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AN INVESTIGATION INTO THE EFFECTS OF NHS REFORMS ON PHYSIOTHERAPY AND ITS MANAGEMENT STRUCTURES IN ENGLAND AND WALES

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Jenkins F. C.

DOCTOR OF PHILOSOPHY

2016

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**AN INVESTIGATION INTO THE EFFECTS OF
NHS REFORMS ON PHYSIOTHERAPY AND
ITS MANAGEMENT STRUCTURES
IN ENGLAND AND WALES**

by

Fiona Charlton Jenkins

A thesis submitted to Plymouth University

in partial fulfilment for the degree of

DOCTOR OF PHILOSOPHY

June 2016

ABSTRACT

Fiona Charlton Jenkins

An Investigation into the Effects of NHS Reforms on Physiotherapy and its Management Structures in England and Wales.

Background. A constantly changing reform agenda has frequently changed NHS management arrangements. Impacts are documented for medicine and nursing but much less so for the third largest profession, physiotherapy.

Aims. To evaluate the impact of NHS reforms on physiotherapy analysing whether the resulting management structures impacted on staff and patient care; comparing English and Welsh arrangements with previous periods.

Method. Observational mixed methods including a narrative literature review; questionnaire census; semi-structured interviews; physiotherapy narrative history; and a normative evaluation of physiotherapy management structures.

Results. NHS reforms had impacted on the structure of physiotherapy management and organisation. Of the eight management structures described in Øvretveit's (1992) schema: Three were not observed; two were observed but needed modification; three were observed and empirically applicable with small modifications; social enterprises had evolved with management structures similar to those in the NHS. The main changes to physiotherapy managers' roles between 1989-2014 were substantial reorganisations affecting the employing organisation and role of the managers with a reduction in Community Trusts and the introduction of competing providers into English NHS physiotherapy. Clinical autonomy had been extended with advanced practice roles in some areas. The role of the professional body and TU (the CSP) was generally well-regarded by managers. The differences between England and Wales related more to management structures than national policy differences.

Conclusions. Most physiotherapists were managed within cross-AHP structures. Devolved structures were increasingly emerging but physiotherapy managers preferred professionally-led structures. Physiotherapy managers ranked the AHP Directorate the highest and the Fragmented structure the lowest. The AHP professions will need to consider merging to conserve their power as professions and to maximise their combined contribution to patient care and organise to meet fiscal challenges in both countries.

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AUTHOR'S DECLARATION

At no time during the registration for the degree of Doctor of Philosophy has the author been registered for any other University award without prior agreement of the Graduate Committee. Work submitted for this research degree at the Plymouth University has not formed part of any other degree either at Plymouth University or at another establishment. This study was financed with the aid of tuition fees from Cardiff and Vale University Health Board.

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Publications:

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Several attended during this period. Those most pertinent to the research:

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- NHS Confederation: 2014, 2015.

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- Janice Mueller Chair of the Board for the regulatory authority for physiotherapists registered in New Zealand
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CHAPTER ONE

INTRODUCTION

1.1 Significance of Changing NHS Organisation for Physiotherapy

The key focus of this research is an investigation into the effects of Health Service reforms on the management and organisation of physiotherapy services in the National Health Service (NHS) in England and Wales which have been on:

“A roller-coaster ride of reform.” (Ham, 2014).

NHS reforms have impacted on restructurings both between organisations and within organisations. Management structures influence the functioning of the NHS, the way that this impacts (or not) on the organisation, training and development of staff as well as the quality of care given to patients is the central focus of this research.

The healthcare workforce accounts for the greatest proportion of spending and holds the key to the quality of healthcare provision (WHO, 2000) therefore its management and organisation need to be both efficient and effective. Allied Health Professions (AHPs) are members of health and care teams who support care and provide treatment that can transform people’s lives, working in many settings, with many other professionals and at all points on the patient pathway (NHS Careers, 2015). 12 AHP professions accounted for 6% of the NHS

workforce and over £2 billion in NHS salary costs (Health Foundation, 2014). As a collective group, yet also distinct professions, AHPs' remit is diverse and far-reaching. However, despite the size of the workforce and the broad scope of care, comprehensive data on the impact of AHPs is not routinely centrally collected and research assessing the impact of AHPs lags behind the larger professions.

Weber (1947,) defined structure, as including the allocation of formal responsibilities, being the linking mechanism between the roles and co-ordinating structures of organisations. He recommended that the appropriate structures should match the pressures between the need for uniformity and diversity, with some diversity being essential for a successful organisation and its areas of management.

The impact of change in structures has been well documented in relation to medical and nursing professions, (Walby *et al*, 1994; British Medical Association (BMA,) 2013; Royal College of Nursing (RCN,) 2012), though little research on the impact relating to physiotherapy other than the "internal market" reforms containing opportunities and threats for AHPs (Øvretveit 1988; Turner 1989; Jones 2000).

Professional regulation has been recognised as an important element of public protection (Health Care Commission 2009,) though Reeves and Smith (2006,) argued that:

“Over-regulating professionals can erode the foundations of their work.”(p. 5).

The NHS has been in a state of accelerating structural change for almost four decades: (*NHS Community Care Act 1990; Health Act 1999,2009; Health and Social Care Act 2003, 2008, 2012; Government of Wales Act 1998, 2006; DHSS,1971,1972a,1979a,b,1982,1983,1987, 1989a,b,1996a,b,1997,1998a,b,c 2000a, 2002a,b, 2003, 2004a,b,c. 2005a, 2006a,b, 2007a, 2008a,b, 2010a,b, 2011b; NHS England 2013b, 2015a,b; WAG, 2005, 2007; WG 2014a.*)

NHS changes have been analysed, with greatest focus on the period post 1989. A review was undertaken of the political architecture, policy, funding and historical events which impacted on NHS structure and management, and in turn may have influenced the organisation and provision of physiotherapy services.

The prominence of medicine as the most scrutinised occupation (Nicholls and Cheek, 2006,) followed closely by the research on nursing, compares with the relative neglect of physiotherapy; the third largest staff group in the NHS, and only the 13th most frequently cited healthcare profession in academic literature and 29th overall in terms of comparative studies. This reflects a wider social science research neglect of physiotherapy, described by Senters (1972,) as:

“The first and largest profession allied to medicine.” (Nicholls and Cheek 2006, p.2337).

The constantly changing political agenda for the NHS frequently challenged management arrangements for physiotherapy, with resulting sequential

changes impacting on service provision and the overall contribution of physiotherapy services. The desire to evaluate whether NHS structural reform impacted on the physiotherapy profession, analysing the management structures in place and determining if there was difference between England and Wales stimulated this research. Physiotherapy in the context of AHPs, was therefore selected as the research professional focus.

The views similar to those put forward by Donabedian (1966,) guided work regarding the elements used to evaluate and compare healthcare quality, proposing a linear relationship between structure, systems and processes during the era of general management. This concept led to an emphasis on reorganising structures with the aim of improving outcomes. Contrasting views were proposed by Mitchell *et al* (1998,) reporting no single direct connection linking interventions and outcomes.

Re-structuring of the NHS has generated much analysis. Light (1997a,) proposed that lessons could be drawn from the improvements by the UK government over the design of managed competition and the underlying trends toward privatisation and class discrimination with the resultant collaborative purchasing for the health needs of communities. Braithwaite (2007,) commented:

“Restructuring health services is a prevalent international activity which the NHS, over almost six decades, has taken to a high art form.

It comes in many versions, involving fitting pieces of the health system jigsaw together in novel configurations. Revamping boxes on organisational charts is popular.”(p.355).

The range of restructurings have included: Merging Trusts, dissolving Trusts, combining and re-combining services in directorates and specialties, as well as the introduction of competitive elements (Edwards 2002; Braithwaite and Westbrook, 2005). Increasing and unprecedented “micromanagement” from the Centre, (Smith *et al* 2001,) was reported to result in constraining the ability of managers to manage.

An SDO report (Sheaff *et al* 2004a, p.5) concluded that, it was misguided to search for the “*one right size*” for each kind of NHS body, thereby recognising the need for flexibility in organisational arrangements and the impact on the professions, requiring engagement to be developed from within organisations, rather than externally imposed. A warning was issued about the continued centralisation of internal structures and management processes, with an indication that:

“Highly centralised and vertically differentiated management structures are liable to have dysfunctional effects.” (p.11).

Physiotherapy managers have roles that are wide-ranging and operating often in complex environments. They work to lead and manage their profession and have experienced the impact of many NHS reorganisations. This has materially affected not only the way in which services have been managed, but the development and shaping of the physiotherapy profession itself. The impact of organisational structure on doctors and nurses is relatively well understood and researched (Bourgeault *et al*, 2009). However, the impact on other professions has often been overlooked and underestimated. In response to the increasingly

“business orientated” and demanding health environment, physiotherapy managers have frequently been required to consider what might be the “best” management structures for their services in several different healthcare systems. This has been a recurrent challenge for physiotherapy managers during the numerous NHS management reviews, reorganisations and reforms.

The 1997, DH commissioned report *“Providing Therapists’ expertise into the new NHS: Developing a Strategic Framework for Good Patient Care”* (Oakley 1997,) noted that therapists, like most other professional groups in the NHS, had been reorganised several times in the recent past, with resulting structures and management arrangements either not being in place sufficiently long enough to be fully evaluated, or not long enough to implement the changes intended by government. The report commented on the effects of organisation and role conflict, stating that:

“Therapists often find themselves at the ‘heart of the problem’ in that they provide specialist services within very complex multi-agency environments to people who often require different types of specialist advice and treatment, whose need is likely to change over time...therapists find themselves cast in the additional roles of co-ordinator, fixer and arbitrator without the necessary resource implications being recognised by the various host organisations.”
(p.8).

This complex arrangement is not uncommon in professional organisations requiring staff to undertake conflicting roles of clinical specialist and resource managers. The review of therapy management arrangements (Oakley 1997,) reported that there were many models of organisation swinging from full locality

devolution to centralisation in therapy directorates with no evidence that the choice of structure adopted was grounded in evidence or research. This supported the finding of Øvretveit (1992,) who developed a schema for possible management structures for the therapy professions, based on research between 1968 and 1990.

The impact of service reorganisation for AHPs, including physiotherapy, though not widely researched, had been reported in a few “Beveridge type” health services, in the UK, (Kinston 1983; CSP 1984; Jones 1987,1989; Øvretveit 1985,1991,1992,1994; Jenkins 2005; Jones and Jenkins 2006) as well as in New Zealand,(Mueller and Needs 2005,) and Australia,(Boyce 1991).

Therapists, with physiotherapy being the largest profession; were described as:

“... too often been undervalued or neglected.” (DH, 2004a).

This articulated the need for therapy services to be more included when evaluating the impact and evaluation of service provision. Their contribution was highlighted by the Secretary of State for Health, Johnson, in his foreword to *“Framing the contribution of Allied Health Professionals”* (DH, 2008d):

“As allied health professionals, you do not always feel you get the recognition that you deserve. Yet the contribution you make to delivering quality healthcare is immense.” (p.6).

It could be concluded that physiotherapy services, though valued clinically, have found their management and structures more difficult to evaluate. This could be an effect of the frequent changes and lack of organisational

consistency. The diversity of management structures and organisation types in which physiotherapists operate has also constrained research into this area.

Concerns in England were reported by AHP managers about service reorganisation leading to loss of posts, redundancies, lack of funds for training and reduced quality of patient care (Jenkins and Jones, 2006). It was suggested that the effectiveness and efficiency of services would be optimised if the change process for management and structures were clearly thought out and implemented methodically. This concurred with Oakley (1997,) reporting issues related to loss of senior therapy manager posts following NHS reorganisation, with loss of morale, professional networks and professional autonomy.

The continuing pattern of organisational re-structuring impacting on AHPs stimulated the need for investigation into the most recent reforms, focussing on the physiotherapy profession in the context of AHPs, and exploring whether there were differences between England and Wales. The significance of the impact of the changing NHS physiotherapy, as well as its management and organisation, framed the research.

1.2 Research Focus

The main research question that looked at whether the NHS reforms influenced physiotherapy management structures, support for staff and care for patients:

“What effect has government policy for the NHS had on the management, organisation and provision of NHS physiotherapy services in England and Wales?”

This was further explored by three supplementary RQs.

1.3 Thesis Structure

The thesis is constructed to provide a theoretical background to the research topic, which is followed by the research methods, findings and discussion.

These all relate to the key focus which is the impact of government policy for the NHS on NHS physiotherapy, its management structures and the resultant impact on care for patients and support for staff development.

Chapter two presents management structures for physiotherapy and their impact, influencing both staff and service users. In Chapter three the wider organisational context of the NHS will be described relating to the organisation arrangements in which physiotherapy has been provided since 1989 as well as presenting and describing the physiotherapy profession and its management structures. Chapter four presents the overarching research question and three supplementary ones. Research methods and choice of research design are found in Chapter five which identifies the research sample being physiotherapy managers. This chapter also includes a description of the methods used to carry out the literature review.

The research findings are presented in order of the research questions. Chapter six presents the findings related to management structures and impact of

organisational change. In chapter seven the findings linked to the impact of organisational change on physiotherapy managers' roles responsibilities and functions are presented. The focus of chapter eight is the different management structures and an assessment of the activities undertaken by physiotherapy managers working in the different structures. Chapter nine sets out an assessment of physiotherapy professionalisation discussing the impact of NHS changes on the profession. Chapter ten presents a comparison of the findings to all the research questions between England and Wales. In Chapter eleven the findings are discussed with critical analysis and final conclusions drawn, with limitations of the study detailed and recommendations for future research.

The policy initiatives have required continuous cycles of change. Some of the more recent ones are outlined in Appendix 1. An overview of the NHS from its early history until 1989 is contained in Appendix 2, with further appendices giving additional background material, with supporting tables, figures and statistical analyses.

The thesis therefore explores how management structures influence the functioning of NHS physiotherapy and the impact of the way different structures have impacted on physiotherapists' training and development and the care given to patients.

CHAPTER TWO

PHYSIOTHERAPY MANAGEMENT STRUCTURES AND THEIR IMPACT

Management structures for physiotherapy establish the context for patient care, directly influencing both staff and service users. Shortell *et al* (1994,) proposed that the hardest challenge for a clinical manager was the challenge of being a provider of care and advice, a clinician and manager of others.

2.1 The Importance of Organisational Structure

Attention to organisation and management of therapy services in the UK was commended by Øvretveit (1991,) to help therapy services innovate in the NHS “public market”. Boyce (2001,) reported that restructuring rather than representing a threat, had provided opportunities for AHPs to create new structures, identities and futures. It can therefore be seen that organisational structures have been topical for many years as they have a fundamental impact on quality of patient care and physiotherapy staff (Jenkins and Jones, 2006.)

Structures can influence organisational effectiveness (Child 1977,) and was reported to be closely related to context, with Woodward (1965,) advocating a technological-imperative rationale. Review of structural variables including:

specialisation, centralisation, configuration and standardisation and contextual variables of size, technology, ownership, location, history and task environment as key factors, suggested size as being of primary importance (Pugh *et al*, 1969). This was supported by Mohammed (2013,) analysing size to be the most significant contextual dimension followed by ownership and control. Whereas, the other contextual dimensions, including technology, were not significant to the overall organisational structure.

West (2001,) in her review of the link between hospital organisation and quality of patient care proposed that too little was known about the relationship between structure, process and outcomes making it difficult to recommend a way of organising services that would improve care.

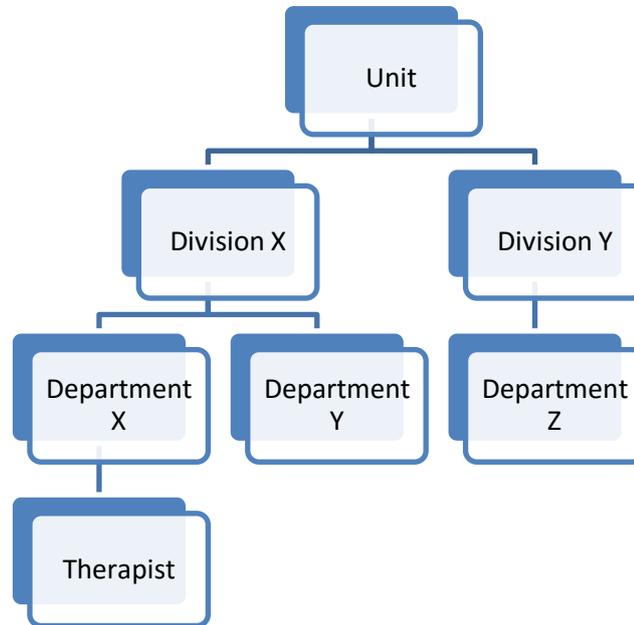
2.2 The Influence of Models of Care

Recognition of the previous dependence on the medical profession and the continued close working with medical and nursing colleagues has been cited as an important factor when reviewing management arrangements and different healthcare models; medical model (Larson 1999); holistic model (Gordon, 1980) and social model (Asadi-Lari *et al* 2004; French 1994). Arguably the NHS is moving away from the medical model of health care towards a socio-medical model demonstrated by policies of integration.

The ways in which services have been historically provided has influenced the structure and in turn its management arrangements. Physiotherapists work in all

In an organisational hierarchy this would be illustrated as:

Fig. 2 Therapy Service Structures Hierarchy (Øvretveit, 1992)



- The “unit”, described the host unit which could be a hospital Trust or Primary Care organisation.
- The “division”, was a clinical directorate or larger structure
- The “department”, possibly representing a health community wide service; cross-organisational, or a single unit department
- The “therapist” could be a uniprofessional grouping, or AHP grouping

Most therapy services were managed from within Units at this time. The therapy service may have been a division in its own right or within a larger division or directorate. Øvretveit (1992,) analysed possible models for organisation of therapy services describing five different models with eight possible model types.

He advised consideration of both the size of the therapy department and the number of therapists involved when considering management structures. The models originally proposed were:

- Model A: Individual private practitioner
- Model B: Directorate or locality-managed
- Model C1: Unit-based single-therapy division
- Model C2: Unit-based combined-therapies division
- Model D1: Unit-based District therapy service
- Model D2: Unit-based combined District therapies
- Variation of D1 or D2: The therapy “service agency”
- Model E: Independent group practice

Boyce (2001,) described five models in Australia which overlapped though differed from the Øvretveit schema, including: Traditional (classical) medical model; Unit dispersment model and three variations of an Allied Health division model. She commended another model following internal matrix principles associated with the “integrated decentralisation” form of organisation.

Despite there being many possible models of structure for physiotherapy services, current provision is characterised by a variety of models, though the NHS structure itself has evolved since Øvretveit published in 1992.

2.4 Management Structures and Physiotherapy Professionalisation

Compared with other professions, there is a small proportion of healthcare professionalisation literature relating to physiotherapy and even fewer reporting on management structures and physiotherapy. Theorists include:

Campbell (1983,) who identified the importance of continued professional education in developing physiotherapy.

Parry (1995,) presented a maverick view of the emergence and development of the profession, looking at the progress and evolution of physiotherapy as a 20th century phenomenon and an example of the status and ambitions of women.

Jones (1991,) proposed the inextricable link between professionalisation, management and clinical considerations.

Jones and Jenkins (2006,) identified that the “trait” theory of professionalisation partly indicated why the professions were managed for many years on a uni-disciplinary basis. They identified that developing government policy and radical changes in the politics, structure, organisation, regulation and management of the NHS, indicated weakening of professional autonomy, authority and power in tandem with strengthening public influence, regulatory transparency and multi-disciplinary working.

The growth of professionalisation and occupational development in the changing NHS had been an important influence on the way in which physiotherapy services had been organised and managed, which has been recorded by Richardson (2015,) as an oral history of physical therapy.

Øvretveit (1991, 1992, 1994,) and in collaboration (Kinston and Øvretveit 1981; Kinston *et al* 1981,) has been the most prolific author and reported on the future organisation of therapy services, their organisation, management structures and autonomy. He has also reported on physiotherapy and the nature of the role and management. Notably he developed an analytical framework describing therapy management structures in place at that time (Fig.1 above).

In common, all of these theorists indicate a relationship between management structure and the quality of care for patients and as well as development of physiotherapists being influenced by physiotherapy professionalisation. Further discussion of physiotherapy professionalisation is set out in Chapter 3.8.

2.5 Factors Required for an Effective and Efficient Service

Re-structuring has impacted on management roles and functions in physiotherapy, which in turn, directly impacted on the management and organisation of staff and the care provided to patients. Jenkins and Jones (2006,) drew together their respective research (Jones, 1989, 2000, Jenkins, 2005); which has gathered information as a consensus view from physiotherapy managers over three periods, presenting the factors which they had identified and commended for management and leadership of an efficient and effective AHP service, which should be enabled by the management structure. This was updated to reflect contemporary terminology.

Table 1 Factors required for an effective and efficient service

A "critical mass" of staff, with a range of expertise to be able to deliver comprehensive patient care and staff development in all specialties.
A service that facilitates cross organisational working and integrated care pathways.
Access to AHP specialists who can develop clinical services, more junior staff expertise and provide a high standard of clinical care.
Provide equality of access for service users across the area.
Inclusion of all core areas of the professional service, ensuring the provision of comprehensive staff CPD education and training, staff rotations and student placements.
Cross service facilitation of support for assistant workforce.
Optimum use of IM&T systems; uniform data collection interpretation, analysis and performance management.
Service that enables the manager to have authority with accountability and responsibility rather than responsibility for providing professional advice only.
Structure that links AHP services into senior committees within the Trust, with post holder accountability to a Director or CEO level post.
Service that is in a position to make full contribution to the objectives of the employing organisation.
Uniformity of clinical governance management and procedures
Effective and efficient uses of all resources to achieve economies of scale and prevention of wasteful duplication.
Structure that facilitates cross-boundary team working
Flexibility to deploy staff to meet variable demand for specialist knowledge and skills.
Ability to respect patient needs and wishes, respecting dignity, privacy and providing safe care
Ability to deploy staff into less "popular" areas.
Ability to provide cover quickly for staff sickness or other absence.
Mechanisms to prevent isolation of staff members working in small teams
Co-ordination of response to government priorities and policies including NICE in the development, provision and monitoring of services.
Co-ordination of input to commissioners.
Uniformity of implementation of "Choice" agenda.

Adapted from: Jenkins and Jones (2006, p.67)

2.6 Current Agenda and Implications for Physiotherapy Structures

The US Institute of Medicine's (1989,) wide-ranging study in the US, noted that the lack of an umbrella position for AHPs, similar to that available to nursing produced difficulties in maximising their organisational contribution. Control of budget was a prime factor in determining the degree of vulnerability felt by

AHPs over the fortunes of the profession. It was noted that factors often neglected in restructuring numerically small specialist professions, in areas with an ideological commitment to decentralisation, include mechanisms for maintaining and developing expertise, and the benefits of collectivity and economies of scale. Although it could be argued that the US health system differs significantly from the UK, the perceived vulnerability felt by the larger AHPs had many similarities.

The current NHS agenda in England and Wales commends community-led services, with care models that ensure the transfer of care and treatment from hospital to community settings being more integrated, efficient and people-centred. The NHS is recognised to be the preferred provider, but not necessarily the only provider.

NHS Wales undertook substantial re-structuring in 2010, reporting that the former structure was “*complex and over-bureaucratic*” (WAG 2009, p.3,) replacing 29 provider organisations (22 LHBs and 7 Trusts) with seven large LHBs and 3 Trusts with new roles of Executive Directors for AHPs/Healthcare Scientists in the LHBs. The English NHS has enacted the most recent reorganisation from April 2013, the implications of which are still “bedding down”. In July 2015 NHS Wales published a Green Paper (WG 2015,) opening a consultation on organisational structures.

There are many reasons to expect that the changes in NHS management and organisation would impact service quality and staff morale. Contingency

theorists (Child 1984; Mullins 1989,) reject the “one best way” approach, proposing that the structure and operation of an organisation are contingent on situational variables it faces. It therefore follows that each organisation needs to find the one “best” model for itself. However, it could equally be argued that the NHS operates in similar, if not identical environments; the same policy, the same funding and the same pool of staff.

2.7 Structural Concerns of Physiotherapists

Organisational structural changes have caused concerns for physiotherapy services (Jones 1991; 2000, Boyce 1992,). These have related to service fragmentation into small teams managed by directorates, divisions or general managers. It has been asserted that the work of many years developing services may have been destroyed. The individual issues included fears that staff would not get the professional support needed and professional standards would drop (DH, 1997). Øvretveit (1992,) argued that many concerns regarding the impact of organisational changes on therapy services had been overlooked. These included difficulties with recruiting and retaining staff, lack of career progression and the head of service being accountable for professional standards without authority. Subsequent studies detailed the differing roles and responsibilities of AHP managers, some having an advisory role only with no managerial responsibilities (Jenkins 2005,) and concerns about likely deterioration in clinical services:

“It is important to have clearly defined decision-making processes which are efficient.” (Leatt et al, 2000)

An essential element of effective management includes co-ordination of staff activities and achievement of organisational objectives with physiotherapy managers being responsible for ensuring the optimum use of resources and catalysts to improve services. The way that services' finances flow within and between organisations has been identified as the primary influence on management structure (Mintzberg 1979; Daft 2004) and has been seen to stimulate comprehensive reforms and address structural problems of public health services (Meessen *et al* 2011). Some physiotherapy services are part of other services, for example physiotherapy employed in a community rehabilitation team. Discussions often relate to whether services should be freestanding, part of other services or a mixture of both when organisational restructuring takes place (Jenkins, 2005).

The roles, responsibilities and functions of managers are wide-ranging and complex (Jenkins and Jones 2006). The scope, spectrum and contribution of these services are often not well understood and therefore physiotherapy services may not always be understood when organisations re-structure. The DoH commissioned report, *“Providing Therapists' expertise into the new NHS: Developing a Strategic Framework for Good Patient Care”* (1997,) noted that therapists, like most other professional groups in the NHS, had been reorganised several times, with resulting structures and management

arrangements not being in place sufficiently long enough to be fully evaluated.

The report commented on the effects of organisation and role conflict:

“Therapists often find themselves at the ‘heart of the problem’ in that they provide specialist services within very complex multi-agency environments to people who often require different types of specialist advice and treatment, whose need is likely to change over time.”

(p.45).

This complex situation might result in management dilemma requiring therapists to undertake conflicting roles of clinical specialists as well as resource negotiators. The concept of role conflict is of significant managerial importance (Khan *et al* 1964,) and a cause of staff stress (Walker v Northumberland County Council, 1995.)

Management structures that eliminate traditional forms of professional association have been cited as limiting the opportunities for AHPs to improve their position and contribution to the organisation (Jones, 1991.) Areas where a dispersed model of AHP staff deployment has been introduced led to dissatisfaction (Saunders, 1992.) The requirement for strong professional leadership with structure and financial support to underpin quality service was commended by Boyce (1993.) Kinston (1983,) argued that inappropriate or insufficient management structures for the AHPs resulted in little effective input into policy-making, resource allocation and long term planning with weak control of pressures on front-line staff. Management structures for physiotherapy services appear to swing between full devolution to localities or clinical directorates and centralisation to AHP or Therapy directorates and individual

departments. The DH (1997,) report found that there was no evidence that the choice of structure adopted for therapy services was grounded in research. The work of Burns and Stalker (1966); Blau (1963,1974) and Mintzberg (1979,1983,) has shown that specialists working in multidisciplinary expert teams with devolved structures needs different support mechanisms to be successful.

Structural changes have led areas of concern for the physiotherapy profession (Jones 1991; Berry 1994; Boyce 2007). Issues such as training of undergraduates, development and retention of specialists cited as critical for the reputation of a service. The effect of loss of staff for whatever reason profoundly affects patient care, both in the short term in getting work done and in the longer term in developing services and junior staff to become the next generation of specialists.

Blau and Schoenherr (1971,) argued for control by giving freedom for staff to exercise their skills and expertise in accordance with the high standards of their profession and by channelling the high motivation associated with the professional role into the service of the organisation. However, professional regulation requires controls and assurances to be factored in. The strategy for AHPs, *“Meeting the Challenge”* (DoH 2000b,) suggested that the AHPs would require strong management and leadership to deliver the requirements of the NHS Plan (DoH 2000a,) which encouraged the wider involvement of the AHPs in providing high-level clinical and managerial leadership and required employers to ensure that AHP skills were fully utilised.

Packwood *et al* (1992,) commented on the significant changes in NHS resource management and perpetual changing management structures were observed (Øvretveit 1992,) giving concerns regarding the impact of these changes on therapy services had been overlooked. The concerns culminated in fears relating to service fragmentation into small teams managed by directorates or general managers. The individual issues included fears that therapists would not get the professional support needed and standards would drop. Fears included the head of service being accountable for “professional standards” without authority to act. Jones (1991,) concurred with the view that the relationship between management and organisational structure for the physiotherapy profession was a dilemma for general managers and therapists alike. In response to the financial downturn impacting on the NHS, the health foundation commissioned Øvretveit (2011a,) to review the evidence on whether improving quality saved money. One of the most crucial areas identified was the importance of clinical coordination in supporting the decision making of clinicians and managers as they look at new models and ways to organise services. However the optimum, models, structures and ways of co-ordinating were not easily identifiable:

“It was not possible to make other, clearer, conclusions about the relative advantages of different coordination approaches. Many approaches involved a combination of coordination and other interventions, and many interventions were poorly described in the research. There is little evidence about which combinations are most effective for different purposes” (Øvretveit, 2011b p.49).

Therapists generally felt more comfortable and preferred a single profession structure which they perceived offered: Quick and easy access to higher level of clinical expertise, the ability to cover more easily for absent colleagues, access for patients to a full range of therapy services, plentiful professional supervision, peer support, a sense of professional identity, the feeling that their manager understands issues which are of importance to them, a greater likelihood of planned career development.

Therapy staff felt that they would run the risk of losing the benefits they had received of a single profession structure, if there was a change to a devolved structure. There was a strong preference from therapists to be managed in uniprofessional management structures. The preferences were unsurprising as the list described the model that most therapists would feel comfortable with and that most of them would have worked in for some time.

In research undertaken by Oakley (1997,) senior Trust (non-AHP) managers were surveyed to find their preferences for therapy management structures. They wanted a structure that could deliver: A client centred approach to delivering care, effective deployment of scarce specialist resources, potential to develop service level agreements to purchase care, possibility of interacting with one therapist rather than multiple in each locality. The senior Trust managers did not have a preference for which structure should deliver the outcomes required. The authors recommended:

“That rather than asking, “how therapists are best managed and organised?” and “Who should manage them?” The emphasis should be

rather on purchasers and providers seeking to ensure data, information, skills and knowledge flow through their respective organisations smoothly, and are integral to formulating good patient care.” (p.163).

This research therefore further explores the models of management and organisation proposed by Øvretveit in 1992 and compares that with current management structures, analysing the impact on physiotherapy patient care and staff. To give context to physiotherapy, the influence of the development of the NHS and its influence on physiotherapy are presented in the next chapter.

CHAPTER THREE

PHYSIOTHERAPY AND THE IMPACT OF GOVERNMENT POLICIES ON MANAGEMENT STRUCTURES

In this chapter firstly the wider organisational context of the NHS will be described relating to the organisation arrangements in which physiotherapy has been provided. Secondly the physiotherapy profession and its structures will be outlined.

A review of the NHS post 1989 is presented giving insight to the issues facing physiotherapy, earlier evolution is set out in Appendix 2. The development of the NHS reflected the political “mood” of each period, with government policies influencing structures and management practice. An understanding of the developing NHS, as an organisation that has continually updated and remodelled itself, is important in appreciating the impetus for change and its impact. The narrative history sets the context in which AHPs, specifically physiotherapy, will be contextualised. Three recent phases of political evolution were identified for the research to be focused on:

1989-97: Early quasi-market exploration

1997-2005: Attenuated market reform

2005-2015: Divergent national policy

The structure, organisation and management of physiotherapy in the NHS in common with the whole NHS, is on a continuum of far reaching and challenging re-design and high impact change. Smith *et al* (2001,) described the 2000 NHS reforms as being “an evidence free zone”, Hands (2000) reported that there was a lack of research to support the NHS changes actually improving NHS performance. Others (Bosanquet *et al* 2001; Klein 2013; Nuffield Trust 2012; Ham 2014) predicted that further changes implemented in the 21st century would significantly challenge the NHS and its founding principles.

In evaluating the impact of NHS changes of NHS re-organisation on physiotherapy, it is necessary to understand the development of physiotherapy from its origins; changes resulting from government policy; its relationship with other AHPs and the impact on management structures (Chapter Two), influenced by changing policy. The timing of changes in physiotherapy has not fully aligned with the periods of policy, as there has usually been implementation lag impacting on physiotherapy. Changes in the profession have influenced quality of patient care.

3.1 1989-98: Early Quasi-Market Exploration

Boyce (1993,) commented that from the late 1980s there had been a growing emphasis on structural reform in countries with publicly funded health systems; changes in the NHS at this time typified these developments (Saltman 1991). This period opened with widespread disquiet and cynicism whether the NHS could provide for young and old (Walker 1999,) and a new generation of staff

who may have lacked vocational attitudes (Rivett, 2009). Another review of the NHS was undertaken, with no formal consultation, and no published terms of reference, with submissions privately received (Butler, 1992). The White Paper "*Working for Patients*" (DHSS 1989a,) was not well received. There was perception that the government was sacrificing the founding principles of the NHS, even the BMA sided with the Labour opposition; a political "first". This paper signalled the end of the medical "veto" in the health policy process.

The NHS and Community Care Act (1990,) encompassed radical reforms of the NHS. The legislation effective from 1991, was based on the three White Papers "*Working for Patients*" (DH 1989a,) "*Caring for People*" (DH 1989b,) and "*Promoting Better Health*" (DHSS 1987).

The agenda focussed on efficiency of resources, with changes in the NHS mirroring the wider political, social and economic changes. The White Papers were born out of the need to review funding (Hoffenberg *et al* 1987):

"Each day we learn of new problems in the NHS...acute hospital services have almost reached breaking point...additional and alternative funding must be found, we call on the government to do something now to save our health service, once the envy of the world." (p.1505).

The 1990s revolutionised the structure of the NHS by separating the functions of care purchasing and care provision, both of which had been previously directed centrally from the DH via the RHAs. Major demand-side policies included the development of GP fundholding and practice-based

commissioning, whereby GPs were encouraged to take on budgets for purchasing elective care from hospitals:

“Giving better care and greater choice for the patient with greater cost effectiveness on the part of the provider, with money following the patient.” (Dennis,1991).

Responsibility for purchasing all other health services was bestowed on HAs. Supply-side reforms included the creation of self-governing hospital Trusts, thereby removing HAs from the day-to-day management of hospitals. Many GPs chose to invest in additional physiotherapy. Following *“Working for Patients”* (DHSS 1989a,) a series of eight associated papers were published (DH 1989c); with a rapid implementation schedule.

Much of the philosophy of the “internal market”, underpinning the reforms, was developed from the work of Enthoven (1985). Developments in international health service structure were reported by; Ham *et al* (1990); Enthoven (1991); Day and Klein (1991). The changes that occurred had some similarities to other healthcare systems, including Australia and Scandinavia (Saltman and Von Otter, 1995).

The introduction of market philosophy into a publicly funded service was designed to improve efficiency, by producing “managed competition” and “regulated markets”. It emphasised financial management of clinical activity aiming to create linkages between clinical activities, decision-making and financial consequences. Critics of market reforms cited “privatisation by stealth”, and an increasingly two-tier system of healthcare created by fundholding

general practices and NHS Trusts, argued the inappropriateness of competition in a publicly funded healthcare system. This produced inequality of services in different parts of the country, known as “post code lottery” (Coulter, 1992). This concept had previously been criticised by Hart (1971,) who described the availability of good medical care as varying inversely with the need for the population served. He further suggested that the inverse care law operated more completely where medical care was most exposed to market forces, and less so where such exposure was reduced. He concluded that the market distribution of medical care was a historically outdated social form. Despite this view, market forces continued to influence publicly funded healthcare systems in several countries (Harrison, 1995).

In their evaluation of the impacts of the internal market on purchasers and providers, it was observed that:

“Perhaps the most striking conclusion . . . is how little overall measurable change there seems to have been related to the core structures and mechanisms of the internal market.” (Le Grand et al, 1998.)

The explanation for this was that the incentives were too weak, and the constraints too strong. However, counter-arguments highlighted “gaming” and problems associated with the regime of “targets and terror”, rather than the impact of marketisation being responsible for changes (Bevan and Hood 2006; Bevan and Skellern, 2011).

Fundamental to the reforms was the concept of freeing DHAs from their responsibility for funding and managing the hospitals and units. Government's

main aim was to increase competition throughout the NHS. Large GP practices were to be encouraged to become fund-holders with commissioning responsibilities. Acute hospitals were able to become self-governing Trusts.

Fundholding GPs held financial leverage over hospital consultants. In 1995, 52 total purchasing pilots were introduced as an experimental pilot, giving GPs extended purchasing powers, with variable success (Goodwin *et al*, 1998).

Although HAs were powerful purchasers in theory, in practice, they were constrained because provider Trusts were heavily dependent on them. There were also difficulties in creating effective Primary Care commissioners.

A cornerstone of the new NHS architecture; the division between purchaser and provider, instead of being a fully-fledged “internal market” saw elements of a “managed market” with the government attempting to use market mechanisms to control parts of the health sector, coined “quasi-market transformation” (Kitchener and Whipp 1997). This described the replacement of government-run monopolistic state providers by competitive “independent” ones. Despite the near annual reorganisations that had taken place in the NHS, this had had no effect on changing the clinical practice of staff (Saltman and von Otter 1995). In contrast Ashburner *et al* (2005,) concluded that earlier analyses of the limited success of reform were not valid, suggesting that the Board level changes signified the beginnings of “organisational transformation”. Enthoven (1999,) on reviewing the impact of the reforms he had suggested in 1985, reported failure to deliver the hoped for transformation, due to the essential conditions for the “market” to operate not being fulfilled. In particular he cited woefully inadequate

information systems, lack of incentives and the burden of constraints from central government.

The White Paper, "*A Service with Ambitions*" (DH 1996b,) built on the experiences gained from the 1991 reforms, aiming to create a high quality integrated health service, organised around the needs of individual patients rather than the convenience of institutions. It was to be a "seamless" service working across organisational boundaries providing care for a well-informed public with "knowledge-based" decision-making. The White Paper placed great emphasis on improving quality. Many similar themes were later to emerge as "New Labour" policies.

Success could be attributed to recognising the need to reduce the power of the medical profession, and the potential for competition to improve services.

Failure could be recorded in the implementation and realising the intended benefits. By 1997 many HAs were in debt, waiting lists were growing and hospital wards were being closed, despite evidence of higher spending, steady increases in staff numbers and the treatment of more patients. Neither the public nor the healthcare professions were satisfied.

3.2 1997-2005: Attenuated Market Reform

The incoming Labour government in 1997 pledged to end the "internal market", though maintained the division between commissioning and providing healthcare. Emphasis was placed on co-operation rather than competition. A

Minister for Public Health was appointed. Emphasis was placed on improving the relationships between the NHS and Social Services. It embarked on a further programme of legislation and organisational change with more local involvement in services, and action zones to improve integration. A further review of health service financing was undertaken.

A series of plans, White Papers and organisational changes were produced (DH 1997a; 1998a, b; 1999) "*The New NHS: Modern. Dependable*" (DH 1997b) suggested that the service would be based on partnership and driven by performance, with taxation and public spending tightly controlled. The Public Service Agreement, as part of the comprehensive spending review (HM Treasury 1998,) launched a "target" culture for public services including the NHS. There followed NHS centralisation, mirroring centralisation at Whitehall. A network of special advisors were established, bringing business experience to influence the policy direction, one of these was Stevens, who later became Chief Executive of NHS England in 2014.

GP fundholding was abolished and replaced by a new GP contract (NHS Executive, 1997). The hospital consultants' contract was implemented after strained negotiations (The Guardian, 2004). The contract gave explicit rules on private practice which was fiercely contested. Doctors were required to meet performance targets set out in agreed job plans. The BMA's credibility; both in the eyes of Ministers and the medical profession, was shaken. A "no vote" was registered by consultants inflamed by government's insistence that there would be no further talks about the contract. The BMA responded warning that 7,000

consultants would quit if Ministers continued to refuse to renegotiate. It advised consultants to work-to-rule against the unpaid overtime that was required to meet waiting-list targets. 60% in England voted for the revised contract on the second vote. Legislation to overcome service fragmentation encouraged integrated care with flexibility to allow health and social care commissioners to pool and share budgets was introduced as well as Care Trusts.

Regulation of health professions was extended by the establishment of the Health Professions Council (*Health Professions Order, 2001*). The Bristol (DH, 2001) and Shipman Inquiries (2002) were followed by a tightening of professional regulation; the BMJ reporting the findings as:

“Nothing short of an earthquake for British medicine” (Salter, 2000).

The government promised to cut waiting lists, cut management costs and improve care for cancer patients (Labour Party, 2001). The main difference was the significant increase in NHS spending (UK public spending, 2009,) with a surprise announced (BBC, 2000) that expenditure would increase at the rate of 4% in real terms.

Table 2 Estimate of UK health expenditure as a % of gross domestic product

Year	Total UK health Spending		Health Expenditure in national accounts	
	£M	As % of GDP	£M	As % of GDP
1997	55,462	6.8%	53,142	6.6%
1998	59,178	6.9%	56,730	6.6%
1999	64,733	7.2%	62,027	6.8%
2000	69,242	7.3%	66,424	7.0%
2001	74,833	7.5%	72,592	7.3%
2002	80,620	7.7%	79,150	7.5%
2003	*	*	86,529	7.8%
2004	*	*	94,768	8.1%
2005	*	*	101,509	8.3%

(National Statistics, 2005)

The government's plan to spend the extra billions was included in "*The NHS Plan*" (DH, 2000a,) which had three main themes:

1. A missionary theme, with a Modernisation Agency to spread good practice
2. A patient protection theme, with professional regulation being re-structured starting with an overhaul of the GMC
3. Increasing patient influence theme, establishing Patient Advocacy and Liaison Services

The *Wanless Report* (2002,) was designed to undertake a fundamental review of the NHS, its performance and financing with recommendations to take the NHS to 2022, reported in the letter to the Chancellor that:

"We have achieved less because we have spent very much less and not spent it well."

This resulted in a series of reforms incorporating a focus on standards, processes and provision; a policy of attenuated market reform. There was a growth of competitive providers, (DH 2002b) with "Payment by Results" having a fixed "tariff". Lastly, further control gave Primary Care Trusts (PCTs) purchasing power and practice-based commissioning. Mannion (2005,) reported that the Practice Based Commissioning introduced in 2005, bore many similarities of the former GP fundholding, though the uptake by GPs was much slower, the incentives less transparent, and processes overly bureaucratic. Individual practices had the option to take on commissioning to a greater or lesser extent. Propper *et al* (2008) reported that analysis of the impact of competition at that time indicated positive results. Subsequent analysis of

international health care models cites the UK ranked 1/11 and the US, the most expensive and competitive system ranked 11/11 (Davis *et al*, 2014).

Private sector organisations built and operated hospitals under the public and private partnerships, and to run clinical services such as independent treatment centres and some NHS walk-in centres. "Contestability" saw the introduction of the potential for inter-provider competition. Baumol (1982,) reported on the vulnerability of a "hit-and-run" market. However, Rashid (1988,) further suggested that where there were retrospective costs which have already been incurred and cannot be recovered, and no "entry fee" incurred to join, that it was difficult to differentiate the new comer from the incumbent. Studies of the effects of this attenuated quasi-market found little evidence of intended improvements. Some suggested that any improvements in quality were due to policies other than competition, with studies of patient choice identifying lack of data on quality of care (Brereton and Grubb, 2010).

Reports suggested that both medical and managerial support for the government was at an all-time low (BMA 2001; Walshe and Smith 2001). The unhappiness felt by managers at this time was suggested by Smith *et al* (2001):

"Not to stem from government's goals for the NHS nor from its diagnosis...It is the way that policy is being implemented: Unprecedented micromanagement from the centre, which has the effect of constraining and undermining the ability of managers to manage. The command and control style, a never ending stream of "must do" edicts, a "name and shame" culture, and the perpetual obsession with organisational

restructuring can only detract from the ability of the NHS to deliver the plan."(p.1262).

