CHARTERED SOCIETY OF PHYSIOTHERAPY

**NHS 10 Year Plan**
The Chartered Society of Physiotherapy
Consultation response

The Chartered Society of Physiotherapy (CSP) is the professional body and trade union for chartered physiotherapists, physiotherapy support workers and students. We represent over 65,000 members.

## 1. What does the CSP want to see included in the 10-Year Health Plan and why?

1.1. **Explicit recognition of the value of rehabilitation provision**. Rehabilitation empowers individuals to restore, maintain or improve physical, mental, cognitive and functional abilities. It overcomes barriers to people resuming normal activities – whether this is work, caring in the family or being active in the community. It is as important to people's health as surgery and medicines, directly determining an individual's healthy life expectancy. Despite overwhelming evidence of its value and cost effectiveness, it is a part of treatment that is routinely missed.

1.2 **ICBs embed rehabilitation and supported self-management** as core operating principles running through all parts of health and care, to reduce the gap in healthy life expectancy. This should be led by strategic leads with cross-sector accountability for performance.

1.3 **Reform funding of primary care.** The Additional Roles Reimbursement Scheme (ARRS) has not delivered all the intended benefits and can be a barrier to integration. Lessons could be learned from other approaches in Scotland and Northern Ireland. Whatever replaces the ARRS needs to cover: full costs of recruitment, training and CPD for non-medical clinicians, and facilitate more advanced practice physiotherapy/AHP roles working across community and primary care.

1.4 **Full implementation of *MSK First Contact Physiotherapist* roles in neighbourhood teams, with 3,000 more physiotherapists with advanced practice skills**. The 2,000 MSK FCP roles that already exist have proven their worth, significantly improving outcomes for patients at 3 months, reducing sickness absence and cutting reliance on opioids. The new neighbourhood centres will need their skills and expertise.

1.5 **Rehabilitation Multi-Disciplinary Teams (MDTs) in neighborhood centres** as part of a transformed rehabilitation pathway, with clinical leadership provided by new *Long-Term Conditions Advanced Practitioners.* See 4.2.

1.6 **Reaffirmed commitment to current policy priorities to improve access to rehabilitation.** The 10-year plan needs to build on the foundations of existing programmes and commit to full implementation of; the Intermediate Care Framework as part of the UEC recovery plan; community MSK, national improvement programmes for pulmonary, stroke and cardiac rehab; urgent community response e.g. AHPs working with ambulance service; frailty and falls prevention, rehabilitation for elective surgery (surgical hubs); and pelvic health physio as part of women's health hubs. It needs to commit to use the learning from these to improve access to other pathways, including cancer rehab and prehab, other neurological conditions, post-ITU. It also needs to commit to a review of children's rehabilitation services, where waiting times are even worse than for adults.

1.7 **Support redesign of rehabilitation to meet the needs of people with multiple long-term conditions with equity embedded at the core**. Although rehabilitation is still commissioned as single condition provision, services are increasingly redesigning to personalise care to meet the needs of people with multiple conditions. New research at scale for a truly integrated multi-condition rehabilitation programme is underway. The new 10-year plan should support this direction of travel, facilitating research into practice and putting in place policies and commissioning to prepare the workforce.

1.8 **A commitment to the next iteration of the Long-Term Workforce Plan prioritising expansion of staffing in the community, including physiotherapy.** There must be a clear commitment to sustainable funding for physiotherapy apprenticeships (see first-year proposed actions), bringing forward a loan forgiveness scheme that is inclusive of AHPs and enhanced access to CPD for NHS physiotherapists and support workers to improve workforce retention. Reaffirming and respecting partnership working with trade unions through the national and regional Social Partnership Forum's agreed role in enabling the Long-Term Workforce Plan ambitions.

## 2. What does the CSP see as the biggest challenges to move care from hospitals to Communities

### System level accountability and leadership

2.1 A significant barrier is that NHS community rehabilitation /physiotherapy services lack visibility and cohesion, often having built up over time in a piecemeal way to respond to needs of the acute sector. All ICBs should have a rehabilitation strategy and director level accountability for rehabilitation across all sectors. Sussex ICB has taken this approach, enabling significant shifts in service delivery in the community. [(1)]

### Implementation of existing policy priorities for rehabilitation

2.2 Existing policy priorities to improve rehabilitation provision (see 1.6) have identified what needs to be done to improve data and mobilise clinical leaders and their teams to transform rehabilitation provision. Now these policies need implementing at scale, making greater use of support workers and the wider workforce, with ringfenced resources. At the same time they need to be networked with neighbourhood services, as part of a cohesive community offer. See 4.2.

