintended consequences for existing support workers seeking to progress. Employers may be less inclined to support apprenticeships at levels 4-6 given there will be an alternative option for learners at these levels. If this happened it would impact detrimentally on support workers who can least afford the time away from work or commitment to student debt of the LLE route. Contrary to the ambitions of the LLE this could inadvertently preclude support workers from accessing further/higher education and career progression. The Government needs to make this clear to employers.

5B. How can we facilitate collaboration between FE and HE providers and employers, to ensure that provision keeps up with industry developments?

5B.1 Regional education/employer consortium. For health and care, this could be through Integrated Care System People Boards and AHP Councils. Where such structures exist between HE providers and their strategic employer partners there is strong evidence that what is developed is more industry relevant.

5B. 2 Whatever the mechanism, the process must ensure that an equal partnership is established. Solely employer-driven provision runs the risk of making demands that are too niche or local to be of benefit to the national workforce. To do otherwise, risks stifling innovation and challenge and can encourage poor practice. Poor practice proliferating within health and care carries significant risk of harm to patients.

5B. 3 Linked to this, provision must be driven by national standards and expectations set by independent bodies such as regulators or professional bodies. This providers learners and the government with the assurance that standards are being driven up and guards against cost cutting exercises that put at risk the quality of experience.

5C. How can we help FE and HE providers to provide modules and courses that offer real value to employers and improve employment prospects for learners?

5C.1 Ensure that the already-established and proven mechanism for employers to feed into programme design and ongoing quality assurance on a rolling/annual basis within healthcare pre-registration programmes becomes the norm across HE and FE provision across the board.

5D. How can providers support and facilitate learners gaining qualifications through modular study?

5D.1 Where modules do not form part of a programme of study leading to a regulated professional qualification (such as healthcare), providers will need to ensure coherence between modules to enable a clear and relevant career journey. This will need to be done in partnership with professional bodies and regulators such as HCPC and NMC.

6. Do you think the move to the LLE will have any particular impacts on people with protected characteristics? If so, which groups and in what ways? Your answer could include information about both the potential challenges and the positive equality outcomes of this policy

6.1 If the move to LLE resulted in employers being less willing to enable Support Workers to take up Apprenticeships it would impact most detrimentally on those who can least afford the time off and expense of the LLE route or for traditional Higher Education routes to degrees. This includes Support Workers with caring responsibilities. See 5A.2

6.2 Similarly if healthcare pre-registration programmes are not protected/prioritised within this new funding stream, we risk a workforce that is not representative of the population of the

UK. Physiotherapy has worked hard to widen access and currently has a student population that is in line with the last census data. We would therefore welcome the suggestion to automatically roll healthcare courses into these new funding arrangements.

7. What barriers might learners with protected characteristics face in accessing/drawing on their LLE and how could these be overcome? Your answer here could include previous consideration of an alternative student finance product for students whose faith has resulted in concerns about traditional loans.

7.1 No comment

8. Should all level 4 to 6 courses which are currently designated for HESF funding be treated as automatically in scope for the LLE? If not, why not, and what additional criteria for inclusion should be considered?

8.1 Yes. See 6.2.

9. Specifically, do you think that the following courses, which currently attract HESF, should be incorporated into the LLE, under the same repayment terms as other provision (i.e. fee loans count towards an individual's four-year fee entitlement)?
o A foundation year integrated into a degree course
o PGCEs
o Integrated Masters (3 years undergraduate plus 1 year Masters)
If not, please explain why?

9.1 Yes. See 6.2

10. What arrangements should be made under the LLE for courses which are over four years and are currently eligible for student finance – including medicine, dentistry and architecture?

10.1 These should also be included and extended to include all healthcare programmes. This would enable pre-registration doctorate routes within physiotherapy to be funded. Highly skilled, evidence based healthcare is an imperative in order to deliver a world-class healthcare system.

11. We are proposing that all HTQs should be in scope of the LLE. Should approval as an HTQ be the sole route for qualifications that are ALL-funded to become eligible for the LLE? If not, why not, and what alternative route(s) would be appropriate? Please include detail on the process and eligibility criteria that would be used in any alternative route.

11.1 No comment

12. In particular, how could employer-relevance be tested as a basis for LLE eligibility?

12.1 We would suggest rather for healthcare courses that independently set national standards are utilised for this purpose. It is essential for a workforce such as health to have a skillset that is nationally transferable providing agility and a wide pool of talent for employers to select from. It also enable learners to have confidence that what they are studying caries relevance throughout the sector.