The National Institute for Health and Clinical Excellence was set up in early 1999 as a Special Health Authority; to identify value for money and to ensure fairness for everyone who uses the NHS (NICE 2009). Its remit pertained largely to prescribing and medicines management. The Commission for Health Improvement was established (*Health Act 1999*,) to improve the quality of patient care in the NHS. It did this by reviewing the care provided by the NHS in England and Wales, aiming to address unacceptable variations in NHS patient care (CHI 1999). To further improve care National Service Frameworks were launched in 2004 (DH 2004d,) to provide a systematic approach to improve standards and quality. The continuum of health policy from the 1980s onwards reflected the importance of measurement to improve quality of health services (Zairi and Jarrar 2001).

"Shifting the Balance of Power: the Next Steps" (DH 2006a,) had the objective to give greater decision-making power to patients and "frontline" staff. This resulted in significant changes with the formation, dissolution and rearrangement of the structure and responsibilities of NHS authorities and Trusts. From 2002, a systematic approach was taken to introducing more competition into the NHS. There was an explicit decision to increase the diversity of types of providers offering services to NHS patients, including organisations from the independent sector (both for-profit and third-sector organisations). Most prominent was the nationally-led process of procurement

of independent-sector treatment centres to provide high-volume, low-risk elective surgery to NHS patients. In addition, a new form of NHS organisation, Foundation Trust (FT) (DH 2003,) was introduced, with greater operational and financial freedom than other NHS Trusts, regulation was undertaken by Monitor, (Monitor 2009). The government also encouraged for-profit providers to supply primary care services, with the intention of increasing capacity in areas with an insufficient diversity of health care providers. This process that saw for-profit firms and social enterprises gain NHS contracts (Allen and Jones 2011), with an overall focus on quality improvement (DH 2004).

The Wanless Reports (2002, 2004,) underpinned the recognition that the NHS was grossly under resourced. Recommendations for the future health service included significant increase in funding from the then 7.7%, to 9.5% in 2007-08, and 12.5% in 2022-23. Lewis and Gillam (2003,) were critical in their analysis of the direction that the government had taken, suggesting that there was little evidence that the policies would be effective. The overarching problem being the ability to turn policy into sustainable change, in a service that has little time to embed the previous reorganisation, with senior and middle managers who were fatigued by constant change and little stability. Farrar (2004,) described the ongoing changes in the NHS:

“The system between practices, PCT’s, Strategic Health Authorities (SHAs) and the DH is a bit like a Newton pendulum.”

3.3 2005-2015: Divergent National Policy

From 2000 the health policy in England and Wales began to diverge, the impact became evident in 2005.

3.3.1 The impact of Welsh devolution

Devolution:

“Is a process of decentralisation, and puts power closer to the citizen so that local factors are better recognised in decision-making.” (Cabinet Office, 2013.)

Welsh devolution has been described as “a process not an event”, (National Assembly of Wales 2015,) tracing its origins back to 1886. *The Government of Wales Act* (1998,) was the first Act to devolve powers to Wales. It created the Welsh Assembly, with Schedule 2 of the Act designating powers as “fields” of authority to the Assembly, including powers for the provision of health services. However, these were not legislative powers. There was no separate executive for Wales, unlike that for Scotland. In 2004, there were recommendations to transform the National Assembly into a full-fledged legislative assembly with primary legislative powers on all matters not explicitly reserved to Westminster. This led to the *Government of Wales Act* (2006).

In 1999 the *National Assembly for Wales (Transfer of Functions) Order*, transferred power to the Assembly over Acts that affected Wales, including the *National Health Service Act* (1977). The first Welsh White Paper on Health for Wales “*NHS Wales: Putting Patients First*” (DH, 1998c). This paper was the basis of the planned reforms and a 10 year plan which set out four new levels of

care. The paper also set out three important themes for healthcare: that it would be people centred, based on partnerships, and concentrate on prevention. The First Minister in 2003 drew a line of “clear red water” between England and Wales, arguing that the people of Wales had different values and priorities and that “choice” was less important. The government of Wales was committed to “collaboration not competition” rejecting Private Finance Initiative as a breach of a “Welsh way”.

The Welsh Assembly based their decisions and arrangements on health on these themes, and in the end (Greer 2004):

“Wales...bet on localism. This means integrating health and local government in order to coordinate care and focus on determinants of health rather than treating the sick. It tries to use localism as the lever to make the NHS into a national health service rather than a national sickness service.” (p.4).

3.3.2 English quasi-marketisation

Following the 2005 General Election and the re-election of the Labour government, there was speculation about future English NHS structure, organisation, management and service provision. The NHS refocused with the intention of changing the whole system, to give more choice and personalised care, empowering people to improve their own health:

“In other words, to move from a service that does things to and for its patients to one which is patient-led, where the service works with patients to support them with their health needs.” Sir Nigel Crisp (DH, 2005a).

Speculation centred on the introduction of practice based commissioning, increased use of the private sector and decrease in the number of PCTs and SHAs, with separation of commissioning and service provision functions and introduction of contestability. The Secretary of State for Health, outlined plans in, *“A patient-led NHS.”* (DH 2005a):

“Now is not the time to rest on our laurels; now is the time to step up the pace of reform. All of this gives us a chance, for the first time, to make real our founding values: a universal service, with equal access free at the point of use, with treatment based on clinical need not ability to pay. This is what we mean by a patient-led NHS: free for all and personal to each.” (p.ii)

In 2005 the DH conducted two consultations, *“Independence, Wellbeing and Choice”* (DH 2005b,) and *“Your health, your care, your say”*; this agenda was set out in the Government White Paper *“Our health, our care, our say”* (DH, 2006b). At the end of 2005 health policy had undergone a significant transformation; the future was set out in another document, *“Health Reforms in England.”*(DH 2005c).

In the 2006 reforms PCTs were reduced from 303 to 152, and new systems of financial flow, payment by results and a tariff system brought instability to NHS finances. By 2006 there was a return to “quasi-marketisation” policy.

Lord Darzi, a London surgeon, led the *NHS Next Stage Review* (DH 2008a,) setting out a vision for a world class NHS that was “fair, personal, effective and safe.” The final paper *“High Quality Care for All”* (DH 2008b,) set out four themes of; fairness, personalisation, innovation and safety quality as being

central to NHS development. It was endorsed by 13 key signatories, including the Prime Minister, Secretary of State and the clinical leads from the English SHA's, signifying senior medical support for the strategy.

The concept of any willing provider (subsequently known as any qualified provider (AQP)) was introduced in 2007, in relation to services for routine elective care, which included out-patient physiotherapy. *The Health Act (2009)*, set out the NHS constitution, quality accounts, payment, innovation and delegated authority powers. In 2009 the Chief Executive Officer (CEO) reported that the English NHS would need to make efficiency savings of £20 Billion. Klein (2013,) described this as a:

“Certain comfortless future” which would be on the spectrum of *“merely awful, to truly cataclysmic.”*(p.262).

The 2010 general election did not have NHS policy as a key election topic. However, the returned coalition government set about one of the most radical programmes of change for the English NHS, since its inception. The 2010 White Paper, *“Equity and Excellence: Liberating the NHS”* (DH 2010a,) announced the aims for the NHS, even though this was not part of manifesto pledges. After much debate and lobbying, many revisions were made. The Bill gained Royal Assent in 2012, more than 14 months after first being tabled; enacted as the *Health and Social Care Act (2012)*, setting in motion a further reorganisation of healthcare in England, (Appendix 3 and 4) The responsibilities included:

The Secretary of State for Health: Ultimate responsibility for the provision of the health service in England.

The Department of Health: Responsible for strategic leadership of the health and social care systems, but no longer the headquarters of the NHS, nor directly managing NHS organisations.

NHS England: Formerly established as the NHS Commissioning Board developed to become an independent body, at arm's length from government.

Clinical commissioning groups (CCGs): On April 1 2013, PCTs were abolished and replaced with CCGs taking on many of the functions of PCTs and some previously undertaken by the DH.

Health and wellbeing boards: Acting as a forum for local commissioners across the NHS, social care, public health and other services.

Public Health England: Established to provide national leadership and expert services to support public health working with local government and the NHS.

2011 saw the first award to a private firm, Circle, to run an NHS hospital; Hinchingbrooke in Cambridgeshire. The AQP model was introduced in 2012 (DH 2011a,) signalling a step change in the introduction of different providers, and a wider breadth of services open to competition. It was the model for the procurement of health services to develop a register of providers who qualify to provide NHS services by meeting pre-set criteria relating to the provision of healthcare. The underlying intention being that multiple potential providers should increase patient choice and promote competition between providers leading to innovation, improvement and increased productivity (PHORCAST, 2014). A wider range of organisations, such as social enterprises, were also being encouraged to become involved in the provision of healthcare in line with

the government's ambition to devolve power from central to local control and increase the involvement of people and organisations in their local communities.

In 2012, PCTs in England were required to open up at least three health services to AQP whether they were from the NHS, private sector, charity, social enterprise or voluntary organisations. In January 2013, the DH reported 105 healthcare firms had been granted AQP status, allowing them to provide NHS services including physiotherapy, dermatology, hearing aids, MRI scanning and psychological therapy. These included 87 providers of different kinds, 38 being private and 26 from the NHS. The Royal College of General Practitioners accused the government of "anatomising" the patient by having different providers for different body parts (Campbell, 2013).

The NHS business plan "*Putting Patients First: The NHS England Business Plan for 2013/14-2015/16*" (NHS England 2013a,) set out commitment to transparency and increasing patients' voice being fundamental to improving patient care. The plan described a scorecard for measuring performance of key priorities, focused on receiving direct feedback from patients, families and NHS staff. It intended to support the cultural change to put people at the centre of the NHS, a key theme in the report by Francis QC (HoC 2013,) following on from the stark findings of the Mid-Staffordshire review (Health Care Commission, 2009).

In assessing the causal effects of competition on outcomes five econometric studies measuring: the intensity of competition and the quality of care, Bevan

and Skellern (2011,) proposed that both eras of competition were ineffective highlighting the difficulty in designing and implementing effective competition. However, those using econometric analyses of the internal market found that competition reduced clinical quality as measured by hospital mortality rates while also reducing waiting times. This analysis implied that the internal market resulted in lower prices and improvements in observable quality (shorter waiting lists,) at the expense of unobservable quality (hospital mortality) and lacked clarity regarding the impact of patient choice on outcomes as well as the actual true cost of effectiveness of competition.

Reeves *et al* (2013,) commented that:

“One neglected aspect of the debate is on austerity’s health effects.”

Financial issues brought influenced the first disestablishment of a FT (BBC 2014,) and a prediction that the challenge faced by many smaller NHS Trusts in ensuring their sustainability, alongside plans to merge FTs in some areas, pointed to a future in which the provider landscape in England would be populated by fewer, larger organisations:

“Not a place for the faint hearted” (Ham, 2013, p.1)

The requirement that all NHS providers should become FTs by the deadline of 2014 was not achieved. Those not fulfilling the requirements explored alternatives including merging with an existing FT and being run by a private company under a franchise arrangement. The *“Better Care Fund”* introduced to

support integration in England (NHS England 2013c,) though criticised by Shadow Secretary of State for Health:

“Giving integration a bad name, by being an old-fashioned transfer of funding from the NHS to a struggling local government sector, with not enough bold thinking and true integration.” (NHS Executive 2014).

Another plan, “*Five year forward view*” (NHS England 2014,) recognised that the predictions of Wanless had been realised, but committing to progress the move towards a primary care led NHS with different models of care and provision. Hinchingsbrooke hospital, the only NHS hospital to be managed by a private company, was reported by the Care Quality Commission (CQC) inspectorate in January 2015 to have findings that were “among the worst it has ever published” (CQC 2015,) being the first ever to have been branded “inadequate” for caring and asked for a government bailout of £10m, six weeks before it is handed back to the public sector (FT 2015). In the same month Greater Manchester and NHS England (NHS England 2015,) announced plans around the future of health and social care with a signed memorandum agreeing to bring together a £6Bn health and social care budgets; a similar population and budget to Wales.

“The NHS belongs to the people” NHS in England (2013b,) set out challenges facing the NHS, calling for action, followed by the development of integrated personal commissioning with patients able to hold budgets for services including physiotherapy (NHS England 2015a). The NHS Trust Development Authority (2014) set out plans to assure alignment of NHS providers’ operational

plans and commissioner plans. In March 2015 , the first wave of 29 NHS England “Vanguard” sites were chosen take a lead on the development new care models acting as the blue prints for the NHS moving forward (NHS England, 2015b). In May 2015 West Suffolk NHS FT, Ipswich Hospital NHS Trust and Norfolk Community Health and Care NHS Trust won a competitive tender for Suffolk community services taking the contract back from Serco private provider back into the NHS from October 2015 and in July 2015 plans were announced for Cornwall’s “NHS devolution” deal (Cornwall Council 2015).

3.3.3 Wales: Back to Bevan, “anti-market”

The NHS in Wales was subject to the same government and policy changes as England up until devolution in 1999, though there were some Welsh specific changes and policy documents leading up to this. In 1982, the eight Area HAs in Wales became nine DHAs. In 1996 Wales merged the District HAs and Family Health Services Authorities into five HAs covering the whole of Wales (NHS Wales 2011). *“Better Health Better Wales”* (NHS Wales 1998,) explicitly made the link between poverty and ill-health.

“Improving Health in Wales-A Plan for the NHS with its partners” (NHS Wales 2001,) proposed new structures and organisational change for the NHS in Wales. The structure was developed to the principles of; simpler for patients to understand, accountable for the actions it takes and the service it delivers, stronger democratic voice in the way it is governed.

The five HAs in Wales were dissolved in this new structure. With the development in 2004 of The Health and Social Care Department, three Regional Offices, the National Leadership and Innovation Agency for Healthcare, Health Commission Wales, The National Public Health Service and The Wales Centre for Health. Services were commissioned by 21 Local Health Boards (LHBs) and provided by 13 NHS Trusts, with 22 Community Health Councils acting as public scrutiny organisations.

“Designed for Life” (WAG 2005,) set out the strategy encapsulating the government’s vision of transforming the Welsh NHS from the national illness service, into a truly national health service. To achieve this, the strategy outlined the kind of health and social care underpinned by aims of: Lifelong health, fast, safe and effective services, world-class care.

Following devolution, the Welsh government set out a commitment to move away from the use of markets and commissioning as seen in England. The manifesto document *“One Wales, A progressive agenda for the government of Wales”* (WAG 2007,) stated:

“We firmly reject the privatization of NHS Services or the organisation of such services on market models. We will guarantee public ownership, public funding and public control of this vital public service.”(p.8).

The government commitment included shared values, common goals and joint aspirations for the people of Wales providing a progressive agenda for improving the quality of life with an ambition to transform Wales into a self-confident, prosperous, healthy nation and society, which is fair to all.

The reorganisation of NHS Wales, on October 1st 2009, created single local health organisations (Health Boards) responsible for delivering all healthcare services within a geographical area (Appendix 5). The new 7 LHBs in Wales replacing former organisations, being responsible for planning, funding, designing, developing and securing the provision of primary, community, in-hospital care services, and specialised services for local populations. The Trusts were provider services; the Welsh Ambulance Trust and a tertiary oncology hospital. The “One Wales” commitment set out a range of actions to strengthen NHS finance and management, including ending the internal market, eliminating NHS use of private sector hospitals and ruling out the use of private finance initiatives.

The Bevan Commission report (WG 2011b,) was commissioned to assess alignment between NHS Wales and the principles for provision as articulated by Bevan, affirming that NHS Wales model remained true to Bevan’s principles, with free prescriptions, free hospital car parking and care free at the point of provision, with no competition from the private sector. The Welsh Health Minister drew on recommendations from the Bevan Commission to coin the term “prudent healthcare” (NHS Confederation 2014,) whereby:

“Healthcare which is conceived managed and delivered in a cautious and wise way characterised by forethought vigilance, and careful budgeting which achieves tangible benefits and quality outcomes for patients’ asserting that the NHS...must change or die by 2020”.

He called for “decisive action” to safeguard the future of the NHS, drawing out three principles of: Do no harm; carry out the minimum appropriate intervention

and promote equity between professionals and patients (Public Health Wales 2014). Wales remained consistent in its belief that common direction of provision within a unified system was the best approach to effect change while ensuring maximum equity of provision (Longley *et al* 2012). Though Smith and Hellowell (2012) reported that:

“Common economic challenges, combined with a tight fiscal policy (that remains excepted from devolution), means the similarities in health care provision across the UK are likely to remain more pronounced than the differences.” (p.178).

3.4 Physiotherapy

The definition of physiotherapy has evolved with development of the profession and the changing environment in which the service operates. The Chartered Society of Physiotherapy (CSP,) the professional body and TU for physiotherapy, defines it as:

“Physiotherapists help people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice. They maintain health for people of all ages, helping patients to manage pain and prevent disease. The profession helps to encourage development and facilitate recovery, enabling people to stay in work while helping them to remain independent for as long as possible.”(CSP 2015a).

Other authors have proffered definitions of physiotherapy including, Cott *et al* (1995,) stating that physiotherapy is based on a multi-dimensional movement continuum, building on the earlier work of Hislop (1975,) and his theory of

pathokinesis. They asserted that movement was central to physiotherapy, with the micro-environment at cellular level in tissue healing, and the macro-environment where the patient may be mobilised into their environment or society. Their concept, though broadly supported, received adverse comment from authors including Allen (2007,) suggesting that the movement continuum was a conceptualisation for physiotherapists, describing their assessment and management, rather than looking at clinical practice which focussed on function and disability. Their work was defined by Glanville (1977):

“Those for whom recovery of a stable future is possible,...patients who require support from time to time during the course of long term illness and those for whom recovery is not possible, who have to face the future with stable disability or progressive deterioration...to make able again.”(p.21).

Patients are referred to physiotherapists from a wide range of sources including, for example, self-referral, medical practitioners, social services and education services. Physiotherapists undertake a significant workload which is not the subject of referral, including public health and occupational health.

Many would concur that the profession has at its core the elements of therapeutic “touching”, movement re-education and electrotherapy (Rose 1989,) with an integral part of physiotherapy practice being clinical diagnosis; a rigorous method of history taking, clinical examination and assessment allowing conclusions to be drawn, aetiology of the patient's problems, to give a clinical diagnosis and subsequent appropriate treatment; the concept of clinical diagnosis underpinning the clinical independence of the physiotherapist. Although the doctor may give a medical diagnosis, the physiotherapists’

independent diagnosis and treatment roles are acknowledged. This represents an important element of clinical autonomy, recognising their distinct contribution to patient care within a discrete body of knowledge and skill; physiotherapists being legally responsible for their own practice.

Professional autonomy was described by the Health Services Organisation Research Unit (Rowbottom 1978,) being at: National level, District level and individual level, known as practice autonomy. Autonomy for physiotherapy was reported to include an additional form of professional autonomy, as well as responsibility of the practitioner who is ultimately in charge “prime responsibility” Øvretveit (1985), who would be the physiotherapy manager if they were a physiotherapist, but not a general manager.

3.4.1 Physiotherapy regulation

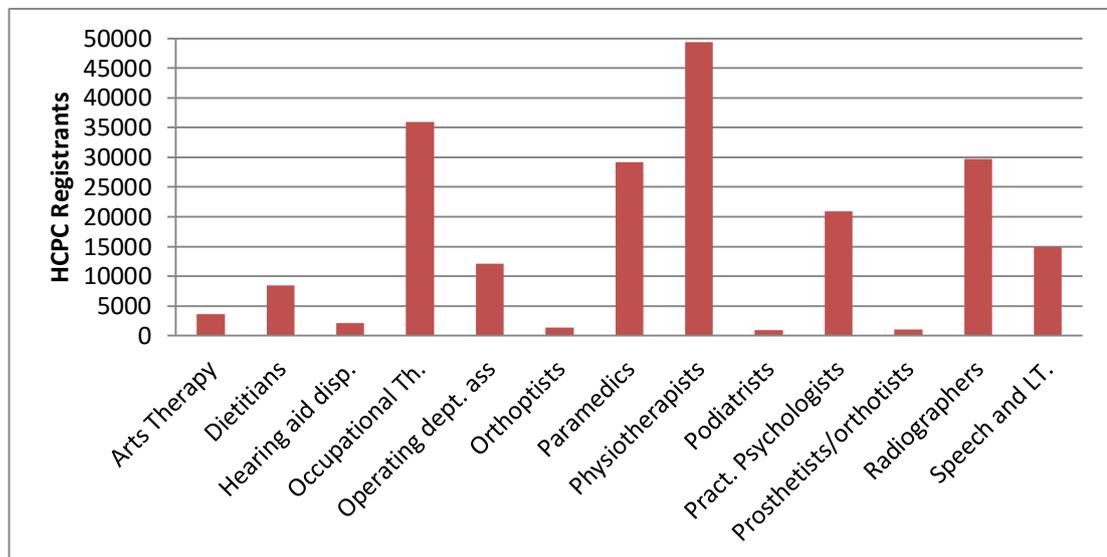
After years of debate and discussion, the Professions Supplementary to Medicine Bill was introduced in 1959, leading to the 1960 Act, which provided for the registration of eight professions. It was passed to ensure a system of regulation to guarantee a supply of well-trained and disciplined professionals for the NHS (Barclay, 1994). The professions became known as “Allied to Medicine” rather than supplementary. The CPSM was superseded by the Health Professions Council (HPC) (*Health Professions Order 2001,*) becoming the Health and Care Professions Council (HCPC) in 2012, these changes took place at the time of attenuated market reform (Chapter 3.2).

Physiotherapy fulfils a variety of professional elements and a series of attributes which have evolved.

3.5 Physiotherapy and the AHPs

The term AHP was coined by Gray, the then CEO of the CSP in 1999, to describe the collective grouping of the health professions formerly known as Professions Allied to Medicine. The term “Allied Health” had been selected to describe the development and status of the professions which were no longer considered to be supplementary to the medical profession. The term AHP was later adopted by the DH to describe the professions referred to in the strategy document, “*Meeting the Challenge*” (DH 2000b). The list of AHPs was subsequently expanded (HCPC 2015a).

Fig. 3 AHP registrants



Source: HCPC (2015a)

Each individual practitioner requires registration with the regulatory body, the HCPC, to work in the NHS and other sectors. Boyce (2007,) suggested that the AHPs should be “allied to one another” with greater strength to be exerted by collaboration rather than performing as discrete professional groupings. The AHPs have been recognised by the DH as having roles that:

“...have too often been undervalued or neglected.” (DH 2000b, p5)

They were cited during the period of attenuated market reform (Chapter 2.6) as being crucial in helping deliver the NHS Plan’s priorities (DH, 2000a). Despite this, AHP services are often not well understood.

The establishment of the HPC in 2002, signalled changes to exert greater governmental control over all of the health care professions, with the subsequent HCPC being responsible to the Council for Healthcare Regulatory Excellence; formally responsible to Parliament. Physiotherapy in the UK is the largest AHP and was also the largest profession regulated by the HCPC until the entry onto the register of social workers in England in 2012. It remains the largest AHP staff group with 49,630 registrant members (HCPC 2015a,) and the third largest direct patient care group in the NHS after doctors and nurses. In June 2015 Elaine Buckley, physiotherapist, was appointed as the new Council Chair of the HCPC (HCPC, 2015b.)

There were 209,481 AHP registrants on 1/5/2015, with physiotherapy representing 24% of all AHPs. These professions have differing historical backgrounds and widely differing numbers of registered practitioners.

Physiotherapy is commonly referred to as a “Therapy” profession being most closely aligned with occupational therapy (OT,) speech and language therapy, dietetics and podiatry.

3.6 The Development of Physiotherapy

The early development is set out in greater detail in Appendix 6. Key milestones included:

Therapeutic massage can trace its origins back to 3000BC. “Medical rubbing” grew in popularity in the late nineteenth century, performed largely by ill-educated but respectable women, with an influx of Swedish men and women lead to a great increase in demand for massage which was provided by doctors and trained nurses, though suggestions that massage establishments were brothels.

Lucy Robinson, Rosalind Paget, Elizabeth Manley and Margaret Palmer trained midwives/nurses and masseurs at the Royal London Hospital, established the Society of Trained Masseuses during 1894. They standardised examinations of competence, developed an ethical code and sought medical patronage.

The strengthening of the status of physiotherapy was influenced by the 1914-18 War, when wounded servicemen needed rehabilitation. In 1916 the Queen become Patron of the Society and in 1920 by the Royal Charter was awarded and the Society changed its name to the Chartered Society of Massage and Medical Gymnastics in 1944 changing its name to the CSP.

The birth of the NHS in 1948 further developed physiotherapy with training schools absorbed into the new NHS. In 1976 the first degree course in physiotherapy was established and in the same year the CSP became an independent TU. 1977 was a landmark year for the profession, with the recognition of the rights of physiotherapists in clinical diagnosis, and the control of their own clinical interventions (HC(77)33). A 1978 a bye-law change in the Society's statutes allowed physiotherapists to treat patients without prior medical referral. The Society of remedial gymnastics and recreational therapy merged with the CSP in 1986.

During the period of “early quasi-market transformation” (1989-98), Physiotherapy became an all graduate entry profession (1992). The CSP joined the TU Congress (TUC) in 1993 and in 1995 injection therapy came within the scope of practice.

During the period of “attenuated market reform” (1997-2005), the NHS Plan (DH 2000a,) announced the introduction of AHP consultant posts, with several new roles developed combining clinical leadership, expert practice and research elements giving recognition for highly skilled practitioner. Supplementary prescribing rights were extended to physiotherapists in 2005.

During the period of “divergent national policy” (2005-2015), the CSP appointed its first female and first physiotherapist, CEO (2013). The first independent prescribing physiotherapists began practicing in April 2014 (CSP 2015c).

Dixon (2003,) described the development of physiotherapy, as: “*From handmaiden to professional*”.

3.7 Health Policy Influencing Physiotherapy Post 1989

“*Working for Patients*” (DoH, 1989a), ignored the multidisciplinary nature of healthcare, perpetuating the doctor and nurse dominance. Internal market reforms in the 1990s introduced a competitive element, with many GP fund-holders investing in physiotherapy, though not all provided from within the NHS.

The NHS and Community Care Act (1990,) and subsequent early quasi-market saw the introduction of competition between hospital Trusts and GPs often investing in community and outpatient physiotherapy. This changed the dynamic of physiotherapy setting it on a more business-like footing. Boyce (1993,) suggested that the medico-centric model of health services in which policy is conceived, was a contributing factor to the lack of appreciation of the impact of health reforms on AHPs.

The NHS Plan, (DH 2000a,) signalled changes during the period of attenuated market reform (Chapter 3.2). It announced the creation of a new role of consultant AHPs, recognising the potential for non-medical staff to develop “expert” status, and PCTs made provision for an AHP Executive role.

Collective bargaining arrangements and pay structures had changed little since the creation of the NHS until the introduction of Agenda for Change (AfC) in 2004. Pre-2004, there was an over-arching joint negotiating body for the sector,

the General Whitley Council, with joint committees and sub committees for the different occupational groups. There were only three grades for clinical practice. The grade of Senior 1 was ill defined to accommodate changing practice and:

“Lacked recognition of skills and expertise” Øvretveit, et al (1982 p.10).

Physiotherapists keen to progress their career, moved into management roles. Changes to legislation from 1992, allowed organisations move away from Whitley terms and conditions. Most Trust’s shadowed Whitley, but a few introduced new pay and grading structures, resulting in some equal pay claims.

During the most recent phase of divergent policy, legislative change, the *Medicines the Human Medicines (Amendment) Regulations (MHMA) (2013,*) impacted on physiotherapy setting the way for physiotherapists to independently prescribe. In Wales this was enacted via devolved legislation in 2014 (WG 2014b.) This legislation would only apply to a small number of staff, but signalled a growing acceptance of extending the roles of physiotherapists. This period, linked with the austerity found across the UK impacted adversely on managerial and senior clinical roles for physiotherapists, as organisations sought to contain their pay bills. It also signalled a move towards 7-day services and integrated working which were reported positively by government in the physiotherapy press (CSP 2015b.)

3.8 Physiotherapy Professionalisation

To comprehend the way physiotherapists work in the NHS and the impact of

management structures an understanding of professionalisation is required, as this affects care for patients and staff development.

Friedson (1989,) proposed that:

“Professions are distinguished by some as being dedicated to public service rather than being concerned only with their own economic interest ... they are sometimes distinguished as being singular by virtue of the special kind of education and knowledge and skill that their members possess... but this definition in itself is not enough” (p.424).

The “professional” was depicted by Perkin (2002,) as being at the centre of contemporary culture; according to Abbott (1988,) they:

“Heal our bodies, measure our profits and save our souls.” (p.1).

Historically, the higher classes occupied the professions and access to them was based on social rank aligned with educational attainment. Perkin (2002,) and Bishop (1997,) observed that as education became more accessible professions were pervading all levels of society, with former “non-professional” occupations seeking professional status and its associated benefits.

Physiotherapy would be in this latter category, as the founders were not from the upper classes.

The features of “true” professions were defined as a set of attributes or traits (Marshall 1939; Greenwood 1957; Carr-Saunders and Wilson 1933,) though Willis (1989). They differentiated professions from other occupational groups, focussing on the professions’ function of maintaining social order (Parsons 1968; Millerson 1964.)

Abbott (1988,) theorised how occupational groups achieved power by controlling expert knowledge constructing themselves by forging links between their distinctive occupations. He coined the term “jurisdiction” to denote the right to control the provision of particular services and activities. Friedson (1988,) gave another dimension, selecting “autonomy” as the central characteristic. Navarro (1986,) however, associated the professions with the oppressive capitalist classes, and not being for the “greater good” of the majority.

Scott (2008,) presented the concept of professional agency, later developed to include the concept of institutional work (Lawrence *et al.*, 2009.) The broader role of professions in processes of institutional change was reported by Muzio *et al* (2013) , with professionalisation being a subset of institutionalisation, representing one of several ways to give order, structure, and meaning and the production of expertise (Suddaby, 2010).

Etzioni (1969,) presented “semi-professions” as teachers, nurses and social workers and reported that their training was shorter, mandate to control their work was less fully granted, their right to privileged communication was less established, and they had less of a specialised body of knowledge with less individual autonomy. The “semi-professional” state was considered by Elzinga (1990,) to be transitional towards full professional status. This classification was criticised by Friedson (1970,) and Torstendahl, (1990.) Physiotherapy may be considered to have gone through a semi-professionalisation stage, with training shorter than medicine, though gaining full mandate for right to privileged information, control of work and clinical autonomy.

Professionalisation has been described as a process of market closure and of the professions gaining monopoly control of work (Larson 1977). A developmental sequence of professionalisation proposed by Wilensky (1967,) detailed the first step as being full-time work, followed by separating a new area of practice from other occupational groups, then the establishment of training schools, leading to the consideration of standards and community recognition, and the establishment of a professional association. Wilensky postulated that this would be followed by inter-occupational conflict, between the new practitioners and older established occupations in the same sphere. This sequence was challenged by physiotherapy as the formation of a professional association emerged before the founding of training schools, supporting the theory proposed by Hall (1968,) of a “sense of calling”, which was extended by Bellah *et al* (1985,) to include “Jobs, careers, and callings.”

Parkin (1979,) described social closure as the usurpation of power by the subordinate groups. Friedson (1984,) further described the changing nature of professional control, arguing that the traditional model of professions became hierarchy-free during the 60s and 70s. He discounted the theories of deprofessionalisation (Haug 1973,) and corporatisation (Esland 1980,) instead proposing a third dimension of professional social control, whereby organised occupations were offered special shelter in the labour market, where members exerted control over their fate. This applied to physiotherapy during this period.

Bureau and Suquet (2009,) supported Abbott (1988,) additionally describing professionalisation as a continuous process, noting that once an occupation had achieved professional status it still had to fight off attempts to downgrade that status with challenges from competing groups.

3.8.1 Professionalisation theory and Physiotherapy

The term “health profession” includes physiotherapy. In describing AHPs, Sim (1985,) reported:

“The term ‘profession’ may be used in both a descriptive and evaluative sense. It may merely denote a group of people who share a common occupation or specific position in the social hierarchy...it may convey a value judgement, implying that, on more subjective criteria, an individual’s behaviour makes him worthy of his professional position”
(p. 14).

Successive reforms of the NHS and government policies have challenged the autonomy and self-regulation of professions (Harrison and McDonald 2007,) as part of a move in public administration towards managerialist approaches (Pollitt 1993; Ferlie 1996; Newman and Clarke 1994). Subsequently professionalisation in healthcare has evolved impacting on physiotherapy and its interrelationships with other professions, organisational management and patients. A consequence of the dominance of the trait-based approach to professions was the status accorded to medicine, institutionalising it as the “yardstick” against which others would be measured.

Two areas have a relative theoretical consensus, the first being the influence of the medical profession in shaping the healthcare provision. The monopoly and power of medicine and its jurisdiction over other health practitioners gave medicine control over their scope of practice (Larkin 1983). The second area is the negotiation of professional boundaries. Friedson (1971,) commented that despite market forces, the health professions had not been able to change their boundaries or scope of practice at will, requiring state authorisation.

Freidson's (1970,) structural analysis gave rise to an all-or-none conception of autonomy where other health occupations can never achieve true autonomy because of medical dominance. An opposing view proposed that degrees of autonomy are possible and which links the increase in autonomy of developing occupations to a decrease in medical dominance (Larkin 1983; Øvretveit 1985.)

Defining occupational aims of health professions include maintaining control over occupational groups to attain high social status (Macdonald 1995; Larkin 1983,) with rewards, privileges and high levels of autonomy (Parkin 1979,) ensuring high standards of practice. Saks (1995, 1983,) argued that there was little evidence to support these claims. An empirically based view of health professions' roles and task boundaries, demonstrated division of labour shaped to the professions' advantage (Allsop and Saks 2002; Larkin 1988.) The concepts of "social closure" and "professional dominance" were key professional goals (Fournier 2000; Larkin 1995,) serving to exclude outsiders (Allsop and Saks 2002), and pertinent to physiotherapy.

Central to these occupational strategies has been the use of professional ideology, in persuading others of the legitimacy of the professions special status (Johnson 1993,) and the competitive nature of inter-professional relationships, where competition has been fundamental to conflict (Abbott, 1988.) Larkin (1983,) proposed the term “occupational imperialism” referring to:

“An arena of tension and conflict between groups being largely shaped in outcome by the differential access of each to exterior power resources” (p.17).

Light (1995,) further described subjugating the needs of other groups to counter their dominance. Furthermore, Hartley (2002,) made reference to the “countervailing powers framework”, identifying the erosive effects upon medical dominance, developed by others with vested interests. The competing forces could be deployed by those wishing to encroach on medical territory to collectively ensure a fundamental shift in the trajectory of medical dominance (De Voe and Sharp 2003.) For physiotherapists, taking on the practice of invasive procedures such as; gynecological assessment and acupuncture are examples of this shift.

Bureau and Suquet (2009,) proposed an alternate view that the focus should be on the interactions between professional groups to control jurisdictions. Of particular significance to physiotherapists and other NHS employees would be the observation of Etzioni (1969); Evetts (2006); Roberts and Donahue (2000); Wilensky (1964,) that a profession’s autonomy and status as a profession are limited when professionals are employed within an organisation. Nursing has

not been categorised as a profession in sociology literature, a key issue being the lack of formal knowledge possessed by nursing as an occupation and of the power associated with it (Yam 2004). In research undertaken with OTs (Clouston and Whitcombe 2008,) the issue of whether they were a profession depended on society's views:

“If a profession may be defined as a folk concept ... one does not attempt to determine what a profession is in an absolute sense so much as to how people in a society determine who is a professional and who is not.”(p.27).

If this theory is applied to physiotherapy questions are posed; to consider whether, and if so how, they can uniquely define a professional identity? How it is valued by society? And what is the impact on patient care?

Light and Levine (1988,) challenged the prevailing model of professional dominance, discussing concepts of deprofessionalisation, corporatisation and proletarianisation proposing that there was evidence that these were the unanticipated consequences of the profession's campaign for autonomy:

“The net effect is to rationalize professional skills so that the physician performance can be subjected to external evaluation” (p.12).

The groups most at risk within a period of overall workforce boundary changes are likely to be the most specialised. Baldwin (2007,) proposed that the continued failure of the health professions to recognise and achieve inter-dependence rather than independence constituted their “Achilles heel”. However, Hewitt and Thomas (2007,) reported that the professions would not

easily be de-professionalised. The colonising attempts of organisations' management would often be met with appropriation strategies on the part of professionals, who may resist rather than reject change, maintaining their position of professional strength and survival. Furthermore, Evetts (2012,) argued that occupational control of the work was the new test for occupational power, authority and status. The observation made by Leicht and Fennel (1997,) illustrated the dilemma of the relationship between organisations and the professions, with control over professional work often vested in professional managers of the employing organisation, this would include physiotherapy managers.

3.8.2 Physiotherapy professional autonomy

Autonomy is an important element of professionalisation impacting on physiotherapy. Professional power was defined in three dimensions of attitudinal autonomy; autonomy in clinical practice and autonomy from the employer (Forsyth and Danisiewicz 1985.) The rise of managerialism was described as "anti-professional", due to its restriction on the autonomy of individual practitioners (Porter 1992). Autonomy is something well-regarded by the professions themselves, including physiotherapists, but an element that organisations have attempted to influence and control.

Professional autonomy carries with it both privileges and responsibilities (Cannavina *et al* 2000). Parry (2005,) in her study of physiotherapy reported that:

“The therapy professions have uniquely developed sets of intellectual capabilities and independent knowledge which are inseparable from professional autonomy and which management needs in order to deliver a high quality service.” (p.310).

Despite being the synthesis of knowledge, clinical guidelines create some tension, with professionals resisting their development and the associated shift in the locus of autonomy. Theorists have argued that professional autonomy may be retained through elite dominance of practitioners, while comparative research suggests that economic autonomy can be traded off to retain clinical autonomy (Rappolt 1997).

Managerial autonomy of a profession describes its freedom from external managerial control and the ability to be self-governing. It has been reported that entrenched professional interests and lack of managerial skills by clinician managers', limit the extent to which autonomy can be realistically devolved to them; with little belief from senior managers that greater autonomy enables healthcare services to be delivered more effectively (Hoque *et al* 2004). For physiotherapy, managerial and professional autonomy has often been described as freedom from medical control and to be self-directing as a profession led by a clinical manager. An important factor changing physiotherapy autonomy and consequent patterns of service provision was the transfer of education and training provision for physiotherapists into the higher education sector. Previously the AHP professional bodies including physiotherapy were responsible for prescribing curricula of study, examining candidates for entry to the professions and ensuring the quality of education

provision. The government strategies directed at changes in the system of care and at patient-centred care support diversification and plurality developing new concepts for the health professions:

“It is the use of knowledge to produce change that should be a central feature of the knowledge effort in the 21st century.” (Shine 2002.)

3.8.3 Physiotherapists’ relationship with medicine

The professional power perspective (Friedson 1970,) argued that medicine’s dominance in the division of labour was grounded by autonomy and self-regulation underpinned by a legislative framework, institutionalising its relationship with the state on which it relied for political and legislative support to maintain its dominant status citing the “technical autonomy” of individual doctors which freed them from evaluation by other occupations pinned their dominant position and “functional autonomy” as:

“The degree to which work can be carried on independently of organizational or medical supervision, and the degree to which it can be sustained by attracting its own clientele” (p.53.)

Willis (1989,) described four approaches used by medicine to maintain its professional dominance: The subordination of other workers; restricting the occupational boundaries of other workers; exclusion, by limiting access to registration and therefore legitimacy; and incorporation of the work of other disciplines into medical practice. Challenges to medical dominance by physiotherapists and others have been reported in studies of inter-occupational relations (Kelleher *et al* 1994; Witz 1992; Strauss *et al* 1963.)

The concept of “control” was also important to Friedson’s (1970) analysis:

“Distinguished from established professions by their relative lack of autonomy, responsibility, authority and prestige.” (p.49).

He cited four ways in which the “paramedical professions” differed from medicine: Knowledge approved by doctors, derived from medical knowledge; work tasks to assist rather than replace medical diagnosis and treatment; work instigated at the request of “orders” of doctors and often supervised by them; occupations accorded a lower prestige status than doctors by the general public. He further suggested that the medical profession maintained dominance by controlling both their own work and that of others. Physiotherapy had managed these arrangements to its advantage.

Øvretveit (1988,) suggested that it was medicine’s authority rather than autonomy which was central to the understanding of changing nature of inter-professional relations and that whilst changes in developing professionalisation have been seen for physiotherapy that corresponded to a decline in aspects of medical dominance, there was no evidence of a significant decline in medical dominance in health services or that the changes which have taken place are solely a resultant on the developing health professions' struggle for autonomy. This could also explain the tension found between medical and non-medical professions, as the latter grew in numbers and extended their skills.

Allsop (2006,) argued that while the state has increased its power at the expense of medicine, it has continued to accommodate medicine more than any other profession. Views differ regarding the significance of medical dominance,

some reporting that it has not declined significantly (Friedson 1970,) and others that the increased independence of other healthcare professions has occurred alongside the continued dominance of medicine (Alaszewski 1977).

Øvretveit (1985,) observed the development of professional autonomy in physiotherapy was related to a decline in corresponding aspects of medical dominance, a concept later explored as “horizontal stratification/jurisdiction”. However, there was no evidence of a causal relationship as often doctors willingly handed over work they did not want and control they did not need. Furthermore, there was some evidence that the state has supported the interests of medicine in granting a limited independence to some professions. Øvretveit’s 1992 study of UK therapy professions showed the regulatory system:

“Did not define a division of labour or provide the absolute autonomy which Friedson predicted.” (p.2).

This revealed a weakness in Friedson’s model of power, neglecting the importance of professional management autonomy of the non-medical professions. Øvretveit (1988,) further commented on professional-management arrangements:

“In the UK, local management structures ... were of crucial significance to professions... these management structures institutionalise practitioner and management autonomy, and that the structural position and authority of head profession-managers was critical to the future of each profession and in defining the work to be carried out.” (p.324).

In contrast others have suggested that subordination was the model of domination through which physiotherapists have been structured (Larkin 1981; Stacey 1992; Willis 1989). Therapists reject “subordination” in favour of a more collaborative relationship with medicine (Bruhn 1992; Gardner and McCoppin 1995). Lopopolo (1997,) suggested that physical therapists fit within Pellegrino's (1983,) definition of professionals as having functions that bring them into direct personal contact and call for direct participation in the healing relationship with the patient. Herk *et al* (2001) reported no evidence of a decline of medical power, though the public were reportedly more critical (Blättel-Mink and Kuhlmann 2003.)

Hafferty and Mc Kinlay (1993,) suggested that there were moved to attack the core of medical autonomy and their monopoly over diagnosis and treatment as well as over other health professions. The announcement in July 2012 of government sanction to pass medicines legislation enabling physiotherapist to become independent prescribers from 2014, was reported (Robinson 2012,) with supporters claiming this would reduce pressure on GPs. Discrete skills, opened up to other professional groups threatening medical dominance along with technology (Timmins and Tanner 2004,) and changing consumer influence (Hartley 2002).

Øvretveit (1985,) predicted that financial pressures would open up areas of work previously barred by the medical profession and lead to new forms of independence for developing health occupations, with the threat to medical dominance in the future coming from the state in its drive to contain healthcare

expenditure, rather than from the increasing independence of developing health occupations.

Johnson's (1972,) typology was adapted by Hollander and Campbell (1990,) defining occupation professionalisation status. They cited medicine as high control over conduct and entry as the archetypal profession. The skilled and highly unionised trades and technical specialists such as nurses and administrators were classified as having a medium level of control over entry and conduct. Physiotherapy would strive to see itself closer to medicine than nursing.

Table 4 A Typology of occupations: The integrative model

		Control over Conduct		
		HIGH	MEDIUM	LOW
Control over Entry	HIGH	Medicine, Law	Architecture Accountancy	
	MEDIUM	University teaching Senior Admin	Bureaucratic professions Unionised skilled workers	Non-Skilled Workers
	LOW		Unionised unskilled workers	Non-Unionised Non-Skilled workers

Hollander and Campbell, (1990) p.25

3.8.4 Managerial control impact on physiotherapy

Mills (1956,) warned about loss of professional autonomy as society was becoming more bureaucratised and Haug (1981,) noted that medicine had only been partially successful resisting the spread of knowledge to para-professionals with management structures and governance eroding medical autonomy; a feature that was observed in physiotherapy (Kinston *et al* 1981).

