Written evidence submitted by the Chartered Society of Physiotherapy (EPW0058)

Consultation response

The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the UK's 63,000 registered physiotherapists, physiotherapy students and support workers and represents 81% of all registered physiotherapists.

Registered physiotherapists are autonomous practitioners, able to independently assess, diagnose and prescribe medicines. The contribution of physiotherapy can be seen at many points of care pathways 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 mobility after injury or illness, provide hands-on care for people with individual and group exercise programmes, support carers, and deliver education to empower people to manage their health.

Summary of CSP recommendations

- 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 workforce targets for implementation of all policies in the Long Term Plan and the Covid Recovery Plan
- 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
- Provide sustainable long-term funding for continuous professional development of the AHP workforce

1. Planning for the workforce

Was the commitment appropriate and was it met?

1.1 No, this commitment has not been met. In spite of significant policy commitments that are dependent on the physiotherapy workforce to deliver, the only workforce target for physiotherapists is as part of the 26,000 target for additional roles in Primary Care[1].

1.2 As part of this the NHS and Government committed to 5,000 First Contact Physiotherapists (FCPs). The evidence shows that FCPs are safe and effective as the first point of contact for people contacting GP practices with musculoskeletal (MSK) issues, and that meeting this target will

significantly relieve pressures on GPs as well as benefitting patients and reducing demands on secondary care.

1.3 Modelling by the CSP showed that with 5,000 FCPs physiotherapists in these roles half of all GP appointments for MSK issues could be managed, which is 10% of all GP consultations, with 1 FCP per 10,000 population. This was endorsed by the Kings Fund who went further and called for 6,000 physiotherapists in primary care[2].

1.4 However, so far there are less than 1,000 FCP roles, and these are covering populations 3-to-5 times the ratio planned. Stretching coverage to this extent is reducing the benefit to individual GPs and hampering successful implementation and embeddedness of FCPs in GP services. We believe that FCPs must be staffed at the originally planned ratio of 1:10,000 for successful implementation. This could mean, for example, targeting areas where there is the greatest need.

1.5 Workforce targets for the implementation of all NHS policy commitments are needed to prevent this problem of 'robbing Peter to pay Paul'. The NHS Long Term Plan[3] included important commitments that will improve patient outcomes and reduce demands on the most expensive parts of the NHS including to improve and expand patient access to cardiac rehabilitation[4].

1.6 National guidance is needed for workforce planning to implement policies in all of these areas. We need national targets for physiotherapists and other AHPs as well as for nurses and doctors.

1.7 The same is true at a local level. Currently Health Education England (HEE) has provided Trusts with short term funding for AHP leaders to develop local AHP plans for the first time. 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.

Was the commitment effectively funded?

1.8 FCP and other additional roles in primary care have been funded through the Additional Roles Reimbursement Scheme (ARRS)[5]. This has enabled implementation. However, where there is poor partnership working across primary and secondary care, there have been disagreements about responsibility for non-salary staffing costs – e.g., where FCPs have split roles, working across MSK community physiotherapy services and GP practices.

1.9 The system needs to know how the funding from the ARRS will be mainstreamed, with greater consideration of how this can support sharing of workforce and associated costs across sectors.

1.10 Furthermore, greater flexibility needs to be introduced and ring-fenced funding. Unlike other professional groups, only FCP physiotherapy roles can be funded through the ARRS. This anomaly needs to be rectified. It is also important to note that the ARRS funding is due to end on 31 March 2024.

1.11 Alongside this there needs to be an expansion in the proportion of non-registered staff - physiotherapy and rehabilitation 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.

1.12 Nationally we need a fully funded workforce staffing plan with biennial independent workforce projections. Locally Integrated Care Boards (ICBs) level workforce boards need to consider AHP workforce plans, and include representations from AHPs.

Did the commitment achieve a positive impact for patients and service users?

1.13 No, the commitment has not delivered a positive impact for patients and service users. 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 and 25% are managing two or more, and these figures are rising[6]. Prevalence of long-term conditions, and multiple long-term conditions, is significantly higher in areas of high deprivation[7].

1.14 Many people who would benefit from rehabilitation are missing out because services are insufficiently staffed to meet need. This results in increased pressure on secondary care, primary care and social care, and worsening disparity in health outcomes. For example, only 15% of people with chronic obstructive pulmonary disease (COPD) deemed eligible for pulmonary rehabilitation in England are referred[8]. Across England, Wales and Northern Ireland only 50% of eligible patients receive cardiac rehabilitation, and this rate is even lower for women, people from Black Asian and Minority Ethnic backgrounds and economically deprived patients.[9]

1.15 Lockdown restrictions, shielding and pausing of wider services such as day centres have led to widespread deconditioning and a deterioration in the mental and physical health of people including those previously not identified by services.