2.3 Commitment to implement the *Intermediate Care Framework* in the 10-year plan is critical. NHS discharge delay data shows that every day over half of those on acute wards are medically fit to be discharged (no longer meet the criteria to remain) but can't be due to lack of intermediate care rehabilitation and support in community services. [(2)] Every year 20,000 people are discharged from acute wards to community beds or care homes without any rehab support. [(3)] As well as driving up costs from the most expensive parts of health and care, the revolving door of admissions and readmissions, and every unnecessary day in a hospital bed causes untold harm to patients through deconditioning, decline in functional ability, and risk of infection. The national programme has succeeded in mobilising stakeholders to see community rehabilitation and intermediate care as essential to UEC recovery and transformation. It has changed the terms of the discussion of patient discharge from one of process (flow) and rather one of people, whose needs go beyond the hospital exit and entrance. Significant progress has been made in piloting roll out and in developing a workforce modelling tool to measure capacity. The focus of this programme now must be implementation, which requires continued prioritisation at a national level, staffing and ringfenced resources for community rehabilitation to work with both people discharged from UEC and those at most risk of admission – for example expanding falls prevention and AHPs working with ambulance services as part of Urgent Community Response. The ongoing development of community rehabilitation teams to deliver

intermediate care and urgent community response/admissions avoidance should be led by new Community Rehabilitation Advanced Practice roles for ageing well (see 2.12).

2.4 Ongoing commitment to improve access to pulmonary rehabilitation programmes is also critical. Chronic Obstructive Pulmonary Disease (COPD) is one of main factors in health inequality and COPD exacerbations are the second biggest cause of emergency admissions (1 in 8). Pulmonary rehabilitation is a proven intervention for people with COPD or other chronic lung conditions. A full economic evaluation of its impact by York Health Economics Consortium for NHSE has shown a significant return on investment from reduced exacerbations, fewer bed days, and quality of life. [4] The national programme has led to greater consistency and productivity, supported by a new data modelling tool. Action is being taken to increase the volume of appropriate referrals from primary care. This must be accompanied by increased capacity in pulmonary rehabilitation services otherwise waiting times – already a problem - will grow. [5]

2.5 In 2023 NHSE launched perinatal pelvic health services (PPHS) to ensure timely access to services that prevent and mitigate common perinatal pelvic health problems resulting from pregnancy and childbirth, as recommended by NICE. [6] The PPHS service specification says that *'The PPHS will ensure that women with symptoms of pelvic health problems have access to appropriately timed pelvic health physiotherapy assessment and personalised treatment – including specialist physiotherapy - in line with NICE Guidance and NHS waiting time standards, as set out in the Constitution handbook'.* [7] Roll out of these has been slow, and pelvic health physiotherapists have not always been involved. The 10-year plan should address this.

2.6 The NHSE National Stroke Programme has developed a National Service Model for an Integrated Community Stroke Service. The SSNAP Spotlight Report: Stroke Rehabilitation shows how the proportion of patients discharged to a stroke/neurology community rehabilitation service or early supported discharge has now increased to 63.4% in 2023/24, compared to 40.7% in 2013/14. [8] Particular attention is required to address staffing, the amount of time that people can have with physiotherapy staff and the proportion of people receiving a 6-month follow-up (currently only 38.8% of people getting this). The 10-year plan should support ongoing progress on this.

2.7 Since 2019, policies to improve access to cardiac rehabilitation have focussed on increasing completion rate and improve access for people from areas of deprivation as well as groups less likely to access services (women and people from black and ethnic minority backgrounds). The NACR Report 2023 shows progress is being made, including from additional funding targeted to enable new services in underserved areas. [9] However further work is required to tackle the continuing inequality of access which the 10-year plan needs to support.

2.8 Community MSK services provide a significant social return on investment (for every £1 spent there is a SROI on average of £4.13), from enabling people to return to work, improved mental wellbeing and much more. [10] Currently, waiting lists for community MSK stand at 349, 000 people, with over 40, 000 of those on the list for between 18 and 52 weeks. [11] Action needs to be taken to reduce this through expanding team capacity combined with full implementation of MSK FCPs integrated to work across community MSK and primary care teams (see 4.4 and 4.5).