Haffery and McKinlay (1993,) suggested that although deprofessionalisation was acknowledged, it had become ignored, with Haug's (1988,) revisionist assessment of deprofessionalisation suggesting that this should be measured by the degree to which the characteristics of a true profession are diminished or lacking for its members, challenging Friedson's professional dominance concept, arguing that bureaucratic control such as general management undermined autonomy.

Increasing specialisation, has been accompanied by a decline in medical power and argued to be the primary target of managerialistic approaches (Williams 1985; Hunter 1991; Harrison 1994). The introduction of salaried employment for doctors and the more stringent requirement for regulation could demonstrate the proletarianisation of all health professions including physiotherapy.

3.8.5 Government influence

Friedson (1994,) predicted that the role of the state would become an arena of:

"Increased intellectual vitality." (p.7).

He argued that through greater concentration on jurisdictional disputes, the role of the state would become more significant. Harrison and Ahmad (2000,) suggested that the state's need both to contain welfare expenditure and to maximise political legitimacy has led to a diminishment in medical power, which would likely affect all health professions (including physiotherapy) with the state wanting, and needing to contain their power, independence and influence. Government policy to safeguard patients weakened the autonomy previously experienced by the health professions, and was perceived as an “attack” on their professional status (Hewitt and Thomas 2007; HoC 2013.)

Øvretveit (1988,) showed how state-mandated recommendations on local management structures for AHPs in the NHS influenced the extent of power and influence exercised by the professions. The concept of perceived bureaucratisation was described by Harrison (1994,) as an important element of culture, as professions become absorbed into larger management structures. Professions have been given the privileges of autonomy, ability to regulate themselves and in some cases earn high pay, in return for offering their skills and knowledge to society. The willingness by states to concede professional powers and regulatory responsibilities has been regarded as “questionable” (Evetts, 2012).

Guidelines have shifted the knowledge base in healthcare through standardisation, potentially constraining the practitioners “right” to exercise clinical judgement (Timmermans 2004). This led to polarisation between a “professional elite” who have strengthened their professional status, and a “rank

and file” who experienced a process of deprofessionalisation (Nadav and Dan 2006.)

Organisational relationships have become problematic (Barley and Kunda, 2006,) leading to “professional bureaucracy” (Mintzberg 1979,) with the effects of corporate control, such as pay structures, restrictions on practice, cost control and quality review. Light and Levine (1988,) defined this corporatisation as:

“The effect of encompassing proletarianisation without the same Marxist assumptions” (p11.)

In common with the proletarianisation and deprofessionalisation theories, McKinlay and Stoeckle (1988,) predicted that corporatisation would be negative for professional power arguing that “corporate rationalisers” would draw their mandate for authority from the need to have standardisation of diagnosis and treatment, cost containment and agents of third party payers, with professionalisation not being desired or desirable by all health professions (Timmons 2011.) Friedson (1984,) argued that professional power was reinforced not eliminated under corporatisation, as it was the elite who shaped and managed many of the managerialistic principles, thereby retaining dominance; though this did not account for Royal patronage such as the CSP’s Charter and state sanction through regulators like the HCPC.

The power of the state remains more powerful than the professions themselves and has the ultimate influence over quality of patient care and staff development affecting physiotherapy.

3.8.6 Physiotherapy stratification

Attempts to change the NHS workforce, through restructuring between organisations, within organisations and within the professions themselves have sought to reconfigure professional responsibilities in pursuit of more effective service provision (Martin *et al* 2009.) NHS managers have gradually achieved a degree of control over health professions since the mid-1980s. Friedson (1984,) suggested that the medical profession still had a monopoly control over knowledge, rebuffing claims that employment status adversely affected the professions. Hybrid structures have emerged in bureaucratised organisations (Mintzberg 1983; Courpasson 2000,) with professions, including physiotherapy, expected to exercise judgement and discretion in their everyday work. The professions' loss of their hegemonic position in healthcare was reportedly due to re-stratification. Whereas, Pickard (2009,) recognised the loss of control, but its limited impact suggesting:

“The loss of autonomy by an individual professional cannot be read off as equating to a loss of control for the profession as a whole.” (p.8).

The creation of new roles, such as extended scope physiotherapists, threatens the power and status of doctors through role substitution (Currie *et al* 2012.) There has also been a move towards role differentiation and stratification (Wulbert 1976). The key to understanding stratification was proposed to relate to the underlying agenda of reducing staff costs, whilst assuring patient safety (Mahmood 2001).

The term “value based health care” was coined (Jewell *et al* 2013,) detailing the aim to have access to quality services at lower cost with greater accountability. Therefore, value-based health care, is a priority for the NHS and a driver for professional stratification, impacting on physiotherapy.

Friedson’s (1985,) analysis of intra-professional stratification proposed three tiers:

1. “Producers”, involved in direct patient care
2. “Knowledge-elite”, engaged in academic clinical roles
3. “Administrative elite”, located in strategic managerial positions.

Professions have always displayed internal competition leading to stratification of both intellectual and economic power, a differentiation between those who formulate standards, give direction, and assert control from others who perform the work. This could be viewed as stratification within the profession, resulting in distinct groups of practitioners, researchers and administrators. The internal changes within a profession are viewed by Marxist theorists as something that is done to the profession, and deprofessionalisation and proletarianisation theorists suggest it is the professions who have done this to themselves.

An alternative view, draws on Bhabha’s (1994,) concept of colonial relationships suggests a middle ground between the attempted domination of colonisers and the counter-pressure of the colonised, where re-stratification occurs and attempts to control yet enable subversive elements to operate successfully (De Cock 1998; Holden 2001).

Vertical substitution can be viewed as requiring a challenge to the status hierarchy with a provider group, often adopting tasks normally undertaken by those of another profession. Vertical substitution normally occurring within a profession, increasing the scope of practice as a natural extension of the role with varying changes in status and reward. Vertical stratification led to the development of physiotherapy assistants.

In 2000, the English NHS began a series of workforce redesign initiatives expanding existing roles and developing new ones (Bohmer and Imison 2013.) AfC implementation, gave more opportunity to develop clinical careers without the need to move into management, breaking down professional barriers (Skills for Health 2008.) The investment in the early 2000s, led to the development of extended scope practitioners and consultant physiotherapists, recognising the value of the clinical career. The stratification that followed demonstrated physiotherapists working more autonomously not only within the scope of their profession but also taking on some new skills previously undertaken by doctors. Ellis and Connell (2001,) reported that a shortage of qualified staff was also regarded as being instrumental in stratification, though the oversupply that happened to physiotherapy in the early 2000s could also be viewed as an instrument to stratify.

Healthcare providers can change disciplinary boundaries by identifying new areas of work, or adopting roles normally undertaken by others, either as demarcationary tactics of encroachment or consensual delegation. This allows movement of the workforce in several directions: diversification, specialisation,

horizontal substitution and vertical substitution (Nancarrow and Borthwicks 2005). Professional boundaries can be subject to both intra-disciplinary and inter-disciplinary change. The former may arise from new forms of service provision, new markets, new technologies or techniques and diversification involving the expansion of professional boundaries within a single discipline, or intra-disciplinary change. Specialisation normally requires post-registration qualifications and restrictive membership groups leading to intra-disciplinary change involving either vertical or horizontal substitution. Substitution termed “encroachment” by Germov (1998,) draws more clearly on concept of social closure and usurpationary nature of strategies aimed at boundary encroachment. The disadvantages of substitution include the risks to professions where existing boundaries are at risk. The division of labour provides the opportunity to replace more expensive practitioners with lower cost workers, a common theme of NHS cost containment (Buchan et al 2000.) Physiotherapy has been seen to take over tasks previously undertaken by doctors; vertically substituting, and task from other AHPs; changing jurisdiction.

Changes in the politics, structure, organisation, regulation and management within healthcare indicates weakening of professional autonomy, authority and power in tandem with strengthening public and patient influence, regulatory transparency, multi-disciplinary team working, vertical and horizontal integration impacting on AHPs (Mueller and Neads 2005.) Boyce (2006,) reported on the emergence of an allied health sub-culture when reviewing the authority relationship between allied health and medicine in Australia. This was reported

as allied health “emerging from the shadow of medicine”, with AHP becoming more professionalised and doctors “letting go” of traditional hierarchies.

3.8.7 Physiotherapy jurisdiction

Øvretveit (1985,) described the changing relationship between medicine and the AHPs in the UK. He challenged the validity of Friedson’s assertion of medical dominance, as did Stacey (1992,) suggesting an opposing view that other health occupations had different types of autonomy to medicine; case autonomy, practice autonomy, self-management and organisational autonomy. Øvretveit’s later work (1988, 1992,) proposed the concept of “profession-management autonomy as well as defining AHP management structures. The growth of AHP autonomy did not necessarily produce a decline in medical dominance. The changing form of medical dominance from direct to indirect resulted in a shift from the original Friedson (1970,) theory, influencing physiotherapy jurisdiction.

Stratification that takes place between professions has been described as “horizontal”, where the more powerful professions encroach on others and vice versa by others taking up ground to extend their boundaries, closely aligned with professional “jurisdiction”. This has been included in a hierarchical framework for production control of hospitals which deals with the balance between service and efficiency, at all levels of planning and control (Vissers, *et al* 2001). Physiotherapy jurisdictional change has seen the development of advanced skills to take on roles such as injecting and prescribing, formerly the

sole domain of medicine. Horizontal substitution occurs when providers from different disciplinary backgrounds, undertake roles that are normally the domain of another implying mutually agreed transfer of tasks or negotiated boundary changes (Abbott 1988). The extent of horizontal substitution has resulted in physiotherapy and other non-medical professions competing with medicine.

3.8.8 Professionalisation characteristics and Physiotherapy

Professionalisation affects the care a health profession like physiotherapy can provide to patients, impacting on professional “freedoms” and its influence through the organisation’s management structure.

Theorists’ propositions were analysed and a set of professionalisation characteristics was developed from a more comprehensive list (Appendix 7):

Table 5 Professionalisation Characteristics

Legislation	<ul style="list-style-type: none"> • Support of the law for practice
Regulation	<ul style="list-style-type: none"> • Self-regulation in return for not-exploitive control
Occupational body	<ul style="list-style-type: none"> • Self-organising ,founding of a professional association • Strong public voice, autonomy from the state • Adoption of a formal code of ethics/standards of conduct • Overseen by a body of representatives
Education	<ul style="list-style-type: none"> • Derived from science and learning with systematic theory • Training schools, systematic theory, specialist body of knowledge • Skill achievement of a certain level (gained through a prolonged period of higher education,) which can be used in non-routine situations • Qualifying examinations and tests of competence <ul style="list-style-type: none"> - Restricted entry - Educationally communicable - Period of professional socialisation - Public, community sanction/ recognition
Professionalism	<ul style="list-style-type: none"> • Values <ul style="list-style-type: none"> - Professionalism - Client care - Quality - Integrity • Culture and personal identity of professional knowledge • Behaviour and ethos that stems from the professionals

	themselves
Practice	<ul style="list-style-type: none"> • Authority with large individual responsibility <ul style="list-style-type: none"> - Community sanction - Right to use discretion and judgment in the performance of work - Prevent others from performing that work • Autonomy <ul style="list-style-type: none"> - Case autonomy - Practice autonomy - Self-management - Organisational autonomy • An altruistic commitment to service • Predominantly Full-time practice
Inter-professional relationships	<ul style="list-style-type: none"> • Inter-occupational conflict between the new practitioners and older established occupations
Public recognition	<ul style="list-style-type: none"> • Meeting a genuine human need <ul style="list-style-type: none"> - Seen as a positive force in social development and a crucial social function • Customer orientation <ul style="list-style-type: none"> - Collegiate control by the profession - "Customer is king" • High prestige and earnings
Power	<ul style="list-style-type: none"> • Power-base <ul style="list-style-type: none"> - Assessment for entry to the profession - Privileges and obligations • Ability to ascertain/ allocate the economic resources needed to complete work

Sources: Flexner (1915); Carr-Saunders and Wilson (1933); Millerson (1964); Friedson (1970,1971,1984,1985,1986,1988,1989,1994,2001); Etzioni (1969,1979); Hoyle and John (1995); Parsons (1952,1968, 2013); Goode (1957,1960,1969); Greenwood (1957); Johnson (1972, 1993); Barber (1963); Wilensky (1964); Hall (1968); Forsyth (1994); Harrison (1994); Abbott (1988,1991); Evetts (2004, 2005, 2006, 2012); Leicht and Fennel (2001); Korczynski (2004); Belfall (1999); Weber(1958); Collins (1979); Murphy (1988); Fielding, Portwood (1980); Adler *et al* (2008); Sitkin and Sutcliff (1991); Baldwin (2007); Dombek(1997); Morell (2007); Bourgeault (2011); Vollmer and Mills (1966); Torstendahl and Burrage 1988); Downie (1990); Dent and Radcliffe (2003); Keiser (2004); Larson (1977).

3.8.9 Deprofessionalisation characteristics and Physiotherapy

Not all healthcare professions display characteristics synonymous with professionalisation, and some could be considered deprofessionalised. These characteristics were identified from theorists' propositions:

Table 6 Deprofessionalisation Characteristics

“Semi - Professions”	<ul style="list-style-type: none"> • Elements of semi-professions <ul style="list-style-type: none"> - Shorter training - Mandate to control work less fully granted - Right to privileged communication less established - Less individual autonomy because more supervision given - Less specialised body of knowledge
Transitional phase (towards full professional status)	In transition, full professional criteria not yet met
Breadth of practice	Less powerful professional groups may find difficulty in enacting boundary-spanning roles reducing breadth of practice
Itinerant professionalism	<ul style="list-style-type: none"> • Contingent (contract) work for professions gives different relationships: <ul style="list-style-type: none"> - Lack of security - Developing skills base - Lack corporate support
Employment	Employee status
Workforce Gender	Traditional male domination, keeping female workforce away

Sources: Etzioni (1969,1979); Torstendahl (1990); Freidson (1970); Elzinga (1990);Currie *et al*(2008); Barley and Kunda (2006); Evetts (2004, 2005, 2006, 2012); Haug (1973,1978); Ritzer (1983) Ritzer and Walcazak(1988);Roberts and Donahue (2000); Wilensky (1964,) Barley and Tolbert (1991);Yam (2004).

Macdonald and Ritzer (1988,) reported that the health professions were “very much alive”, with hospitals demonstrating improved performing when they have senior staff from clinical backgrounds (HSJ 2009,). However, Morrell (2003,) questioned whether the core values could survive in a secular culture characterised by commercialism, confrontation and self-interest.

Opinions about professional work vary (Muzio and Kirkpatrick 2011b.) Weber (1958,) described bureaucracy to represent the direction of changing society, and Ritzer (1983,) described the McDonaldization of society. This concept represented the fast-food restaurant as having become a more representative contemporary paradigm, representing predictability, quantifiable measures,

efficiency and standardisation, stifling the “art” of health professions; including physiotherapy.

3.9 The Impact on Physiotherapy Management Structures

Early management structures in which physiotherapists worked were focussed either on product or function (Oliveira and Takahashi 2012). Health organisations tend strongly to functional structures – organised as professional sub-hierarchies (“silos”) within each healthcare providers. A “product-line” organisation would consist of one manager, for all e.g. paediatrics services, line-managing a collection of doctors, nurses, AHPs and other professions, all as equal-status members of one team.

Mintzberg (1979, 1992,) proposed that organisations could be differentiated along three dimensions:

1. The key part of the organisation; the part that plays the major role in determining success or failure
2. The prime coordinating mechanism; the major method used to coordinate its activities
3. The type of decentralisation used; the extent to which subordinates are involved in decision-making.

For physiotherapy the type of decentralisation chosen has guided their management structure during recent periods:

In the period of “early quasi-market transformation” structural reform from 1989-1998, physiotherapy structures were affected by the division of purchaser and

provider, which brought a commissioning perspective and contractual arrangements. The Districts were gradually dissolved and physiotherapy services became increasingly fragmented. This period also saw the introduction of the internal market with private physiotherapists entering the NHS market. This arguably gave patients greater choice but also changed the former District services with elements competing to provide services, and patients not having all their physiotherapy services provided from one centrally managed and organised service. This introduced greater variation in quality, standards and governance as there was no longer one accountable physiotherapy manager for all physiotherapy in a geographical area.

The period of “attenuated market reform” from 1997-2005 introduced co-operation rather than competition into healthcare. This removed GP fundholding and saw the withdrawal of private physiotherapists contracted under this arrangement. The strengthening of the purchaser/provider split increased the power of community PCTs, and saw the development and strengthening of community physiotherapy services, providing treatment closer to home for patients and the development of PCT physiotherapy management structures. The increasing number of providers saw a fragmentation of care between hospital and community and resulted in many small physiotherapy services in community and mental health organisations. The “target” culture of this period required physiotherapy managers to account for performance measures such as waiting times. Additionally the advent of evidence-based practice required physiotherapists to provide evidenced-based care, which influenced clinical

practice during this period. More physiotherapy managers were required as the number of organisations increased, but some small organisation did not have a breadth of physiotherapy services to provide, and competing organisations often did not allow networking between physiotherapy managers. Therefore, this period saw increased fragmentation and less standardisation of quality between organisations. Practically is resulted in the larger organisations training and developing junior staff, as they had greater expertise and critical mass of staff. The physiotherapy managers' role in acute hospital settings required management of greater numbers of staff in more specialties than those in community settings, where physiotherapy numbers remained relatively fewer.

The period of “divergent national policy” 2005-2015, saw quasi-marketisation in England with increasing competition and fragmentation as physiotherapy services were included as part of the AQP initiative. This resulted in Acute Trusts in many areas losing outpatient service provision to new providers, and new entrants such as social enterprise organisations, taking on defined areas of service provision such as community services. Physiotherapy management structures were impacted when organisations mergers or fragmented, or when physiotherapy services were “lost” resulting in a reduction of physiotherapy manager roles and in some cases a lowering of the pay Band. This period in Wales saw a consolidation of services, back to mirror in many cases the former District type services, as Health Boards took on both commissioning and provision of services for a geographical area. This drew physiotherapy services together, consolidating the physiotherapy managers' role across a wide range

of services. In both countries a development of an AHP manager role was seen, which brought AHP services closer together, in both management and clinical practice.

3.10 Conclusion

The matrix organisation structure type, in which many physiotherapists worked with their AHP colleagues, crossed traditional organisational management structures (Galbraith, 2009). Improved communication together with the introduction of expert patient programmes and patient and public involvement initiatives with availability of electronic knowledge, enhanced opportunities for patients to be more knowledgeable when accessing and receiving care. Care modelled around the patient rather than the needs of professional groups, such as physiotherapy, had challenging traditional professional power (Hurst 1996; Nancarrow 2003; Friedson 2001; Exworthy *et al* 2003) over the three periods studied. This demonstrated a shift from “functional” to “product” structure. Political imperatives have therefore been strong triggers for change aimed at creating a patient-led NHS, with the patient, not the professions, such as physiotherapists, being “king”.

The changes that have taken place in the structure, organisation and management of the NHS since its inception represent a large cycle of reform affecting the way in which physiotherapists have been managed and organised. The structural changes to NHS Physiotherapy seem to have moved from a District service, to a more fragmented model, with the introduction of private

providers in England, and a return to a more joined- up district service in Wales. Organisational structure have been shown to impact on how the organisations' shape themselves to deliver the NHS policy requirements impacting on how professional groups are managed, and how professions are enabled to use their skills to benefit patient care whilst ensuring the staff are well-trained and educated.

The management structure selected brings together the formal configuration between individuals and groups regarding the allocation of tasks, responsibilities, and authority within the organisation (Greenberg 2011). The organisation's structure gives it the form to fulfil its function in the environment (Nelson and Quick 2011,) and in NHS physiotherapy this impacts on patient care and staff development. Physiotherapists have often found themselves justifying their contribution and their position in the management structure of the organisation. Therefore, the impact of changing NHS structures can be seen to be of significance to physiotherapists and their patients, as structures influence availability of care and its quality.

Taking into account the literature reviewed for this thesis, it is reasonable to conclude that there are both strengths and challenges for NHS physiotherapists. England reported an intention to reduce workforce costs by 20% (Mitchell 2014,) and reduced undergraduate commissioning numbers for a range of health professions including physiotherapy. Wales implemented a pay settlement inflating wages (WG 2014b,) whilst also requiring stringent cost

savings. This poses major challenges to traditional professional hierarchies and stratification impacting on the skills available for to provide high quality patient care, as well as the consideration of the structures in organisations to enable maximum efficiency and assure a well-trained, skilled workforce to meet patient needs.

This review of NHS development across three distinct periods has made it possible to reflect on the political circumstances that led to its continuous development and the succession of policy initiatives which have continuously impacted on the structuring and function of the NHS, including physiotherapy; affecting quality of patient care and development of staff. The research questions were therefore constructed to explore these issues, and are set out in the following chapter.

CHAPTER FOUR

RESEARCH QUESTIONS

In this chapter the RQs are presented and discussed, they were developed to gather data on the impact of management structures affecting physiotherapy, patient care and support for staff development.

Previous research had shown that physiotherapy services had been influenced by organisational change, impacting on restructuring both between organisations and within organisations; however it had not identified the current physiotherapy management structures in the NHS, their impact on the profession, managers' roles, staff or patient care. Therefore RQs were developed to gain better insight.

4.1 Overarching RQ

“What effect has government policy for the NHS had on the management, organisation and provision of NHS physiotherapy services in England and Wales?”

This question was developed to look at the impact of the reforms on physiotherapy management structures and the influence of different structures on key outcomes.

The main question formed a framework for further discrete, yet interconnected RQs covering empirical and theoretical contexts. The study includes and compares physiotherapy services in England and Wales. The services differ in the political context of their national policy, as well as management structures and breadth of geographical areas provided for. Service models varied in terms of management structure, some being uni-professionally managed by a professional Head of physiotherapy services, others managed within a therapy or AHP Directorate model and some managed in devolved units or care groups. An aim of the research was, therefore, to define contemporary management structures for physiotherapy.

4.2 RQs

Three further questions were designed to facilitate research relating to the different models of physiotherapy services, the status of physiotherapy as a profession and analysis of the roles of physiotherapy managers; these were assessed using normative criteria. RQ 2 and RQ 3 each examine in more detail a component of RQ 1 exploring how the different management structures for physiotherapy impacted on physiotherapy, patient care and staff.

4.2.1 RQ 1

RQ1: How do models for the management structures and provision of NHS physiotherapy services differ in terms of access and scope of practice?

- a. What are the organisational changes that have taken place in physiotherapy services?

To what extent and in what ways have successive decisions about the organisation and management of physiotherapy services, up to and including the most recent reforms, shown continuity with previous organisational changes?

- b. How have physiotherapy management roles, responsibilities and functions changed during the period since 1989?

To what extent and in which ways do physiotherapy managers participate in decision-making within the organisational management hierarchy of provider organisations?

- c. What is the comparison between England and Wales in these respects?

4.2.2 RQ 2

A normative question was developed to provide advice on how physiotherapy services may be structured. This observational study approach presented parameters and factors contributing to what might be an effectively managed service in RQ3.

RQ2. How do the different models of physiotherapy management found rate against the domains and elements of the assessment tool for evaluating AHP management structures devised by Jones and Jenkins (2006, 2010) and revised by Jenkins and Jones (2011)?

4.2.3 RQ 3

RQ3: What impact has NHS changes had on the professionalisation process of the physiotherapy profession?

- a. How do the organisational arrangements for physiotherapists in terms of management structure and professionalisation compare to the models proposed by professionalisation theorists?
- b. How has professional stratification been affected by NHS policy changes?
- c. What is the comparison between England and Wales in these respects?

4.3 Relevance and Context of RQs

The period of focus for the research is the continuum of NHS reforms from 1989-2013/14, including England and Wales, covering several periods of policy change. This research focused on physiotherapy but is also relevant to other AHPs. The areas investigated are the spectrum of management structures, professionalisation, physiotherapy management structures and how they relate and impact on strategy, planning, service provision, patients and staff.

Normative questioning was based on value judgements of the domains and elements set out by Jones, Jenkins, (2006, 2010,) and updated by Jenkins, Jones (2011,) and also developed following an extensive review of literature presented in the first three chapters. The “model” physiotherapy service being one which would offer prompt treatment, clinical assessment undertaken by a skilled practitioner, with a broad range of specialist staff to provide expert

treatment and cross cover when required as well as training and development for physiotherapists and students. The service would embrace evidence-based practice and R&D, contributing to the development of knowledge and skills within the profession, working collaboratively with other professions. Patient outcomes would be recorded and evidenced to be effective and well-respected by the public. The service would be involved in developing and implementing organisational strategy. Data and information would be routinely collected and used to influence strategy and evaluate performance. The service would also actively seek feedback from stakeholders in assuring service quality and supporting service development.

All of these elements would contribute to supporting staff development and clinical expertise, impacting on care for patients and directly influenced by the physiotherapy management structure within the organisation and the way in which physiotherapists were given autonomy to use their skills and perform their duties.

The methods deployed to gather data are the focus of chapter five.

CHAPTER FIVE

METHODS

In this chapter the methods and framework for the research to answer the three RQs are presented. This enabled data to be collected relating to management structures, the roles of managers and the impact on physiotherapy, staff and patient care.

5.1 Choice of Design

The research topic required investigation by an observational study, as neither a randomised controlled study nor quasi-experiment design would have been feasible. The study design comprised a mixed methods approach with five separate elements. The sampling approach targeted physiotherapists including those holding the most senior physiotherapy management role in the organisation, and those with long careers in physiotherapy management.

The first element was a narrative literature review to give a theoretical understanding of the research topic and identify previous publications and gaps in the literature.

The second element was a questionnaire census, designed to gather data from the senior physiotherapy managers in England and Wales. The purpose of the

questionnaire survey was to gather information from current physiotherapy services, about aspects of their management and organisation, the roles of the physiotherapy manager and elements of physiotherapy professionalisation. This method also identified the different management structures in place and types of organisations. This method was used to answer parts of RQ1b, 1c, 2 and 3.

The third element was semi-structured interviews (SSIs) with experienced physiotherapy managers. The in-depth interviews gave rich qualitative data from the managers who had all worked throughout the three periods of organisational change, and drew on their reflections of their professional careers as NHS physiotherapy managers. The purpose of this method was to gain qualitative data about the impact of changing NHS policy on physiotherapy services and the profession, probing more deeply than the questionnaire survey. It also identified the different management structures that experienced managers had worked in throughout their careers. This method was used to answer parts of RQs 1a, 1c, 2 and 3.

The fourth element included a narrative history of physiotherapy. This required a review and analysis of texts and documents and the survey census. The purpose of this method was to provide an historical narrative of the profession, from its inception to contemporary practice and how changing NHS policy impacted on the development of the profession in the changing structure and organisation of NHS services. This method was used to answer RQ1a. A review of professionalisation literature was undertaken including that by Friedson, Wilensky, Greenwood and Etzioni, enabling a compilation of theorists'

propositions about professions. Assessment was undertaken using a set of professionalisation characteristics developed from theorists propositions (Table 5). This method was used to answer RQ 3.

A normative evaluation of the management structure of physiotherapy services was undertaken. This analysis included a cross sectional framework analysis of data against the normative framework of the Jenkins and Jones (2011) ATEAHPMS (Appendix 9,) comparing different physiotherapy management structures. This method was used to answer parts of all three RQs.

The cross-sectional study facilitated comparison between different services, in England and Wales. It enabled compilation of current physiotherapy management structures in place as well as identifying the different organisational types. A 50% response rate was identified as one that would be deemed satisfactory (Richardson, 2005,) though there lacks an agreed “standard” for an acceptable response rate (Edwards *et al*, 2002.) Therefore a response rate of >50% was aimed for.

5.1.1 Summary of research design

This is set out below linking each RQ with the research methods.

Table 7

Research design summary

RQ1. How do models for the management structures and provision of NHS physiotherapy services differ in terms of access and scope of practice?			
Research Question	Design	Data Collection	Analysis
<p>a) What are the organisational changes that have taken place in physiotherapy services since 1989?</p> <p>To what extent and in what ways have decisions about the organisation and management of physiotherapy services shown continuity with previous organisational changes, up to and including the 2010/11 reforms?</p>	<p>The historical narrative study and documentary analysis, enabled investigation of the background and context of NHS organisational change and the extent to which policy has been put into practice. It identified current management structures and further extended to analyse the implications of recent policy changes in England and Wales relating to physiotherapy services. The in-depth interviews also included questions relating to the change over many years.</p>	<p>The documentary analysis review enabled a study of policy developments and changes to identify any recurring themes and examples of how policy change impacted on physiotherapy management arrangements. Data from policy documents, contemporary and historical, journals, books and secondary sources including reportage and eye witness reports. The interviews were recorded and transcribed.</p>	<p>Periodisation of the reforms.</p> <p>Compilation of management structure typology.</p> <p>Discourse analysis of policy and managerial documents and data.</p> <p>Observation of the impact and changes to physiotherapy management arrangements resulted from the reforms.</p> <p>Thematic analysis of interview data.</p>
<p>b) How have physiotherapy management roles, responsibilities and functions changed during the period since 1989?</p> <p>To what extent and in which ways do physiotherapy managers participate in</p>	<p><i>Census</i> via a questionnaire survey and interviews designed to gather information to build a comprehensive picture of how physiotherapy services have developed in terms of access, scope of</p>	<p><i>Questionnaire:</i> A census study was performed targeting all of the senior physiotherapy managers in the NHS provider units in England and Wales. In-depth interviews, until saturation of themes was achieved. This facilitated access to those physiotherapy managers who had</p>	<p>Software to analyse data from questionnaire</p> <p>Thematic analysis of transcribed -depth interviews.</p>

decision-making within the organisational management hierarchy of provider organisations?	practice, expertise of staff and financial efficiency during the research period. This also includes historical narrative study of management roles, presenting groupings and relationships in a hierarchical relationship covering the research period.	recently retired, or moved into other roles, that would not have been picked up by the national questionnaire survey. The interviews comprised semi-structured questions.	
c)What is the comparison between England and Wales in these respects?	As outlined in a) and b) above	As outlined in a) and b) above	Anglo/Welsh analysis was undertaken, comparing results identified in a) and b) above, from both countries to identify similarities and differences
<u>RQ2. How do the different models of physiotherapy management found rate against the domains and elements of the assessment tool for evaluating AHP management structures devised by Jones and Jenkins (2006, 2010) and revised by Jenkins and Jones (2011)?</u>			
	A combination of the design detailed in questions one and two- historical narrative, framework analysis and normative evaluation	The ATEAHPMS was incorporated into the census survey enabling different management structures for physiotherapy to be identified and analysed in terms of the managers role, responsibilities and functions. It was also tested for validity in the SSIs	The different management structures were identified, and analysed in respect of their effectiveness at demonstrating effective management of physiotherapy. A within-case analysis was followed by thematic analysis across the cases, i.e., a cross-case analysis. Categorical aggregation was used where issue-relevant meanings emerge from the data. Direct interpretation was undertaken when single issues were highlighted. Patterns were drawn looking for correspondence between two or more categories. Natural generalisations were developed from the data analysis, to identify whether “norms” could be identified.
<u>RQ3. What impact have the changes in the professionalisation process had on the physiotherapy profession?</u>			
a) How do the organisational		Data from contemporary	Comparison of theoretical predictions with historical

arrangements for physiotherapists in terms of management structure and professionalisation compare to the models proposed by professionalisation theorists?	Normative evaluation with framework analysis using an assessment developed from by theorists' historical narrative. This was informed by a narrative history of the physiotherapy profession, informed by documents and the census survey.	policy documents and secondary sources including reportage and eye witness reports.	narrative using a normative framework developed to compare reported practice across the ten standards and the theory driven professionalisation criteria. Comparison of normative framework with periods of change.
b) How has professional stratification been affected by NHS policy changes?		In addition data gathered via the ATEAHPMS as part of the census survey.	Analysis of Physiotherapy, during the research period using theorists' models of professionalisation.
c) What is the comparison between England and Wales in these respects		Transcribed interviews	Thematic analysis of in-depth interviews Software to analyse data from census questionnaire

5.2 Process for Gaining Research Approval

The procedure for gaining research permission was complex and protracted.

Identifying the organisations which provided physiotherapy in NHS England was difficult, due to the recent changes where many primary care providers had transferred their service provider function to other organisations. Other organisational changes including mergers, amalgamation of acute and primary care provision and initiation of other types of provider also created difficulties in identifying both provider organisations and specifically those providing physiotherapy. There were inconsistencies and differences between the English and Welsh process (Appendix 10), Research permission was granted (Appendix 11.)

5.3 Literature Review

Literature searching was undertaken as part of the research theoretical background, identifying what was already known in the subject and related areas (Cresswell, 2008). It was also undertaken to provide the historical context for the research, the evolution of the NHS, and policy changes as well the development of the physiotherapy profession and theories of professionalisation. The literature review fulfilled the requirement commended by Strauss and Corbin (1990,) of stimulating theoretic sensitivity, providing secondary sources of data, stimulating questioning during data gathering, directing theoretical sampling and providing supplementary validation.

An extensive range of literature including books, articles, papers, government documents, Masters Dissertations, Doctoral Theses and grey literature were drawn upon to provide the theoretical basis for the research. Literature searches were conducted on the Plymouth University, CSP and Health of Wales libraries.

A study was deemed suitable for inclusion if it met all the following criteria:

- NHS reforms in England and/or Wales, post 1987
- The management and provision of NHS physiotherapy services post 1987
- The management and provision of AHPs in the UK and other “Beveridge type” health services
- The evolution of the physiotherapy profession

- Professionalisation and physiotherapy
- English written material (or Welsh or other language translated into English)

The search strategy was developed to meet the RQ’s requirements. These included the themes of physiotherapy, professionalisation, professional evolution, NHS, organisation and management structures. Alternative terms including US spellings such as “organization” and “professionalization” as well as “physical therapy” were used. Database limiters were selected appropriately, such as publication date and written or translated into English. Boolean Operators were used and truncation symbols; as required. Search criteria were adapted according to the database. Advice was sought from the CSP library services regarding search criteria for profession specific data. The following sources and databases were searched:

Table 8 Literature search data bases

AMED	Allied and Complementary Medicine Database
ASSIA	Applied Social Science Index and Abstracts
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CIRRIE	Center for International Rehabilitation Research Information and Exchange
CSP Library catalogue	CSP collection of publications and documents
Department of Health	Publications Library
DH Data	Key Department of Health documents
Health of Wales Information Services (HOWIS) http://www.wales.nhs.uk/	Subject gateway
HMIC	Health Management Information Consortium Database. Containing DH data, King’s Fund database and Health Information Management Information Service Database
Nursing and Allied Health Comprehensive Collection	Database
Medline / Pubmed	Database
NHS Evidence . http://www.evidence.nhs.uk/	Subject gateway

PEDro : http://www.pedro.org.au/	Database for AHP systematic reviews
PubMed/Medline	US National Library of Medicine
UK Parliament http://www.parliament.uk/index.cfm http://www.parliament.uk/business/publications/hansard/	Government publications
Welsh Assembly Government	NHS Wales key publications
Worldcat	World's largest network of library content and services

Search engines used were:

- AllTheWeb <http://www.alltheweb.com>
- Exalead <http://www.exalead.co.uk/search>
- Trip database <https://www.tripdatabase.com/>
- Google Scholar <https://scholar.google.co.uk>

There were four main literatures searches. The topics were selected to bring into focus the background to physiotherapy as a profession and how management has evolved in line with the changing NHS and the impact on management and organisation of therapists as well as the impact on the professionalisation process, thereby informing the RQs and research methods.

The primary search centred on:

NHS reforms and physiotherapy

Table 9 NHS organisation and physiotherapy

Search terms	Results
Physiotherapy (physical therapy) or NHS Organisation (organization)	57174
Physiotherapy (physical therapy) and NHS organisation (organization)	35
Inclusion criteria not met	32
Valid results	3

Physiotherapy evolution

Table 10 **Physiotherapy evolution**

Search terms	Results
Physiotherapy (physical therapy) or profession	136,184
Physiotherapy (physical therapy) and profession	1428
Physiotherapy (physical therapy) and profession evolution	13
Inclusion criteria not met	12
Valid results	1

Physiotherapy professionalisation

Table 11 **Physiotherapy professionalisation**

Search terms	Results
Physiotherapy (physical therapy) or professionalization (professionalisation)	59,215
Physiotherapy (physical therapy) and professionalization (professionalisation)	20
Inclusion criteria not met	15
Valid results	5

Physiotherapy management quality

Table 12 **Physiotherapy management quality**

Search terms	Results
Physiotherapy (physical therapy) or management quality	157,662
Physiotherapy (physical therapy) and management quality	11
Inclusion criteria not met	8
Valid results	3

The approach by Wolcott (1990) was adopted, weaving the theoretical content into the thesis rather than “dumping” into a literature chapter. Rather than

having a chapter entitled “Literature Review”, the information from the literature search has been included as part of the background to the research in the introductory chapters and where relevant in the finding, discussion and conclusion chapters.

5.4 Questionnaire Survey

The questionnaire was designed for physiotherapy managers as it was considered they would know most about physiotherapy management structures and the impact on staff development and care for patients. To identify participants a review of all NHS organisations was undertaken, identifying those which provided physiotherapy services, and the name of the most senior physiotherapist to invite to be part of the census survey. The questionnaire was designed to provide data related to physiotherapy management structures and the roles of physiotherapy managers. It also assisted in identifying the names of possible participants for the in-depth interviews. A census was chosen to give maximum coverage inviting participants from all provider organisations to provide data eliminating selection bias and maximising response rate to increase validity, giving every manager an opportunity to participate. 248 physiotherapy providers were initially identified and 123 responses were received.

The questionnaire layout was constructed to be effective in design, wording and measurement to enable accurate processing and analysis (Oppenheim 2000,)

while still gaining the necessary information (Lund and Gram, 1998.) It was designed to: maximise response rate, minimise bias between responders and non-responders, ensure clarity and unambiguity of questions and responses and ensure accuracy of completion (McColl *et al*, 2001.)

5.4.1 Questionnaire development and piloting

The questionnaire was developed in word processed format to enable it to be piloted, and revised as necessary. It initially contained a series of 120 questions. It was reviewed to test clarity of understanding, ease of response, suitability for analysis and length of time to complete. After five drafts it was piloted by five physiotherapy managers; two from Wales, three from England. The pilot managers were known to the researcher, covering different organisation types. They were selected as it was thought that they would give constructive views completing the task in time. All responded with comments, including:

- Questionnaire too long (x 4 respondents)
- Off-putting having numbered questions (x3)
- Like having numbered questions (x1)
- Would be better chunked into sections (x4)
- Need to alter the list of organisation types (x3)
- Need to make questions mandatory if a high response required (x5)
- Free text, time consuming, make it optional (x5)
- Would like to see it online to try the electronic version (x2)

- Minutes to complete: 17, 20, 25, 25, 30

Revisions were made incorporating the listed above and uploaded onto open source software; LimeSurvey V1.91 (LimeSurvey 2011.) It was not possible to number the questions as the software did not have this facility, though they were coded for the author in the review section.

The questionnaire (Appendix 12), was divided into 6 sections:

1. Your Current Role
2. Provision of Physiotherapy Services since 2008
3. Your Roles, Responsibilities and Duties
4. The Chartered Society of Physiotherapy and your Links
5. Some Information about You
6. Manager's Views

The questions were reduced down to 72, with some key questions classified as mandatory. The invitation letter advised that it would take 20-25 minutes to complete. Two of the pilot testers who expressed a preference, were then invited to review the online version. There were three errors which needed rectification; a spelling mistake, an additional bullet that required deletion, changing the status of one question to make it non-mandatory.

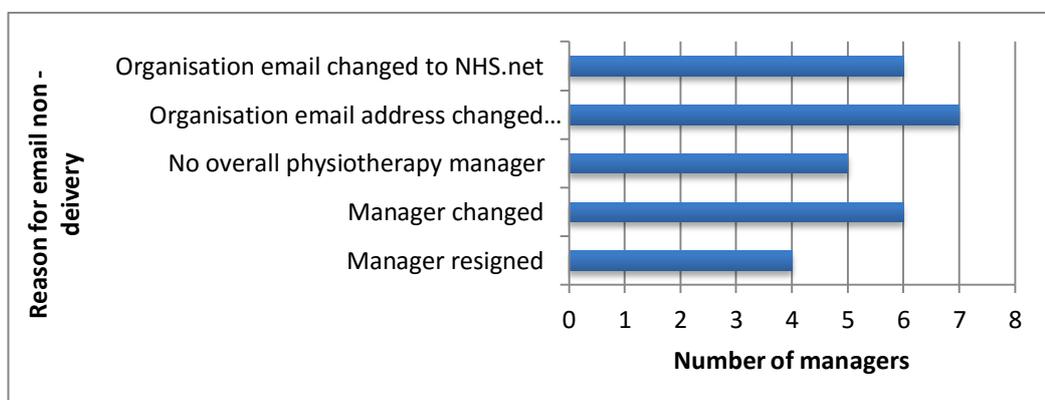
5.4.2 Questionnaire transmission

The questionnaire survey of physiotherapy managers in England and Wales was undertaken from March 2013-October 2013. Invitations to participate in the

questionnaire survey were sent with the questionnaire to the physiotherapy manager or most senior physiotherapist (i.e. Head of physiotherapy/lead physiotherapist) in each of these organisations. No requests were sent to physiotherapists in executive director roles, as the management of physiotherapy services was not considered to be an executive function. Invitations were sent via email; requiring a valid email address, making 231 the number of organisations invited to participate in the research.

The email invitation was sent to physiotherapy managers once research permission had been received, giving an overview of the research, and an invitation to “click” onto the web link and commence the survey. The first batch of recipients received an option to “reject” before the over view was read. This was rectified and all subsequent recipients received the full overview, and as implied consent was being used, the option to “reject” was not required. Effort had been made to assure the correct email addresses. However, of the 172 invitations sent, 28 were returned undelivered. All of these were followed up by the researcher telephoning the service to try and obtain the correct email address. There were a variety of reasons for non-provision.