13. We are aware that some courses (e.g. medical degree courses, some ALLfunded courses) are not currently structured around individual credit-bearing modules. Should such courses be excluded from any form of modular funding, and if so on what grounds and criteria?

13.1 No. They must continue to be included and the system need to take account of and allow for these anomalies. Pre-registration healthcare programmes including physiotherapy make use of non-credit bearing but mandatory components to enable the breadth and depth required of a newly qualified competent practitioner. To not take account of these needs runs the risk of deskilling a workforce and lowering the quality, which is the very opposite of what the LLE is seeking to achieve.

13.2 With overall attrition on physiotherapy courses under 3%, and employment data showing a workforce supply that is starting to keep pace with demand, any change to this would be detrimental to employers and to patients on the receiving end of the care.

14. We are seeking views on whether to set a minimum amount per funding application equivalent to 30 credits. This is not a minimum module size, as smaller modules could be "bundled" together to meet the minimum application amount. What are your views on this proposal?

14.1 Again, exceptions must be made for healthcare programmes.

15. Which (if any) courses should be funded per-academic year (i.e. using the same basis as the current-HESF-system), and which courses should be funded according to the number of credits in the course?

15.1 Healthcare programmes must retain their current funding model and be funded for their entirety, not modular components. With exceptions made for funding, support resit opportunities. Again, this risks compromising the quality of provision.

16. Do you/does your provider currently use a credit framework or follow credit rules, and if so which framework or rules do you/they use? (e.g. OfS credit table, Ofqual credit conditions).

16.1 No comment.

17. In brief, what internal processes do you/they have to ensure compliance with the framework or rules?

17.1 No comment.

18. What impact could modular study have on study mobility across the UK?

18.1 Unless distance learning is brought into the criteria then the potential benefit to the non-registered healthcare workforce is limited. The consultation document identifies that finances are a barrier to study and retraining. Those seeking level 4 or 5 training are likely to have complicating factors meaning that they aren't mobile. They therefore won't be able to move in order to undertake a module delivered in another part of the country or across the four countries. In the CSPs opinion, it is not realistic to expect student mobility at this scale.

19. How can the LLE promote and encourage flexible study across England, Scotland, Wales, and Northern Ireland?

19.1 Scotland has a different level/credit framework known as the Scottish credit and qualifications framework. Levels 4-6 are equivalent to 8-10 in the Scottish framework. Learners and employers will therefore need clear accessible information to understand the equivalence.

19.2 Given that funding structures and employment opportunities are not congruent or open to all across the four countries, we see no way for the LLE to encourage flexible study across

the four nations. The Welsh bursary and streamlining process for pre-registration healthcare programmes would mean that the LLE would be unable to achieve its aims.

20. What should be the most important considerations when determining how the lifetime entitlement will work?

20.1 There must be exemptions in place for healthcare programmes enabling them to be studied as a whole and within a set-time frame. Physiotherapy ad other healthcare courses require learners to complete their studies within a maximum period of six years (for BSc) and for an MSc (Pre-registration) within four. This ensures a high quality learner experience and currency of students' learning, ensuring that they are industry ready.

21. What, if any, age-related restrictions should be in place for the LLE that would impact on an individual's ability to access their loan entitlement?

21.1 None. Lifelong learning should be just that. Age restrictions on retraining are discriminatory and should not be applied.

22. We propose that we only fund individuals taking modules that are derived from a full course. Do you think that there should be restrictions in place so that borrowers should not be able to use their whole entitlement on a successful of individual modules which are not on track to a full qualification? We would welcome your views on what these restrictions should be.

22.1 It is imperative that this is in place for pre-registration healthcare modules and that additionally it should be clear to learners that simply by studying a number of modules equating to 360 credits from a number of different provides will not be considered sufficient to secure employment as a physiotherapist. Learners must be aware that they will need to study a series of sequential and interconnected modules from one provider in order to be deemed safe, competent and able to meet the regulatory requirements for entry into the profession.

22.2 However for those working within healthcare as a support worker, or studying to further their career once qualified then no to place such a restriction may hinder career progression, particularly if the learner is looking to broaden or change focus. It may then be more than appropriate to undertake a series of discrete and unconnected modules.

23. In a system where modularised study is widespread, how we can we ensure that leaners and employers understand what programmes of study deliver the skills that employers need?

23.1 See 5c.1

24. When considering restrictions by level and subject, how could the government ensure that the LLE is used for high-value learning that meets the needs of employers and the economy??

24.1 Continue to fund support pre-registration healthcare provision and ensure that whatever is introduced makes allowance for this type of provision. They are already proven to be high quality with low attrition (3% attrition of first years 2019/2) and high success rate (in 2020 50% graduates were awarded first class degrees, and 40% awarded 2:1).