**A shift to personalisation and patient agency**

2.9 Rehabilitation has historically been designed as part of single condition pathways around secondary care services. This is a barrier to personalised care. Services are gradually redesigning to meet the needs of people with multiple conditions – for example, designing in psychological support in many community stroke and cardiac rehabilitation services, and the integration of some respiratory and cardiac rehab. However, this is not happening fast

enough or at scale. The evidence for exercise-based rehabilitation for people living with 25 different health conditions, is well established. However, a lack of evidence as to the value of a multiple condition rehabilitation has held back widespread change. [12] This is now being addressed by an NIHR multi-centre randomised controlled trial of personalised exercise-based rehabilitation for people with multiple conditions in 20 sites. The trial called PERFORM is led by University Hospitals Leicester NHS Trust. [13] The new 10-year plan should support this direction of travel towards provision of high-quality multiple long-term conditions rehabilitation in the community.

2.10 The culture of NHS provision historically has tended to treat patients as passive recipients of interventions. The success of rehabilitation is based on the partnership with patients, driven by an individual's goals and adopting rehabilitation as a core operating principle will itself help to shift this culture to one of empowerment and patient agency. The success of rehabilitation is based on the partnership with patients, driven by an individual's goals. Clinicians trained to take a patient-centred psychosocial approach as a core part of training, such as physiotherapists, have an important enabling role in shifting this culture and supporting patient agency. This approach could be strengthened by providing core training for enhancing therapist's skills of listening, coaching, and motivational interviewing. (see 4.2) Adopting rehabilitation as a core operating principle will itself help to shift this culture to one of empowerment and patient agency. This approach could be strengthened by providing core training for enhancing therapist's skills of listening, coaching, and motivational interviewing.

2.11 This approach has been taken by dozens of musculoskeletal providers in the development of Community Appointment Days (CADs), following the lead of the social enterprise, *HERE* in Sussex. Key components of CADs are that they are open to people on the waiting list, take place in non-medical settings (e.g. community centres), provide people with direct access to physios and other clinicians, as well as a wider range of non-NHS and non-health services e.g. DWP, Citizens Advice, bereavement support. Some CADs (e.g. South London) have targeted people on the waiting list in areas of highest deprivation. All CADs are focussed on listening to patients without judgement, to find out what matters to them, taking a thoroughly personalised approach. There is now interest in using this model tailored for other patient groups and communities. Evaluation on the Sussex service shows it has significantly reduced waiting lists, is popular with patients and has increased staff morale and job satisfaction. [14] Community services (not only MSK) should be supported to roll out this approach, using insight from the forthcoming large-scale trial which hopes to be starting in 2025.

2.12 Many rehabilitation services are training up former patients and carers as volunteer 'patient buddies' to be members of the team in different forms of co-production. This has improved the quality of care by supporting and motivating patients in their rehabilitation journey, improving participation rates and results. This model is well established in the Hope pulmonary rehabilitation and falls prevention service in a deprived area of Grimsby, run by social enterprise *Care Plus Group.* [15] The role of patient buddies is now being trialled at scale by 30 pulmonary rehabilitation services in a research project called Improve, led by King's College London. There are similar initiatives in community stroke services. It would enable a sea change in NHS culture if these initiatives were supported to be mainstream.

**Creating leadership for community rehabilitation**

2.13 The shift from hospital to community relies on an increase in leadership through advanced practice and consultant level AHP roles with a breadth of expertise across multiple conditions, in community and neighbourhood teams. NHSE (formerly HEE) has already endorsed credential specifications for two community-based rehabilitation advanced practice roles, one for healthy ageing, the other for physical activity for people with long-term conditions. [16] (see 2.3 and 4.2), However, these roles largely don't exist, and there are few courses delivering training required to meet these credentials. Currently, advanced

practice training is largely modelled on nursing or on the ACP medical roles. A commitment on advanced practice community therapy roles would provide the necessary assurance for university providers of the demand and for individual therapists of the value of undertaking the training.

### Staffing levels

2.14 Physiotherapy is a workforce solution and can be a significant enabler of the shift to community. Despite significant expansion in training places over the last decade we still have many more applicants to study physiotherapy than there are university places. The NHS is not capitalising on this or fully supporting further expansion. [17] This is in a context where 1-in-3 physiotherapists works outside the NHS, so there is competition for staff.

2.15 Non-registered support workers play an important role in physiotherapy and rehabilitation services. However, the ratio of support workers to registered practitioners is usually much lower than in nursing. A 2023 survey of over 500 physiotherapy managers in the NHS, showed significant support for increasing this ratio for physiotherapy. [18] An expansion in the physiotherapy/rehabilitation support workforce needs to be accompanied with opportunities to develop and upskill – through apprenticeships, training and protected CPD time, using underpinning governance to support safe and effective delegation.