Fig. 4 Reason for failure to deliver questionnaire invitation



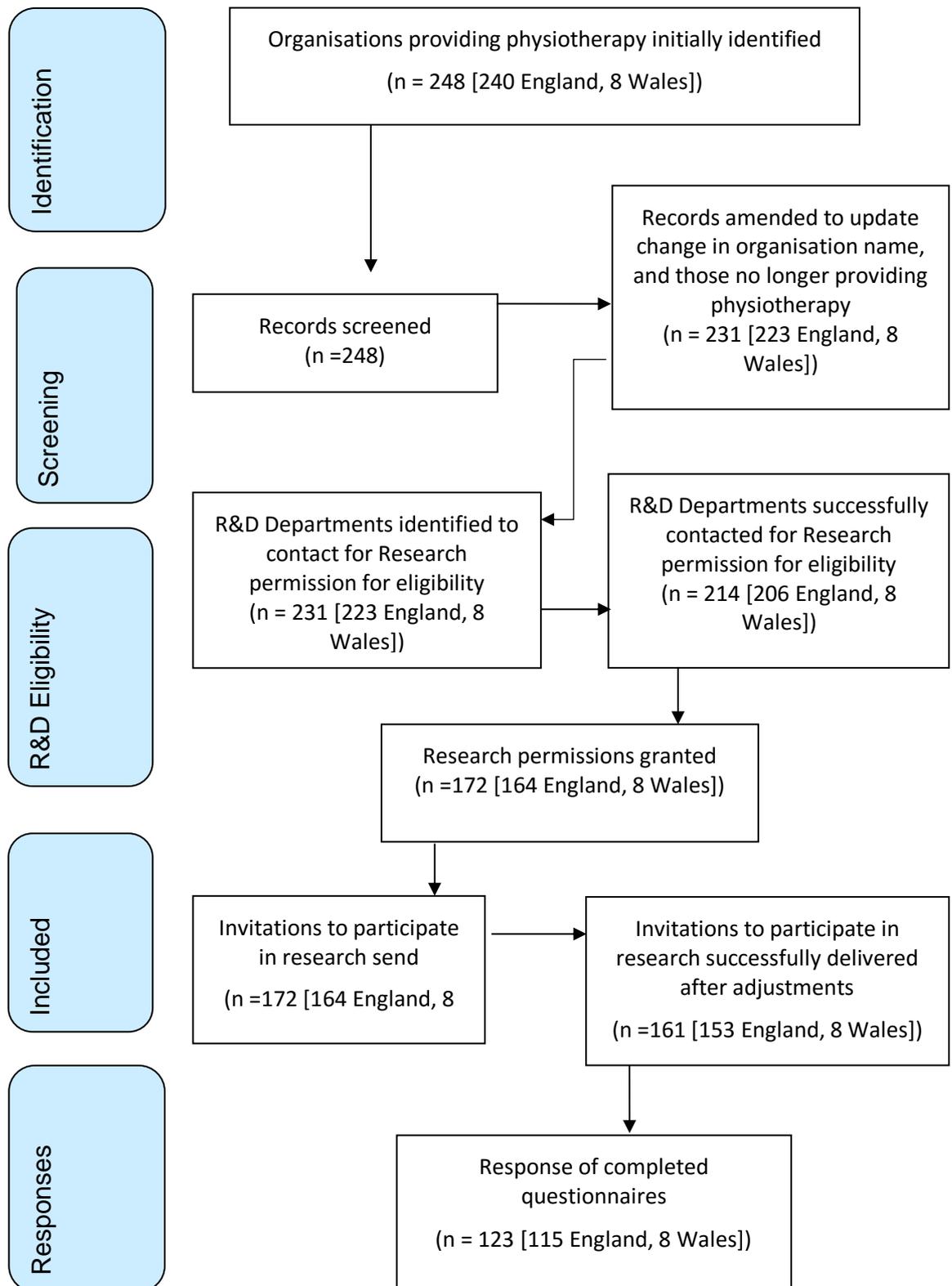
17 of the 28 incorrect email addresses were corrected. Five contacts identified that they used to be the physiotherapy manager, but that the service no longer had a physiotherapy manager or named physiotherapy leader, and that their role had changed. An additional six reported that their manager had changed in recent months, making the email address invalid, and another four reported that the physiotherapy manager had resigned and had not been replaced. Change in organisations and migration of Trust email accounts to the English nhs.net system also invalidated some contact details, which were subsequently amended.

5.4.3 Questionnaire participants and response patterns

The participants were physiotherapists. A modified Prisma diagram (Moher *et al* 2009,) was developed to illustrate the number of participants from the physiotherapy provider organisations identified to the final participants. Of the initial 248 NHS organisations identified as physiotherapy providers, 231 were undertaking this function at the time of the survey (17 were no longer providing physiotherapy; they were all from Community Trusts in England). Of the 161 invited participants 123 replied; an overall response rate of 76%.

Fig. 5

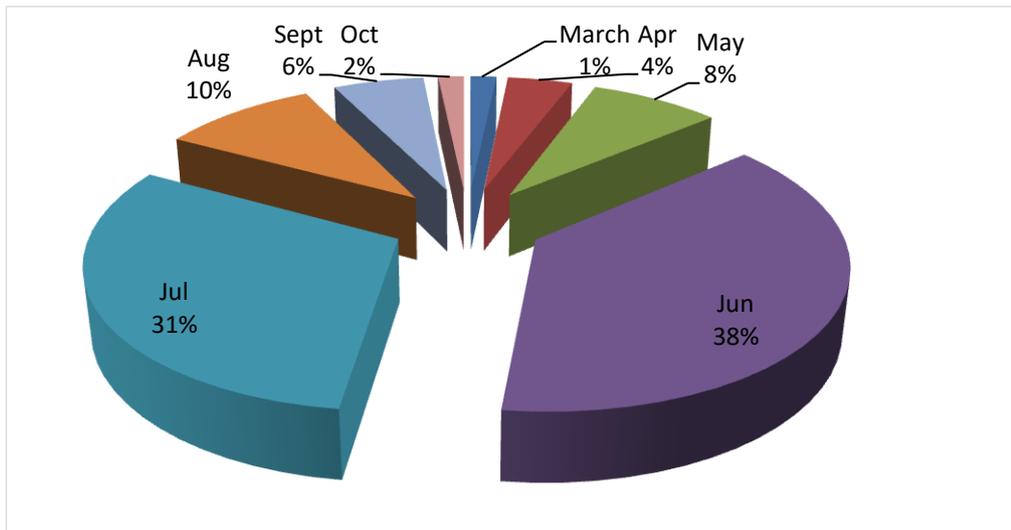
Modified PRISMA flow diagram



5.4.4 Monthly response

Research permission was slow to be received eventually taking six months; it was not possible to wait for all of them to be received before sending the questionnaire out. Therefore, once approval had been gained from the R&D departments, the physiotherapy managers for the relevant organisations were batched into weekly groups and were sent an invitation by email to participate in the questionnaire. This contained a web link to the online survey.

Fig. 6 Monthly response to questionnaire survey



The response rate was reviewed weekly, with completion of the web-based questionnaire being slow. After nine weeks of poor responses it was decided to send the questionnaire out as a word processed document by email. This was identical to the online version, except the questions were numbered to help with presentation as there were not screens to “click” through. All managers who had not responded by 17 June 2013, and the organisations who subsequently gave research permission, were invited to take part using the word processed

version, which could either be emailed back to the researcher, or sent by post. 17 were completed on LimeSurvey, 105 used the word processed version and emailed it back, one used the word processed version and posted it back.

5.4.5 NHS physiotherapy manager respondents by organisational type

An analysis was undertaken of the different organisation types of the respondents. It should be noted that all respondents were NHS physiotherapy managers. The categories assigned reflected the different types of organisations in place.

- Acute Trusts were the largest organisation type and the highest number of responses, 122 Trusts in total, 87 invited, 53 responded
- Care Trusts were the smallest type by number, there were 5 Trusts in total, 3 were invited and 3 responded
- Partnership Trusts were the lowest number of responses, 6 Trusts in total, 4 were invited and 2 responded.

Analysis was undertaken of the 231 organisations providing physiotherapy, (223 English, 8 Welsh) to identify the proportion of different organisation types. The final cohort of responses was reviewed to determine whether there it was proportionate from each organisation type. All organisation types responded.

5.4.6 Analysis of organisational profile

The pattern of responses differed from the total profile of organisation types. This could be attributed to the transfer of 12 of the 24 community providers in England moving largely into Mixed Trusts and “Other” Trusts. Different organisation types were identified as part of the preparatory phase, with their relative percentage assigned (column a). Further analysis identified the organisation types that provided physiotherapy (column b). The organisation type of respondents was then analysed (column c). The overall analysis identified a disparity between the three columns.

Table 13 Organisation type respondents

Organisation type	a. % NHS Organisations	b. % Physiotherapy Providers	c. Total Respondents
Mental Health Trust	4	7	6 (5%)
Partnership Trust	3	3	2 (2%)
Care Trust	2	2	3(2%)
Community Trust	32	20	12(10%)
Social Enterprise	1	2	5(4%)
Other	0	1	7 (6%)
Tertiary Trust	6	3	6 (5%)
Acute Trust	49	51	53 (43%)
Mixed Trust	0	8	21 (17%)
Welsh Health Board	3	3	8 (7%)

A large discrepancy was seen in Community Trusts. They were identified as being 32% of NHS organisations, with 20% of them providing physiotherapy services some had physiotherapy provided by other organisations. The respondents from Community Trusts were only 10%, due to the trend to withdraw from service provision extended.

In the original list of provider types “Mixed Trusts” were not identified. However 8% of organisations which provided physiotherapy were providers of both acute and community service and therefore labelled as “Mixed”, these accounted for 17% of respondents; signifying acute providers extending service provision to community services. This may also have accounted for the reduction in the Acute Trust responses from the expected profile.

Welsh Health Boards with a 100% response rate changed from 3% of the original profile to 7% of respondents. The responses received from Welsh Health Boards, Social Enterprises, Tertiary Trusts were proportionately higher than those from other organisation types.

5.4.7 Geographical analysis of questionnaire respondents

Physiotherapy provider organisations were divided into geographical areas; 4 NHS England regions (established in 2012) and Wales. The organisations giving research permission by geographical area ranged from 42% (48, Midlands) to 100% (8, Wales) of physiotherapy provider organisations. When this was further analysed in relation to the questionnaires that were delivered to the correct physiotherapy manager with an active email address, the percentage response rate ranged from 61% (20) in the Midlands to 100% (8) in Wales. The organisational name element of the email address had changed for many.

The Midlands was consistent with other English regions regarding reorganisation changes, but physiotherapy managers were most difficult to identify. Only 33 managers were identifiable by valid email address, indicating a substantial amount of organisational change taking place. However, this did not unduly impact on the overall results, as 61% response rate from the Midlands was acceptable.

5.4.8 Interpreting the questionnaire response rate

There were virtually full data sets for 123 questionnaires, (121 complete, 2 with <2% missing fields). This gave comprehensive data to analyse. The pattern of responses was not skewed for the distribution of overall organisational types, though Community Trusts had been re-organised and many no longer existed as provider organisations. Therefore the shift of community services was an influence on respondents and response rates. Some data fields for the questionnaire survey were incomplete, but this related only to those who did not hold full management roles, or did not provide physiotherapy services. The response rate indicates that this is a subject of importance to physiotherapy managers, which concurs with comments received directly from them. The findings assume that using a combination of online survey and emailed word processed version did not alter the responses. Nulty (2008,) reported that online surveys achieved response rates that were much lower than the paper-based ones (on average, 33% compared with 56%). Therefore, the combined approach of online and paper based was deemed appropriate to maximise

uptake which was consistent with the observations of Kroth *et al* (2009.) 85% of managers used the word processed version of the questionnaire and 15% used the online version, with online respondents coming from all organisation types.

This response rate of 76% of those who gave research permission, across the whole range of organisation types, represents a reasonably proportionate response from all organisational sub-groups demonstrating a very satisfactory level by researchers (Richardson 2005,) who recommended 50% as an acceptable response rate in social research postal surveys to give good validity to the findings.

5.4.9 Survey data analysis

The questionnaire survey data were collated by LimeSurvey (2011,) and exported to IBM SPSS v 21(2014). A data file was created and information entered in the format defined by the codebook. The data file was checked for errors and corrected.

Non-parametric statistical tests were used as these suited the data (Pallant 2010,) as they did not make assumptions about the underlying population distribution. The tests used were:

1. Chi square test for independence was used to determine whether two categorical variables were associated. It compared the frequency of cases found in the various categories of one variable across the different categories of another variable. The main value of interest from the output

was the Pearson chi square value. Where there was a 2 by 2 table the Yates' Correction for Continuity was used compensating for the overestimate of the chi square value.

2. Fisher Exact test was used to calculate the exact probability value for the relationship between two dichotomous variables calculating the difference between the data observed and the data expected, considering the given marginal and the assumptions of the model of independence. This test was used where there were small values.
3. Kruskal-Wallis "between groups" Test; the non-parametric alternative to a one-way between-groups analysis of variance used to compare the scores on some continuous variable for three or more groups. The scores were converted to ranks and the mean rank for each group compared.

A significance level was chosen before data collection and set to 0.05 (5%) (Craparo 2007.) Valid statistical comparisons between management structures and organisation types in most instances were only valid when data were pooled to increase the size of categories. Data from the following groups were pooled into these larger groups:

- A. 4 organisation types: Welsh Health Boards, Acute Trusts (including tertiary), Mixed Trusts and Community (including social enterprise, partnership and mental health). This enabled Wales to be a distinct category and kept clear boundaries between those proving community based, acute and a combination of both.

- B. 3 organisation types: Acute Trusts, Mixed Trusts (including Welsh Health Boards) and Community. This addressed the requirement to pool Wales due to only 8 Health Boards and some small cell numbers. The nearest match for Wales was the Mixed Trust.
- C. 2 main organisation types: Mainly acute providers, and mainly community providers
- D. 2 main management structure types : Professionally managed (AHP directorate, AHP Sub-directorate and Physiotherapy directorate) and Dispersed (fragmented and clinical pathway)
- E. By Nation: England and Wales

The majority of statistical analyses showed no significant association between management structures.

5.5 Professionalisation and Deprofessionalisation Analytical Frameworks

Analytical frameworks were developed being informed by propositions dating from 1915, including theoretical propositions from more than 50 theorists, with Friedsons' work being the main contribution. The criteria set out frameworks which any profession could be analysed against and was used to assess physiotherapy. This was further constructed to enable an assessment of physiotherapy across the three periods of research. An intensity rating score where:

Green = Complete compliance with set of norms (>80%)

Amber = Partial compliance (26%-79%)

Red = No compliance (<25%)

A normative judgement approach (Dart 2009,) used by the researcher rated the criteria drawing on data from the research participants and literature review.

5.6 Semi Structured Interviews

Telephone interviews were selected with experienced physiotherapists, to enable the researcher to include participants from remote and distant locations and also enabled taping of the interviews before transcription, as commended by Saks, (1983.) This facilitated content and thematic development, Schegloff (1992.) The interviews were conducted during March and April 2014, to gain an in-depth understanding of the views of experienced physiotherapy managers who had gone through several periods of NHS changes during their careers. This was designed to facilitate discussion relating to aspects of management and organisation of services as laid out in the RQs with initial data collection having been analysed from the questionnaire survey. This method was used to answer parts of RQs.

This longitudinal, retrospective study element was the preferred method as interviews (Miller and Glassner 2011,):

“Provide a meaningful opportunity to study and theorise about the social world...providing real evidence of the phenomena under investigation”
(p.131.)

SSIs were chosen to produce further insight to some areas considered worthy

of further exploration following analysis of the questionnaires. This method has been cited as an ideal way of exploring a “bounded system” over time, through detailed in-depth data collection involving multiple sources of information rich in content (Creswell 2008). The value of this method was to explore in detail the impact of NHS policy and management changes over a career span, by gathering views and recollections of physiotherapy service managers who had worked during periods of NHS reorganisation and change. Focus groups were discounted as they would not be practicable due to geography, time commitment and cost.

The semi-structured questions were designed to be idiographic in the first instance (Smith *et al* 1995,) being concerned with understanding the “particular” in detail. The limitations of this technique as outlined by Silverman (2011,) citing opposition from “purists” and “emotionalists” were noted. This technique was selected as a method of examining the impact of NHS changes on physiotherapy, from the point of view of the physiotherapy managers who had experienced the impact of NHS changes during the course of their careers and was therefore a method of identifying culturally embedded normative explanations, providing insight into both the nature of the phenomenon and the context and cultural frames used to make sense of their experiences. Collins (1990,) argued that to make legitimate knowledge claims researchers should live or experienced their subjects’ material, which was fulfilled by the researcher in this study, having worked as a physiotherapy manager through several periods of NHS change.

5.6.1 Sampling strategy for semi structured interviews

The participants were all registered physiotherapists working in NHS and were selected by purposive sampling strategies, following examples provided in the typology of sampling strategies in qualitative enquiry proposed by Miles and Huberman (1994.) The sample included experienced physiotherapy managers who have worked in NHS physiotherapy services as managers through a period of sustained organisational and managerial change.

The inclusion criteria were:

- Research permission requirements had been satisfied
- All participants had been physiotherapists since at least 1987 and experienced subsequent NHS reorganisations, observing the impact on their services and profession over time
- The participants had all worked in the NHS as managers of physiotherapy services for more than 10 years
- Participants were purposefully selected to come from different organisation types and different geographical areas; ensuring some organisations were English and some Welsh.

They were identified by a question in the survey which asked for the contact details (if known), of an experienced physiotherapy manager, who had been in post in 1987 and worked in a management role. This date has been selected knowing that some managers would have retired, but may still be contactable. In addition snowballing and chain techniques were used to identify people who

were known to be “information-rich” and were contactable.

When inviting participants for the SSIs selecting a manager from a community provider organisation required six attempts, as the first five had left their roles, or the organisation had changed in the period between the questionnaire survey and the interviews.

Although “maximum variation” is a favoured technique for case study sampling (Creswell 2008,) physiotherapy managers with experience of 27 years were few in number. Therefore, the techniques selected were suited to the purpose.

The sample method facilitated a two stage filtering, by length of experience in a physiotherapy management position and by developing sub-sets of geographical location and population served. The filtering enabled comparison across the parameters:

- 8 (66%) were in physiotherapy/AHP management roles
- 1 (8%) had taken up an Extended Scope practitioner (clinical) role, having formerly been a physiotherapy manager
- 3 (25%,) the longest serving managers had all gone through reorganisation and retired in the last year through the NHS voluntary severance scheme.

Table 14 Demographic details of SSI participants

Demographics	Years' Experience
Median years as a Physiotherapist	32.5 (20-44)
Median years as a Physiotherapy manager	21.7 (10-37)
Geographical Area	
South	4
London	1
Midlands	3
North	2
Wales	2
Organisation Type	
Acute Foundation Trust	3
Mixed Trust	3
Mental Health Trust	1
Community Trust	1
Social Enterprise	1
Children's Trust	1
Health Board	1
Tertiary Trust	1
Employment Status	
Physiotherapy lead	2
AHP lead	5
Extended Scope Practitioner	1
Retired or taken voluntary severance	4

The demographic details of the managers are presented as grouped data to protect anonymity. Each interviewee was assigned a number (SSIx), which was subsequently used in the findings chapters where quotes were used. The type of organisation and its structure was expected to have influenced the physiotherapy managers' experiences. To help contextualise the views on management structures for physiotherapy, the semi-structured interviewees were asked to identify which different models they had managed during their career. They had collectively experience of all the identified management structures, with all having worked in more than one type of structure.

Table 15 Informants employment management structures

Physiotherapy management structure	Number working in this model
AHP Directorate	11
AHP Sub Directorate	3
Physiotherapy Directorate	9
Clinical Pathway	5
Fragmented	6
Social Enterprise	1

5.6.2 Interview procedure

Individual SSIs allowed discussion of both pre-determined topics and new or unexpected topics raised by the participants (Burman 1994.) A consent form to participate was developed (Appendix 13,) which all interviewees were required to complete and return. An interview schedule with questions was developed (Appendix 14,) and had been informed from review of the literature and data gathered through the questionnaire survey.

The topic areas were: NHS changes, changes in the profession, changing relationship with other professions, the status of the physiotherapy as a profession, management structures, views of the experience of general management, management, roles and responsibilities and their future predictions for the profession.

A pilot interview was carried out with two managers. This identified the need for two prompt cards, which were sent to the interviewees in advance (Appendix15). All interviews were carried out by telephone and took 20-30 minutes. They were all tape recorded with appropriate consent procedures and

written up (Appendix16). Data was collected until saturation of themes was achieved, which in turn influenced the sample size. In total, 12 managers were interviewed.

5.6.3 Analytical method

12 experienced managers were purposefully selected and interviewed via telephone. Participants came from England and Wales and had worked in a wide range of management structures.

Five themes emerged inductively through analysis of the SSIs transcripts using an Inductive Thematic Analysis (ITA) method. They were specifically identified as areas of importance to physiotherapy managers when discussing the changing NHS and the impact on physiotherapy services and the profession.

The themes were:

1. Impact of cost constraints
2. Key influences on the development of the profession
3. Inter professional relationships
4. Peak time for the profession
5. Future predictions

The themes are presented under the relevant sections of the three RQs.

The analysis was nomothetic, where generalisations were made using the ITA approach outlined by Braun and Clarke (2006, 2012.) This is as an essentialist

or realist method reporting experiences, meanings and the reality of participants; the experience of people gained through their lives. It assumes a unidirectional relationship between meaning, experience and language with language uses in the interviews articulating meaning and experience (Potter and Wetherell, 1987). ITA also has characteristics of a constructionist and contextualist method, giving it flexibility as a preferred method for reporting patterns within data sets, enabling interpretation of aspects linked to the research topic and thereby matching what the researcher wanted to know from the interviews. Unlike interpretative phenomenological analysis (Smith and Osborne 2003,) and grounded theory (Corbin and Strauss 2008,) thematic analysis is not theoretically bounded, and does not have multiple variations (Charmaz, 2006.)

ITA had the advantage of being able to search for themes and patterns across the entire data set rather than within the data item, making it suited as the preferred analytical method, combining interactionism and pragmatism, with elements of focussing on techniques to interpret relationships, interpretations and “meanings” Gibbs (2007.) The method selected involved a number of choices which were explicitly considered before data collection and analysis, and revisited as an ongoing reflexive dialogue during analysis. These questions included:

1. Type of analysis: Entire data set versus detailed analysis of themes
2. Theme capture and pattern of response

3. Prevalence of theme in terms of space within each data item and across the full data set, and the degree of flexibility in identifying themes by prevalence
4. “Keyness” of themes in relation to RQs
5. Refinement of sub-themes
6. Inductive or deductive analysis: Inductive “bottom up” analysis was selected coding data without trying to fit it into a pre-existing coding framework, though prior reading of relevant literature added elements of deductive analysis
7. Semantic or latent themes: Latent level analysis was chosen to identify and examine underlying ideas and assumptions, thereby shaping the semantic content of the data
8. Epistemology: An essentialist/realist approach was selected to theorise motivations and experiences of the physiotherapist managers’ roles working in the changing NHS

The six-phase ITA (Braun and Clarke 2006,) was followed to structure the analytical process:

1. Data familiarisation and transcription, checking transcripts back against the audio tape. Generation of an initial list of ideas about the data.
2. Generating initial “basic” codes from semantic and latent content
3. Searching for themes by sorting codes into potential themes
4. Reviewing themes
5. Refining and defining themes
6. Writing up

Free text data from the questionnaire survey was also extracted and analysed as part of the ITA process. Thematic analysis and analytical coding led to data reduction (Miles and Huberman 1994.) this enabled theme identification across

the whole data set, rather than in relation to the semi-structured questions, giving a deeper analysis and more meaningful interpretation.

In addition to the qualitative data, it was also possible to identify the management structures that the participants had worked in throughout their careers and cross reference this with the management structures identified in the questionnaire survey responses. The final interpretive stage described “lessons learned” (Lincoln and Guba, 1985.)

5.7 Narrative History

The narrative history of physiotherapy was informed by the SSIs, census data and the literature review (Chapters 2 and 3.) The retrospective historical study enabled an analysis of the impact of policy changes during the research period, with the main focus being from 1987 onwards. Historical sensitivity requires an examination of the relevant historical evidence when undertaking research giving a theoretic basis and context for the research (Sim and Wright, 2000):

“It helps us to understand how we are governed” (Silverman 2001 p.21.)

The purpose of this historical narrative of the profession was to contextualise the evolution of physiotherapy and professional issues, including the period from its inception up to contemporary practice, detailing how the evolving NHS policy impacted on the development of the profession in the changing structure and organisation of NHS services. This empirical method contributed to providing a realistic evaluation of government policies gathering data from a

wide range of sources to enable cross comparison and “triangulation” (Denzin, 2012.) Particular attention was paid to contemporary policy developments, taking into account the programme theories for each period of reform identifying whether the NHS has been on one continuum of reform since the late 1980s. The narrative history tested Bosanquet’s (1983,) assumption about the poor state of the NHS, and the impact of policy change.

5.8 Normative Evaluation

The census survey and SSI data was also used as raw material for a normative analysis of management practice in NHS physiotherapy in England and Wales. An evaluative approach commended by Stake (1995,) was undertaken to explore normative evaluation of management arrangements for physiotherapy services and physiotherapy professionalisation.

5.8.1 Management structure assessment

The Jenkins and Jones (2011,) revision (Appendix 9) of their 2006 and 2010 ATEAHPMS was used gather data on management components undertaken by participants. In 2005 there were no ATEAHPMS designed and developed specifically for AHP services. Management arrangements for the AHPs often lacked consistency and clarity as they did not comfortably “fit” Trust management structures. Therefore, Jones and Jenkins (2006) developed a bespoke normative assessment for AHPs, aimed at evaluating management and management structures in the context of quality, effective, efficient and

economical service provision. It was developed following research dating back to the early 1980s, identifying the main areas of therapy managers' roles, responsibilities and duties defined following a questionnaire survey and analysis of job descriptions (Jones 1987, 1989, 1991, 2000,) who made the case that, following analysis of the job content, duties and responsibilities of the senior physiotherapy manager the key to an understanding of the management process and the work of physiotherapy managers in the context of physiotherapy itself and the NHS as a whole and an outline of the major management functions clearly demonstrated the interdependence and integrated relationship of the clinical, professional and managerial aspects of the work. The post-holders were considered the professional and clinical heads of service with an overall management function essential to maximising effectiveness and efficiency in the service. The ATEAHPMS was also informed by work from Øvretveit (1991, 1992,) Berry (1994,) and Jenkins (2005). The ATEAHPMS facilitates users to assess AHP structures under 10 non-prioritised management domains:

1. Strategic management
2. Clinical governance
3. Human resource management
4. Clinical/professional requirements
5. Operational/service management
6. Resource management
7. Information management

8. Education
9. Commissioning
10. Service improvement/ re-design

The ATEAHPMS is normative, being based on research regarding what constitutes the job content of duties, roles and responsibilities and how that translates into service management. The domains identified for physiotherapy managers' functions also concurred with independent research undertaken by Kinston (1983,) Oakley (1997,) and a series of workshops held at the Brunel Institute of organisation and Social Studies in 1984. The scoring mechanism is a RAG rating, with each individual element being scored where:

Green = Complete compliance with set of norms (>80%)

Amber = Partial compliance (26%-79%)

Red = No compliance (<25%)

The elements of each domain are totalled for the RAG scores, giving an indication of the strengths and areas for possible improvement.

The ATEAHPMS was piloted and validated in England, Wales, Australia, Ireland and New Zealand for a range of Therapy services, and published originally in 2006 (Jones, Jenkins 2006.) Subsequently it was slightly revised and updated to take account of changing terminology and functions, and further published during the intermediate stage of this research (Jenkins and Jones, 2011.) It has been used widely by AHP managers including physiotherapists since its original publication in 2006.

Section three of the questionnaire asked factual questions relating to the domains of functions and responsibilities of physiotherapy managers performed in their role these included for example: strategy, clinical governance, financial management and R&D. The elements of the 10 domains were listed and managers were asked to indicate which ones they were responsible for undertaking.

5.8.2 Gap analysis

A gap analysis was undertaken as part of the normative assessment using the ATEAHPMS to determine the differences between different physiotherapy management structures and the roles undertaken by physiotherapy managers in the services. This was selected to display differences in roles and responsibilities of managers working in different management structures. A gap analysis is designed to provide a foundation for measuring investment of time, money and human resources required to achieve a particular outcome; in this case the management of a physiotherapy service. Gap analysis is commended by Projects in Controlled Environments (2015,) methodology and helped identify deficiencies between management structures. Domain elements of the Jenkins, Jones (2011,) ATEAHPMS were analysed where they scored below the total mean.

5.9 Limitations of Methods

Participants: The study was empirically limited, in that it related to only one AHP; physiotherapy. Physiotherapy being the largest AHP group and within the NHS was seen as a good likely indicator for the smaller AHP professions. It is therefore reasonable to predict that the findings of this research may resonate with other AHPs, both those within the NHS in England and Wales, in the other home countries, and possibly in other Beveridge-type healthcare systems. The research did not include the views of non-physiotherapists, in particular, no generalist managers, no medical managers, no other clinical professions and no patients/public, recognising that others may have different views; this was a limitation but also a recommendation for future research. The study also included only NHS and Social Enterprise physiotherapy managers, not those providing NHS physiotherapy from other AQP non-NHS providers.

Sampling: The study only covered England and Wales and did not represent the entire UK, but did include two different national models of NHS provision and the majority of NHS provider organisations in the UK. A census was selected to reduce selection bias. The research area included England and Wales to provide a natural experiment, as physiotherapy services had developed from similar NHS policies and structures before a divergence in national organisation and focus from 2000 onwards, enabling an evaluation of different models both within each country and between countries.

Questionnaire content: The questionnaire Q3.8 “commissioning/service planning”, would have benefitted from having a definition, as there was inconsistency in interpretation. It would have been useful to have asked managers more detail of their management structure and how it operated, as well as the inter-linkages with other professions and their management structures. It would also have been informative to ask whether any participants thought that the AHPs should merge into one profession. Additionally it would have been helpful to know if managers had used the TU services of the CSP to support their jobs, to determine whether this may have accounted for their support for this function. A few questions could have been re-designed to reduce small numbers of responses in some categories to facilitate more valid statistical analyses.

Self-reported data: The data was limited by the fact that it could not be independently verified. There were possible sources of bias including selection, and response bias though this was minimised by having a large data set.

Professionalisation assessment: The normative judgement approach was undertaken only by the researcher. It is recognised that having only one person undertake an assessment would limit reliability.

ATEAHPMS: The criteria used to assess managers’ functions were based on a normative assessment using the Jenkins and Jones (2011,) model. The rating system used was undertaken by the researcher only, which is acknowledged as a limitation; however the scoring was undertaken against standard criteria. If the

ATEAHPMS had been flawed then the validity of the findings would have been compromised. The ATEAHPMS itself was based on earlier research spanning 25 years and was found to strongly represent the roles undertaken by physiotherapy managers, demonstrated by the mean of 81% of managers undertaking the 10 domains contained in it.

Literature: The researcher was a primary English speaker and reader, therefore literature reviewed was limited to English or English translation. All publications relating to Wales were produced bilingually.

5.9.1 Mitigations

Design: The cross sectional questionnaire collected data at one point in time, whereas the in-depth interviews captured longitudinal data over more than twenty years. The narrative information underwent content analysis. The use of multiple methods including triangulation has been recognised as a means of enhancing validity and reliability (Bradley *et al*, 2007.) All data from questionnaires was inputted either directly by participants or by a third party into Lime survey, keeping the researcher distant from data inputting. Additionally the potential for problematic methodological triangulation was overcome by selecting different methods to answer each separate research question. Principles of falsifiability as proposed by Popper (Rowbottom 2010,) were adopted, seeking disconfirming evidence. The normative frameworks were used to analyse data in a structured format to aid presentation of data and findings.

The survey was not a complete census as reorganisations and lack of valid email addresses reduced the sample size, though an overall response rate of 76% of delivered questionnaires was a very acceptable response rate. There may be a possible source of bias with Midlands respondents (61%) relatively underweighted, and Wales overweighted (100%.) Although Wales appeared relatively overweighted, with only eight organisations this might be regarded as beneficial to give a census response from a small cohort. The Midlands still had sizeable respondents (20) and any underweighting was probably compensated for by the other English regions.

The semi-structured interviewees were selected by nominations from the questionnaire survey, then purposefully selected to give a range of organisation types, regions and countries. Data was collected until saturation was achieved. Although the sample size was small,(12) the data was comprehensive and included responses from both countries and all management structures with geographical spread and was therefore trustworthy. A comprehensive review of all study limitations are set out in Chapter 11.4.

5.10 Research Governance

Research governance complied with standards laid out in the Research Governance Framework for Health and Social Care (England) (DH 2005d,) and the Research Governance Framework for Health and Social Care in Wales (2009). Both documents lay down a consistent framework for governing research activity. Research permission was granted (Appendix 11,) ethical

approval was not required. The selection of methods and their utilisation enabled the researcher to generate valuable data for analysis; exploring the management structures for physiotherapy and their impact on support for staff development, the profession and patient care.

CHAPTER SIX

FINDINGS:

PHYSIOTHERAPY MANAGEMENT STRUCTURES: THE IMPACT OF ORGANISATIONAL CHANGES

In Chapters 6-10 the findings to the three RQs are presented. Comparison is made with previous research including Jones (1989, 2000) and Jenkins (2005). It should be noted that the changes from 2008 had embedded in Wales in 2009, but the English changes were slower to be enacted, with some changes still taking place at the time of the research in 2013/14. Additional Tables, Figures, and statistical data are in Appendices 17, 18 and 19. In this chapter the findings to RQ1 are presented, analysing physiotherapy management structures and their impact on staff and patient care.

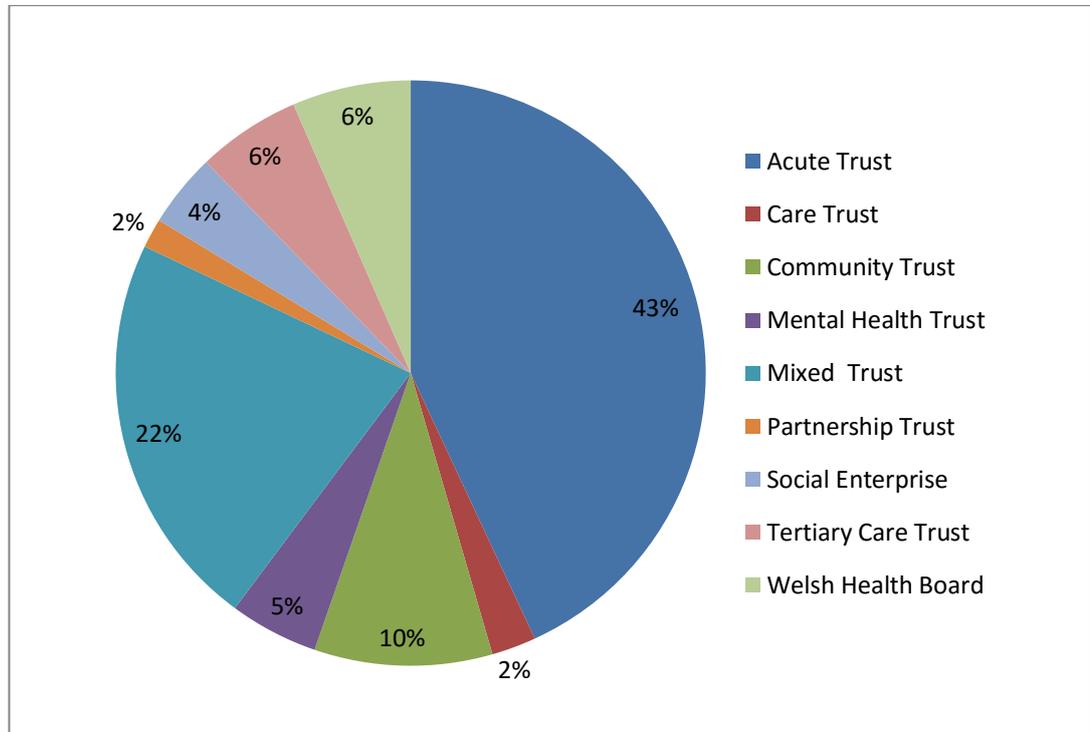
NHS Wales' physiotherapy services were provided by seven Health Boards and one Tertiary Trust; they have been grouped together as "Welsh Health Boards" to facilitate ease of national comparison with the 115 English organisations. The category of "other" was analysed revealing this to be a "Mixed Trust" with these responses reported grouped together. Free text comments from the questionnaire survey were combined with the semi-structured interview data and thematically analysed. Quotes from semi-structured interviewees were labelled (SSI,) and the questionnaire respondents identified by their assigned

research number. Øvretveit (1992,) referred to “models of organisation”, describing the way physiotherapy services were organised. This has been referred to as “management structure”, a term which is widely used in NHS physiotherapy.

6.1 Physiotherapy: Organisational types

Physiotherapy managers reported nine different organisational types. Social Enterprise organisations were set up as an alternative to NHS providers. There were no private enterprise companies in the study. It is acknowledged that with the advent of AQP, these organisations were developing, though still relatively new and few in number.

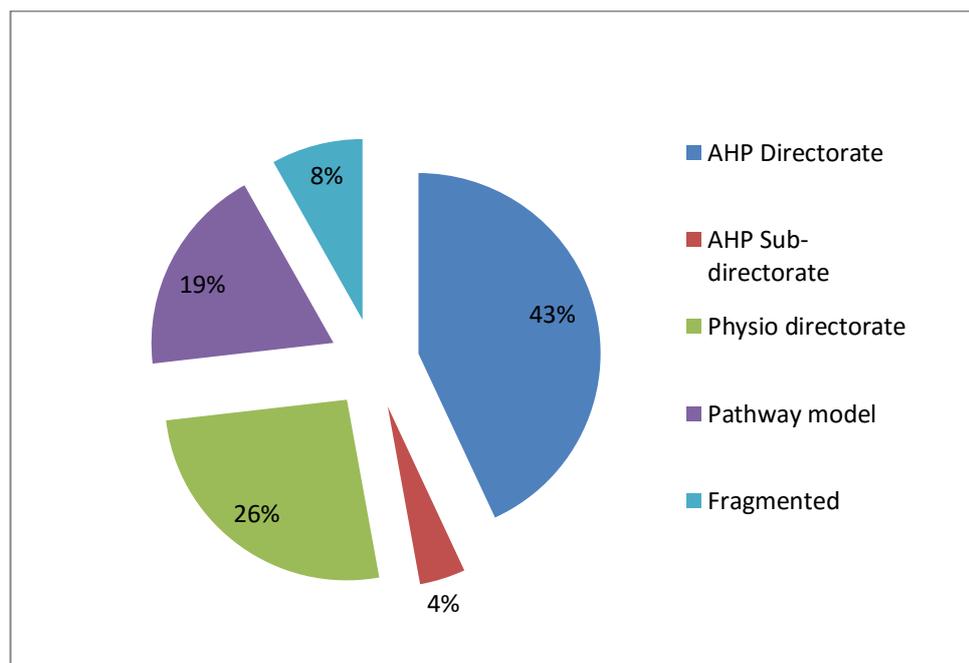
Fig. 7 **Types of organisation**



6.2 Management Structures: Comparison with Øvretveit (1992)

Five different management structures were identified. Although Social Enterprises were a different organisation type, the physiotherapy managers reported similar structures to when they were in the NHS. The managers of the services and the staff had been transferred from the previous NHS organisations and structured themselves in a similar way within the new organisations. It was the type of organisation that was different, rather than the management structure.

Fig. 8 **Physiotherapy management structures**



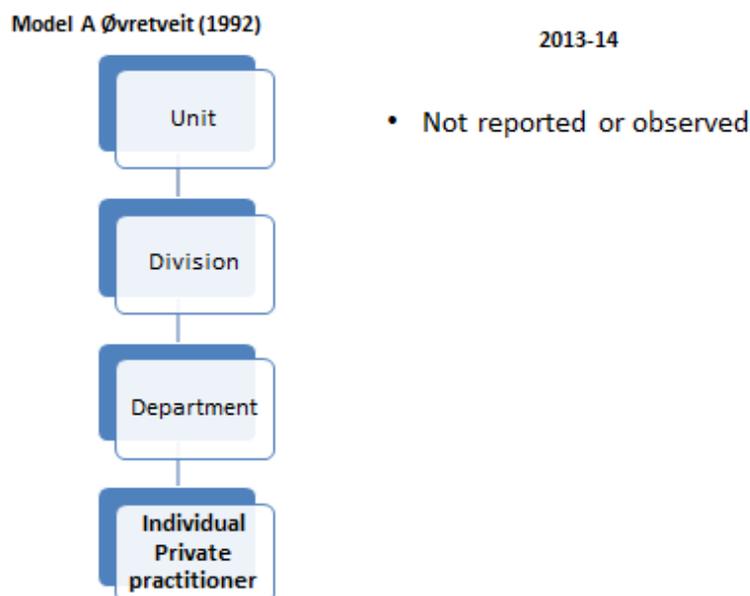
Øvretveit's (1992,) schema described eight different management structures for therapy services (Chapter 2.) He advised consideration of both the size of the therapy department and the number of therapists involved when considering management structures. The research findings enabled the 1992 schema to be

reviewed for “fit” and to be brought up-to-date. The comparison of models of organisation revealed:

6.2.1 Model A: Individual private practitioner

The Øvretveit (1992) Model A was not observed and not evidenced as a current model. This was perhaps unexpected, in light of AQP policy which identified physiotherapy as a possible early AQP candidate.

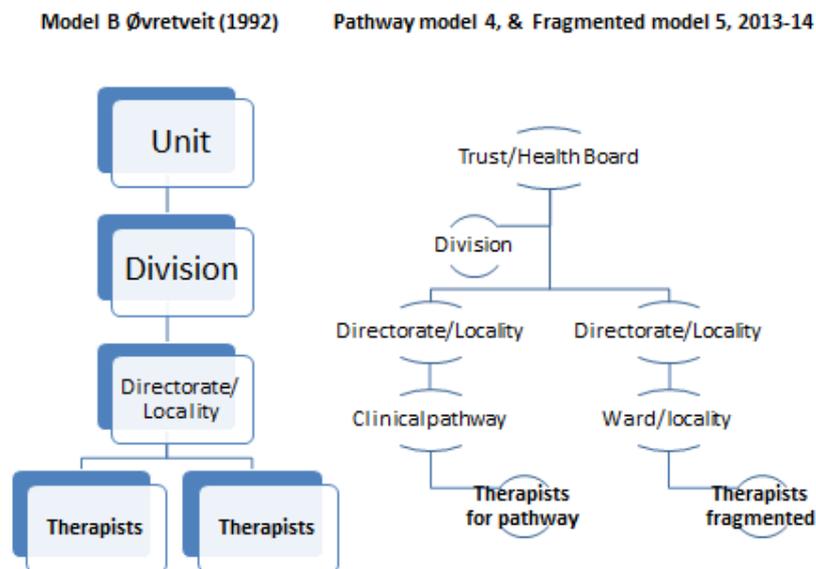
Fig. 9 Individual private practitioner comparison



6.2.2 Model B: Directorate or locality-managed

The Øvretveit Model B was similar to the pathway model 4 and fragmented model 5 described by physiotherapy managers. The similarity being that the clinical front line physiotherapists were not managed as part of a physiotherapy “family”, but being dispersed and managed as part of a multidisciplinary team.

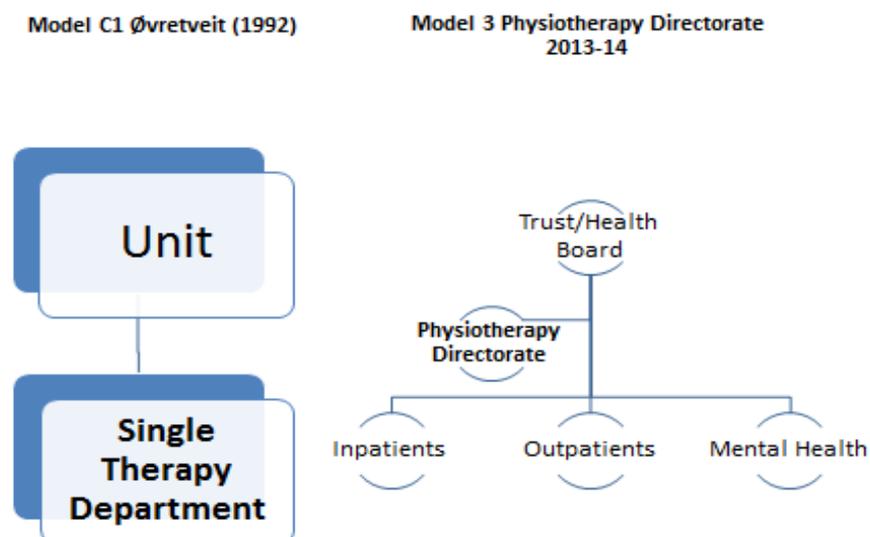
Fig. 10 Directorate or locality-managed comparison



6.2.3 Model C1: Unit-based single-therapy division

The physiotherapy directorate model C1 described as the most frequently occurring in 1992, was still in place and was the second most frequently occurring model. This is evidence of the practical limits of NHS restructuring reforms on physiotherapy management structures.

Fig.11 Unit-based single-therapy division comparison

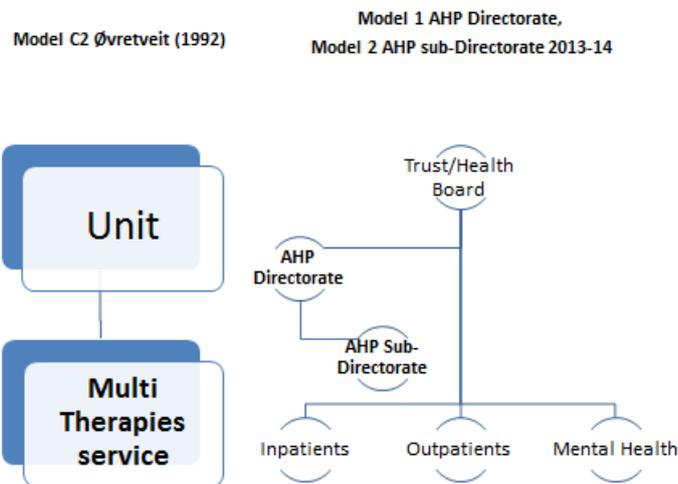


6.2.4 Model C2: Unit-based combined-therapies division

The C2 model from 1992 was the most popular in 2013/14. It was viewed largely as an AHP Directorate (Model 1), where all AHPs were management collectively, or as a AHP sub-directorate (Model 2) where AHP teams were in smaller groupings across the organisation.