1.16 In addition, Long Covid is affecting an estimated 1.8 million people, with almost all requiring supported self-management[10], and an estimated 90% requiring a rehabilitation programme to regain their health[11].

2. Building a skilled workforce

Was the commitment met overall?

2.1 None of the commitments have been met. 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 physiotherapists and other AHPs and limits the input of AHPs into workforce strategy and planning at a local level.

2.2 The NHS Long Term Plan[12] highlights a need to nurture new leaders and enable capable clinicians, from every professional background, to reach the most senior levels of leadership.[13] In the physiotherapy workforce this is not currently the case and action needs to be taken by employers to ensure the proportion of the physiotherapy workforce with certain protected characteristics in senior roles is equivalent to the proportion of those in less senior roles.

Was the commitment effectively funded?

2.3 Physiotherapists and other AHPs can play a significant role in driving quality improvement and modernisation of care in community and primary care positions through Advanced Clinical Practice (ACP) roles, as well as in roles such as FCPs that require advanced practice skills. Currently those roles are concentrated in the acute sector. It is important that a significant proportion of HEE target in 2022/23 for 800 trainee Advanced Practitioners in primary care are developed to drive quality improvements in community-based rehabilitation. [14]

2.4 To achieve the commitment to 5,000 additional physiotherapists with advanced practice skills in First Contact roles requires investment in in service training and a clear career development pathway.[15] It is essential that FCPs – designated by HEE as 'enhanced capabilities' requiring ACP but not full Advanced Practitioners - are also considered within the training and development of advanced practitioners, as this is a current gap.

2.5 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 FCP and other advanced practice roles required by the Long Term Plan.

2.6 In some areas services are experiencing difficulties recruiting established (Band 6) physiotherapists. This is largely due to failure to establish a necessary pipeline by investing in accelerating development of longer standing Band 5s to Band 6 and increased recruiting of more newly qualified staff to ensure backfill for the resulting B5 vacancies.

2.7 The lack of career development opportunities for physiotherapists in the NHS, particularly in the community, means that people get stuck in their career, and the time between someone being a new graduate to being ready to take up an FCP or ACP role, is 10-15 years. Providing a structured career framework would speed this up to around 7 years. Currently the biggest loss of physiotherapists from the NHS is early on in their careers, suggesting that they see better careers opportunities as physiotherapists outside of the NHS.

Did the commitment achieve a positive impact for patients and service users?

2.8 While patients have benefited from FCPs, their limited implementation so far, and insufficient staffing in rehabilitation services means that overall commitments have not yet achieved their full potential and most patients will not have the benefit of an FCP attached to their GP practice.

2.9 The Integration white paper is clear that the driver for integration isn't an end in itself, but necessary to meeting population needs, and the increasing numbers with multiple long-term conditions.[16] For example, people with COPD are twice as likely to suffer from depression and over a third have osteoporosis[17].

2.10 Rehabilitation is critical to meeting these needs, and is the interface between sectors and settings. But it is currently siloed by medical condition and sector. This is inefficient and results in a confusing system that is ultimately bad for patients who need personalised and holistic care that is easy to access. It results in rehabilitation located in hospital department out-patients when it doesn't need to be and inconsistency in quality standards.

2.11 The poor integration of rehabilitation and lack of consistent access is a driver of health inequity. There is a strong relationship between levels of deprivation and populations with protected characteristics,[18] the development of multiple long-term conditions and poor mobility.[19]

2.12 The CSP supports the goals and content of the Integration white paper[20] and believes it is essential to improving performance, prevention and personalisation of services and further implementation of the NHS Long Term Plan.[21]

2.13 The CSP welcomes the direction on digital and data described in the Integration white paper. We need easier systems to collect and share data, and better interoperability between systems. National agreements are needed on what data should be collected to allow benchmarking and to identify variation in provision and outcome.

2.14 The CSP supports primary care and community health services to develop hybrid working practices for service delivery that are part of a personalised menu of options that improves access (for example for people in rural areas, people who don't drive or have access to public transport, people who work) and takes into account different communication needs and levels of digital literacy.

3. Well-being at work

Was the commitment met?