25. Are there other restrictions we should consider on the use individuals can make of their entitlement??

25.1 No comment.

26. Do you think a future system should include a facility for provider-based bursaries, which providers allocate directly to students? ,

26.1 No if the purpose is for this to be student-led and owned it runs contrary to your ambitions.

27. Should maintenance support, like fees, be proportional, so that e.g. modules which amount to one-quarter of a full-time year of study carry an entitlement to onequarter of the maintenance support that the latter does?

27.1 This should be assessed on an individual basis based on needs/circumstance.

28. Are there courses or circumstances for which maintenance should not be offered (e.g. where students are studying below a certain level of intensity)

28.1 No.

29. Currently means-tested elements of the maintenance system relate to family income. Should this be reconceptualised for a system with more adult participation, and if so, how

29.1 Yes, particularly if you are looking to encourage retraining.

30. To what extent do you think maintenance support would be a consideration for learner access to, and progression through, LLE funded courses?

30.1 No comment.

31. Do you think a maintenance offer should differ by course type, mode of study (e.g. part-time), or learner circumstances such as age, income, or caring responsibilities?

31.1 Pre-registration healthcare courses should attract a higher offer in recognition of the fact that there are higher costs associated with studying on them – uniforms, DBS clearance, occupational health requirements and cost associated with placement travel for example. Caring responsibilities, income etc should be taken into account to support equity of access.

32. How can we support flexibility whilst maintaining high quality provision through the introduction of the LLE??

32.1 No comment.

33. How should the approach to quality change to support the introduction of the LLE?

33.1 By seeking to apply what works successfully in disciplines within healthcare such as physiotherapy across all disciplines.

34. What, if any, regulatory changes might be needed to support a modular system?

34.1 If the suggested exemptions for pre-registration courses are applied then regulatory change should not be required. We would not support changes that required regulatory change. A focus on quality assured outcomes based whole course approval safeguards patients, delivers for employers, meets national and local workforce needs and is delivered cost-effectively for the taxpayer. Any change that destabilises this successful model within healthcare should be avoided.

35. Are there opportunities to simplify the regulatory regimes that will operate under the LLE

35.1 No comment.

36. How should government look to facilitate new and innovative provision while supporting high quality provision?

36.1 Learn from healthcare pre-registration quality assurance mechanisms.

37 Specifically, we welcome views on how quality assessment and regulation could best work for level 4 and 5 technical education within the wider LLE context

37.1 Look at models in existence at level 6 and emulate them. The key to driving provision is a light touch and outcomes-based approach. Increasing funding available for education providers at institutional level to provide high quality pastoral, academic and support services will be critical in quality improvement. If learning is to become wholly modular then learners access and support to these services may become fragmented or be compromised by cuts to these services due to loss of income (particularly if as you propose to mandate the cost of 30 credit modules throughout the sector). Due recognition needs to be given to the wrap around services mentioned about in learners achieving academic success. Even more so for those from disadvantaged backgrounds.

38. What arrangements should be made under the LLE for courses which are over four years and are currently eligible for student finance – including medicine, dentistry and architecture?

38.1 Retain the funding and make this available for healthcare programmes so that the pre-registration doctorate routes would become available for funding.

39. How can the introduction of the LLE support credit recognition and transfer between providers? (Including those across the Devolved Administrations).

39.1 We would caution against it for healthcare pre-registration courses.

40A. How far does successful credit transfer depend on mutually recognised credit frameworks?

40A.1 No comment.

40B. Is a single credit framework a precondition for easy credit transfer?

40B.1 No, education providers already understand equivalence. Learners will need to be supported but with clear explanations this would be more achievable than fully restructuring frameworks.

41. If relevant, please provide details of any bespoke arrangements you have with other providers that support credit recognition and transfer?

41.1 No comment.

42. Which features of credit accumulation, such as size (that is a minimum number), or subject, should apply to a credit recognition and transfer policy?

42.1 No comment.

43. Should there be a time-limit on how long modules stay current? Should this vary by subject?

43.1 Yes, this should be in line with national standards – see 20.1

44. How can prior workplace or experiential learning be more consistently recognised for credit?

44.1 No comment.

45. How might government work with professional standards bodies to facilitate recognition of prior workplace or experiential learning?

45.1 No comment.

46. Are there courses/subjects which would particularly benefit from accreditation of prior workplace learning?

46.1 No comment.

47. What data should be collected to facilitate credit recognition and transfer?

47.1 No comment.

48. How can the process be more transparent?

48.1 No comment.

49. Would you like us to keep your comments confidential?

49.1 No.