In light of the previous section, NHS restructuring has therefore had this quite widespread effect on NHS physiotherapy management. It is a partial move from functional to product management structure, but an incomplete move taken only as far as a multi-AHP structure.

Fig.12 Unit-based combined-therapies division comparison

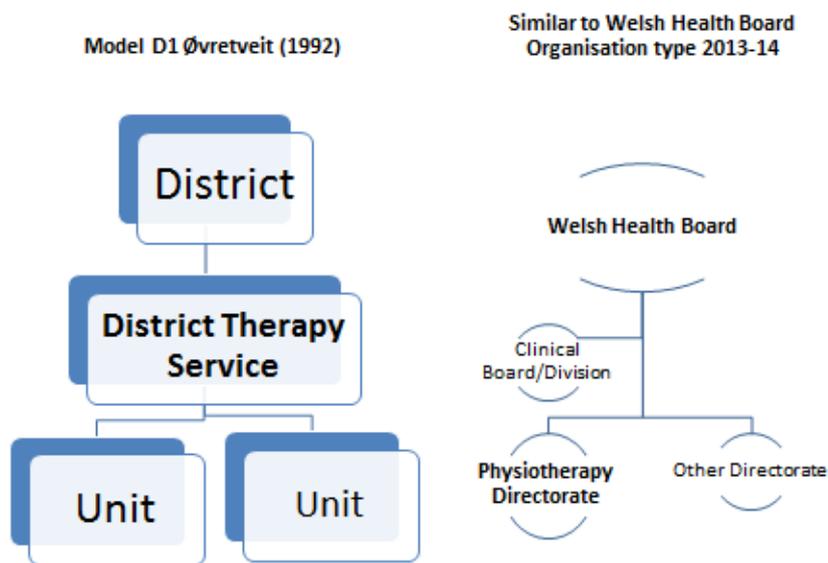


6.2.5 Model D1: Unit-based District therapy service

This 1992 model could be adapted, as this was similar to the Welsh Health Boards provided services across a District (hospital, community and mental health services) as a Physiotherapy Directorate.

A limitation of reforms was the impact on physiotherapy structures. As the Welsh reforms occurred, either changes to physiotherapy structures did not result, or the reform implementers did not think them necessary. This resulted in Welsh NHS physiotherapy services being less affected by reforms than those in England.

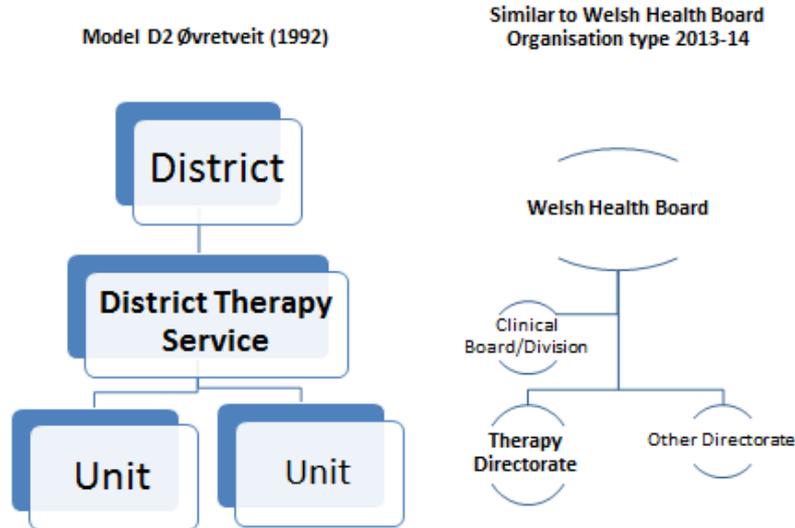
Fig.13 Unit-based District therapy service comparison



6.2.6 Model D2: Unit-based combined District therapies

This 1992 model could be adapted, as this was similar to the way in which the majority of Welsh Health Boards provided services as a Therapy Directorate, which similar to model D1 above demonstrating the limited impact of NHS change in Wales on the way that physiotherapy services were structured.

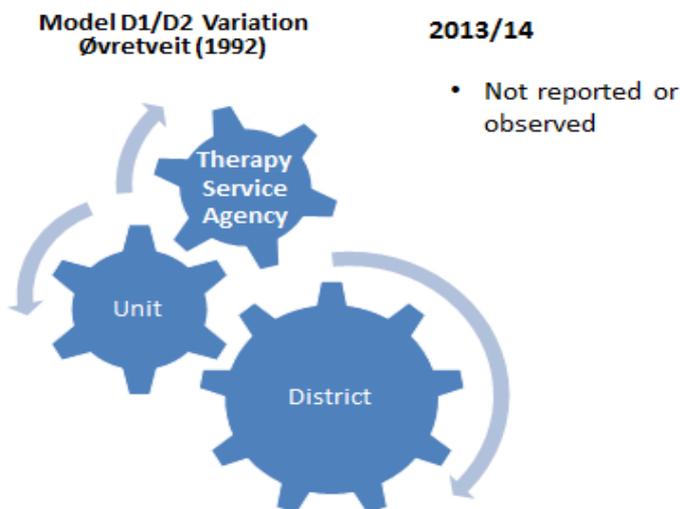
Fig.14 Unit-based combined District therapies comparison



6.2.7 Variation of D1 or D2: Therapy “service agency”

Variation of D1 or D2, The therapy “service agency”, was external to the organisation; it was implemented once in Bath but failed and not replicated. There was rapportage that the failure was due to lack of robustness in NHS commissioning at that time, making this model unattractive as the business model was poorly developed. This model was not observed and not evidenced as a current model.

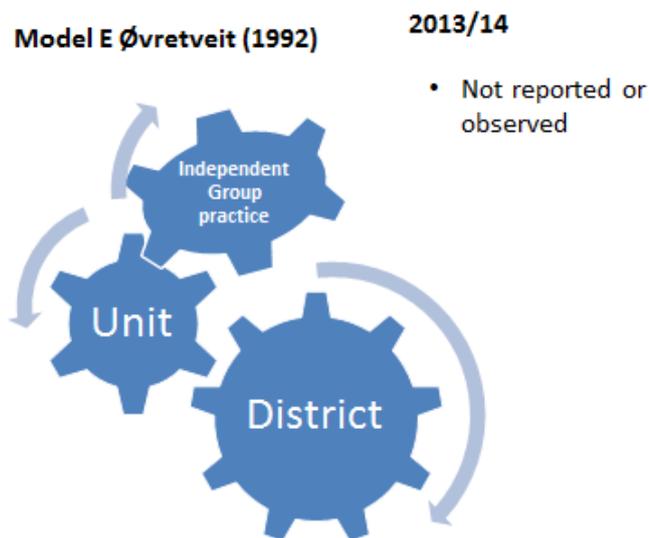
Fig.15 Therapy “service agency” comparison



6.2.8 Model E: Independent group practice

Model E Independent group practice, was external to the organisation. It was not observed and not evidenced as a current model. This was perhaps unexpected, in light of AQP policy which identified physiotherapy as a possible early AQP candidate.

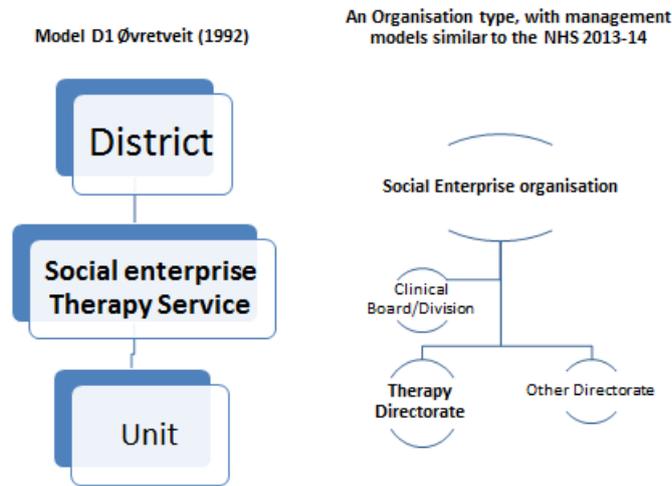
Fig.16 Independent group practice



6.2.9 Organisation type to add

Social Enterprise was considered by Øvretveit (1992) as an organisational management structure, however this was reported as a type of organisation not a management structure, i.e. a new ownership and governance model for an otherwise unchanged physiotherapy structures within it.

Fig.17 Social Enterprise



Three types described by Øvretveit: Individual private practitioner, therapies agency and independent group practice did not feature. An individual private practitioner would possibly lack the range of skills to provide a comprehensive service, being single handed and possibly cause governance concerns. The therapies agency was a theoretical model in 1992, but quickly failed. The independent group practice was a professional partnership of clinicians, with special legal personality. Social enterprise organisation had different controls and aims (Allen and Jones, 2011.)

The model of Districts and Units has since changed, making this terminology obsolete, though recognising that there are larger organisations in some areas providing services across hospitals and community, and smaller services in others providing a single site service.

6.3 Differences Between Management Structures

A comparison between 1992 and 2013/14 is presented. The 2013/14 physiotherapy structures were numbered for ease of reference.

Table 16 Comparison between physiotherapy management structures 1992:2013/14

Management model: Øvretveit (1992)	Empirical observed organisational structures (2013/14)	Similarities and differences between 1992 and 2013/14 models
<p>A. Individual private practitioner</p> <p>The practitioner is self-employed and has independence within the law and codes of conduct to decide their own working arrangements.</p>	Not observed	Individual private practitioners not identified by physiotherapy managers as providing NHS commissioned services, unlike 1992.
<p>B. Directorate or Locality managed</p> <p>Therapists are employed by a provider unit, and managed by clinical directorates, localities or other sub-unit divisions. Therapy services (individual or department) are financed and provided as part of these divisional services from within divisions. There may or may not be a therapist advisor inside or outside the directorate. Requires professional links with external physiotherapy service. Sometimes known as “dispersed” or “totally fragmented” model</p>	<p>Clinical Pathway (model 4)</p> <p>Physiotherapy managed as part of a specialty pathway. Physiotherapists organised as part of a multidisciplinary team around a patient group e.g. musculoskeletal, community. There is not normally a physiotherapy manager leading the team, professional leadership normally provided externally</p> <p style="text-align: center;">And</p> <p>Fragmented (model 5)</p> <p>Physiotherapy staff are dispersed across divisions and directorates, managed as part of multidisciplinary teams rather than as part of a physiotherapy structure, with no physiotherapy “department” with physiotherapy advisory mechanism.</p>	<p>Locality managed physiotherapists in some places, but organised different from directorate managed, as the latter was normally led by a physiotherapist or AHP. Physiotherapists reported as being managed within clinical pathway teams with professional leadership provided from the main physiotherapy service within the organisation.</p> <p>With a fragmented model there is not necessarily a “parent” unit, but other elements are similar where AHP services are dispersed.</p> <p>Also similarities to the dispersed model where it may just be physiotherapy that is fragmented alone and not part of an AHP service</p>
<p>C Unit based single or combined Therapies</p>		

<p>Division</p> <p>C1. Unit based single therapy division</p> <p>One therapy service is a separate division in its own right within a unit structure, rather than being part of another division. The therapy services like a directorate or care programme for planning and financial systems and for contracting purposes, and is managed by a head therapist. Most therapists are contracted by the head therapist to work in the unit's directorates or localities, as part of these services. May be competition within the unit for the same staff.</p>	<p>Physiotherapy Directorate (model3)</p> <p>Physiotherapy managed as one uni-professional service, with a head of physiotherapy managing and leading the entire service</p>	<p>Physiotherapy as a stand-alone service is still a model, managed by a service Head.</p> <p>No reporting of competition for the same staff as they were organised around clinical specialty areas, though junior staff may be selective and preference "core" areas.</p>
<p>C2. Unit based combined AHP Division</p> <p>Therapists are grouped together in one division or therapies directorate. Lead general managers bring therapy services together, each therapy service in the combined unit, competes with therapy services in other units.</p>	<p>AHP Directorate (model 1)</p> <p>Physiotherapy is managed as one service as part an AHP grouping within one organisation, whether its remit is in one sector or across the health community. Providing therapy to various directorates/ localities with a monopoly of provision.</p> <p>AHP Sub-Directorate (model 2)</p> <p>Physiotherapy is part of an AHP sub-group e.g. AHP trauma team managed as a group of AHPs, similar to the Clinical Pathway, but AHPs grouped together and led by an AHP.</p>	<p>Therapists grouped together as AHPs; the most frequently reported model, though not led by a general manager but by a lead AHP.</p> <p>A mix between C2 and B models of 1992, demonstrating elements of both.</p>
<p>D. Unit based District Therapies</p> <p>D 1. Unit based District Therapy service</p> <p>All therapists in the district are managed as separate divisions within a "parent" unit. A high proportion of therapy services are contracted to purchasers external to the parent unit rather than internal purchasers (e.g. Unit directorates)</p>	<p>Possibly a variation of AHP Directorate (model 1)</p>	<p>In place in 1992, but not obviously operating in 2013/14 would require more in-depth analysis to determine if this was a matrix model of "organised decentralisation"</p>

<p>D2. Unit based combined District therapies</p> <p>Similar to C2, but in this case 2 or more District services are managed from the “parent” unit and combined to form a “District services division”, in the “parent” unit</p>	Not observed	The breakdown of English District models has excluded this model, and Welsh organisations did not have a unit based structure
<p>Variation of models D1 & D2 : “Therapy Services Agency”</p> <p>A variation of D1 or D2 in which therapy services are not managed by a general manager. The service is linked to a host unit, rather than managed by a “parent” unit. One difference is that in D the unit manager can retain therapy surpluses, but not in the “Service Agency” variation.</p>	Not observed	N/A
<p>E. Independent group practice</p> <p>In this theoretical model therapists form their own for profit practice. An option existed for therapists to leave NHS employment and form a separate business to contract with the NHS, often directly with GPs</p>	Not observed	N/A

6.3.1 Management structures

Physiotherapy managers reported that the profession was led by a majority of multi therapies/AHP leadership managers. The five different models were described to be operationally managed in compliance with three different normative conceptual models.

Horizontal roles of multi professional management/leadership; with a relatively flat management structure (Walshe and Rundall 2001; Lukas *et al* 2007,) held by 63% of respondents, where a physiotherapist was the leader for both their

own profession and other AHP services. As the lead AHP, they would be managed by either a general manager or another profession. There were also examples where the horizontal AHP lead role was held by a different AHP profession. Physiotherapists were the large majority of these post holders; 24% of all AHP and 41% of the 6 “therapy” professions. Physiotherapists held more than their proportionate share of senior AHP leadership roles, demonstrating ability to work in these senior management posts. This structure enabled 18 (15%,) to manage discrete pathways (e.g. musculoskeletal) as well as being the lead for their profession.

Vertical management/leadership roles; where the Head physiotherapist managed the physiotherapy profession only, or was a clinical lead with no broader AHP management function in the organisation. This uni-professional model (Mintzberg 1979; Bohmer 2010,) was held by 43 (35%). Semi-detached uni-professional structures are reported to promote specialised technical skills, conserving professional status and give rein to professionals' motivation, values and technical standards (Lane *et al.*,1991; Vandenberghe,1999.) Opponents report disadvantages of “silo” working (Buchanan *et al*, 2013.) The vertical roles were uni-organisational and multi-organisational.

Multidimensional management/leadership functions (matrix management role); as described by Burns and Stalker (1961,) Øvretveit (1992,) Courpasson (2000.) This model was delivered from a central service across the organisation using both vertical and horizontal functions interconnecting with other structures; laying one or more forms of departmentalisation on top of an existing

form (Burns and Wholey,1993). These roles were undertaken 79 (64%,) including those who were multiprofessional AHP managers and those with the title of physiotherapy manager, requiring the post holder to manage vertically and horizontally in performing their duties. This identified the requirement for physiotherapy to work with several departments and multidisciplinary teams in the provision of patient care, with the consequent resources and skills (Sy and Côte 2004).

The relevance of management structures and the way they were operationalised were reported by respondents to be extremely important in guiding the scope of their role, the range of services provided to patients and the expertise of the physiotherapists. Management structures fundamentally influenced the autonomy of the profession and its contribution to healthcare.

Management structures were analysed by type of organisation.

Table 17 Management structures and organisation types

Organisation type	Model 1 AHP Directorate	Model 2 AHP sub-Directorate	Model 3 Physio Directorate	Model 4 Pathway	Model 5 Fragmented	Number and % of total
Welsh H B	6	0	2	0	0	8 (7%)
Acute T	24	3	13	9	4	53 (43%)
Mental H T	4	0	1	0	1	6 (5%)
Soc. Ent	0	0	1	3	1	5 (4%)
Community T	5	1	3	2	1	12 (10%)
Mixed T	9	1	9	7	1	27 (22%)
Tertiary T	3	0	2	1	1	7 (6%)
Care T	1	0	1	1	0	3 (2%)
Partnership T	1	0	0	0	1	2 (2%)
Total	53 (43%)	5 (4%)	32 (26%)	23 (19%)	10 (8%)	123 (100%)

It should be noted that Care Trusts, Social Enterprise and Partnership Trusts had small numbers in the study cohort when making generalisations, though this reflects the national picture of them being few in number. Acute Trusts, Mixed Trusts and Community Trusts had all five management structures in place and accounted for 75% of organisations. Social enterprise was the only organisation type not to have AHP groupings, but this related to the limited services provided by them, which was largely provided by physiotherapists and some Occupational Therapists. Therefore possible confounding factors such as organisation type, organisation size, type of services provided and clinical specialism mix did not account for the management structures in place.

6.3.2 Differences of access between the observed structures

Access to physiotherapy services was reported to be an important aspect of a service's provision to patients. In rank descending order, the physiotherapy managers' top two rated positive impacts following the 2008 reforms were:

1. Reduced waiting time for treatment; improved access
2. More community care; facilitating access

Some respondents reported both.

Table 18 Management structures and improved access

Structure	Improved access, reduced waits	More community services
1. AHP Directorate	13 (25%)	7(13%)
2. AHP Sub-Directorate	2 (40%)	0
3. Physiotherapy Directorate	9 (28%)	2(6%)
4. Clinical pathway	5 (22%)	3 (13%)
5. Fragmented	3 (30%)	0

Physiotherapy managers in all management structures reported similarities, with waiting times reducing. This implied that there was nothing to choose between the extant management structures in that respect. The influence of “Tier 1” waiting time targets influenced all physiotherapy services in all organisation types, as overall organisational performance required reduced waiting times for all outpatient specialties including physiotherapy. However this was not consistent for all physiotherapy services as a substantial number reported increased waiting times (see Table 19 below).

AHP Sub-Directorate and devolved models differed as access to more community based services was not evident.

The top two rated negative characteristics were; longer waits, restricting timely access (which conflicted with the view of the top rated characteristic being reduced waits, but was reported by fewer) and reduced clinical posts, reducing physiotherapy treatment time. The most recent reforms were reported to have impacted on the number of physiotherapy posts.

Table 19 Management structures and reduced access

Structure	No physiotherapy provided	Poorer access, longer waits	Reduced clinical posts
1. AHP Directorate	1(2%)	15 (28%)	3 (6%)
2. AHP Sub-Directorate	1(20%)	2 (40%)	0
3. Physiotherapy Directorate	1(3%)	6 (19%)	1(3%)
4. Clinical pathway	2(9%)	5 (22%)	1 (4%)
5. Fragmented	0	0	0

There were similarities between models 1, 3 and 4 with some reporting poorer access with longer waiting times. This finding was supported by an interviewee:

SSI 11 [1] *“Our waits were down, then we lost even more staff, we just don’t have the capacity anymore.”*

The informants of the fragmented model reported neither longer waits, nor reduced clinical posts. The most dissimilar was model 2, AHP Sub-Directorate reporting the most increased waiting times and the greatest impact by the loss of physiotherapy service provision.

Table 20 Management structures and equity of access

Structure	More equal access
1. AHP Directorate	28(50%)
2. AHP Sub-Directorate	3(60%)
3. Physiotherapy Directorate	12(38%)
4. Clinical pathway	12(52%)
5. Fragmented	0

Models 1, 2 and 4 had the greatest similarity with equity of access. Model 5, fragmented, reported no improvement.

6.3.3 Differences of scope of service between the observed models

Scope of service had several characteristics. 64 (52%) of physiotherapy managers reported a broader scope of their role since 2008.

Comments related to scope included:

R12 [1,20] *“Post now involves therapy management rather than physiotherapy only.”*

R115 *“Community physios have TUPE'd from Community Trust.”*

Table 21 Change of scope of role since 2008

Structure	Broader	Narrower	No change
1. AHP Directorate	31(59%)	1 (2%)	21 (40%)
2. AHP Sub-Directorate	5 (100%)	0	0
3. Physiotherapy Directorate	8 (25%)	3 (9%)	21 (66%)
4. Pathway	14 (61%)	2 (9%)	7 (30%)
5. Fragmented	6 (60%)	0	4 (40%)

The range of specialisms provided also affected scope of the service. 25 (20%) reported a decrease in the range of clinical services/specialties.

Table 22 Decrease in the range of clinical services/ specialties provided

Structure	Yes	No
1. AHP Directorate	13 (25%)	40 (75%)
2. AHP Sub-Directorate	0	5 (100%)
3. Physiotherapy Directorate	5 (16%)	27 (84%)
4. Pathway	5 (22%)	18 (78%)
5. Fragmented	2 (20%)	8 (80%)

One interviewee commented:

SSI1 *“We have been party to AQP which has taken our outpatient service away.”*

6.3.4 Clinical autonomy

In a series of questions about the impact of NHS changes physiotherapy managers reported that the highest disagreement 67(55%,) was that clinical autonomy for physiotherapists had decreased, though 56 (46%) actually reported reduced clinical autonomy.

Table 23 Physiotherapy service has decreased clinical autonomy

Structure	Number	%
1. AHP Directorate	24	45
2. AHP Sub-Directorate	2	40
3. Physiotherapy Directorate	18	56
4. Pathway	10	44
5. Fragmented	2	20

6.3.5 Quality of care

46(37%) of physiotherapy managers reported reduction in the quality of care since 2008, therefore 63% did not.

Table 24 Deteriorated quality of physiotherapy care

Structure	Number	%
1. AHP Directorate	18	34
2. AHP Sub-Directorate	1	20
3. Physiotherapy Directorate	15	47
4. Pathway	9	39
5. Fragmented	3	30

7.3.6 Promotion opportunities

87 (71%) of physiotherapy managers reported reduced career opportunities compared with 2008. Clinical staff and managers were affected in both countries; a net loss of 22 (18%) physiotherapy manager posts.

Table 25 **Reduced scope for promotion**

Structure	Number	%
1. AHP Directorate	36	68
2. AHP Sub-Directorate	4	80
3. Physiotherapy Directorate	23	72
4. Pathway	18	78
5. Fragmented	6	60

This position was supported by an interviewee:

SS11 *“Our most senior physio post is now a Band 7.”*

Whereas previously physiotherapy managerial Bands were all in Band 8, ranging from 8a-8d and Band 7 was considered a clinical band.

6.3.7 Departmental facilities

Physiotherapy managers reported that 27(22%) of services had lost or reduced departmental facilities, though 78% did not. There were neither patterns across types of management structure, nor any evidence of confounders. This was influenced by competing organisational requirements for efficient use of space, though would have reduced rehabilitation facilities as a consequence.

R53 [87,1,11] *“Squeeze on space, other departments moved into therapy area and we have downsized.”*

Table 26 **Lost or reduced departmental facilities**

Structure	Number	%
1. AHP Directorate	12	23
2. AHP Sub-directorate	3	60
3. Physiotherapy directorate	3	9
4. Pathway	3	30
5. Fragmented	27	22

6.3.8 Number of organisations provided to

Physiotherapy managers reported similarities between all models, with services being mainly provided to one organisation.

Table 27 Number of NHS organisations physiotherapy provided to

Structure	0	1	2	3
1. AHP Directorate	1	40	9	2
2. AHP Sub-Directorate	1	3	1	0
3. Physiotherapy Directorate	3	21	8	0
4. Clinical pathway	3	13	6	1
5. Fragmented	2	5	1	1

All models provided physiotherapy to non-NHS organisations. Models 1 and 4 providing physiotherapy services to the greatest number of non-NHS organisations which would have included charitable sector and other settings, those these were not a substantial number.

Table 28 Number of non-NHS organisations physiotherapy provided to

Structure	0	1	2	3
1. AHP Directorate	43	6	0	2
2. AHP Sub-Directorate	3	1	0	0
3. Physiotherapy Directorate	26	3	1	0
4. Clinical pathway	15	6	0	2
5. Fragmented	7	2	0	0

6.3.9 Management of non-physiotherapists

Physiotherapy managers for all management structures reported that 95(77%) managed non-physiotherapy staff, with up to 10 other staff groups managed.

The main groups were physiotherapy assistants, clerical and occupational therapists. Non-AHP groups managed were nurses, doctors and orthodontists.

Table 29 Other staff groups managed

Structure	Number	%
1. AHP Directorate	45	85
2. AHP Sub-Directorate	4	80
3. Physiotherapy Directorate	31	97
4. Clinical pathway	21	91
5. Fragmented	7	70

6.3.10 Effect of service change

64(52%) of physiotherapy managers, reported greater fragmentation since 2008. Community organisations had significantly more physiotherapy services sub-divided between directorates and divisions than acute organisations:

Table 30 Services more fragmented now compared with 3 years ago

Structure	Number	%
1. AHP Directorate	27	51
2. AHP Sub Directorate	1	20
3. Physiotherapy Directorate	19	59
4. Clinical pathway	13	57
5. Fragmented	4	40

This was commented on by an interviewee:

SSI11 *“We lost services as we became fragmented, we are more fragmented than ever before.”*

Physiotherapy managers reported 45(37%) of organisations had decreased physiotherapy services/specialties provided. This was the minority response in

all management structures as 63% did not report this finding. There was neither any pattern across types of management structure, nor any evidence of confounders.

Table 31 Decreased range of clinical services/specialties provided

Structure	Number	%
1. AHP Directorate	13	25
2. AHP Sub-Directorate	0	0
3. Physiotherapy Directorate	5	16
4. Pathway	2	9
5. Fragmented	25	20

Only small numbers of services no longer provided physiotherapy.

Table 32 No longer any physiotherapy service provided

Structure	Number	%
1. AHP Directorate	1	2
2. AHP Sub-Directorate	1	20
3. Physiotherapy Directorate	1	3
4. Pathway	2	9
5. Fragmented	0	0

Physiotherapy managers in 48 (39%) of organisations had expanded services. The only structure where this was the majority position was the physiotherapy directorate. 61% did not report this finding. There was neither any pattern across types of management structure, nor any evidence of confounders.

Table 33 Service expanded to provide for a wider area

Structure	Number	%
1. AHP Directorate	18	34
2. AHP Sub Directorate	2	40
3. Physiotherapy Directorate	16	60
4. Clinical pathway	10	44
5. Fragmented	2	20

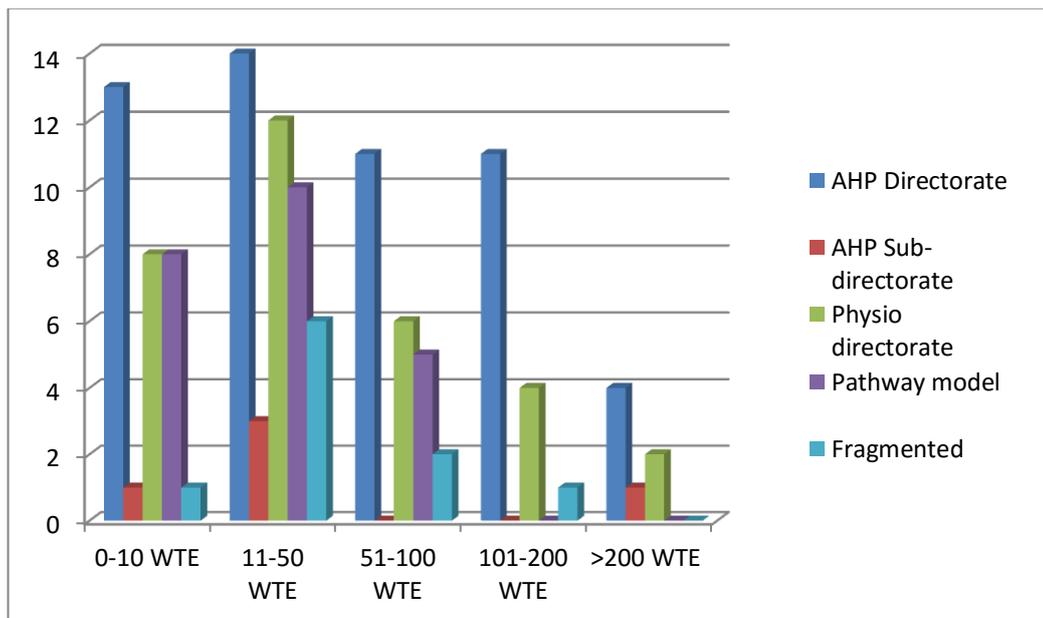
This was illustrated by an interviewee:

SS16 “We have expanded to take on musculoskeletal services previously provided by the Community Trust.”

6.4 Different Staffing Numbers Between Observed Models

Physiotherapy managers reported that the AHP and Physiotherapy Directorates employed the largest numbers of staff. The AHP Sub-Directorate employed one large group of staff, but also some small groupings. The Pathway structure had relatively smaller staff numbers, and the fragmented model fewest staff overall.

Fig. 18 Number of Whole Time Equivalent (WTE) physiotherapists managed



6.5 Rating of Different Management Structures

The different management structures were rated by respondents regarding its ability to enable the provision of an effective and efficient physiotherapy service (Jones and Jenkins, 2006). The findings implied that the majority of services (AHP Directorate,) were structured providing the characteristics identified. The least able to provide the factors required for an efficient and effective physiotherapy service were the devolved structures.

Table 34 Rating of management structures for an effective and efficient service

Key service requirement	Management structures				
	AHP Directorate	AHP Sub-Directorate	Physio Directorate	Pathway	Fragmented
Maintaining quality of care	3	5	1	2	4
Uniformity of safety and quality	5	3	5	2	1
Provide equity of access	3	5	2	4	1
Access to specialist skills	5	3	5	2	1
Provide all core specialisms	5	3	5	1	2
“Critical mass” of staff	5	3	4	1	2
Skills/capacity to support education	5	3	5	2	1
Cross service support for assistants	5	3	4	1	2
Skills and capacity to support R&D	5	3	4	2	1
Flexibility to deployment of staff	5	3	4	1	2
Cover for staff sickness/absence	5	3	4	1	2
Manager authority/accountability	5	3	5	2	1
Service strategically positioned	5	3	4	2	1
Implementation of national priorities	5	3	5	1	2
Strategic organisational links	5	3	4	1	2
Supports cross-	5	3	5	2	1

boundary working					
Support professional networking	5	3	4	2	1
Effective and efficient resource use	5	3	5	1	2
Commissioning links	5	3	4	2	1
Commissioning implementation	5	3	5	2	1
Optimum use of data/IM&T	5	3	4	1	2
Optimum use of financial resources	5	3	4	2	1
Total	125	81	109	45	41

[Best performance= 5; worst performance= 1]

6.6 Managers' Preferences for Models of Physiotherapy Services

Although the research from the census survey demonstrated only one significant association between the observed models, managers reported a preference for management structures which maintained their AHP and/or physiotherapy identity. The SSIs explored this further. Of the interviewees, 11(92%,) recommended an AHP Directorate, (8 were either in that structure now, or when they retired).The remaining 1(8%,) recommending a fragmented model, this manager was currently working in a fragmented model. The Social Enterprise manager did not see their structure as being particularly different from the NHS. Therefore, the preferred and recommended management structure was either the one that was currently being worked in, or an AHP Directorate model which they had previously worked in, and one that was led by a physiotherapist. This data corroborated this finding of Øvretveit (1992).

To explore further the themes underpinning the interviewees' preferences, responses were analysed:

A supportive AHP identity:

SSI6 [10] *“More power and understanding of AHP issues. Support for one another.”*

Opportunities to support professional development:

SSI1 *“Maximising opportunities for training and development, undergraduate and post graduate career development.”*

Affordability:

SS17 *“Financial economies of scale sharing skills and reducing duplication.”*

The physiotherapy managers' least preferred management structure was the fragmented one, 9 (75%). Themes were:

Poorer patient care:

SSI 3 [11] *“It's disjointed, with little development opportunity for staff, un-coordinated, limited supervision and worse for patients.”*

Loss of professional identity and focus:

SSI8 *“Not best for us as a profession we get lost and lose support of other physios and skills across specialities – no new blood brought into the system.”*

The physiotherapy directorate model was poorly recommended 3 (25%).

SSI8 *“It's going backwards”*

Fear of medical dominance:

SSI8 [9] *“It's inevitable that teams will be led by medics and they don't know what they don't know ... you lose expertise and your best staff move.”*

This corresponded with findings from Mental Health services, where medical leadership has not always been favoured by other professions particularly when medics attempt to display “soft” leadership (Sheaff *et al*, 2003).

Physiotherapy managers were minded not to move back to being a uni-professional service, but were fearful of a fragmented structure providing good quality patient care. There were concerns that the fragmented structure would impact on professional development and holistic skills. Participants’ preference for a physiotherapy managed service was expressed:

SSI2 “Where ever possible physiotherapy should have its own manager to oversee the service.”

The underpinning beliefs and values that preference choice of management structures was the ability to provide good patient care, with a range of skills and expertise. There was also a desire to maintain a professional identity collaboratively with other AHPs, discrete from medicine and nursing. The perceived fear of non-AHP models was lack of identity and being subsumed by larger professions competing for limited resources.

Many managers were not working in their most favoured structure (AHP type).

There was also a degree of pragmatism reported:

SSI1 [10] “Some people are clutching onto the dark ages...there will be less lead roles, more fragmentation and more management by other professions... stop grumbling and get real.”

6.7 Changes/Discontinuities of Organisational and Management Changes

The main organisational and management changes/discontinuities during the period since 1989 were analysed.

6.7.1 Impact of government health policy

Analysis was undertaken to review the impact of changes reported on each individual organisation type. The notable changes demonstrating discontinuity with previous periods across all organisations were:

- 79 (65%) had re-structured since 2008
- 60 (49%) of services had changes in physiotherapy management
- 40 (33%) had merged with another organisation
- 40 (33%) had their physiotherapy service sub-divided between directorates
- 33 (27%) had their service managed by someone other than a physiotherapist, when previously a physiotherapist was their manager
- 11(9%) had their service managed by a physiotherapist when previously it was not
- 10% had been affected by aspects of tendering out services

Further uncertainty was reported and a cause of concern for some managers:

SSI 4[9] "We're having yet another therapies review as we are merging with the Community and Care Trust; goodness knows what that will mean."

Acute organisations were impacted significantly (Table 83.)

6.7.2 Cost constraints

There was a view from all interviewees that organisational pressure to save money was the main driver for change. This had been apparent from 2008 and was ongoing. The impact of the annual cost improvement programmes (CIP), where a blanket percentage saving is placed on all budgets was reported as being disliked.

SS18[13,12] “CIPs should be shot at dawn!”

With physiotherapy budgets being normally > 95% staffing costs, savings necessitated reduction of staff posts and skill mix to provide services at a lower cost. Physiotherapy budgets were therefore mainly staffing budgets, demonstrating the highly “hands-on” nature of the service.

Cost constraints were reported as a consistent feature during the interviewees’ responses. It was cited as impacting directly on front-line staff affecting the quality of patient care, by reduction in staff training budgets, delays in recruitment, less senior staff and fewer opportunities for development, further impacting on scope of practice:

SSI 4 “There’s not enough money to invest in long term conditions rehabilitation.”

Although all participants reported negatively about the impact of cost pressures, there was comment that illustrated a positive element, requiring the profession to be outcomes focussed.

SSI 1 “As money’s tight, you have to provide evidence-base care with good outcomes if you want to be commissioned.”

6.7.3 Expertise

Physiotherapy managers from all organisation types reported concerns about loss of expertise, as senior posts reduced. This led in some organisations to poorer access in fewer locations, lengthening waiting times, less breadth of expertise and scope of services.

Some physiotherapy management posts had been removed from management structures, with part time advisory roles offered, not dissimilar to those of the mid-2000s, which were regarded as tokenistic and nugatory.

SSI11 “The physiotherapy advisor role was only one day a week, they offered me the AHP advisor role for 2 days a week, I went back to clinical work as it’s not doable, they haven’t advertised the post yet.”

6.7.4 Constant restructuring

The impact of England’s most recent NHS changes had affected all organisation types, reported by physiotherapy managers as creating greater anxiety than in previous periods. The main impact has been restructuring which had brought a period of instability for physiotherapy managers, and was still ongoing, including both their services and their own jobs. Community Trusts were affected the most.

The changes in England with the dissolution of PCTs had instigated another cycle of change, bringing back together some of the acute and community providers that had previously fragmented:

SSI2[3] “Yet again we are going through changes, and we will likely end up back where we were 15 years ago”

6.7.5 Mergers and fragmentation

Mergers and service fragmentation were reported by physiotherapy managers from all management structures, with only 41(33%) of respondents unaffected. Community services had expanded most, though a merger for one organisation would be viewed as fragmentation by another. Although different in concept, the implications and consequences were felt similarly by physiotherapy managers. More managers referred to fragmentation of services within their organisation, where pathway management was breaking up the traditional physiotherapy department. Service changes such as AHP groupings, were seen as less threatening. Therefore the impact of mergers and fragmentation was open to varied interpretation; though largely disliked:

SSI 2 “It felt like the bigger organisation was swallowing the smaller one, my job was put at risk as was the other manager.”

This suggested that the managers were reporting stressful experiences where there was no “winner”; a lose: lose, situation.

Services were reported as being more disjointed than ever before.

SSI 1 “Constant reorganisation all throughout my career, why can’t we be left to get on and treat patients?”

For many managers this resulted in the biggest impact on physiotherapy during their career:

SSI 5 “The way it was done was very brutal; I was so distressed I burst into tears ... They treated everyone poorly, organisational bereavement counselling was provided... kill, kill, kill.”

It was also reported that physiotherapy services were more fragmented than previously, taking focus away from day-to-day service provision, with a big impact of increased bureaucracy:

SSI 3 “Senior managers get distracted by the latest phase of churn. This takes focus away from your own service, things get delayed... people move and you have to start all over again, it’s a built-in inertia.”

Although the driver for the majority of these mergers and service fragmentation had been cited as cost containment, it was perceived that they actually increased costs:

SSI 8 “The merger was never evaluated, cost a small fortune and was not to the benefit of patients.”

The only service manager who supported a fragmented model for their service, cited positive changes with less hierarchy and the ability to grow more staff and take on more services:

SSI 6 “We tendered to bring back the community service 3 years ago, and have increased our organisation by half again.”

Although working successfully in a fragmented model, the risks for the profession were recognised:

SSI 6 “It’s easy to have a fragmented model as a poor solution, not looking after the career development of staff; it needs to be carefully overseen.”

The respondents reported that mergers and fragmentation with the primary driver being cost containment were detrimental to physiotherapy services and the care that could be provided to patients. Reorganisation for greater community control was not uniformly disliked. There was a degree of pragmatism to make whatever structures work the best possible:

SSI1 “It’s not the model I would have chosen but we have to make it work; work for patients and staff.”

6.7.6 Provider competition

Although there had been the introduction of a quasi-market economy in the 1980s, the most significant recent change in England had accelerated competition including AQP, though it was reportedly dwindling (Williams, 2014). This had added a new tension for managers including those who commented they may be threatened by tendering, as well as those who had won tenders, but had no certainty regarding continuity of contracts:

SSI 9 “Our CCG will be tendering to 13 different contracts at the same time in 2015, we are only one of them.”

Informants reported that NHS England “AQP” initiative (DH, 2011a,) had impacted on 28% of services, with additional ones being affected by tendering.

As primary care organisations shifted towards commissioning, secondary care and mental health organisations picked up provision of more services affecting 65% of English organisations. Competition was also reported to adversely impact on inter-organisational collaboration:

SSI 10 *“There’s much more secrecy and competition, ... people won’t share. It’s tougher than I have ever known it ... little chance of promotion, fearful someone will take over our service.”*

Competition in England increased inter-organisational rivalry raising concerns of a drive to privatise the NHS (Ham *et al*, 2015). Though others argued that competition was necessary to delivering improvements (Hazell, 2014).

6.7.7 Shift towards community care

At the time of this research in 2013-2014, both England and Wales had national policies requiring the further shift of services from an acute hospital focus towards stronger community-led services. The scale of change reported by physiotherapy managers illustrated the major reorganisation under way in England, caused by the dissolution of PCTs and the dispersing of community provider responsibilities. The setting up of CCGs was also part of the policy intention affecting this change. The tradition of hospital-led care was reported:

SSI 6 *“When I first trained everyone worked in a hospital, everything was run from acute, that’s laughable; now its all community-led”*

Most organisation types were affected by the changes in community services. Only Social Enterprises reported no impact on physiotherapy management by

the move to transfer services to the community. Their response indicated that they were new organisations set up as a result of the change:

SSI 9 “ We were a community provider before and had to decide to set up as a community interest company or let the service be run by someone else, since weve been here there has been less change for us than the hospitals”

Physiotherapy managers reported organisations affected by developing community services: Care Trusts 3(100%,) Partnership Trusts 2(100%,) Tertiary Trusts 5(83%,) Welsh Health Boards 6(75%,) Acute Trusts 32(60%,) Community Trusts 5(42%,) Mixed Trusts 7(34%,)

There was reported to be lack of pace in expanding community provision which the government policy had indicated:

SSI 7 “There is an agenda to develop community services but the hospitals have more and more to do, we can’t stretch to the community as much as we would like.”

The Community Trust managers whose organisations had survived as community providers, reported being less affected than most of the other organisation types. It was the former PCTs, no longer in existence following the 2012 reforms, that had borne the impact of significant community restructuring.

6.7.8 Impact on patient care

In the period post 2008 the majority reported boundaries between organisations which did not follow patient pathways. In 2005 managers reported being “piggy

in the middle” between acute and community care, trying to negotiate the best deal for patients; which appears to have continued for many. This was not a feature of the 1989 research. The adverse impact on patient care brought by organisational changes was raised in all three research periods, but more referenced as years have progressed.

The impact was associated with substantial investments in the NHS in the early 2000s, which was regarded for many at the “hey day” as care for patients, was supported by more staff and funding to develop staff, helping extend and enhance their clinical skills. There was reported to be a growth of physiotherapy advisory (non-management) posts during this time, which were felt by many to be nugatory. This had shown some limited resurgence in the period post 2008. The reforms in 1989 were associated with cost savings.

In descending priority order the reported impacts on patient care were:

1. Increased waiting time for treatment
2. More care in the community
3. Increased pressure for staff
4. Reduced time for clinical treatment episodes
5. More fragmented care
6. Increased use of care pathways
7. Merging of professional boundaries
8. More rapid discharge from acute settings
9. Greater acuity of inpatients
10. 7 day in-patient service

There was no pattern of organisation type affected, waiting time had increased for the majority, but has also decreased for some.

Chi square analysis and Yates' continuity correction of the association between the two most highly prioritised impacts on the 2008 period changes on patient care, demonstrated no significant association between acute and community organisations (Group C.)

6.7.9 Physiotherapy managers' influence

The phase of PCGs and PCTs, although disruptive, were reported with a degree of fondness due to the ability of physiotherapy managers to influence:

SS12[8] "When we were in the PCT on the Executive we were listened to and respected, when we lost this post it reverted to being just doctors and nurses and we lost our voice and the respect."