2.16 There has been a disconnect between NHS policy priorities to modernise and policies on staffing and workforce planning at all levels, which has meant insufficient staff with the right skills to deliver transformation. Addressing this requires system-wide workforce planning based on an assessment of staffing requirements to deliver policies, along with changes to funding flows. Staffing level guidance and tools used by trusts need to be inclusive of allied health professionals (AHPs). This is currently not the case, which means that trusts are not fulfilling their obligation to keep staffing levels under review to guide workforce planning. For the first time a commitment for AHP staffing guidance has been agreed to be started as part of the National Quality Board Effective Staffing Programme. [19] The 10-year plan should indicate support for this direction of travel to a more multi-professional approach to staffing guidance and trust-level workforce reviews.

### Retention

2.17 Insufficient staffing in physiotherapy and rehabilitation teams has become part of a vicious cycle, driving physiotherapy staff to leaving the NHS to work in other sectors where they feel they can deliver better quality of care.

2.18 The physiotherapy leaver rate is also driven by a lack of development opportunities – with particularly high NHS leaver rates of physiotherapists and support workers within 3-5 years. The CSP encourages the profession to embrace diverse, non-linear career paths. The CSP Physiotherapy Career Framework highlights the value of developing skills across the four pillars of practice: clinical, leadership, education, and research. [20, 21] The CSP also promotes preceptorships to support physiotherapy staff early in their careers and at the point of transition and advocates inclusive access to opportunities. To retain physiotherapy staff, including the support workforce, trusts need to create opportunities for development within the NHS and outside – for example, by making it easier for physiotherapy staff to work across sectors or take up secondments, to bring new ideas and learning back into the NHS.

2.19 Apprenticeships could significantly improve retention but there are key barriers to overcome. Funding for universities is insufficient to provide the level of support apprenticeships need, and administrative processes are too burdensome. Employers require additional funding for backfill and practice placements. The funding support from the Office for Students is currently uncoordinated with system workforce planning. The

expected announcement of a new funding model has been delayed. Furthermore, plans to de-fund level 7 programmes pose a risk to the development of physiotherapists in enhanced and advanced practice roles. The new funding model must be launched as planned, along with an exception for Enhanced and Advanced Clinical Practitioner programmes in the defunding of level 7 health apprenticeships. The latter needs communicating at pace to provide certainty to education providers and avoid disruption or withdrawal of provision. Work with employers and support workers is also required to improve awareness of the benefits of level 3 and 5 apprenticeships for support workers and normalise uptake.

2.19 A recent wellbeing survey of the physiotherapy workforce showed that over half (56%) felt stressed because of poor work life balance and nearly half demonstrated work-related burnout. [22] Despite changes from September 2021 to enhance rights for flexible working, flexibility is still not the norm for NHS staff, with gaps in awareness of rights and policy, poor practice, and lingering barriers and misperceptions. The lack of flexibility can drive out staff who would otherwise stay – last year over 30,000 staff left their NHS role due to work-life balance. More work is required to retain the physiotherapy workforce, including through promotion of the evidence of benefits of flexible working arrangements, along with tackling staffing levels. [23]

## 3. What does the CSP see as the biggest challenges and enablers to making better use of technology in health and care?

3.1 The experience of the pandemic has accelerated digital delivery of rehabilitation. Pockets of innovation predated the Covid crisis, enabling the rapid mainstreaming of virtual appointments as part of business as usual where safe and appropriate. Guidance that has followed has been invaluable in addressing the concerns of patients and staff about an impact on quality and digital exclusion. For example, CSP advice, the British Thoracic Society Quality Statement and NICE guidance on digital provision of pulmonary rehabilitation clarifies that digital is optional, to expand access to those who otherwise would not be able to. [24, 25] Similar guidance has been developed across multiple conditions. These are being actively used to guide development of a digital rehabilitation service offer that expands accessibility.

3.2 A lack of data outside of hospitals has long been a major barrier to driving change – making patient need and performance in meeting it invisible. This has been known for decades, and reluctance to tackle in the past may have been because of a nervousness of making visible the scale of need in the community.