3.1 None of the commitments have been met. For mental health the 2021 NHS Staff Survey showed 50% of physiotherapists in the last three months surveyed had come to work despite not feeling well enough to work. 36% of physiotherapists often feel burnt out and 49% feel worn out at the end of their shift. 46% of physiotherapists in the last 12 months of the survey indicated that they have felt unwell due to work related stress. [22]

3.2 In the last year of the 2021 survey 25% of physiotherapists were reporting having experienced MSK due to work activities. 26% of physiotherapists stated they have experienced bullying, harassment or abuse in the past 12 months at work from the public and service users. Health care workers with protected characteristics more likely to experience this at work.[23]

3.2 More needs to be done to tackle the root causes of workplace stress and ill health in the physiotherapy workforce rather than rely on an individual's resilience. To reduce burnout the recent strong growth in physiotherapy student numbers must translate into timely posts. Expanding the support workforce, as a proportion of the physiotherapy workforce and higher-level role development for existing support workers will also reduce pressure.

3.3 As specialists in MSK health, physiotherapists are perfectly positioned to support employees to return to, or remain in work, where there might otherwise be significant employment consequences. There is potential for physiotherapists to have an increasing role in helping employees of all ages to maintain their fitness for work. The CSP believes that all people who require support to stay in work, should be supported to do so by their employers where this is reasonably practicable.

3.4 CSP is a member of the Social Partnership Forum as part of the group we encourage increase commitment to tackling bullying in the workplace.

3.5 The CSP believe that to meet the needs of physiotherapy staff, flexible working needs to be accessible to everyone, voluntary and enable a genuine balance between home and work life but this has not been the case. 2021 NHS Staff survey data highlighted that despite national changes to the NHS staff contract to incentivise flexible working the number of physiotherapists nationwide who are pleased with their opportunities for flexible working patterns actually dropped in the latest data with many individual employers seeing larger drops.[24]

3.6 In spite of NHS England's focus on workforce wellbeing in recent years, staff experience has been relatively static with no increase in wellbeing reported.

Did the commitment achieve a positive impact for patients and service users?

3.7 Only one in five NHS physiotherapists in England believe they have enough colleagues to do their job properly. 37% of physiotherapists reported having enough staff to do their jobs satisfactorily. Only 33% of physiotherapy respondents stated being able to meet all the conflicting demands on their time at work in 2021 –a reduction of over seven percentage points from 2020. The number of physiotherapy respondents reporting having adequate materials, supplies and equipment to do their work declined from 52.5% to 46.4% over the same period.[25]

3.8 Downward trends are also seen with physiotherapy support workers who generally report worse experiences than their registered colleagues, and whose data is grouped together with other NHS support staff in the published results.[26]

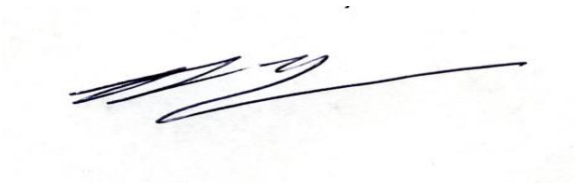
3.9 These findings raise concerns that the crisis in the NHS is creating an increasingly unsafe environment both for CSP members and patients. In 2021, the number of physiotherapists being satisfied with the quality of their organisation's patient care is 69%. This is a drop from 75% in 2020.[27]

3.10 August 2021's NHS all-staff sickness rate of 5.1% was over 1 percentage point higher than the previous year (Aug 2020 being 3.9%).[28]

3.11 NHSE data on retention suggests that around 7% of physiotherapists who work for the NHS leave to carry on practicing in other sectors and do so early on in their careers.[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.

3.12 CSP members – spoken to in Quarter 4 2021 as part of the CSP's NHS Pay Review Body evidence gathering process – describe how the pandemic has exacerbated physiotherapy staff's fatigue, stress and burnout, with resultant negative impacts on service delivery and patient outcomes. For example, an NHS community rehabilitation service lead describes how their *"team have [had to]… work through Covid for 2 years nearly and had to adjust to lots of changes, so overwork is a massive issue… Staff felt very isolated and this has heightened their stress and burnout. Waiting lists have increased dramatically. Patients are therefore having to wait longer to be seen and the optimum time to see them has been missed on occasions*."

3.13 The NHS needs to maintain the physiotherapy workforce to aid its Covid recovery and deliver its transformation agenda. However, our evidence above details a healthcare staffing crisis that - without urgent intervention - will become a permanent feature across the NHS



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