This extended to the current period for a few:

R87 "More influence on the Directors at a high level, previously not in direct line of senior management."

Managers reported valuing having influence at the highest levels in the organisation, with knowledge of their service and the ability to influence through a manager who knew the profession and understood the parameters of physiotherapy, and commended representation and its impact:

SS17 "Greater representation, gives breadth, develops staff, and therefore best for patients."

6.7.10 Level of satisfaction with management arrangements

The majority of physiotherapy managers 71 (58%) reported being satisfied in some respects. Though 98 (77%) rated their level of satisfaction as less highly than in 2008, with 12 (10%) rating it better and 16 (13%) much the same. The changes post 2008 had re-organised physiotherapy services to have largely less favoured management arrangement and less satisfied managers.

The comments articulated a dislike of being managed by a non-physiotherapist, with lack of strategic influence. Managers disliked not being able to make decisions independently and added bureaucracy of hierarchical decision-making. In clinical practice physiotherapists are able to make diagnostic decisions and act on them without the need for authorisation from another, frustration was expressed when managerial decision-making was less autonomous.

When organisations were pooled into 2 main types (Group C,) Chi-square test of independence (with Yates' continuity Correction) was undertaken, demonstrating significant areas of discontinuity.

Table 35 Relation between organisation type and government policy impact

Independent Variable	χ^2	$p =$	Interpretation
1. Part of the physiotherapy services being tendered out	(1, n = 123) = 6.819	0.009	Acute Trusts were more affected by having part of their service tendered out than Community Trusts.
2. Physiotherapy services having expanded to take on providing for a wider geographical area	(1, n = 123) = 3.724	0.054	Community Trusts had expanded to take on providing for a wider geographical area to a greater extent than Acute Trusts.
3. A decrease in the range of clinical services provided	(1, n = 123) = 3.724	0.054	Acute Trusts were affected by decrease in the range of clinical services provided than Community Trusts.
4. Physiotherapy services	(1, n = 123)	0.001	In Community Trusts 75% of

subdivided between different divisions/directorates	= 12.043		physiotherapy services were subdivided compared with 25% in Acute Trusts
5. There had been no change in physiotherapy management arrangements	(1, n = 123) = 4.230	0.040	There has been significant change in physiotherapy management arrangements in Community Trusts compared with Acute Trusts.

There was absence of a significant relationship between other factors including access and cost savings which may have been anticipated.

Acute Trust physiotherapy managers reported being affected the most by organisational change. In contrast, community services had expanded more, though their services were more fragmented, with a higher degree of management reorganisation than Acute Trusts.

6.7.11 Impact on morale

Lowering of morale was a consistent feature during periods of reform. Morale was reported as being adversely affected in the period post 2008 and in 1989, whereas in 2006 morale was influenced by the impact of reorganisation, not by service cuts.

Adverse impacts reported were related to roles being disbanded, downgraded and lack of “value” in their organisational contribution. Poor morale reflected the anxiety of physiotherapy managers not being in control of managing their own service, and financial constraints impacting adversely on clinical practice.

Table 36 Lowering of morale: Management structure

Structure	Number	%
1. AHP Directorate	43	81
2. AHP Sub-Directorate	4	80
3. Physiotherapy Directorate	27	84
4. Pathway	20	87
5. Fragmented	5	50

The area of highest overall agreement on the impact of recent changes was the lowering of morale reported by 99 (81%) participants. This was reported a cause for concern as this related to the physiotherapy staff not just the managers:

SS110: "Staff need a sense of family [a physiotherapy department with staff together], it affects patient care, happy values, gives better patient care."

This was further analysed by organisation type, the smaller organisation types 3, 4, 8 and 9 all reported reduced staff morale. A Fisher Exact test reported no significant association.

Table 37 Lowering of morale: Organisation type

Structure	Number	%
1. Welsh Health Board	5	63
2. Acute Trust	45	85
3. Mental Health	6	100
4. Social Enterprise	3	100
5. Community	9	75
6. Mixed	21	78
7. Tertiary	5	71
8. Care	3	100
9. Partnership	2	100

6.8 Continuities of Organisational and Management Changes

The main continuities were reported by physiotherapy managers to be:

Constant change used to cycles of change:

SSI7[14] *“I’ve lost count how many times we have been re-organised it’s been a constant throughout my career, heads down and here we go again.”*

Slow pace of integration: No mention was made about the impact of intergration with social care or pooled budgets, despite there being three Care Trusts in the research cohort. The research period may have been too soon for this to have impacted widely.

Visibility and influence: Some managers reported 2005 as a period of great opportunity for them:

SSI8 *“People started to take notice (of physiotherapy managers on the PEC) we could make them aware as we had greater visibility.”*

The need to be visible in organisations was reported as a constant feature:

R20 *“Loss of Director of Therapy/ Head of physio post, therefore much more difficult to be visible to influence at Board level.”*

Preference for being managed by a physiotherapist: Several reported the preference for being managed by someone from their own profession, though Government policy had impacted on this.

Preference for managing services over a wide geographical area

Managers reported the benefits of managing services over a wider, enabling greater continuity of between primary and secondary care.

R57 *“Much better to manage across the whole health community, better for patients.”*

Cost containment; departmental facilities: Physiotherapy departments require sizable estate and equipment, such as hydrotherapy pools and gymnasia which had been scrutinised to ensure efficiency. Loss or reduction of these facilities was reported to have impacted on the capacity and range of services. Research in the 1990s also reported pressure on departmental facilities; this has therefore been a feature through periods of reform.

6.8.1 Views of semi-structured interview informants

The views expressed by the informants when interviewed indicated that in comparison with the period prior to 2008 reforms, the majority of physiotherapy managers reported that their services had a less clear mission and were more fragmented in some areas, but had more equal access for patients and referrers to their services. Quality of physiotherapy had improved, but staff were less highly banded with reduced career opportunities. Morale of the physiotherapy staff was markedly worse, but clinical autonomy had improved. Boundaries between professions had become less clear. Physiotherapy managers felt valued and Board level influence had improved, with the status of physiotherapy in the organisation also improving and a trend of shifting services from acute to community provision.

This illustrated a position of organisations recognising the value of physiotherapists, but ensuring staff costs were controlled, promoting multi-professional working and a consequent reduction in career progression opportunities. There was reported to be an 18% shift away from physiotherapy services being managed by a physiotherapist, which may have contributed to their views. Managers were dissatisfied with the position of being responsible for defending their service from budgetary pressures, supporting their clinical staff to provide care to patients and with less chance of personal career development:

SSI4 *“Staff measure you by your ability to defend the budget from attack.”*

Acute and community services were reported as seeing most change due to financial pressures, which were unanimously perceived unfavourably with several mentioning loss of management posts. The managers who reported the greatest impact were those who had personally been involved in the changes, with those who were the longest serving managers with more than 30 years' experience, reporting this change as:

SSI4 *“The most significant and devastating of my whole career.”*

Chi square analysis of the the primary reported impact of the 2008 changes on patient care demonstrated no significant association between acute and community organisations.

6.9 Impact of Confounding Factors

Analysis of the survey data was undertaken to assess whether potentially confounding factors such as organisation size, type, range of services and patient mix were associated with management structure and with key outcomes. Table 34 (above) itemized the identified 22 key service requirements for an efficient and effective physiotherapy service (Jones and Jenkins, 2006), including factors such as maintaining quality of care, uniformity of quality and safety, efficient use of resources, critical mass of staff and access to specialist skills. The three professionally led models rated higher than the two devolved models. The responses for these were explored:

6.9.1 Organisational size

Relatively smaller organisations had fewer physiotherapists, and therefore informants reported that they did not have critical mass in terms of staff to cross cover for absence or a range of clinical specialisms in which to train and develop staff. Therefore smaller organisations would lack resilience in its physiotherapy workforce and need to access agencies to cover staff vacancies and external support to train and develop staff with holistic skills. However managers in these smaller organisations may consider these arrangements suited to their needs, with a requirement for staff with generic non specialist skills, though physiotherapy managers reported otherwise. This illustrates that some physiotherapy management models can only apply where certain reform 'confounders' are obtained and limits what organisational models are feasible.

6.9.2 Organisation type

The type of organisation was another differentiating factor. It should be noted that Care Trusts, Social Enterprise and Partnership Trusts had small numbers in the study cohort when making generalisations, though this reflects the national picture of them being few in number, and size appeared to be a confounding factor. These organisations were similar in size to Mental Health Trusts and many Community Trusts but smaller than Acute Trusts, Mixed Trusts and Welsh Health Boards. It is therefore possible that some of the same factors would apply to smaller organisation types as to smaller organisation size.

Even where the organisation type was relatively small, a broad range of specialisms would be required e.g. Community Trust may need physiotherapists to provide treatment to: musculoskeletal outpatients, women's health outpatients, pain management out patients, amputee rehabilitation, neurological rehabilitation, inpatient-rehabilitation, community based reablement, hospital at home, pulmonary rehabilitation, cardiac rehabilitation, children's physiotherapy in both education and community settings, learning disabilities etc. A smaller organisation size, did not necessarily indicate smaller scope of services or reduced number of specialties, but scope was not the same as larger organisations. The circumstances that drove the size-constraint related more to critical mass and access to expertise required to provide breadth of specialist services, impacting on patient care and support for staff development. Smaller organisations tended to provide more "generic" care.

6.9.3 Range of services

The range of physiotherapy services provided by an organisation was related to the patient mix and clinical specialties required. For services providing a pathway of care e.g. respiratory, the main skills required by physiotherapists would be pulmonary related. It could be argued that having access to broad specialisms would not be required. However in the clinical setting patients often present with multiple pathologies and do require more holistic skills e.g. musculoskeletal skills, biopsychosocial skills as well as experience of both hospital and community services. Physiotherapy managers reported adverse impacts on staff being focused in narrow clinical pathways, which was seen as adversely impacting on the development of skills and creating vulnerability for continuity of care if clinical pathways were fragmented.

Therefore management structures affected physiotherapy; its leadership, organisation and provision and also differed in terms of access and scope of services. There were technical constraints, including critical mass of staff, confounding for how far the NHS reforms were able to affect provider organisational structures and therefore the policy outcomes intended.

Management structures were assessed to impact on both support for staff development and care for patients. Successive decisions about the organisation and management of physiotherapy services showed some continuity with previous organisational changes, one such continuity was the persistence of technical, size and case-mix constraints which were not reformed or restructured away.

CHAPTER SEVEN

FINDINGS:

THE IMPACT OF ORGANISATIONAL CHANGES ON PHYSIOTHERAPY ROLES, RESPONSIBILITIES AND FUNCTIONS

The roles, responsibilities and functions of physiotherapy managers influence the scope of the service, and the functions of staff, directly impacting on patient care. In this chapter the findings to RQ1b are presented, analysing the impact of organisational changes.

7.1 The Impact of Changes on Physiotherapy Managers' Roles

Policy changes had impacted on physiotherapy managers' roles. In 2013/14, 123 (100%) had a provider function, with 115 (94%) holding joint managerial/professional leadership roles. The most popular job title was "Head of AHP/Therapies". 123 (100%) reported that their role contained service provision, 110 (89%) being totally in a provider role. 13 (11%) reported elements of planning and commissioning and one solely a commissioner. Planning had been included to reflect the Welsh NHS planned care system, in

contrast to the English commissioned service model. However, 6 English respondents reported that they undertook planning and may have interpreted this differently. This was selected for further exploration during the SSIs and recorded as a limitation (Chapters 5.9 and 11.4.)

116 (94%,) of physiotherapy managers reported holding joint managerial/professional leadership roles. These combined functions of service management and clinical leadership, being the senior accountable professional lead for regulatory standards. Five held only clinical leadership roles (non-managerial) and two were entirely clinical, yet advised to be the most senior physiotherapists in the organisation.

In 2013/14 the majority of physiotherapy managers 64 (52%,) reported role changes since 2008, only Care Trusts and Partnership Trusts reporting no changes. Mental Health Trusts had seen the greatest proportion of change, 5 (83%,) followed by Social Enterprises 5 (80%).

- 53 (65%) of physiotherapy services had been re-structured
- 39 (49%) of all services were sub-divided into directorates/ divisions
- 39 (49%) of physiotherapy services had taken over provision of physiotherapy services; largely English community physiotherapy services
- 22 (27%) of physiotherapy services were not managed by a physiotherapist, when previously they had been

- 7 (9%) were managed by a physiotherapist when previously they had not been

This identified a net loss of 22 (18%,) of the management of the physiotherapy services by a physiotherapist. Some of these would have been respondents who had reverted to clinical practice, other managers may have changed roles into non-physiotherapy management, retired, taken voluntary severance or been made redundant. Responses from those who had been influenced by NHS changes post 2008 were themed: The most frequently reported theme (36,) was the physiotherapy manager role broadening responsibilities for a wider multi-disciplinary team:

R67 "With management re-structuring and a reduction in posts, I now have more management responsibilities for a larger multi-disciplinary and multi-professional team."

Restructuring was the second reported theme (34):

R9 "Loss of physiotherapy services manager post, created physiotherapy professional advisor role, initially 2 days/week, remainder of role as principal physiotherapist with clinical/operational management responsibilities".

Eight had taken on broader organisational/managerial roles:

R119 "Less clinical research, far more strategic leadership for areas such as competitive tendering, AQP and contract management".

Seven had seen their manager role downgraded:

R78 "De-banded, doing the same role, AFC has been ignored."

Two had moved from manager roles to become fully clinical:

R34 "There was a Head of service post; this has now gone so a lot of the managerial roles have been included in the clinical lead role."

11 had changed organisations, with two leaving the NHS.

7.1.1 Job title and organisation type

Managers had noted more changes during the recent reforms:

SSI3 [7]"I used to organise a single service with great flexibility moving staff, money, and equipment with in-service education across the board...and much more, to some extent this broke down."

SSI11 "I (Head of physiotherapy) went back to being an ESP, as the post was dissolved when we merged."

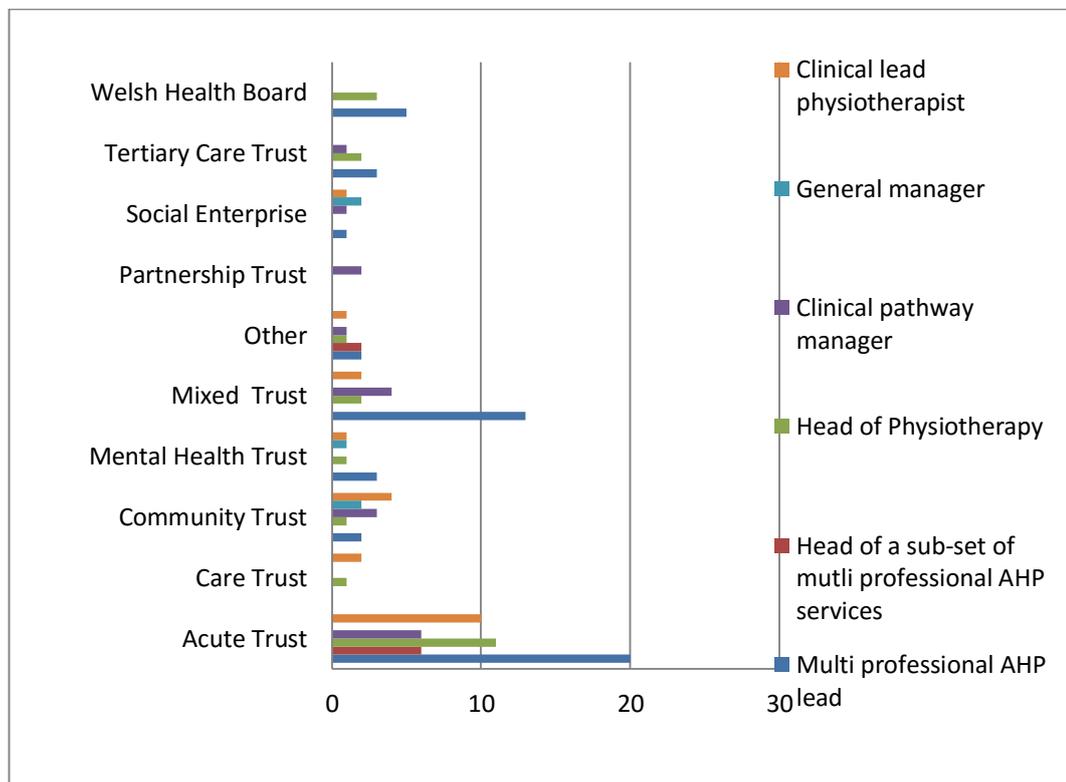
115 organisations (93%) had a senior physiotherapy manager or clinical lead as their Head. The most popular title was Head of AHP or Head of therapies; a multi-professional lead post. 49 (40%) of physiotherapists also held the lead role for AHPs/ therapies. 57 (46%) managed some grouping of AHPs. The title Head of physiotherapy 22 (18%) and clinical lead physiotherapist 21(17%,) described roles of uni-professional horizontal managers.

Other uni-professional clinical leadership non-managerial roles were held by 21(17%) including a Consultant. The Consultant role was designed to be a clinical "expert", not a manager, implying that physiotherapists were managed by a non-physiotherapy manager. A sizable proportion 18 (15%) also managed clinical pathways e.g. musculoskeletal pathway. There were responses from 9

(7%) organisations indicating that the most senior physiotherapy role was not held by a physiotherapist. One of these was a Head of Podiatry in a clinical director role. Eight organisations reported that the most senior role was held by a general manager, with the lead physiotherapist having a clinical role. Further analysis identified no professional leadership in one Mental Health Trust, with the other seven organisations having part-time professional lead roles.

The job title category was analysed in relation to organisation type:

Fig. 19 Job title and organisation type



Chi square analysis (Group C) of the primary reported impact of the 2008 changes on patient care demonstrated no significant association.

7.1.2 Employing organisation

Analysis of employer was undertaken:

Table 38 **Employing organisation**

Organisation type	Current employer	Former employer	2005 employer	1989 employer
Mental Health Trust	6 (5%)	0	5%	0
Partnership Trust	2 (2%)	0	0	0
Care Trust	3(2%)	0	0	0
Community Trust	12 (10%)	24 (20%)	48%	0
Social Enterprise	5 (4%)	0	0	0
Other	7 (6%)	0	2%	10%
Tertiary Trust	6 (5%)	0	5%	0
Acute Trust	53 (43%)	72 (59%)	40%	0
Mixed Trust	21 (17%)	27 (22%)	0	0
Welsh Health Board	8 (7%)	0	0	0
District Health Authority	0	0	0	90%

There was reported to be a large change of employer type from the 1990s Districts; to a majority of PCT employers in 2005; to a current majority of acute provider organisations, with an extension of the quasi-market into primary care.

The majority of managers reported gaining prior experience in Acute Trusts.

There was less diversity of employing organisations in the former posts. Welsh Health Boards were the most similar to the former DHAs, providing all services across a geographical area, being some of the largest organisations. In 2005 48% of respondents were from PCTs; 41% came from Acute Trusts; the remaining 11% were divided between Teaching Trusts, Mental Health Trusts and Children's Trust. In 2013/14 43% came from Acute Trusts which had reportedly expanded to provide community services, demonstrating a shift

towards some larger organisation types in England, but also some relatively small organisations in respect of Social Enterprise and Care Trusts.

7.1.3 Change in number of physiotherapy managers

The NHS reforms were intended to reduce bureaucracy, putting more staff to front-line clinical care. Post 2008 only 2% held multi-professional AHP managerial posts. The 2005 survey of English organisations, reported 83% of physiotherapy managers holding full managerial roles and 17% advisory positions. The number of advisory only roles was reported to have decreased by 10% since 2005, indicating that roles where management and leadership were not combined had become less prevalent.

The respondents reported having been involved in upto 20 reorganisations, with many having their jobs put at risk at some stage. 68 (55%) reported a reduction in management roles after 2008. 8 (7%) reported an increase in management posts and 47 (38%) unchanged. Care Trusts were the only organisation type reported to have an overall increase in physiotherapy manager jobs 3 (100%,) but only 2% of the total participants. Although the Welsh reorganisation had reduced 22 organisations to 8, physiotherapy managers reported largely undertaken roles that spanned across organisations prior to the 2008 reforms.

Chi square analysis (Group C,) of the impact on the reduction of physiotherapy managers' posts by organisation type demonstrated significant association, with acute organisations having a larger reduction in manager posts.

7.1.4 Clinical role

Physiotherapy managers in all types of organisation types reported undertaking clinical work. 66 (54%) of them undertook clinical work in addition to their managerial functions. In 2005 this was 20%; in 1989 the job description for a District Physiotherapist reported 76% undertaking clinical work.

In Care Trusts and Partnership Trusts (some of the smallest organisations,) every physiotherapy manager undertook some clinical work. However, Social Enterprise and Mental Health physiotherapy services were relatively small and only 40-50% of these managers reported undertaking clinical work. The largest physiotherapy providers in terms of physiotherapists employed - the Welsh Health Boards - were in the middle of the range (63%,) whereas Mixed Trusts - the second largest size in terms of staff employed- undertook the least clinical work (24%). The ability to undertake clinical work was fulfilled in all organisation types and management structures, but was reported to be inconsistent and not related to size or type of organisation.

Table 39 **Hours undertaking clinical work**

Hours	Count	Percentage
<7.5 hours	40	61
8 - 18 hours	15	23
19 - 30 hours	8	12
> 30 hours	3	4

Of those who undertook clinical work; the mean number of hours of clinical work was 9.5 hours/week, the mode was 6.5 hours/week and the standard deviation

was 9.5 hours/week. Of the 3 who spent > 30 hours undertaking clinical work, 2 were professional leads and one a clinical lead. All were from Acute Trusts and had previously held the physiotherapy manager role which had been removed, requiring them to return to full-time clinical work. They were not undertaking a physiotherapy manager role in their current position. 40 (59%) who undertook clinical work managed <40 WTE, 28 (41%) undertook clinical work whilst managing larger staff numbers (between 40 WTE and 380 WTE). The larger organisations with greatest breadth of services, reported fewer hours of clinical time deployed by their managers; 65% of full-time physiotherapy managers also reported undertaking clinical work. Part-time managers undertook a higher proportion of clinical work. A Kruskal-Wallis Test (Group C) revealed a statistically non-significant association in hours worked by the physiotherapy managers and organisation type.

7.1.5 Clinical practice

The growth of evidence-based practice featured strongly, as a driver for growth of roles and expanding clinical practice which has been a consistent feature over recent years. The development of consultant posts and extended scope practitioners was widely cited demonstrating the growth of professional practice, taking on some roles previously undertaken by medical staff, and developing the scope of the profession to include research and leadership functions giving the profession greater visibility:

SSI3 *“It was a big boost to develop the consultant role to show off our skills and capabilities.”*

However, there was comparison between the 2005 research when these posts developed, and the current status, where the same function is required but at less of a cost, at a lower grade:

SSI4 *“Our consultant is retiring I didn’t even dare consider to ask to replace like with like.”*

SSI8 *“You’re just expected to deliver; for a lower cost.”*

Changes were also noted in the development of the assistant role taking on delegated tasks that had previously been undertaken by a registered physiotherapist:

SSI1 [6] *“We have many more assistants, it’s the way we skill mix to meet budget demands.”*

Clinical practice had therefore changed with a focus on the patient rather than the individual profession, enabling sharing of skills between professions where appropriate.

Informants reported the period around 2005 as an opportunity for some community physiotherapy managers to develop commissioning skills, when PGGs were formed and Executive committee roles were available to physiotherapist:

SSI11 *“Working with Drs, PCGs and PCTs was a great learning curve.”*

There was reference to a *“dreadful”* time in 2006 when there was over supply of new graduates and physiotherapists could not get jobs due to inadequate

workforce planning with a mismatch between supply and demand, and at other times under supply; a constant fluctuation.

Providing a continuous service was reported to have become a stronger feature:

SSI2 “We dare not have any gaps now, we are required to provide full cover, and at last have backfill for maternity leave...it’s hard to keep track, hard to manage, but helps succession planning and good for staff.”

A large majority referred to greater degree of multidisciplinary working, and blurring of professional boundaries, particularly in community settings:

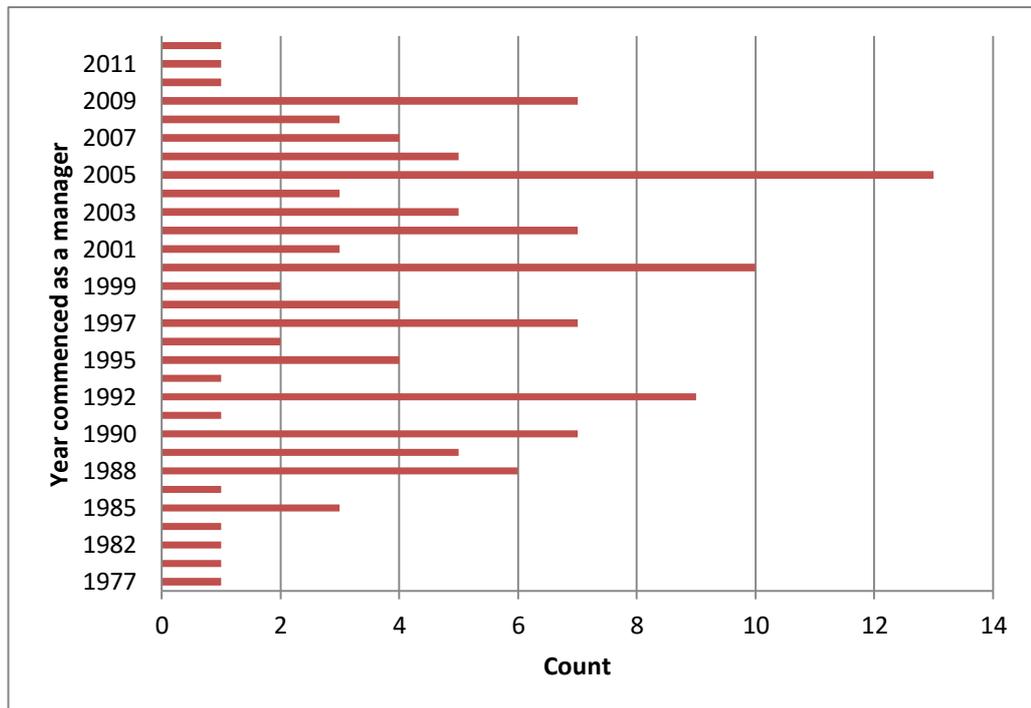
SSI6 “We’ve come closer together as an MDT and share where we can, it’s better for patients”.

7.1.6 Experience of respondents

Of the 121 respondents, the longest-standing physiotherapy manager reported qualifying in 1967, and the most recent in 2005. 88 (72%) qualified before 1985, and 104 (85%) before 1994. The mean number of years post qualification was 25 years (range 7- 45 years.) The modal year for qualification was 1991, with 15 qualifying.

The longest time reported spent in clinical practice prior to moving into management was 30 years. The shortest was 4 years. The largest proportion 48 (41%,) had undertaken 6-10 years of clinical practice prior to moving into management, followed by 22 (19%) with 11-15 years’, and 22 (19%) with 16-20 years’ experience.

Fig. 20 Year commenced as a physiotherapy manager



Mode = 7 years, Standard deviation $\sigma = 7.4$ years

Further analysis was undertaken to identify if the length of time from qualification to first physiotherapy manager job. This had decreased every decade: 1960s=17years; 1970s=16years; 1980s=13years; 1990=12years; 2000s=6years.

7.1.7 Time in physiotherapy manager posts

Physiotherapy managers were a long-serving workforce, reporting working on average more than 5 years in each of their last three posts, and 60 (48%) more than a decade in one of their last three posts. 38 (31%) reported taking up their current post between 2001-2006, (6-11 years of experience); 34 (28%) had 2 or less years of experience in their current role; a sizeable proportion with limited

experience. 13 (11%) had taken up their first management post since 2008, therefore newly appointed managers were not all in their first manager role. The longest serving manager reported being in their current role for 32 years.

Physiotherapy managers in Acute Trusts reported being the longest serving, with 16 (30%) having > 10 years' experience in their current post and also the highest proportion of managers with > 8 years' experience (70%). The physiotherapy managers with the highest proportion of short serving managers were in Community Trusts, with 8 (67%) having < 4 years' experience in their current role. In Welsh Health Boards physiotherapy managers had 4 (50%) with 8 years' experience in their current post and 4 (50%) with 1-7 years' experience. The mean time reportedly spent in their current post was 6.6 years (compared with a mean of 7.3 years in England). English physiotherapy managers had greater diversity of length of time in post, with 15% (17) had been in post for longer than the longest serving Welsh manager, but another 15% (17) in post for < 2 years. Prior to the current post, the longest serving physiotherapy manager reported 23 years in their former job; the mean being 7 years. The largest proportion, 40 (36%,) spent 3-5 years in the job two posts ago; the mean being 5 years.

Physiotherapy managers' experience was reported to have changed:

SSI 12 "When I look back people in management were those who had worked the longest and were the oldest...now much more junior."

7.1.8 Career path

Physiotherapy managers all reported being a clinical physiotherapist before moving into a management role. 93 (76%) of their former posts were full-time. 70 (57%) of former posts were a combined management/professional lead role; 15 (12%) were professional advisory management roles; and 38 (31%) solely clinical.

7.1.9 Contracted hours and organisation type

A Kruskal-Wallis Test (Group A), revealed a statistically insignificant association in the contracted hours worked by organisation type. 93 (76%) worked full-time (37.5 hours) 5 days/week; 14 (11%) worked 4 days/week; 7 (6%) 3 days/week; 6 (5%) 2 days/week; 3 (2%) 1 day/week.

Different working patterns were analysed and reviewed by organisation type. The only organisation types reported to have a majority proportion of part-time physiotherapy managers were English Community Trusts (mean 43 WTE); and Social Enterprises (mean 25 WTE,) both were smaller organisation types. When asked about the post prior to the current one, 93 (76%) were full-time and 30 (24%,) the same as currently. Therefore physiotherapy managers when changing roles, report that they normally worked the same number of hours.

7.1.10 Remuneration

Organisational change has often been associated with impacts on salaries.

Physiotherapy managers were nearly all paid on the AfC pay scale ranging from Band 7 to Band 9 (£30,764 - £98,453.)

Table 40 Pay scales 1989-2014

	Post name	1989 Top of Scale	2000 Top of Scale	2004 Top of Scale Pre AFC	2005 Top of scale Post AFC	2014 Top of scale	1989 (pay inflator calculation 2014)	2000 (pay inflator calculation 2014)
Managerial Grades	District* 2 - 1	21,200	34,000	40,323			49,635	51,472
	Supt 4 - 1	18,555	30,730	31,960			43,442	46,522
	Band 8 – 9**				86,240	98,453		
	Band 7				35,247	40,558		
Senior Clinical Grades	Senior 2 - 1	14,025	21,290				32,836	32,230
	Band 6 - 7				35,247	40,558		
Entry Clinical Grade	Physiotherapist	10,250	17,825				23,998	26,985
	Band 5			20,415	23,442	27,901		

Key: Red = Whitley grades; *Low numbers highest grade

Blue = AfC bands; ** High numbers highest band

The majority of physiotherapy managers in both countries 38 (31%,) were paid on Band 8b (mid-scale circa. £50K). In 2005 no managers reported being paid on Band 7, with all 8a or above, and the majority 8b and 8c. In 1989 Whitley scales were in place.

The wide range of pay bands for physiotherapy managers reflected role diversity and organisational practices. The pay system did not reward size of staff group managed. Those on Band 7 were remunerated at the same rate as

experienced clinicians, whereas Band 9 would likely be leads for research and development and managing in complex environments as required by the factor analysis in the “Banding” system. Although the names of posts had changed since 1989, comparisons can be made between managerial and clinical grades. When a pay inflator was calculated (Historic Inflation Calculator, 2014,) managers were reportedly earning almost double the top rate of pay for those in the most senior grades (Band 9,) though less than the inflator comparator for the more junior management grade (Band 7). All the clinical grades earned more in 2014 than the inflationary comparators. There was discontinuity with previous periods of reform in regard to physiotherapy managers pay, due to the cost reduction requirement for NHS staff pay, and the changes in pension contribution and retirement age (NHS Employers, 2014).

No organisation type reported an overall upward trend for bandings. 4 (3%) reported upward trend, including; 1 Mental Health Trust, 1 Welsh Health Board and 2 Acute Trusts. 49 (40%) reported no change, including; 6 (100%) Tertiary Trusts, 4 (50%) Welsh Health Boards, 9 (43%) Mixed Trusts and 15 (28%) Acute Trusts. 69 (57%) reported regrading downwards as a trend. The greatest downward trend in bandings was in Community Trusts 9 (75%), Acute Trusts 36 (68%), and Mixed Trusts 12 (57%). Care Trusts were the only organisation type not to report a downward trend.

Fisher Exact test (Group C) demonstrated no significant association with regard to changes in AFC bandings.

7.1.11 Management qualifications and membership

Management qualifications were analysed to determine the level of physiotherapy managers' qualification. 4(3%) respondents reported having no management training or qualification. Several had more than one type. The majority 74 (60%,) had undertaken local non-accredited training. 37 (30%) had undertaken Masters level management qualification, with 4(3%) having an MBA and 3 (2%) a Doctoral management qualification. Given the size and complexity of many of the physiotherapy services it was surprising that more formal management education was not reported.

The CSP Leaders and Managers of Physiotherapy services (LaMPS) professional network offers support, access to mentoring and twice yearly study days, though no accredited training. It had 127 members (Oct. 2014,) 0.2% of the total membership. The BMA developed a committee for medical managers in 2012. It runs a Level 4, 6 day medical leadership programme, but does not publish membership numbers. The RCN runs the "nurses in management and leadership forum", and also runs and funds a range of programmes which have reportedly positively impacted on nurse leadership capability (Cunningham and Mackenzie 2005.) 4 (3%) of physiotherapy managers were members of the Institute for Healthcare Management, the professional association for healthcare managers; a body that provides accredited training.

7.1.12 Management restructurings and threats to job

Management restructuring was reported by physiotherapy managers to have been consistent through all periods of reform. 4 (3%) had not been subject to organisational re-structuring during their career. The modal number of re-structuring was 5, with the standard deviation of 2.72. One physiotherapy manager had been through 20 reorganisations.

Re-structuring was a common experience though the frequency and impact of the reorganisations was variable. 52 (42%) had had their job put at risk; 44 (36%) had needed to re-apply for their job during re-structuring; 26 had had their job removed from the organisational structure; 12 (10%) had been downgraded; one had a mutually agreed resignation and one was made redundant.

7.1.13 Inter-professional relationships

Changing roles affected relationships. Inter-professional relationship changes occurred between the AHPs versus the other health professions and between the AHPs themselves:

SS11 "Together (AHPs) we stand a chance."

This illustrated the frustration with doctors and nurses being the forefront professions in the NHS, and the frustration of AHPs often been neglected, and reportedly rarely cited in NHS political debate. This signified views from physiotherapy managers that uni-professional AHPs were too small to have

impact in the macro healthcare environment. The informants reported largely favourable relationships with the medical profession:

SSI 3” They say they couldn’t manage without us and rely on us for our valued input to patient care.”

However relationships with nursing were largely reported to be more adversarial:

SSI9 [2] “They think they can do our job, but they work to protocols, being bigger in numbers gives them strength, they see us as useful...to an extent”

Many informants felt the best solution was for the AHPs to unite and gain critical mass. The loss of physiotherapy management posts had been offset to some extent by the coming together of AHP management structures. Several reported favourably AHPs being grouped together:

SSI6[9] “People took notice of us when we grouped as AHPs, one voice, one credible group, not too small to be ignored”

This came with some trade-offs, and was not welcomed by all informants:

SSI8 “We were pushed to integrate with OT.”

There was an undertone of AHP professional rivalry and some minor unwelcomed integration, with a preference to remain a standalone physiotherapy service. Several reported the perceived threat that physiotherapy was to other AHPs:

SSI7 [10] “We are the biggest, and best placed to be the AHP leaders. Speech and Language think they are better than us, but they are too small on their own, the OTs will always feel threatened by us.”

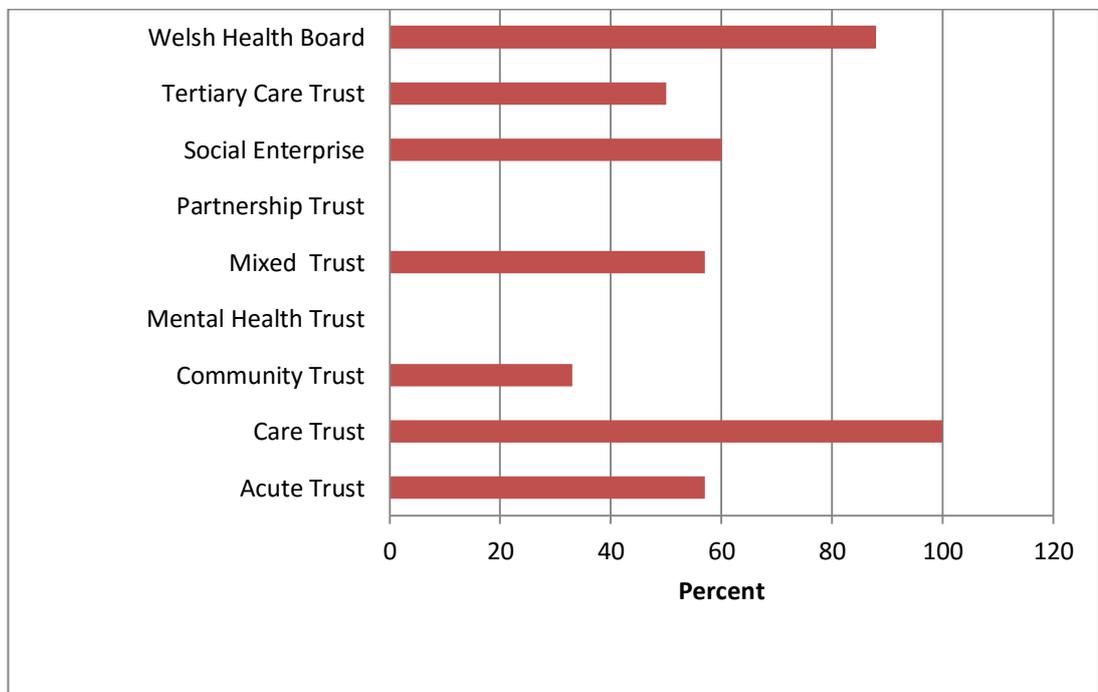
The Allied Health Profession forum (AHPf) was cited as a vehicle that could help AHP integration, but also how it has been ineffectual:

SSI 3 “ The AHPf should be leading integration of the AHPs, but as its made up of the professional bodies, there is no incentive for it to work, as it would weaken the influence of the individual member organisations.”

7.1.14 Links with SHA/national AHP groups

Physiotherapy managers reported that in 2005, 45% of regions had an AHP officer, with 55% reporting effective links with their regional AHP groups. The variable pattern represented inconsistencies for networking, suggesting a culture of competition not collaboration. There was reported to be variable pattern of links with regional/national AHP groups.

Fig.21 Links with national and regional AHP groups



7.2 Impact of Changes on Managers' Decision-making

Physiotherapy managers reported undertaking decision-making tasks. The roles and functions of physiotherapy managers (Jenkins and Jones 2011,) were rated by respondents for importance, also identifying whether any other functions were part of their role. All categories listed were considered part of a physiotherapy manager's role and part of their decision-making function, including a mix of upward and downward decision-making. The domains were scored out of 10, with 10 being very important. Some managers scored 10 for all domains. There was very little difference between the domains, and none scoring less than 8/10. The results were compared with previous periods. Clinical governance was rated the most important task of a manager:

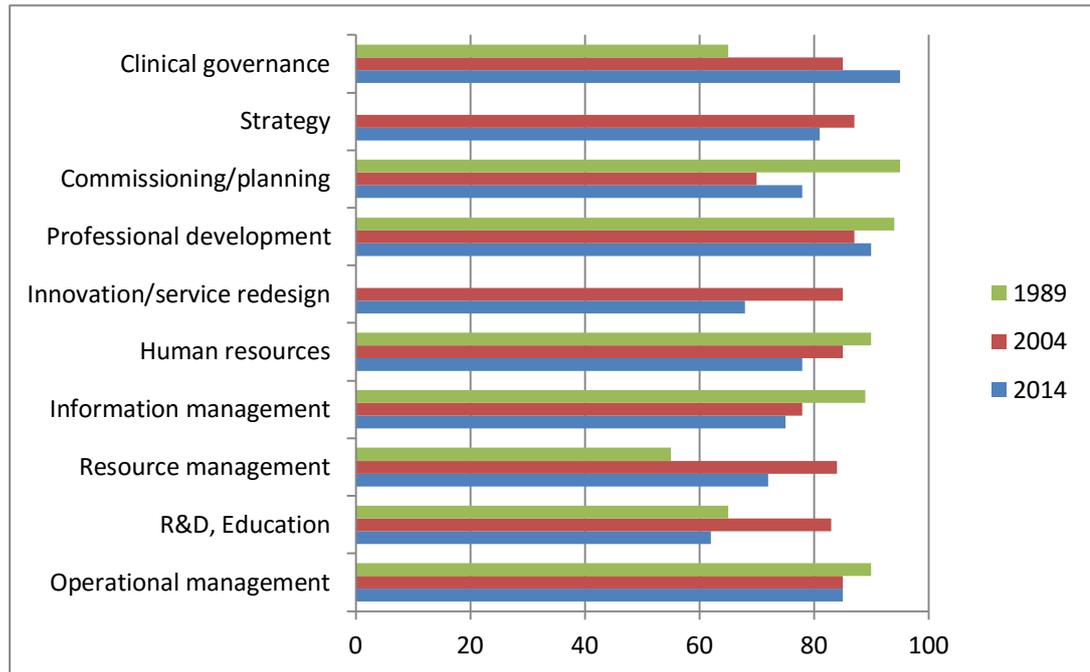
SSI11 "It's all about patient safety."

Commissioning and service planning related largely to workforce and service planning and influencing commissioners, rather than actual commissioning of services. Commissioning of services had moved to clinical commissioning groups in England and was therefore outside the remit of NHS provider services.

Human resources were highlighted as an important task, which reflected on the reputation of the physiotherapy manager:

SSI4 "You're only as good as your lieutenants."

Fig. 22 **Physiotherapy managers' management domains**



There were no roles of the physiotherapy manager job that fell outside these domains except for clinical work, which was undertaken by the majority for some of their time. The management domains, which were confirmed as being undertaken by all the experienced managers in the SSIs, were compared with earlier periods of research to determine if the scope of the managers' role had changed.

Chi square test for independence (Group C acute and community organisations) indicated significant association in:

- *Human resources*: Responsibility as appointing officer for recruitment
- *Resource management*: Responsibility for costing, pricing and contract monitoring

- *Innovation and service redesign*: Providing 7 day working in some services
- *R&D and education*: Initiating R&D projects for their service

There were a variety of decision-making functions which varied, though only significant when pooled for Group C (above) except for networks between physiotherapists that was also significant demonstrating less networking in community organisations, compared with acute and mixed organisations (Group B). The benefits of autonomy of decision-making were described by informants:

SSI7 "I am best placed to determine, what services to provide, what staff skills needed are and how physiotherapy can contribute to the organisation's strategy. I need to be free to move resources to reflect changing needs and develop staff."

7.2.1 Decision-making accountability

Physiotherapy managers reported elements of decision-making disliking the complications of horizontal and vertical decision-making constraining their ability to make timely decisions. The bureaucracy of decision-making authority was the main dislike. This was consistent in all management structures and all organisation types. In clinical practice physiotherapists were able to make diagnostic decisions and act on them without the need for prior authorisation, frustration was expressed when managerial decision-making was less autonomous.

7.2.2 Strategic representation

Physiotherapy managers reported that Executive Directors of nursing represented physiotherapy on Boards in 55 (45%) of organisations.

Physiotherapy was the professional background of 22 (18%) of Board level representatives; 11(14%) were general managers; 14 (11%) occupational therapists. Social Enterprise companies had the greatest percentage of physiotherapists at Board level 3 (60%); Welsh Health Boards 3 (43%); Acute Trusts 12 (23%). Other organisation types did not have sizeable representation by physiotherapists.