3.3 Significant steps forward have been taken just in the last few years – with the community services data set from 2022 showing waiting times; regular data collected showing numbers of people in acute hospital beds because of a lack of community provision; the new NHSE pulmonary rehabilitation data platform; the expansion of stroke audits (SSNAP) to community provision; a new intermediate care capacity modelling tool and local data sharing agreements being made between health and social care. [26, 27] These are positive steps in the right direction to be built upon.

3.4 The CSP contributed to and supports the Community Rehabilitation Alliance Data Task and Finish Group submission.

## 4. What does the CSP see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

### Increasing physiotherapy and rehabilitation expertise in neighbourhood teams

4.1 Physiotherapy and rehabilitation are key to secondary prevention with loss of mobility and associated loss of social connectedness significant risk factors in the development of multiple long-term conditions, particularly among the poorest households. People with long-term conditions currently struggle to access self-care advice at an early stage, from a source they trust. CSP research funded by Sport England shows that people with long-term conditions are commonly nervous about exercising without advice from a trusted source, for fear of making their condition worse, and that physiotherapists are highly ranked (on a par with doctors) as a trusted source of information about long-term conditions and exercise. (28) Evidence also shows that receiving a diagnosis of a long-term condition is the point for many people they are most likely to take in and be motivated to act on self-care advice. (29) Enabling advice from the right trusted clinician early on can also enable patients to make better informed choices for example choosing conservative approaches, such as strengthening and exercise rather than surgery. However, it can be years after the initial diagnosis before someone is ill enough to speak to a specialist or qualify for NHS rehabilitation in line with NICE guidelines. Not having this small amount of input at the front-end means it is a wasted opportunity, during which time people's lives are impacted – including people with long-term conditions in their 40s and 50s being pushed out of the workforce – driving both income and health inequality.

4.2 A new vision for rehabilitation at the neighbourhood level can be provided through placing Rehab MDTS in neighbourhood teams, led by new *Long-Term Conditions Advanced Practitioner* roles (see 2.13). These teams would provide access to high-quality early advice and support to empower people to manage symptoms of long-term conditions (muscle weakness, balance problems, breathlessness, anxiety), fully preparing people for rehabilitation as part of treatment, and their role in this. They would direct to a wealth of self-care support, such as the CSP's *Stronger My Way*, Sport England's *We Are Undefeatable* and refer to sources of local support from voluntary, fitness, private sector and public health. Providing this early clinical assurance and leadership would significantly enhance people's ability to self-manage conditions, reducing needs in the future. They will be qualified to identify red flags and refer appropriately for NHS community services and medical treatment – knowing when this is and isn't needed. Most importantly they would build cross-sector partnerships to harness the full contribution of non-NHS sectors to enable patient agency in self-care.

4.3 Rehab MDTs in neighbourhoods could also enable wrap around support people to live well while waiting for treatment (e.g. surgery) and those requiring further support after short-term therapy input to avert an admission (urgent community response) or enable discharge (intermediate care, early supported discharge).

4.4 MSK First Contact Physiotherapist (FCPs) with advanced practice skills are already in place in many primary care teams. Musculoskeletal conditions account for around 20% of all GP appointments. (30) It is the top cause of sickness absence from work and closely connected to the second, which is anxiety and depression. MSK FCP roles were created to address the barrier to people getting early advice and support to manage their MSK condition. (31) The former Government promised 5,000 to manage half of all MSK appointments seen by GPs. However, so far there are just over 2000 MSK FCP roles. They have proven that putting their expertise into primary care, at the front end of the MSK pathway has sped up diagnosis, and increased people's confidence and ability to manage the condition, which for most people (c70%) is all that is required. The evidence shows that they are safe and effective, that patients' conditions improve quicker, with significantly fewer days off work and improved outcomes at 3 months compared to those seen by the

GP, and a major reduction in opioid prescribing. [32] They are cost-effective, allowing GPs to see other patients that require their skills and reducing inappropriate referrals for diagnostic testing, community MSK services and orthopaedics. However, they are stretched too thin – covering areas of populations several times the size of the original modelling. This makes them unsustainable, and the full value is not being realised. It is essential that at least 3000 further MSK FCP roles to meet the original target of 5,000 are created, prioritising areas with highest needs and lowest staffing to population ratios.

**Reforms to primary care funding to support integration**

4.5 Integration between primary care and NHS services is poor. This has been demonstrated in the implementation of MSK FCPs roles to date, funded through the Additional Roles Reimbursement Scheme (ARRS), particularly where FCPs are directly employed by primary care. To be effective they must be integrated with community MSK services (The CSP recommends that whatever funding model replaces the ARRS must support better integration). In our view, this can best be achieved by MSK FCP roles being employed by the main MSK community provider. This will also reduce the burden of training and supervision within primary care and increase access for FCPs to peer support from the wider MSK team. This improved model for the rollout of MSK FCPs in neighbourhood services would support the ambitions described above for access to rehabilitation and self-care expertise.