6 (11%) of Acute Trusts had a Board level physiotherapist in England even though this was not a statutory requirement. It was not explicit from all respondents whether these roles were Executive posts. In Wales there was a statutory Executive function for therapists and healthcare scientists in LHBs with 3 of the 7 posts being held by physiotherapists at the time of the research; these were not physiotherapy manager roles.

There was reported to be only 12% of organisations with physiotherapy managers represented on the identified key strategic committees. This would have required physiotherapy managers to be effective at influencing upwards. Strategic representation was considered important to influence the organisation and support managers in making strategic decisions. The role of Board level physiotherapist and AHP roles is an area that had not been researched previously and is one worthy of future consideration.

In 1989 analysis of the job content of the District physiotherapist job descriptions did not gather data on strategic representation. It was probable that several of the post holders held these functions, particularly the 8% who held general management functions in addition to their physiotherapy role, but this was not recorded nationally. The 2005 research reported 43% of respondents having a seat on an Executive Board committee, the greatest number of these (20%) being on a PCT Executive committee, which had since been disbanded.

7.2.3 Accountable officer for Physiotherapy manager

Physiotherapy managers reported the importance of influencing their line manager. There were 15 different titles for these accountable officers. The greatest proportion 33 (38%,) reported to another AHP e.g. clinical director therapies, 28 (24%) reported to a general manager, 7 (6%) reported to another profession e.g. Head of nursing/medical director, one reported directly to the CEO. 54 (44%) reported to a non-clinical professional (general) manager. Of the AHPs, physiotherapy was the profession managers most frequently reported to 20 (16%). General managers were most likely to line manage physiotherapy managers in Care Trusts and Partnership Trusts, in larger organisations e.g. Acute Trusts, Tertiary Care Trusts and Welsh Health Boards, General Managers were least likely to line manage the physiotherapy managers. Due to the diversity of accountable officers statistical analysis was not valid.

In all large organisation types, other AHPs were reported to be most likely to line-manage the physiotherapy manager, with the majority of the AHPs being other more senior physiotherapists. As the line manager for the Head of physiotherapy there was:

- a lead AHP for every 1540 registered physiotherapists
- a lead nurse for every 8045 registered physiotherapists
- a lead doctor for every 68,383 registered physiotherapists

NHS England workforce data identified that there were 5 times more nurses than AHPs, and twice as many doctors as AHPs. AHP data was not sub-categorised by individual profession (Health and Social Care Information Centre, 2013).

7.2.4 Board representation

The relationship with the Board member and their knowledge of physiotherapy was reported by physiotherapy managers to be a major part of upward influencing. 34% reported a Board level AHP. In 2005 there were only 18% and in 1989 this was not reported as a finding.

7.2.5 Seats on organisational committees

The ability of a physiotherapy manager to influence upwards in the organisation was reported to be associated with participation in organisational committees and influencing organisational decision-making. Acute Trusts and Mixed Acute

and Community Trusts reported the greatest proportion of physiotherapy representation on committees in their organisations. Physiotherapy managers reported to most likely to have a seat on clinical governance (48%) and quality committees (33%,) with workforce and R&D also being substantial areas for involvement. Only 10% of physiotherapy managers had a seat on service improvement groups, these were all from Acute Trusts and Welsh Health Boards. Most organisations had a strategic finance committee, but only 9% reported having a seat on it. Physiotherapy managers from three organisation types reported having representation on a finance committee: 2 (50%) Social Enterprise; 9 (17%) Acute Trusts; 1 (7%) Mixed Trusts. The small sample of Social Enterprise organisations made statistical analysis invalid.

There was no pattern of seats on committees when analysed by organisational type. A Chi-square test (Group C,) indicated no significant association between organisation type and a seat on clinical audit, quality, clinical board and directorate board committees, but significant association between organisation type and a seat on a divisional board.

7.2.6 Change in focus of role

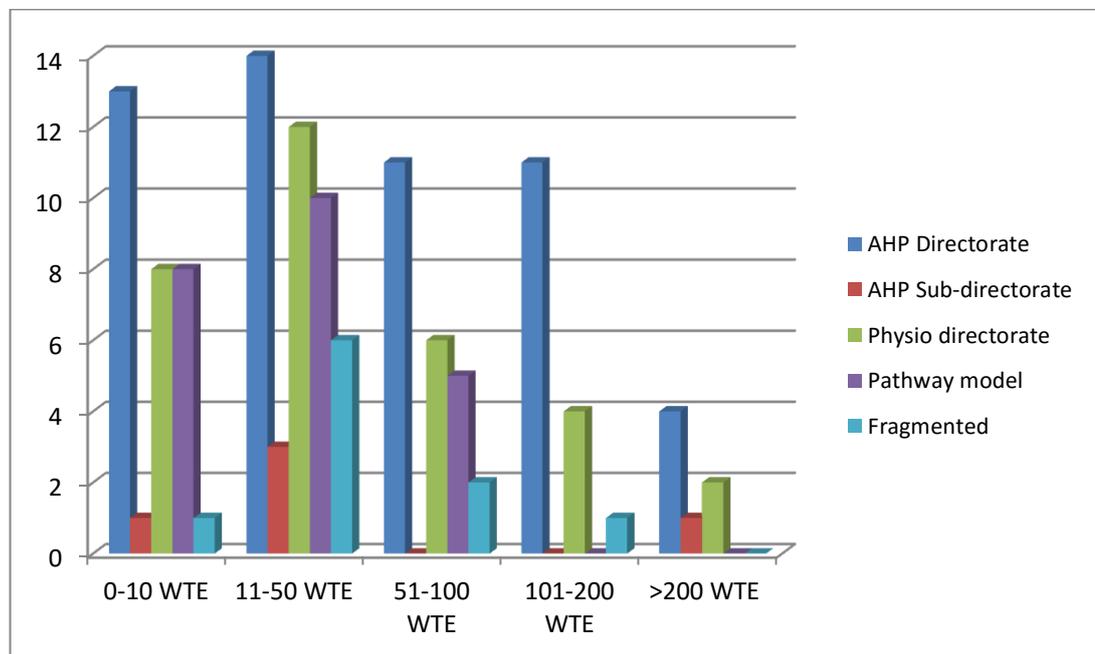
Expanded roles with greater span of control and decision-making were reported by the majority of physiotherapy managers to be moving away from their uni professional service management role. 64 (52%) reported their management job was less physiotherapy focussed than previously, 52 (43%) more or less the same and 6 (5%) more physiotherapy focussed.

7.2.7 Number of staff managed

The main function of downward decision-making related to staff management functions, the size of the staff group might indicate the scale of the role.

Physiotherapy managers reported the least number of staff managed as zero, in 11 organisations and the largest being 280 WTE. A Kruskal-Wallis Test (Group A,) revealed a statistically significant association in the number of staff managed. The Welsh Health Boards had the highest median of 210 WTE. In 2005, the number physiotherapists managed ranged from 0-145 WTE with a mean of 40 WTE. There was a mixed pattern of changing workforce numbers, with the majority 68 (55%) reporting reduction. This was influenced by Acute Trusts with 32 (26%) reporting overall decrease.

Fig.23 WTE staff employed by management structure



Mean = 53.56 WTE; Mode = 1-20 WTE

7.2.8 Budget management

A key part of downward decision-making was budgetary control. 77 (62%) of physiotherapy managers reported decreased budgets; 13 (10%) reported no change in real terms of their budget allocation; 9 (7%) were unsure of changes to budget; 24 (20%) reported increased budget but of these 15 had taken on community service provision and transferred staff to their organisation. Only 9 (7%) had increased budgets.

Taking into account inflation, Acute Trusts reported a substantial reduction in physiotherapy budgets since 2008, with 39 (74%) reporting a reduction. 7 (33%) of Mixed Acute and Community Trusts reported an increase in budgets which was not surprising given the shift of PCT services into many of these organisations, though in contrast, 10 (48%) reported an overall decrease in budget. 3 (50%) Tertiary Trusts reported increases, another 3 reported no change in real terms; being the least affected organisation type. In Wales 3 (37.5%) organisations reported increased budgets, 3 (37.5%) decreased budgets and 2 (15%) stayed the same.

61% (75) reported the reduced budget as the main impact of changes since 2008, impacting on decision-making. Those who were not budget holders reported being less able to influence financial decisions. Therefore budget management was considered advantageous, though challenging.

All organisation types were reported to be required to make annual cost improvements efficiency savings (CIP), 30 (57%) of Acute Trust physiotherapy

managers reported a requirement to make an annual CIP saving > 5%. 17 organisations were not required to make savings. 7 organisations, all Acute Trusts, required > 10% of budget (up to 15%). The modal response was 5% of budget by 24 (20%) organisations, with standard deviation of 14%. A Kruskal-Wallis Test (Group A) revealed a statistically insignificant association in the percentage of cost releasing savings.

The roles, responsibilities and functions of managers' roles demonstrated many consistencies with previous periods, and many similarities in the current management structures largely lacking significant association between the different organisation types and management structures.

7.2.9 Management autonomy

Informants outlined the benefits of physiotherapy management autonomy (Chapter 3.4) and the ability to make decisions with authority rather than top-down control. This grew considerably after 1977, which was viewed positively:

SSI5 [12] "Physiotherapists began to manage their own services rather than run by medics."

This had progressed as the profession became more autonomous, though there were some inconsistencies. Increased management autonomy since 2008 was reported by 42 (34%) respondents. This was the main impact reported by three organisation types representing 10% of the total respondents, including: Care Trusts 3 (100%); Welsh Health Boards 6 (75%); Social Enterprise 3 (60%).

Less management autonomy was reported overall by 55 (45%). This was reported as the main impact by Community Trusts 9 (75%); Acute 24 (43%) and Mixed Trusts 10 (38%).

Chi square analysis (Group C) of the impact on the reduction of autonomy by organisation type, demonstrated no significant association, though a variety of explanations were cited:

R11 “More decisions influenced by money, meaning my hands are tied to make changes/develop services.”

R120 “Therapy services have are well respected within the Trust and recognition has been given for good financial and operational performance.”

One Mental Health manager was very content with their position:

SSI6 “We have a model of distributed leadership; we ask for forgiveness not permission and are held to account more than previously.”

Less management autonomy was reported in the larger organisations reporting constraints in their management, even where AHP structures were in place. The larger organisations appeared to constrain the autonomy of the physiotherapy manager by restructuring:

SSI8 “We have to go through more lines to get a decision made, the hierarchy is worse than ever.”

A restriction to autonomy was a concern in Community Trusts:

SSI2 “When the service was together as one with a physio manager in charge we had full understanding how we worked and able to make autonomous decisions, now we’re fragmented we get lost and forgotten.”

7.2.10 Views of interviewees

The SSIs informants revealed changes in roles affecting decision-making. There were examples of a more junior manager stepping-up to manage the whole service when the senior manager post was removed:

SSI1 “We used to have a manager for all physio (Band 8b,) her post went; I am left in charge as the most senior physio, on a band 7.”

Also the senior post being downgraded, affecting decision-making responsibilities:

SSI11 “Physio managers were abolished; they gave me an advisor role for 2 days a week.”

However, there were also examples where posts had expanded increasing decision-making requirements:

SSI6 “I haven’t worked with physiotherapy only for a while; my role has grown to take on all AHPs.”

The roles, responsibilities and functions of physiotherapy managers were shown to influence the scope of the service, and the functions of staff, directly impacting on patient care and changing through the different periods of reform.

CHAPTER EIGHT

FINDINGS:

ASSESSMENT OF MANAGEMENT STRUCTURES

In this chapter the findings to RQ2 with some elements relating to RQ3 are presented, assessing the different management structures for the roles, responsibilities and functions of physiotherapy managers in providing the functions necessary for supporting staff development and care for patients. The data has been used for two different types of analysis. A normative evaluation was undertaken, reviewing the elements that Jenkins and Jones (2011,) (Jones and Jenkins 2006a, 2010,) identified as key aspects of physiotherapy management. The background to the ATEAHPMS was set out in Chapter 5.8.1. A gap analysis was undertaken (Chapter 5.8.2,) of elements which scored less than the total mean, to determine differences between management structures.

8.1 Different Models of Physiotherapy Organisational Management

Data from section three of the questionnaire presenting the normative domains of the ATEAHPMS was reviewed. Respondents detailed their roles, responsibilities and functions for the 10 management domains, identifying functions they fulfilled (green rated). They were not asked to rate where they

only partially fulfilled the function (amber rated). The areas of non-compliance equated to red rating using the original ATEAHPMS scoring mechanism.

Analysis was undertaken to determine whether there were differences between the management structures, each was rated in descending priority order, with 1 representing the highest rated structure and 5 the lowest.

8.2 Assessment of Activities Undertaken by Physiotherapy Managers

The results of the smaller devolved structure types; AHP sub-directorate and fragmented structures, should be viewed noting that sample size was small. Chi Square, Fisher Exact and Kruskal Wallis tests were performed to determine whether there were significant associations between the professionally-led structures (1-3) and the devolved structures (4 and 5). The mean score of all domains was 81%. The domain and individual element scores were:

8.2.1 Strategy

The most frequently occurring task was development of strategy and planning (97%,) followed by workforce planning, (95%). Management and monitoring external contracts (63%) was the least frequent responsibility.

Table 41 Physiotherapy managers' strategic functions

Strategy	AHP directorate	AHP sub-directorate	Physio directorate	Pathway	Fragmented
Development of strategy and planning for your physiotherapy service(s)	96%	100%	97%	91%	100%
Input into physiotherapy workforce planning	89%	100%	100%	87%	100%
					Contd.

Input into multidisciplinary workforce planning	68%	100%	59%	87%	80%
Strategic development and partnership working with other organisations	83%	80%	72%	78%	80%
Interpretation and implementation of Government policies and initiatives across your physiotherapy service(s)	89%	100%	91%	91%	90%
Management and monitoring external contracts	47%	60%	69%	61%	80%
Total Mean	79%	90%	81%	83%	88%
Rank	5	1	4	3	2

Physiotherapy managers in the AHP sub-directorate structure reported undertaking the highest (90%) and the AHP Directorate the least (79%) strategic duties, though all structures involved the physiotherapy manager in a substantial amount of strategic duties with 84% of the total performing these functions and no significant association. A gap analysis was undertaken:

Table 42 **Gap analysis: Strategy**

Strategy	AHP dir.	AHP sub	Physio dir.	Path.	Frag
Input into multidisciplinary workforce planning	68%		59%		80%
Strategic development and partnership working with other organisations		80%	72%	78%	80%
Management and monitoring external contracts	47%	60%	69%	61%	80%

8.2.2 Clinical governance

Physiotherapy managers in all structures undertook a large proportion of clinical governance duties; a key part of physiotherapy managers' roles. The most frequently occurring tasks were ensuring positive patient experience (99%) and

implementing evidence-based practice (99%). Health and safety (63%) was the least undertaken responsibility.

Table 43 Physiotherapy managers' clinical governance functions

Clinical Governance	AHP directorate	AHP sub-directorate	Physio directorate	Pathway	Fragmented
Ensuring positive patient experience	96%	100%	100%	100%	100%
Implementation of evidence-based practice	93%	100%	100%	100%	100%
Clinical audit	93%	100%	97%	96%	90%
Health and safety	91%	100%	100%	91%	90%
Management of risk	91%	100%	100%	96%	100%
Response to complaints	91%	100%	97%	91%	100%
Total Mean	93%	100%	99%	96%	97%
Rank	5	1	2	4	3

Physiotherapy managers in the AHP sub-directorate demonstrated 100% of managers undertaking all clinical governance tasks, and the AHP Directorate the least (93%). All structure involved the physiotherapy manager in a substantial amount of clinical governance duties, 97% of the total performing these functions and no significant association. A gap analysis was not required.

8.2.3 Professional development

The most frequently occurring tasks reported were clinical and professional leadership (95%,) followed by ensuring skill mix (94%,) and communicating about physiotherapy (94%). Professional consultancy (88%) was the least.

All structures involved a substantial amount of professional development duties with 91% of the total performing these functions and no significant association.

Table 44 Physiotherapy managers' professional development functions

Professional Development	AHP directorate	AHP sub-directorate	Physio directorate	Pathway	Fragmented
Clinical and professional leadership	91%	100%	97%	96%	90%
Providing consultancy for staff on physiotherapy professional issues	87%	100%	100%	83%	60%
Ensuring sufficient staff to give "critical mass"	89%	100%	94%	78%	80%
Ensuring skill mix of physiotherapists to give correct grade mix	91%	100%	97%	91%	90%
Communication with physiotherapists across the organisation?	87%	100%	97%	96%	90%
Continued Professional Development linked to staff appraisal across the whole service?	85%	100%	100%	83%	80%
Post-graduate education to meet service and staff needs	93%	100%	97%	91%	70%
Comprehensive in-service training programmes	91%	100%	94%	83%	70%
Total Mean	89%	100%	97%	88%	79%
Rank	3	1	2	4	5

Physiotherapy managers in the AHP sub-directorate demonstrated 100% of managers undertaking all tasks, the fragmented structures (79%) undertook the least. This would likely be of concern for the quality of care provided to patients and staff working in the service wanting to develop skills and progress their careers. A gap analysis was undertaken:

Table 45 Gap analysis: Professional development

Professional development	AHP dir.	AHP sub	Physio dir.	Path	Frag
Providing consultancy for staff on physiotherapy professional issues					60%
Ensuring sufficient staff to give "critical mass"				78%	80%
CPD linked to staff appraisal across the whole service					80%
Post-graduate education to meet service and staff needs					70%
Comprehensive in-service training programmes					70%

8.2.4 Operational management

The most commonly undertaken task by physiotherapy managers was performance management (95%). This was significantly different with acute physiotherapy managers undertaking more networking than community managers. Networking of physiotherapists across organisations was the least frequently undertaken task (74%), in contrast to the medical profession, who report strong inter-organisational networks (Harrison and Ahmad, 2000)

Table 46 Physiotherapy managers' operational management functions

Operational Management	AHP directorate	AHP sub-directorate	Physio directorate	Pathway	Fragmented
Staff deployment in all areas across the service(s)	81%	100%	78%	70%	80%
Day-to-day operational management of staff in clinical areas	83%	80%	97%	78%	90%
Development of physiotherapy policies and procedures	87%	100%	97%	78%	90%
Performance management and clinical standards monitoring	89%	80%	97%	91%	90%
Networks between physiotherapists within the organisation	85%	100%	94%	87%	80%
Networks between physiotherapists across organisations	68%	100%	66%	74%	60%
Inter-disciplinary working between professions within the organisation	79%	100%	85%	70%	90%
Capacity and demand management of physiotherapy services	83%	100%	97%	83%	90%
Performance management of physiotherapy services	89%	100%	94%	91%	100%
Total Mean	83%	96%	89%	80%	86%
Rank	4	1	2	5	3

Physiotherapy managers in the AHP sub-directorate demonstrated 96% of managers undertaking all tasks. The clinical pathway managers (80%,) undertook the least; functions which were presumably picked up by non-physiotherapy managers. All structures involved the physiotherapy manager in a substantial amount of operational management duties with 87% of the total performing these functions, statistical analysis demonstrated a significant association with physiotherapy managers in acute organisations undertaking more operational management than in community organisations. A gap analysis of operational management domain was undertaken:

Table 47 **Gap analysis: Operational management**

Elements	AHP dir.	AHP sub	Physio dir.	Path	Frag
Staff deployment in all areas across the service(s)			78%	70%	80%
Day-to-day operational management of staff in clinical areas		80%		78%	
Development of physiotherapy policies and procedures				78%	
Performance management and clinical standards monitoring		80%			
Networks between physiotherapists across organisations	68%		66%	74%	60%
Inter-disciplinary working between professions within the organisation	79%			70%	

8.2.5 Human resources

The most commonly undertaken task by physiotherapy managers was ensuring dissemination and implementation of HR policies and procedures (89%).

Responsible officer status for dismissal of staff was the least frequently undertaken task (41%).

Table 48 Physiotherapy managers' human resource functions

Human Resources	AHP directorate	AHP sub-directorate	Physio directorate	Pathway	Fragmented
Recruitment Process	87%	100%	94%	70%	80%
Appointing officer for physiotherapy recruitment	74%	100%	88%	74%	60%
Disciplinary policy implementation for physiotherapy staff	81%	80%	91%	74%	80%
Responsible officer status for dismissal of staff	45%	20%	63%	26%	50%
Ensuring dissemination and implementation of HR policies and procedures across your service(s)	81%	100%	88%	87%	90%
Skill mix review	81%	100%	91%	78%	90%
Total Mean	75%	83%	86%	68%	75%
Rank	3	2	1	5	3

The physiotherapy directorate managers reported 86% undertaking all tasks.

The clinical pathway (68%,) undertook the least, tasks which were presumably picked up by non-physiotherapy managers. All structures involved the physiotherapy manager in a substantial amount of human resource duties with 77% of the total performing these functions. The devolved models undertook significantly less recruitment and less skill mix review than the professionally-led models. A gap analysis was undertaken.

Table 49 Gap analysis: Human resources

Elements	AHP dir.	AHP sub	Physio dir.	Path	Frag
Recruitment Process				70%	80%
Appointing officer for physiotherapy recruitment	74%			74%	60%
Disciplinary policy implementation		80%		74%	80%
Responsible officer status for dismissal of staff	45%	20%	63%	26%	50%
Skill mix review				78%	

8.2.6 Resource management

The most frequently occurring task undertaken by physiotherapy managers was capacity and demand management (91%). Tendering was only undertaken by (45%) reducing overall mean scores for this domain, though acute organisations were significantly impacted by tendering for physiotherapy services. Managing resources was therefore an important part of most managers' roles requiring them to be skilled in financial management.

Table 50 Physiotherapy managers' resource management functions

Resource Management	AHP directorate	AHP sub-directorate	Physio directorate	Pathway	Fragmented
Budget setting i.e. agreeing annual budget	72%	60%	81%	61%	80%
Managing the budget for your service(s)	79%	80%	94%	74%	90%
Costing and pricing of your service	70%	60%	81%	57%	60%
Contract monitoring	68%	80%	72%	52%	80%
Making cash releasing efficiency savings	81%	100%	85%	74%	90%
Participation in financial planning and monitoring	85%	100%	91%	74%	100%
Developing Income generation projects	68%	100%	72%	65%	80%
Charitable Trust funds	59%	60%	63%	44%	60%
Purchasing and stock control	83%	80%	94%	65%	90%
Involvement in capital project planning	64%	80%	53%	30%	50%
Capacity and Demand management	85%	100%	91%	87%	90%
Tendering processes	40%	60%	31%	35%	60%
Total Mean	71%	80%	76%	60%	78%
Rank	4	1	3	5	2

Physiotherapy managers in the AHP sub-directorate demonstrated 80% undertaking all tasks. The pathway (60%) undertook the least. All structures involved the physiotherapy manager in a substantial amount of resource

management duties with 73% of the total performing these functions and no significant association. A gap analysis was undertaken:

Table 51 Gap analysis: Resource management

Elements	AHP dir.	AHP sub	Physio dir.	Path	Frag
Budget setting i.e. agreeing annual budget	72%	60%	81%	61%	80%
Managing the budget for your service(s)	79%	80%		74%	
Costing and pricing of your service	70%	60%		57%	60%
Contract monitoring	68%	80%	72%	52%	80%
Making efficiency savings				74%	
Participation in financial planning and monitoring				74%	
Developing Income generation projects	68%		72%	65%	80%
Charitable Trust funds	59%	60%	63%	44%	60%
Purchasing and stock control		80%		65%	
Involvement in capital project planning	64%		53%	30%	50%
Tendering processes	40%	60%	31%	35%	60%

8.2.7 Information management

The most frequently occurring task of physiotherapy managers was monitoring compliance with standards for record keeping (95%). The least frequently undertaken tasks were monitoring case mix and uniform data sets,(62%).

Physiotherapy managers in the AHP sub-directorate (93%) undertook the most information management, and fragmented (61%,) the least. All structures involved the manager in a substantial amount of information management duties with 80% of the total performing these functions. The devolved structures undertook less information management duties, but there was no significant association.

Table 52 Physiotherapy managers' information management functions

Information Management	AHP directorate	AHP sub-directorate	Physio directorate	Pathway	Fragmented
Management of clinical and managerial information throughout your service(s)	87%	80%	94%	74%	70%
Interpretation and reporting of information	89%	100%	97%	91%	70%
Monitoring and reporting throughput activity	93%	100%	94%	91%	70%
Monitoring/ reporting case mix	64%	80%	66%	61%	40%
Uniformity of information for patients across the whole service(s)	72%	80%	75%	87%	50%
Uniform data sets and coding across the whole service(s)	68%	100%	63%	57%	20%
Monitoring of compliance with regulatory and professional standard for record keeping of your staff	91%	100%	94%	91%	100%
Monitoring and reporting of clinical outcomes	89%	100%	91%	87%	70%
Total Mean	82%	93%	84%	80%	61%
Rank	3	1	2	4	5

A gap analysis of the information management domain was undertaken:

Table 53 Gap analysis: Information management

Elements	AHP dir.	AHP sub	Physio dir.	Path	Frag
Management of clinical and managerial information throughout your service(s)		80%		74%	70%
Interpretation and reporting of information					70%
Monitoring and reporting throughput activity					70%
Monitoring and reporting case mix		80%	66%	61%	40%
Uniformity of information for patients across the whole service(s)	72%	80%	75%	87%	50%
Uniform data sets and coding across the whole service(s)	68%		63%	57%	20%
Monitoring and reporting of clinical outcomes					70%

8.2.8 Commissioning/service planning

Capacity and demand planning was the most frequent commissioning/service management task (93%,) undertaken by physiotherapy managers, and provider input to the commissioning process (56%) the least.

Analysed by management structure, physiotherapy managers in the AHP sub-directorate undertook the most commissioning/service planning (100%) with little difference between the rest. 81% overall were involved in commissioning/service planning, with no significant association.

Table 54 Physiotherapy managers' commissioning/service planning functions

Commissioning/Service Planning	AHP directorate	AHP sub-directorate	Physio directorate	Pathway	Fragmented
Managing the provider input to commissioning programmes on behalf of your organisation for your service(s)	47%	100%	44%	61%	30%
Involving service-users in service development and planning for your service(s)	79%	100%	94%	74%	70%
Developing Service Specifications for your service(s)	74%	100%	72%	78%	90%
Capacity and demand planning for your service(s)	91%	100%	84%	91%	100%
Planning service developments for your service(s)	91%	100%	88%	91%	90%
Total Mean	76%	100%	76%	79%	76%
Rank	3	1	3	2	3

A gap analysis of the commissioning/service planning domain was undertaken:

Table 55 Gap analysis: Commissioning/planning

Elements	AHP dir.	AHP sub	Physio dir.	Path	Frag
Managing the provider input to commissioning programmes on behalf of your organisation for your service(s)	47%		44%	61%	30%
Involving service-users in service development and planning for your service(s)	79%			74%	70%
Developing Service Specifications for your service(s)	74%		72%	78%	
Managing the provider input to commissioning programmes on behalf of your organisation for your service(s)	47%		44%	61%	30%
Involving service-users in service development and planning for your service(s)	79%			74%	70%
Developing Service Specifications for your service(s)	74%		72%	78%	

8.2.9 Innovation and service re-design

Service re-design (92%) and multidisciplinary service re-design (92%) were the tasks most frequently undertaken by physiotherapy managers. Involvement with voluntary organisations the least frequently undertaken task (50%).

Table 56 Physiotherapy managers' innovation/service re-design functions

Innovation and Service Re-design	AHP directorate	AHP sub-directorate	Physio directorate	Pathway	Fragmented
Service re-design projects across your physiotherapy service(s)	94%	100%	88%	87%	90%
Participation in multi-disciplinary service re-design projects	91%	100%	94%	87%	90%
Introducing higher band roles such as Extended Scope Practitioners	76%	100%	78%	65%	80%
Providing 7-day working in some services	72%	80%	84%	48%	70%
Involvement of voluntary organisations in service planning	59%	60%	63%	30%	40%
Preparing submissions for national awards/conferences	59%	60%	66%	57%	60%
Total Mean	75%	83%	79%	62%	72%
Rank	3	1	2	5	

Physiotherapy managers in the AHP sub-directorate model (83%) undertook the most tasks and the fragmented structure (72%,) the least. 74% of the participants performed these functions. There was a significant association with physiotherapy managers in acute organisations providing more 7-day services than community organisations and more preparation for national awards. A gap analysis of innovation/service re-design domain was undertaken:

Table 57 Gap analysis: Innovation/service re-design

Elements	AHP dir.	AHP sub	Physio dir.	Path	Frag
Introducing higher band roles such as Extended Scope Practitioners	76%		78%	65%	80%
Providing 7-day working in some services	72%	80%		48%	70%
Involvement of voluntary organisations in service planning	59%	60%	63%	30%	40%
Preparing submissions for national awards/conferences	59%	60%	66%	57%	60%
Introducing higher band roles such as Extended Scope Practitioners	76%		78%	65%	80%

8.2.10 Research, development and education

Table 58 Physiotherapy managers' R&D and education functions

Research, Development and Education	AHP directorate	AHP sub-directorate	Physio directorate	Pathway	Fragmented
Input to the pre-registration education contract setting for your service(s)	76%	80%	72%	70%	80%
Input to post-registration education demand forecasting programme	53%	100%	38%	35%	40%
Manage the budget for your service post-graduate education and training	66%	80%	56%	39%	60%
Initiate and manage R&D projects for your service(s)	74%	80%	66%	48%	30%
Providing Under-graduate physiotherapy training and development placements	89%	100%	91%	74%	90%
Act as the "point of contact" for HEIs	79%	60%	84%	48%	40%
Total Mean	73%	83%	68%	52%	57%
Rank	2	1	3	5	4

The task most frequently performed by physiotherapy managers was providing undergraduate clinical placements (89%) and input to post-registration education demand forecasting the least (53%).

There was substantial variance in the support given by physiotherapy managers to R&D and education between the different structures. These were most strongly supported by the AHP sub-directorate (83%) and AHP directorate (73%). The clinical pathway (52%,) undertaking the least. 67% of the total performed these functions. There was a significant association with the devolved structures undertaking less R&D and education, than the professionally-led ones (Table 98.)

A gap analysis of R&D and education domain was undertaken:

Table 59 Gap analysis: Research, development and education

Elements	AHP dir.	AHP sub	Physio dir.	Path	Frag
Input to the pre-registration education contract setting for your service(s)	76%	80%	72%	70%	80%
Input to post-registration education demand forecasting programme	53%			35%	40%
Manage the budget for your service post-graduate education and training	66%	80%	56%	39%	60%
Initiate and manage R&D projects for your service(s)	74%	80%	66%	48%	30%
Providing Under-graduate physiotherapy training and development placements				74%	
Act as the "point of contact" for HEIs	79%	60%		48%	40%

8.3 Physiotherapy Manager Functions and Professionalisation

Some elements of professionalisation (Chapter 3) were closely associated with the functions of physiotherapy managers. Analysis was undertaken to compare

each management domain, comparing where all elements were fulfilled, with those where either none or only some of the elements were fulfilled.

When services were led by a physiotherapist, in AHP and physiotherapy directorate structures, more management functions were undertaken. Where management was distributed by a clinical pathway or fragmented structure i.e. a devolved structure, the physiotherapy manager was less involved in management functions and reliant on others to assure comprehensive management of the physiotherapy service, arguably impacting on professionalisation and stratification.

Aspects where physiotherapy became more professionalised were:

Legislation: Physiotherapy managers were able to influence via their networks and professional body, for example protection of title and independent prescribing. This might require the manager to have established networks and facilitated to have professional links. This could be directly influenced by the models of management and the authorisation of the manager to participate in professional networks.

Professional Body: 99% of Physiotherapy managers responding reporting being members of their professional body, the CSP, this fulfilled this professionalisation element.

Education: The role of the physiotherapy managers in supporting education, by clinical placements for undergraduates and staff sufficiently knowledgeable to

undertake student education and also support for post-graduate education were key areas where the manager held responsibilities.

Professionalism: Setting standards and monitoring them, was a role undertaken by the majority of physiotherapy managers, though more difficult to ensure consistency of application across the profession in devolved structures.

Practice: Professional autonomy and adherence to scope of practice being an individual practitioner responsibility and part of the regulatory requirement. The role of the physiotherapy managers would be to ensure that this is adhered to.

Inter-professional relationships: The physiotherapy manager was well placed to develop a culture of collaboration and co-operation with other professions, but also to ensure that others recognise the scope and boundary of physiotherapy.

Public recognition: The physiotherapy managers reported a pivotal role in marketing their services to the public, other professions, their organisation as well as potential new graduates, ensuring positive public relations.

Power: The physiotherapy managers' role of strategic influencing was considered an important function and undertaken by the large majority.

Jurisdiction: The physiotherapy manager would be pivotal in expanding their service into new areas and developing staff, challenging traditional territory

would be required, as other professions may not recognise the potential for physiotherapy to take on new roles and responsibilities.

Aspects where physiotherapy became less professionalised or threatening deprofessionalisation were:

Regulation: These functions were mandatory underpinned by legislation. The monitoring of regulatory requirements would require organisational implementation, for example, ensuring staff meet requirements for registration and re-validation as well as reporting issues of concern to the HCPC.

Experience of regulatory requirements and an accountable officer are requirements for all organisations and would have been an area of concern for the two organisations reporting that they had no designated accountable physiotherapy officer.

Practice: Lack of input to R&D, education and development and IM&T domains are a cause for concern, as these essential functions develop the evidence base supporting education and training as well as measuring performance.

Power: Recent changes to devolved structures as well as the impact of cost containment impacted on the senior posts in organisations and potentially the power-base of the profession.

Financial control: This required physiotherapy managers to execute their duties in reducing costs to meet CIP requirements. Although widely disliked by managers, cost reduction was a feature for most. The implications were either

fewer staff or cheaper staff; which reduced the number of higher banded staff, and in a few instances removed the physiotherapy manager post.

Development of “new” roles: Financial controls required managers to skill-mix their workforce to make it affordable. New roles had been developed for support workers, arguably, deskilling physiotherapy. However, new roles had also been developed for physiotherapists working into new clinical areas; formerly roles undertaken by doctors.

Performance monitoring: This requirement of public sector services gave physiotherapy managers’ roles in undertaking monitoring for organisational audit. This would include for example, scrutinising staff activity, clinical outcomes, budget monitoring, workforce metrics, benchmarking criteria as well as being accountable to achieve “targets” such as referral to treatment times.

Loss of discrete knowledge: Physiotherapy knowledge was not entirely discrete, with some of the underpinning theory being shared with many health professions. Technical and practical skills remained largely discrete and unique to the profession, though others were cited as attempting to encroach; including rehabilitation nurses.

Oversupply of physiotherapists: The majority of managers had a workforce planning function predicting the numbers and types of staff required for the future workforce. Accuracy in prediction as well as commissioned undergraduate placements had for many been questionable. The mid-2000s saw an oversupply of physiotherapists but this had returned to balance with

physiotherapy being removed from the national list of shortage occupations (CSP, 2007). Respondents suggested that this may be reverting to a situation of under-supply.

Itinerant professionalism: Managers controlled the use of locum staff, and largely tried not to appoint them due to excessive cost and lack of service continuity. The use of locums had reduced substantially in recent years due to workforce planning, and itinerant professionalism a less prevalent feature of the physiotherapy workforce.

The roles required of the physiotherapy manager, and the ways the roles were discharged directly influenced the way in which the profession worked and was controlled in the organisation, impacting on the elements of professionalisation and deprofessionalisation. The success of the physiotherapy manager in controlling their multiple roles would determine the professionalisation trajectory of physiotherapy. Comparison between England and Wales is set out in Chapter 10.5.

8.4 RQ2 Summary of Findings

The normative domains and elements assessment of the 10 domains of the (Jenkins and Jones, 2011) ATEAHPMS, rated each organisational type, identifying whether there were differences between the roles and duties undertaken by physiotherapy managers, between the identified management models which evolved since the models of 1992. The ATEAHPMS was used

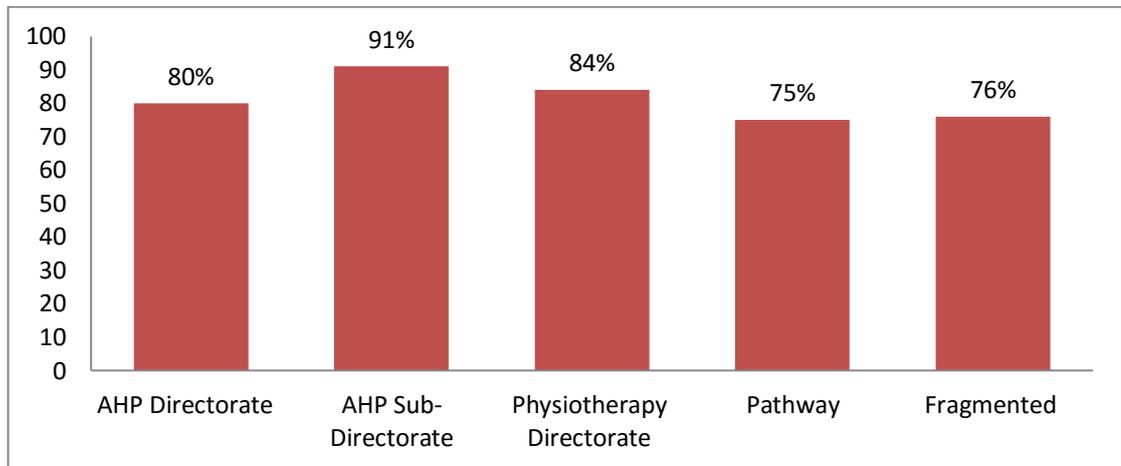
by the researcher to score the norms, which were then ranked according to its rating 1= best placed, 5= worst. The only significant association between models was R&D/Education.

Table 60 Overall Management structures assessment

Domains	Management structures				
	AHP Directorate	AHP Sub-Directorate	Physio Directorate	Pathway	Fragmented
Strategy	79%	90%	81%	83%	88%
Clinical governance	93%	100%	99%	96%	97%
Professional development	89%	100%	97%	88%	79%
Operational management	83%	96%	89%	80%	86%
Human resources	75%	83%	86%	68%	75%
Resource management	71%	80%	76%	60%	78%
Information management	82%	93%	84%	80%	61%
Commissioning/ service planning	76%	100%	76%	79%	76%
Innovation and service re-design	75%	83%	79%	62%	72%
Research, development and education	73%	83%	68%	52%	57%
TOTAL SCORE	80%	91%	84%	75%	76%
Rank	3	1	2	5	4

The data enabled the management structures to be rated using the ATEAHPMS normative domains and elements. The ATEAHPMS included domains which captured the key elements of a physiotherapy managers role, with a mean total score for all organisations of 81% being achieved, and concurred with the middle management activities described by Buchanan *et al* (2013).

Fig. 24 **ATEAHPMS: Management structures rating**



This analysis and assessment of physiotherapy in the different management structures demonstrated that the professionally-led structures rated more highly than the devolved ones, and that the majority of physiotherapists were in management structures where the physiotherapy manager undertook the greater proportion of the roles, responsibilities and functions of the 10 domains set out in the ATEAHPMS normative assessment of management structures.

The overarching objective in developing the ATEAHPMS was to ensure as far as possible that AHP management arrangements, structures and organisations were focussed on infrastructures that facilitated and supported the provision of the best possible outcomes for patients, service providers and organisations. For this to occur staff need to be developed and supported. The majority of managers were able to demonstrate that they were undertaking the necessary functions. Managers also reported that the ATEAHPMS included all their roles except clinical practice.

CHAPTER NINE

FINDINGS:

PHYSIOTHERAPY PROFESSIONALISATION, THE IMPACT OF NHS CHANGES AND MANAGEMENT STRUCTURES

The research focussed largely on management structures, though the development of physiotherapy and changes through different periods of reform identified that professionalisation had also impacted on staff development, autonomy to practice and therefore directly influenced patient care. This chapter explores how physiotherapy professionalisation has both influenced management structure and in turn been influenced by it.

The findings to RQ3 are presented, including details from the literature review, SSIs and questionnaire survey provided data on professionalisation. Theorists had differing propositions relating to what constitutes a profession. These were reviewed, analysed and amalgamated into a complex of nine domains and 50 attributes presented as a set of characteristics against which any profession could be assessed and used to analyse physiotherapy. The findings were cross referenced with the Hollander and Campbell (1990) typology of occupations. Stratification of the profession in relation to NHS policy change is presented

along with an analysis of differences between England and Wales in relation to the impact of NHS changes on professionalisation and its impact on support for staff and patient care.

9.1 Assessment of Physiotherapy Professionalisation since 1989

In the analysis of physiotherapy it was determined that support through legislation has been well established and strengthened through protection of the titles “physiotherapist” and “physical therapist” as well as change in legislation to enable physiotherapists to prescribe some medicines independently.

Regulation was highly rated. The establishment of the HCP in 2001 replaced the CPSM strengthening regulation and later giving protection of title. The HCP, and subsequent the HCPC, had taken over some CSP powers and functions, weakening the professional body. The HCPC had afforded greater accountability and protection for the public, even though this impacted on the profession. Physiotherapy had strengthened its educational underpinning, by becoming an all-graduate profession. Entry to physiotherapy being typically 300-370 UCAS points with examination and 3-4 year training, comparing with medicine requiring typically 360 UCAS points, with 5-6 years training and nursing typically 280 UCS points and three years training (The Complete University Guide, 2014.)

Professionalism was reported as being an area of strength in all characteristics except professional socialisation. Professional autonomy and independent practice had been a constant feature since HC(77)33 (DHSS, 1977.) There had

also been a move away from part-time practice. There was evidence of rivalry with nursing relating to access to management roles and their perceived power by the size of their profession, and evidence of less medical control over physiotherapists from the 1980s (Øvretveit, 1985.) Sanction and support for the profession has been constant, and strengthened by a positive media image.