**The potential for public information campaigns to support primary prevention**

4.6 Public information campaigns also play an important role as evidenced by the FAST stroke campaign. Evidence from Canada, France and Australia suggests that a public information campaign on back pain cuts sickness absence and reduces the number of primary care appointments for back pain. [33-36] This could make a strong contribution to the prevention agenda and reduce the costs of back pain to the NHS, benefits and loss of productivity. The CSP would be pleased to provide clinical support for this.

## 5. CSP specific policy ideas for change short, medium and long term

<u>Quick to do (within the next 1-2 years)</u>

1. Recognition of rehabilitation as a core NHS service within the NHS Constitution, as important as medicines and surgery.
2. Commit to developing a national action plan with targets on reducing the healthy life expectancy gap which should include a focus on rehabilitation services.
3. All ICBs appoint a strategic lead for rehabilitation and reducing the gap in healthy life expectancy and change national policy to stipulate a place for Chief AHPs on Trust Executive Boards.
4. Funding for ongoing work on data infrastructure, training, culture change to support the shift to community
5. Ensure current commitments to improve access to rehabilitation are reflected in annual NHS planning guidance with ringfenced funding and that all NHS Trusts include AHPs in their biannual staffing reviews to inform workforce planning.
6. Reform ARRS to enable full rollout of MSK FCPs and advanced practice roles for long-term conditions, working across more integrated primary and community NHS teams.
7. Ministers agree to update laws to enable physiotherapists to prescribe from a wider list of controlled drugs, to reduce unnecessary prescribing.
8. Rapidly upskilling physiotherapists to fill the growing shortage of band 6, 7 and 8 physiotherapists.
9. Funding supernumerary recruitment of support workers and newly-qualified physiotherapists to meet capacity gaps and provide the pipeline and backfill for higher banded roles.

10. Expand physiotherapy apprenticeships for registered and non-registered staff through a new funding model, while retaining level 7 health apprenticeship funding.
11. Ensure the 2025 revision of the NHS Long Term Workforce Plan goes further in expanding the rehabilitation workforce, fully utilising existing supply to meet need, including physiotherapy, and reaffirming commitment to partnership working with trade unions through the national and regional Social Partnership Forums to support improvements to staff experience and wellbeing.

Medium term change (next 2-5 years)

1. Work with the NHSE Chief AHP Officer team and the National Quality Board to develop staffing levels guidance and workforce planning tools for AHPs, prioritising services outside of hospital.
2. Bring forward a loan forgiveness policy to support retention among AHPs and nurses.
3. Invest in a public information campaign on back pain – learning from other countries who have done this successfully.
4. Introduce new performance measures linked to funding that would drive funding to community-based rehabilitation and ensure ROI created by community-based rehabilitation and intermediate care is reinvested into those services.
5. Carry out a review of existing policy priorities to expand access to rehabilitation to make recommendations on applying lessons to rehabilitation for other patient groups, including a focussed review on paediatric physiotherapy and children's services.
6. Work with NICE to ensure the latest research on innovative rehabilitation service design can be quickly put into guidance – such as anticipated evidence on multiple long term condition rehab, the role of rehab buddies, the community appointment day approach.
7. Investment in the practice educator and academic workforce to ensure sufficient capacity and quality of educators, including for those on apprenticeships, through implementation of the NHSE Educator Workforce Strategy.
8. Delivery of integrated systems / datasets, identification and deployment of technology that supports rehabilitation and the shift to community

Long term change, more than 5 years

1. Investment in data systems that capture population need, patient outcomes and service delivery and staffing outside of acute hospitals, building on the work started in this area.
2. Commissioning arrangements that enable an increased proportion of NHS funding is spent in community and primary care services
3. Integration of wearables, transition to implementation of predictive analytics, preventative health, population health etc.
4. Work with trade unions and the pay review body to address the long-term decline (in real terms) of NHS pay.

Rob Yeldham
Director of Policy, Strategy and Engagement
The Chartered Society of Physiotherapy
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- ends -

For further information on anything contained in this response or any aspect of The Chartered Society of Physiotherapy's work, please contact:
Rachel Newton
Head of Policy
newtonr@csp.org.uk

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