An assessment of physiotherapy professionalisation was undertaken developed from a comprehensive template of professionalisation characteristics, designed to group key theoretic criteria. This was used to compare the three periods:

Table 61 Professionalisation characteristics: Physiotherapy assessment

TRAIT		2013/ 14	2005	1989	Impact of NHS changes influencing rating
Legislation	1. Support of the law for practice	3	2	2	Further legislation to enable independent prescribing as set out in legislation 2013/2014
	2. Political agitation directed toward the protection of the association by law	3	3	1	Protection of title "physiotherapist" from 2003.
Regulation	3. Ethical Code of Practice and Standards of Conduct, overseen by a body of representatives from within the field itself	3	3	2	Strengthening of regulation by the HCPC from 2001
	4. Self-regulation in return for non-exploitive control	3	3	3	Strengthened by reports e.g. Francis, (Mid-Staffordshire,) Andrew (Wales)
Occupational Body	5. Self-organising formation of an association	2	2	3	HCPC control education and regulation since 2001
	6. Professional body having a strong public voice	2	2	3	Shift of power from profession to HCPC since 2001, which was greater than the former regulatory power of the Council for Professions Supplementary to Medicine (CPSM)
	7. <i>Occupational body and autonomy from the state</i>				<i>Autonomy from state not possible for regulated occupations</i>
	8. Adoption of a formal code	2 3	2 3	2 3	Constant and unchanged

Education	9. Restricted entry	2	2	3	Entry to training managed more by universities than the profession (though by academic physiotherapists,) HCPC has more power than profession in validating BSc curricula, though the profession writes syllabus and inputs to validation
	10. Qualifying examinations and tests of competence: Academic Knowledge	3	3	3	Examination and curricula setting transferred to HCPC from 2001, though largely led by academic physiotherapists
	11. Training schools, systematic theory and specialist body of knowledge	3	3	3	Constant
	12. Derived from science and learning, with systematic theory	3	3	2	Strengthened
	13. Educationally communicable	3	3	2	Profession moved from diploma level qualification to all graduate profession, and from some polytechnics to universities
	14. Skill achievement of a certain level (gained through a prolonged period of higher education)	3	3	2	Development of post graduate qualifications
	15. Levels of knowledge for societal benefit	3	3	3	Constant
Professionalism	16. Culture and personal identity of professional knowledge, behaviour and ethos that stems from the professionals themselves	3	3	3	Constant
	17. Period of professional socialisation	2	2	2	Post graduate era less period for professional socialisation
	18. A culture of professional knowledge, skills, behaviour and ethos	3	3	3	Constant
	19. Knowledge and skills based occupations dealing with risk and uncertainty	3	3	3	Constant
	20. "Professionalism" being self- controlling with structures concerned with values, attitudes and behaviour	3	3	3	Constant
	21. Interrelated and mutually balancing: - Values - Quality - Client (patient)care	3	3	3	Constant
	22. Personal integrity in doing	3	3	3	Constant

	one's work				
Practice	23. Full time practice	3	3	2	Profession promoted its suitability for part time working
	24. "Customer orientation, customer is king"	3	3	3	Constant
	25. Large individual responsibility	3	3	3	Constant
	26. Authority	3	3	3	Constant
	27. Autonomy of clinical practice	3	3	3	Constant
	28. Significant autonomy of decision-making	3	3	3	Constant and strengthened
	29. An altruistic commitment to service	3	3	3	Constant
	30. Right to use discretion and judgment in the performance of work	3	3	3	Constant
	31. Ascertain the economic resources needed to complete his/her work	3	3	3	Constant
	32. Ability to allocate ALL the economic resources needed	2	2	2	Within boundaries of allocated public sector budget, judgement of relative priorities for resourcing required therefore <i>not necessarily able to allocate ALL resources needed for entire service</i>
	33. Power to determine: - Who is qualified to perform a defined set of tasks - To prevent all others from performing that work - To control the criteria by which to evaluate performance	2	2	2	Core practice is defined however margins of the profession not discreet and therefore difficult to control, as this may vary from between organisations depending on training and competence assessment. Not overt in taking skills from other professions
	34. <i>Diagnosis</i> : Assign subjective properties to the objective problems with which the professions work i.e. able to undertake clinical diagnosis	3	3	3	Constant
	35. <i>Treatment</i> . To classify the empirical data to suggest a prescription	3	3	3	Constant
36. <i>Inference</i> : Inference between diagnosis and treatment is often automatic but sometimes, has to be much more complex and involves expertise i.e. not	2	2	3	Weakened by guidelines and standardisation	

	protocolised				
	37. <i>Legitimate Authority:</i> - Confidence - Confidentiality - Competence - Contract - Community responsibility - Commitment	3	3	3	Constant
	38. <i>Jurisdiction:</i> - Taking over medical tasks and functions <i>by force or subterfuge</i> - Seeking out newly defined or abandoned territories - Develop a consensus which will enable them to work together with other professions in a harmonious and integrated way - Professional personhood - Personal integrity in doing one's work, and not letting others invade	3	3	2	<i>Subterfuge not a cultural norm for health professions</i> Injection therapy in scope of profession since 1995 Independent prescribing taking on medical tasks in a restricted capacity (2013/2014) Acupuncture in scope of practice and a registerable and regulated skill Less developed advanced roles in the 1990s, less enabled to take on medical tasks
Inter-professional relationships	39. Power differences between professional-subgroups	2	2	3	AHP identity developing
	40. Inter-occupational conflict between the new practitioners and older established occupations	2	2	1	Merger of physiotherapy with remedial gymnasts in 1985 not fully embedded until 1989. Development of AHPf and strengthening of AHP relationships at local level.
Public recognition	41. Provision of a crucial social function and human need, Health care to "treat and cure"	3	3	3	Fulfilled
	42. Public, community sanction/ recognition	3	3	3	Well-liked, evidenced by self-referral
	43. High prestige and earnings	2	2	1	Pay scales not same as Medicine
	44. Professions seen as a positive force in social development	3	3	3	Constant
	45. Service orientation	3	3	3	Constant
Power	46. Collegiate control (by profession)	2	2	3	HCPC has taken over some functions as former CPSM regulation has less powers
	47. Patronage (by client/patient)	3	3	2	Self-referral demonstrates client valued and favoured service
	48. Mediation (by the state)	2	2	3	HCPC regulation and mediation stronger than former CPSM
	49. Privileges and obligations	3	3	3	Constant
	50. Control of the market in	1	2	2	Market controlled by

	which they operate				Government, and extended competition in England, combined with as service users being more aware of their rights and the utilisation of consumer "Choice"
	Total scores (max 150)	135	136	132	

Intensity scale rating:

1 = Not/ Poorly achieved, 2 = Partially achieved, 3 = Fully/Highly achieved

Red = not fulfilled

Fulfillment of the professional attributes varied during the three periods from: 132/150 in 1989, 136/150 in 2005 to 135 /150 in 2013/14. This reflected the evolution of the physiotherapy profession, with a move to strengthen professionalisation in the legislation domain with greater support of the law for practice and perform roles formerly undertaken by medicine. The development the non-regulated support workers has threatened professionalisation demonstrating a changing healthcare environment.

The three low rated attributes in 1989 had changed. Earnings had increased with the introduction of AfC, merger with the remedial gymnast profession has reduced professional rivalry with the most similar profession, and protection of the title "physiotherapist" had given recognition to the profession and the standards which were required to use the name.

According to the typology of occupations "integrative model" (Table 4) analysis of the research findings indicated that the physiotherapy profession was "highly professionalised", with a high degree of control over entry to the profession. Academic entry requirements gave medicine higher control and nursing lower control. Control over conduct was similar with different regulatory bodies holding

professions to account; registration with the HCPC being a requirement for physiotherapist NHS employment.

9.2 Physiotherapy Deprofessionalisation

Several theories have been reported which serve to reduce the power of the professions including elements of deprofessionalisation, bureaucratisation, proletarianisation and the development of “semi-professions” (Chapter 3).

These were used to develop deprofessionalisation characteristics.

Physiotherapy was analysed to determine whether any elements were present and whether organisational change since 1989 had impacted.

Table 62 Deprofessionalisation characteristics: Physiotherapy assessment

Domains	Physiotherapy Assessment	2013 /14	2005	1989
“Semi - Professions”	<ul style="list-style-type: none"> • No evidence of shorter training • Mandate to control work fully granted • Right to privileged communication established • Individual autonomy limited supervision • Specialised body of knowledge 	1	1	1
Transition stage towards professionalisation	<ul style="list-style-type: none"> • Lack of <ul style="list-style-type: none"> - Legislative sanction - HEI training and education - Public sanction - Occupational body - Professionalism - Inter-professional relationships - Regulatory control - freedom from financial control 	1	1	1
Breadth of practice	Boundary-spanning roles, extended scope and consultant roles developed	1	2	3
Itinerant professionalism	Contingent work for small minority of locum staff, though locum staff have been a workforce feature for many years, though less prevalent due to cost constraints	1	2	2
Employee status	NHS physiotherapists not self-employed subject to employment terms and conditions	2	2	2
Feminised workforce	Female dominated profession but increasing male membership during last two decades	2	2	3
TOTAL Score (Maximum = 18)		9	10	12

A three point intensity scale was used to rate each domain where; 1= low impact on deprofessionalisation, 2 = moderate impact, 3 = high impact.

Deprofessionalisation of physiotherapy varied during the three periods from: 12/18 (67%) in 1989, 10/18(55%) in 2005 and 9/18 (50%) in 2013/14. Factors putting pressure to deprofessionalise physiotherapy included merging professional boundaries, including increased use of support staff. The development of the physiotherapy assistant role was highlighted by informants:

SSI 5[8]“Assistants are a vital part of the workforce, we couldn’t manage without them.”

This indicated that the profession has been content to devolve some of its former tasks to non-registered staff, vertically stratifying. Physiotherapists undertook initial patient assessment, decided appropriate intervention and held the ultimate responsibility whether or not to delegate, therefore still being clinically and legally responsible. This is similar to other nursing and some AHPs, but less so in medicine, though the evolution of the physician associate introduced a similar support for doctors (NHS Careers, 2014.)

Regulation was a feature of both professionalisation and de-professionalisation. The domain causing further pressure to deprofessionalise was reported as pay and terms and conditions, with 57% of physiotherapy managers reporting downward pressure on bandings, being consistent with the drive to reduce costs (NHS England, 2013.) This limited career progression, impacting most significantly in Acute Trusts, affecting both countries. Factors that deflected deprofessionalisation included; growing breadth of practice, increased

remuneration, and improved workforce planning reducing the need for locums; development of advanced practitioner boundary spanning roles. The impact of evidence-based medicine had demystified expert knowledge and stimulated a levelling between professions (Timmermans and Berg, 2010.) There had been a reduction in UK feminisation of physiotherapy over recent years, though differences between health professions. In 2014, 71% of UK physiotherapists were female, compared with nursing (90%) and medicine (53%), (WHO, 2014.)

The elements of proletarianisation observed were not of the Marxist tradition of downward social mobility, but more aligned to that described by Debord (1994,) of factory logic being applied to the intellectual professions. Physiotherapy managers demonstrated a high percentage of CSP membership with 122 (99%) reporting membership. The reported high TU membership could be indicative of the drive to resist proletarianisation and downward pressure on pay and terms and conditions.

The analysis demonstrated considerable pressures to deprofessionalise physiotherapy, but this was consistent with other healthcare professions; arguably the medical profession had a stronger power-base protecting its autonomy and authority.

9.3 Professional Stratification and NHS Policy Change

The current global health agenda includes “value based health care” (Jewell *et al* 2013,) requiring quality assured services at lower cost with greater

accountability. This was of highest priority for the NHS and a driver for physiotherapy professional stratification. Two types of stratification were identified:

9.3.1 Vertical stratification within physiotherapy

There were several drivers for vertical stratification within the profession. The introduction of an all-graduate profession in 1992, stratified the profession between those who trained earlier with a Diploma qualification and latter graduates. Diploma physiotherapists did not undertake research as part of their core qualification and were less educated to critically evaluate evidence-based practice. Post-graduate education enabled development of expert practitioners rather than the reported:

SSI6 “Subservient handmaidens” of former years.”

Arguably it also introduced a different type of person into the profession:

SSI10 “Graduates changed the type of people coming into the profession, much more competitive and with different expectations; a different type of person wanting due reward and a career for life.”

Physiotherapy managers commented on the contribution of support staff, revealing that the profession has been content to devolve some of its former functions to non-registered staff, stratifying the profession to have higher skill levels, though owning the delegated tasks as part of professional accountability. It was commented that:

SSI8 “Assistants are a vital part of the workforce, we couldn’t manage without them, they do lots of tasks we used to.”

More flexible working policies were in place with greater numbers of part-time working arrangements and mixed patterns of working, stratifying the clinical workforce with a mix of full-time career physiotherapist, portfolio workers and part-timers. There was also reported to be some on zero hour's contracts. Staff members were less loyal to one employer than previously.

The McMillan report (DHSS 1973,) was a milestone for managerial autonomy, stratifying a management hierarchy within the profession such as Head of service, specialism managers and team leaders. Developments in managerial autonomy had helped the profession strengthen and grow, stratifying new senior management roles. The research finding concurred with Pollitt and Bouckaert's (2011,) observations of public sector managerialism. However, recent management reorganisations and the impact of mergers and restructuring led to several managers having threats to their job and its future. For some, new management arrangements affected their autonomy (Rowbottom 1978,) and therefore the stratification:

SSI 3 [11,7] *"Many more managers putting their oar in, without much knowledge or experience, you spend half your life teaching them."*

The introduction of AfC in 2005, gave opportunities for physiotherapists to move up both clinical and managerial salary bands, stratifying the profession:

SSI11 *"Pay demonstrates your "worth" both individually and between professions, it gives you status and makes you feel valued by others"*.

Conversely, cost containment has been cited as restricting the profession, influencing downward stratification, with more junior posts and assistants at the expense of seniors and managers, affecting staff development:

SSI1 *“We have less and less seniors, less skills to develop junior staff”.*

Empirical analysis of management structures was undertaken using the stratification domains to determine differences.

Table 63 Physiotherapy vertical stratification: Management structures

Stratification Domains	Management structures				
	AHP Directorate	AHP Sub-Directorate	Physio Directorate	Pathway	Fragmented
Producers	3	3	3	3	3
Knowledge elite	3	3	2	2	1
Administrative elite	3	2	2	1	1
Diversification	3	3	3	2	1
Specialisation	3	3	3	3	1
Vertical substitution	3	3	3	2	1
Jurisdictional substitution	2	2	2	3	3
TOTAL SCORE	21	19	18	16	11

Intensity scale 1= Not/Poorly achieved, 2= Partially achieved, 3= Fully/Highly achieved

The AHP Directorate structure was the most stratified and the fragmented the least. All structures had similar “producers” which were Band 5 and 6 staff. The roles for higher clinical bands 7- 8C (knowledge elite) as well as managerial bands 7- 9 (administrative elite) were least supported in the devolved structures, possibly due to cost containment, or the difficulty in “making the case” for the added value of higher banded posts. Devolved structures showed less inter-professional stratification.

Diversification was least demonstrated in the fragmented structure, with less roles for advanced practitioner, though the pathway rated highly for specialisation in one clinical area. Vertical substitution was more prevalent in professionally-led structures; though jurisdictional change a stronger feature of devolved structures. This indicates a greater propensity for merging role boundaries in structures which were not physiotherapy-led.

9.3.2 Jurisdictional change

Gaining clinical autonomy following HC(77)33 (DHSS 1977,) was considered a key milestone for physiotherapists as first line practitioners to make a clinical diagnosis, treat appropriately and discharge patients. This came about after a long period of lobbying particularly by the CSP. The clinical autonomy the memorandum afforded to physiotherapy was a watershed and did not relate to all the AHPs. These changes were reported positively by all who mentioned them:

SSI 3 "Clinical autonomy changed rapidly and quickly after 1977, it differentiated us".

Management autonomy was interpreted to mean freedom from medical control, as opposed to the "Thatcher" interpretation of leaving managers to manage (Day and Klein 1991). Freedom from medical control after 1977 stratified the profession from the control of medicine.

The establishment of the HCP in 2001 brought new standards relating to registrants' education, professional knowledge and skills, behaviour (conduct,

performance and ethics) and health which included legal protection of the member titles, including “physiotherapist”. This stratified physiotherapy from unregulated practitioners, positioning the profession to develop within the boundaries of regulation:

SSI 5 “DH policy has brought about protection of title, injecting and prescribing, following sustained pressure from the professional bodies”.

Regulation also identified the scope of each profession, stratifying one from another.

Physiotherapy managers reported elements of both professional collaboration and rivalry. Inter-professional personal relationships were a strong influence. Although much was said about the benefits of working together, the individual professional background appeared to be the “trump card”:

SSI6 “When push comes to shove, we all revert back to our own profession.”

A recurring theme in the interviews discussing the relationship with doctors was the accompaniment often was a small laugh or pause:

SSI10 “[laugh] some consultants act as part of a team, others don’t think anyone else has much to contribute, GPs are different.”

It was perceived that some doctors felt that physiotherapists were too strong and independent, affecting medical stratification. There was a small cluster referring to doctors as, “Gods” but with younger “medics” cited as being better multidisciplinary team players. Relationships with the medical profession were reported to have changed. Pre-1977, doctors used to prescribe physiotherapy,

however, since professional autonomy has been in place the relationship had developed. The vast majority reported very favourable links with the doctors who had grown to recognise the skills and expertise of physiotherapists:

SSI9[12] "They say we can't do without you, we're seen as a vital part of the team, its good they recognise our unique contribution".

Physiotherapy managers largely recognised that a professional hierarchy still existed and envied the medical profession for its power and dominance. The relationship with nursing focussed more on professional rivalry and competition, with very few comments of collaboration:

SSI8 "Nurses don't change their mind about us, we are useful, to an extent."

This was interpreted as overt resentment for the power of nurses being a larger profession and to an extent dictating the role and involvement of physiotherapists in some pathways of care; notably inpatient work, where nurses were the ward team leaders. With physiotherapy posts subject to cost-cutting, nurses had taken up some of the functions and expanded to the detriment to physiotherapy causing tension:

SSI4 "Nurses are taking over the world and some of their skills are dubious to say the least".

Nurses were reported by participants to be encroaching on physiotherapists' territory, without the skills to provide rehabilitation. Given recent concerns in England and Wales about the quality of care given by frontline nurses, comments were made in this respect and concern that nurses would further expand at the detriment of physiotherapy:

SSI3 “Nurses don’t always have the balance right between academic and practical skills, care is not what it was and they need to do something about it.”

It was felt that nurses by their sheer numbers had an advantage in their profile, though they became a degree profession later than physiotherapists with lower academic entry requirements:

SSI11 “We leapt ahead; degrees, doctorates and R&D, but they are catching up fast.”

These comments related to the competition for financial resources, which nurses appeared to be winning; a protagonist for professional tension.

Regarding other AHPs, there was an undertone of professional rivalry with OT, unlike any of the other AHPs. This may be due to OT being the closest profession to physiotherapy in scope of practice, and also the second largest AHP profession:

SSI 7 “OTs were slower to get moving, they have not developed at the same pace.”

All physiotherapy managers commented positively on the growth of an AHP identity being grouped together in management structures:

SSI7[8] “We’ve been a Therapies Directorate since 2005, I would not want to go back, we need to support each other, together we are strong, we would be even more efficient and effective if we were one AHP profession with subspecialties.”

Physiotherapy managers reported being aware that physiotherapy was seen as the dominant AHP:

SSI5 *“We have to work hard not to be seen as bully boys.”*

The jurisdiction and stratification of physiotherapy had extended and arguably had been enhanced, to be one of an AHP profession. The positive view of identity could have related to organisational identity and the concept of productive and sustainable potential of self-actualisation, at a collective, rather than just a personal level (Haslam *et al* 2000.)

Having AHPs working closely together was reported positively for patients and staff. The rise of multidisciplinary working and reduced inter-professional hierarchies were considered to impact positively on patient care. Good relationships with other AHP managers were also reported favourably, with physiotherapists being seen as leaders:

SSI2 [9] *“My peer AHP managers recognise physiotherapists as being flexible and proactive “doers”, traits they did not recognise in their own profession”*

Jurisdictional change has seen physiotherapists move into the former sole domain of medicine, but had also seen support staff move into physiotherapists' territory. Many managers cited out-patient self-referral; where patients use physiotherapy as a first contact rather than requiring medical referral, a crucial factor in autonomy and one that has differentiated the profession in recent years:

SSI 4[3] *“Self-referral is great, we can offer the whole package and people like it; patients and doctors.”*

The ability for organisations to deploy physiotherapists as first-line practitioners has enabled re-design of the traditional medical-led workforce model in some areas, most noticeably musculoskeletal care.

There was evidence regarding the influence of education in stratifying the profession. The all degree entry profession was reported to have made it:

SSI 5 “More academic and less technical.”

Graduate education was reported to provide less hours of clinical undergraduate experience, impacting on the “readiness” for post graduate practice. Graduate status was viewed positively, in terms of evidence-based practice, outcomes focus and R&D, there was also reference to trade-offs:

SSI6 “We’ve lost our softer skills of good communication and listening, our profession needs to influence others to make changes to their health, you need to be a people person.”

9.4 The Role of the Professional Body

The CSP as the professional, educational and TU body included 52,000 Chartered physiotherapists, students and assistants. It is therefore not a single entity of a professional body but multi-faceted. It became a combined professional body and TU in 1976, with 99% of physiotherapists being members, and approximately 60% (31,200) working in the NHS (CSP 2010b.)

This compares with the medical profession with 146,075 working in the NHS (NHS Confederation 2013.) The BMA being the professional association and

registered TU with a membership of 151,000, providing membership for those working outside the NHS too. The medical Royal Colleges are associations requiring examination to join. Nursing has 369,868 qualified staff working in the NHS (NHS Confederation 2013,) who largely belong to 2 TUs; Unison a TU with a healthcare branch including 130,704 nursing staff, and the RCN with 410,000 members. The nursing unions also include student nurses and healthcare assistants who are non registered by the NMC (regulator,) and has a large number of staff working outside the NHS. However, all three professions are highly unionised, and with the exception of Unison, the professional bodies are also TUs. The Francis inquiry (HoC 2013,) challenged the arrangements of joint TU and professional body suggesting there was an inherent conflict recommending that the RCN should consider dividing its professional association and TU functions into two bodies, rather than across internal divisions.

Data was gathered regarding the views of physiotherapy managers on the combined functions and its effect on professionalisation. Of the 123 respondents, only one was not a current member of the CSP, but had been so in the past; 99% of managers were members. Poor value for money, was cited as the reason for non-membership. When asked to rate the importance of being a member of the CSP, the greatest cluster of responses 73 (59%,) indicated that being a TU as well as a professional body gave the “best of both worlds.” A secondary cluster 25 (20%,) felt that the dual function devalued the profession and suggested that the roles should be split. 5 (4%,) were unsure whether the

dual function was beneficial and 5 (4%) felt that there was no place for TUs in healthcare. 35 (28%) of managers questioned the merits of the CSP being a combined professional body and TU.

**Table 64 Importance of professional body functions:
Physiotherapy managers' rating**

Functions	Low importance	Moderate importance	Important	Very important
Setting Codes/professional standards	0	6	17	100
Professional advice	1	6	30	85
Support on national NHS issues	3	3	33	76
Being a member of your professional body	5	11	32	75
Profession can withdraw membership rights	9	20	27	67
Clinical interest/occupational groups	1	11	41	62
Research and development	1	10	51	61
TU function	4	8	49	60
Professional networking	6	14	39	59
Membership leaders and managers group	8	15	37	57
Publications	1	10	50	54
Education and training	1	13	50	54
Website	3	19	43	54
Resource Centre (Library)	11	27	35	42
Opened membership to assistants	8	35	39	41
Annual Congress (professional)	13	26	46	31
Representative conference (TU)	27	28	39	28
CSP Boards/Branches	24	31	43	23

Of the 18 CSP functions listed, 15 were rated as very important and three as important (the modal score highlighted in italics). None were rated low or moderate importance. Setting professional codes and standards was considered the most important function. The least rated was the annual

representative conference; part of the TU function. Therefore the professional body functions were rated most highly of the CSP multiple functions.

When asked what they thought the “proper” role of the CSP should be: 80% (98) thought the CSP should be both a professional body and a TU; 18% (22) thought the CSP should be a professional body only; 2% (3) thought the CSP should be neither, recommending that the CSP merge with other AHP organisations to give a stronger voice. 121 respondents detailed their views which were thematically analysed. The attributes supporting professionalisation affecting the CSP were:

- *Legislation*: CSP as a lobby organisation, influencing legislative change e.g. prescribing (Act of Parliament, 2013,) Executive roles in Welsh Health Boards
- *Regulation*: Previously the CSP had formal representation at the HCP. The subsequent change to the HCPC withdrew mandatory profession specific representation
- *Occupational body*: Being self-organising with a strong public voice, requiring ongoing communication work
- *Education*: Influencing HEIs regarding curriculum, though not having accountability for accreditation. Responsibility to influence and potentially accredit post-graduate education including management training
- *Professionalism*: Leading role in developing profession culture including values, behaviour and attitudes
- *Practice*: Influence relating to professional autonomy, requiring ongoing lobbying, as well as jurisdiction, particularly seeking out areas to newly define within scope and defending encroachment
- *Inter-professional relationships*: Particularly with other professions through national fora such as the AHPf and the TUC.

- *Public recognition*: By ongoing media communications work and influencing the national pay review body
- *Power*: Maintaining collegiate control and support from others for the profession, acknowledging benefits to patient care and society

Table 65 Themed responses: Importance of CSP roles

Themes	No. Respondents
Having the TU with the professional body works well, and is needed to survive the changing NHS	36
Need physiotherapists involved in TU function they understand the issues	16
No conflict of interest, they are 100% for members	10
Tension in trying to represent what can be two conflicting roles	9
Do not agree with unions in healthcare	6
Good to have both with one subscription	5
Support physiotherapists carers and legal aspects	5
Professional issues have decreased focus at the CSP. TU very important but perhaps should be separated.	5
Having TU as well de-professionalises us, too political	5
Personal good experience from both arms of the CSP	5
Need the legal cover	5
Other unions too militant	5
Having seen the lack of engagement from professionals whose professional body is not their TU, this is of concern	4
Other unions more powerful voice	4
Don't understand the issues, no view on this	1

Physiotherapy managers reported strong views regarding TU function for the CSP; only two did not leave a comment; one other indicating that they did not have a view. 90 (74%,) gave positive comments regarding the dual function, 10 thought there was no conflict of interest with the dual functions, though nine thought that there was. Five thought other unions were too militant and four

indicated that other unions were more powerful; inferring that the CSP could be stronger as a TU. Specific comments included:

SSI7 [R98 &SSI1] “Changing roles mean that there is a lot of insecurity and fears over loss of professional identity; the CSP helps to support professionals in their new roles whilst maintaining their professional standards.”

SSI3 [R56] “The TU aspect currently leads the society but emphasis should be on professional membership for a professional body. Even the Code of Professional Conduct has been abandoned.”

The professionalisation of physiotherapy has been developed with the CSP having dual functions for almost 40 years. The professional body itself has been on a continuum of professionalisation since its inception (CSP, 2014.) There was evidence that most managers supported and valued the TU function. There was a large majority of members in favour of this combined role, though a sizeable 28% minority challenging this position. There was insight to the role of the TU being one of individual advocacy which managers may have benefitted from, as opposed to the national lobbying and policy influencing TU function, perhaps explaining the level of support for TU function and its influence on professionalisation.

9.5 Professionalisation and Management Structures

Professionalisation can influence management structures and also be influenced by it. Therefore analysis was undertaken to determine whether there was a cause and effect relationship.

As assessment was undertaken to rate the achievement of professionalisation domains, analysed by the five different management structures.

Table 66 Physiotherapy Professionalisation: Management structure assessment

Domains	Management structures				
	AHP Directorate	AHP Sub-Directorate	Physio Directorate	Pathway	Fragmented
Legislation	3	3	3	3	3
Regulation	3	3	3	3	3
Occupational body	3	3	3	3	3
Education	3	3	3	2	2
Professionalism	3	3	3	3	3
Practice	3	3	3	2	2
Inter-professional relationships	3	2	2	2	2
Public recognition	3	3	3	3	3
Power	3	3	2	1	1
TOTAL SCORE	27	26	25	22	22

Intensity scale 1= Not/Poorly achieved, 2= Partially achieved, 3= Fully/Highly achieved

The professionally-led models rated higher than the devolved models. The elements that rated lower in the fragmented models were: education, practice and power.

9.5.1 Deprofessionalisation and management structures

A further analysis was undertaken to rate physiotherapy deprofessionalisation by the different management structures. The devolved models rated higher for deprofessionalisation than the professionally-led models.

Table 67**Physiotherapy Deprofessionalisation: Management structure assessment**

Domains	Management structures				
	AHP Directorate	AHP Sub-Directorate	Physio Directorate	Pathway	Fragmented
Professional regulation	1	1	1	1	1
Regulation of training and education including transfer to HEIs	1	1	1	1	1
Regulation of remuneration, and terms and conditions	1	1	1	1	1
Financial control	2	2	2	2	2
Deskilling, development of “new” roles and merging boundaries	2	2	2	3	3
Performance monitoring and reporting	2	2	2	3	3
Loss of discrete body of knowledge	2	2	2	3	3
Oversupply of registered practitioners	2	2	2	2	2
“Semi – Professions”	1	1	1	2	2
Transitional phase towards full profession	1	1	1	1	1
Breadth of practice	1	1	1	3	2
Itinerant professionalism	1	1	1	2	2
Feminised workforce	2	2	2	2	2
TOTAL SCORE	19	19	19	26	25

Intensity scale 1= Not/Poorly achieved, 2= Partially achieved, 3= Fully/Highly achieved

The fragmented models demonstrated more deprofessionalisation elements in the areas of: deskilling, performance monitoring and reporting, traits of semi-professions, breadth of practice, and itinerant professionalism.

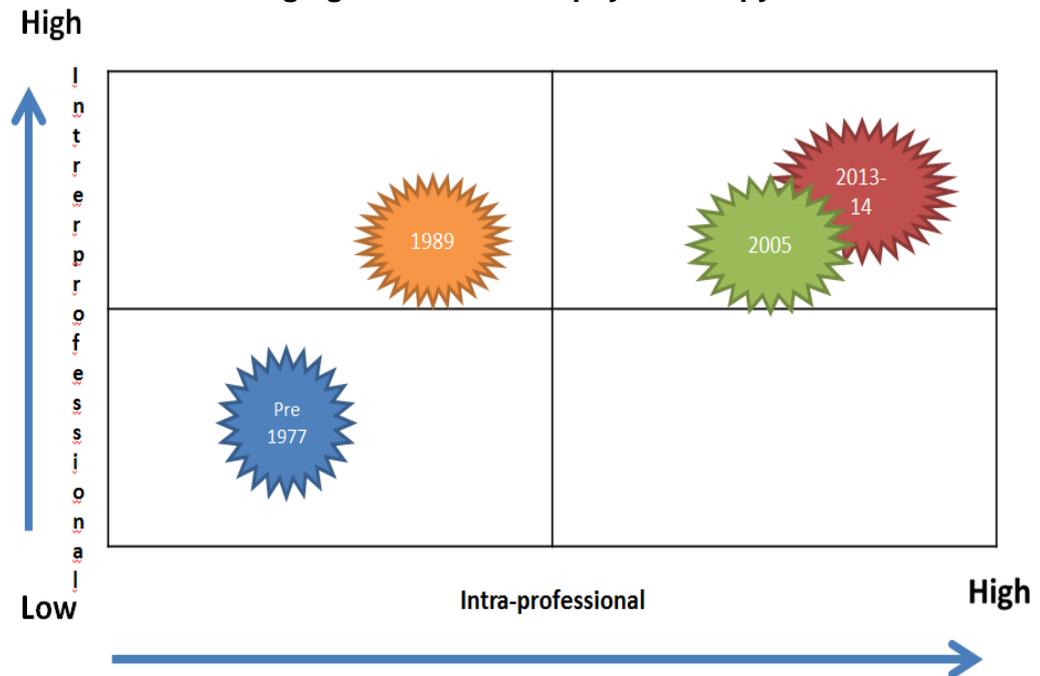
9.6 RQ2 Summary: Analysis of professional stratification

The impact of NHS changes has created models of professional stratification, where some physiotherapy managers no longer managed an entire service.

Where these devolved structures occurred, the 10 domains of physiotherapy management were less fulfilled. The role of the CSP was important in

professionalisation and also its TU function and largely well-regarded by managers. An analysis of stratification of physiotherapy identified:

Fig. 25 Changing stratification of physiotherapy



Stratification in 2013/14 rated at high on both axes and had slightly increased inter-professional stratification due to competition for resources with other professions, though workforce boundary mergers have the potential to reduce this in the future. The publication of HC(77)33 had the greatest impact, followed by the changes brought with AfC and the development of extended roles and changing jurisdiction. Professionalisation as well as management structures can therefore be seen to have influenced physiotherapy, affecting staff development and care for patients.

CHAPTER TEN

FINDINGS:

ENGLAND AND WALES COMPARISON

To determine whether there were difference in management structures and support for staff and care to patients a comparison between England and Wales was undertaken. In this chapter the findings to the three RQs are presented, comparing England and Wales. Unless stated, there were no statistically significant associations between countries.

Comparing health systems was reported to be “notoriously tricky” (Edwards 2015,) proposing that it was irrefutable that the Welsh population is older, sicker and more deprived than the English population; so its NHS has to work harder. Others report that NHS England receives less funds/head than the rest of the UK NHS (Nuffield Trust, 2012). Comparisons using the separate reports on each country from the European Observatory on Health Systems and Policies (Longley *et al* 2012,) as well as Ham *et al* (2013,) emphasised the opportunity provided by the UK’s “natural experiment”, found it difficult to draw lessons from the experience of the different countries in the absence of well-designed comparative evaluations, and the:

“Formidable difficulties in making comparisons” from routinely available data, *“because often these are collected in different ways in different countries”* (p.78).

Harrison (2011) also commented on the “design to doodle” spectrum, questioning whether there was a blueprint for the changes made to the English NHS; seeking to identify whether the NHS in 2011 was the result of “cock-up theory” or “conspiracy theory.”

This research therefore contributes to the need for comparable data in the field of physiotherapy.

10.1 RQ1c Physiotherapy Management Structures

To determine whether there were similarities or differences between England and Wales in respect of management structures and provision of physiotherapy services, responses to RQ1a and 1b were analysed by country and overall aggregated findings.

Table 68 Comparison of impact of organisational changes

Organisational changes that had taken place	Differences	Similarities
Governments’ policy Implications	4	4
Impact on physiotherapy practice	1	1
Physiotherapy management and leadership models	2	3
Impact for Physiotherapy managers	1	2
Total RQ1A	8	10

There were more similarities in the changes that had taken place, and slightly more differences in roles, responsibilities and functions.

Table 69 Comparison of impact of changes in role, responsibilities and functions

Change in roles, responsibilities and functions	Differences	Similarities
Physiotherapy Managers' role	1	1
Responsibilities	3	1
Functions of Physiotherapy manager	3	1
Decision making	0	3
Total RQ1B	7	6

In 1989, both countries has the same health system with physiotherapy managers organised and structured similarly. In 2005 there was not a review of the impact of changes in Wales; though unlike England this was not a major period of reorganisation. It would appear, that the period post 2008 has seen the greatest divergence of the healthcare systems and impact on physiotherapy managers. Even though the health systems were operating to different legislations, the impact on physiotherapy managers has had many similarities.

10.2 RQ 1c Policy Comparison

At macro level there were similarities and analysis at micro level demonstrated little significant difference. The differences related largely to the impact of organisational restructuring with policy implications influencing national direction of change. Policy intention represented divergence between the two nations, with different NHS policy since 2000, when Health was devolved to the Welsh Assembly Government, and Westminster formed English policy (Chapter 2.7.1).

Both countries have a tax-funded service with universal coverage, similar values and operating principles, offering comprehensive benefits. Yet since devolution, there have been diverging policies for health care, with reorganisations taking place in both countries at different times (Chapter 2). The 2008 reforms in England and Wales signalled a greater divergence (Harrison, 2009,) with England moving more towards managed competition with a strong focus on commissioning, and Wales moving in the opposite direction, with a planned care system, merging units into combined providers and commissioners of healthcare, having no fragmentation. Klein (2007,) proposed that although policy-making styles differed NHS relations between policymakers and professionals had become more antagonistic over the decades in England with a “trinitarian mimic” market model emerged, based on consumer choice, a plurality of providers competing for custom and money following the patient. He further comments that comparison between UK countries should be based on revealed values, not officially promulgated with policy revealing the meaning and weight attached to often ambiguous and conflicting values.

In England since 2006, there has been a greater emphasis on provider-based competition and individual patient choice, underpinned by a system of regulated prices and a new set of regulatory bodies. Klein (2007,) described the English NHS moving from the “church”, with concepts of: Paternalism, planning, need, priorities, trust and monolithic. To the “garage model”, with concepts of: Consumerism, responsiveness, demand, choice, contract and pluralistic. The extensive reforms in England brought about by the contentious *Health and*

Social Care Act (2012,) was launched with claims that the reforms would mean a shift away from top-down performance management relationships as the principal lever for accountability towards a stronger reliance on regulation and local scrutiny (King's Fund 2011b.)

In Wales the division of purchasing from providing health care was abolished in 2009, free prescription drugs provided; purchase of NHS funded care from private hospitals and clinics discouraged, returning to an management structure similar to that before the introduction of the first "internal market" (Bevan *et al* 2014). A review of policy outcomes (Michael and Tanner, 2007,) reported to range from an uncomplicated notion of "fairness" to a strong belief in a Welsh communitarian tradition which inspired the universalism at the core of Bevan's NHS. The Health Minister (2015) recognised the difficulty in realising policy intention commenting that:

"Making policy, even with new and radical approaches, is relatively easy; implementing the ideas is something else." Drakeford (2006.)

The English reforms were not completely enacted until after the research period. It was not possible to determine whether the impacts in Wales and England were due primarily to organisational change, financial austerity measures, or working practices, but findings suggest it was a combination, indicating that divergence may extend as the English reforms embed, or possibly converge as models of devolution extend in England. The case for devolved models of funding and health and social care collaboration have extended to include Manchester (NHS England 2014,) and Cornwall (Cornwall

Council 2015). Despite these differences, there have also been substantial similarities in both countries including growing attention to patient safety, and patient involvement development of more coordinated integrated care, and reducing waiting times with overall improvement in services.

10.2.1 Organisational change: Mergers and fragmentation

A dimension of mergers (Gaynor *et al* 2014,) was reported as the impact on the “marginal constituency”. The seven large Welsh Health Boards and Trusts were developed in 2008 by the merger of up to eight different organisations per Health Board, a total of 22 organisations were merged into the eight, with two (25%,) of managers reporting a merger affecting them. In England, mergers had often been seen as one larger organisation taking over another smaller, or poorly performing one (King’s Fund 2013.) In both countries mergers were reported as being disruptive, but more so in England, where 40 (35%) were affected:

SSI6 *“They ripped our service apart, merging two organisations was brutal.”*

10.2.2 Commissioning intelligence

With the development of CCGs in England during 2013, it was not clear where their intelligence on physiotherapy came from, as it was not part of physiotherapy providers’ management functions (though they did undertake planning functions). There were few CCGs with physiotherapists and AHPs in

managerial positions. Welsh physiotherapy managers were involved in service planning functions for physiotherapy with the executive directors of therapy and health science informing commissioning arrangements.

10.2.3 Competition

Competition had become a feature of the English NHS (Monitor 2014.) The introduction in England of non-NHS employed physiotherapy providers from 2008 signaled a different model for England with the subsequent introduction of AQP for physiotherapy (DH 2011a). Competition had been present, but less prevalent for physiotherapy, in earlier periods of reform. Prior to devolution both nations had introduced GP fundholding in the late 1980s and early 1990s, which promoted the use of private practitioner physiotherapists in primary care. Competition was not a feature in the Welsh NHS being dissuaded by the “One Wales” strategy (WAG 2007.)

10.2.4 Waiting times

For outpatient physiotherapy services, national policy for referral to treatment targets has resulted in Wales having longer target waits than England. Though analysis determined no significant association. It was reported:

SS17 “It’s wrong that patients have to wait longer than in England, but we just aren’t resourced well enough, if it’s not a tier 1 target you don’t get funds.”

10.2.5 Public health

This important element of physiotherapy practice was impacted by policy change, being consolidated as core business in Welsh LHBs and moving into local government in England:

SSI3 “We used to educate patients more about looking after their health, now we are commissioned for short turnaround times, which affects patient care.”

10.2.6 Strategic representation

In Wales, three of the seven (43%,) of Health Boards with a statutory Executive post for therapists and healthcare scientists, had a physiotherapist in post (though these could have been filled by other professions). Welsh managers reported improved strategic representation linked with these appointments. This compared with 2% (2) of Board level posts in England and no legislation to require an AHP at Board level. It would therefore appear to be more difficult to get physiotherapists in Board roles in English NHS organisations, likely due to different statute.

In both countries the government advisor role for AHPs would be suited for a physiotherapist to be appointed. In both countries the former postholders were physiotherapists, but not the current postholders.

10.2.7 Community services agenda

Both countries shared the vision of a shift of care from hospital, to care closer to home and a strategy for integration with social care. 47% in England reported this strategy change compared with 75% in Wales. However, neither country reported visible changes moving at the pace that both governments' policy had intended (Ham, *et al* 2013.)

10.2.8 Impact of cost constraints

Austerity measures impacted on service provision in both countries, with governments managing the financial challenges differently. England reported government imposed ring-fenced funding with inflationary cost increases (Nuffield Trust 2012,) with a term phrased as the "Nicholson Challenge" setting out the requirement for health and social care services to achieve 4% year-on-year efficiency gains (£15-£20Bn between 2011-14); to allow them to meet rising demand for care through a period of minimal real resource growth (HoC, 2013). The Welsh government chose not to ring-fence budgets, (NHS Confederation 2013b,) with health spending cut in real terms by 4.3 per cent between 2009/10 and 2012/13 , although there were cash injections in 2014/15 and planned for 2015/16 partly to reverse the trend.

While Wales spent more per/head on healthcare than England, when adjusted for the age profile of the population, it spent significantly less per 'age-adjusted'

person than comparable regions of the UK, such as the North East (NAO, 2012.)

The combination of austerity and organisational change was of concern for the majority of respondents regardless of organisation type or country:

SSI7 [2] "I've been a manager for 35 years, I can never remember such tough times having to cut services."

SSI10 "You've got to provide better services with less money, we've changed some roles, and actually extended our service, it's better for patients."

10.2.9 Policy impact comparison

There were several areas of difference in the research findings between England and Wales. The NAO (2012,) further reported that despite the shared history and similarities between the four UK nations, there were considerable variations in areas such as:

- Life expectancy at birth (men) , 2008–2010: England 78.6 years, Wales 77.6 years
- Life expectancy at birth (women) , 2008–2010: England 82.6 years, Wales 81.8 years
- Spending per person on health services, 2010-11: England, £1,900, Wales £2,017 (England has consistently devoted the highest proportion of total public spending to health services (22.0 per cent in 2010-11))
- Number of GPs (headcount) per 100,000 people, 2009: England 70, Wales 65.

Much of the data collected by national statistics authorities were inconsistent

and not directly comparable, though health need was reported lower in England. The NAO was unable to draw conclusions about which health service was achieving the best value for money.

Light (1997b,) proposed that health care systems were driven primarily by values, not by economic forces. The values embedded in the health services in Wales, were reported to be complex and under tension, but distinct from England in their commitment to communities and participation rather than markets and technical solutions (Greer and Rowland, 2007.)

The King's Fund review of the UK NHS (Bevan *et al* 2014,) concluded that so far, the different policies adopted by each country appear to have made little difference to long-term national trends of compared indicators. Except in relation to those areas covered by national targets, variations in performance of the health service within England were greater across many metrics than variations between England and Wales, indicating that local conditions and historical influences may be more important.

10.3 RQ1c Policy Consequence for Physiotherapy Managers

The physiotherapy managers had been in their current post for a mean of one year less in Wales, with more full-time working and more clinical experience before taking up management positions. Both countries had a majority of managers who also undertook clinical duties. England had a greater diversity of physiotherapy management structures.

The main impacts reported in Wales related to growth of responsibilities, managing more staff, more corporate role, broader multi-professional working and organisational change. In England managers reported organisational change being the most reported impact, and austerity impacts including downgrading of posts, as well as moves to social enterprise and increased competition.

10.3.1 Physiotherapy management structures

Physiotherapy managers in England reported deployment of all five structures identified. The AHP directorate was the most frequently occurring; 6 (75%) in Wales and 47 (41%) in England. The only other structure found in Wales was a physiotherapy directorate, 2 (25%).

England utilised a broader range of management structures, but consistent with Wales, favoured AHP structures. Only England reported use of the fragmented, pathway and AHP sub-directorate structures. In both countries multi professional AHP leads were most prevalent:

SSI 6 *“We’re team AHP now, no longer a silo.”*

10.3.2 Job title and organisation type

England reported a wider variety of posts than Wales demonstrating greater diversity, which included some of the most senior physiotherapist role in an organisation not actually undertaking a managerial function. England had

introduced some physiotherapists as clinical pathway managers which were not reported in Wales.

10.3.3 Managers' roles

In Wales all 8 (100%,) physiotherapy manager roles incorporated professional as well as managerial lead functions and were called "Head of Physiotherapy", with some additional titles including, "Clinical Director Therapies", "Assistant Director" and "Head of Therapies".

SSI12 "There are Executive Therapy leads now; we are much more visible strategically".

In England there was a greater variety, nine (8%,) reported better Executive leadership.

It was surprising that Wales did not report greater impact caused by organisational change, as the 22 LHBs had reduced to seven LHBs and two Trusts though the impact on physiotherapy manager roles was not reported, possibly because many managers already covered larger geographical areas beyond one LHB. It was unsurprising that the English managers reported changes, given the scale of reorganisation.

Both countries reported physiotherapy managers undertaking clinical work; 62% (5) of managers in Wales and 50% (58) of managers in England. An increase compared with 2005, but less than 1989.

10.3.4 Occupation of line manager

In Wales 3 (38%,) of physiotherapy managers reported to another physiotherapist and 38% to a general manager. In England, 11 (10%) of physiotherapy managers reported to another physiotherapist and 51 (44%,) to a general manager.

10.3.5 Remuneration

Neither country reported an overall upward trend for staff bandings. In Wales 5 (63%,) reported re-grading downwards as a trend, compared with 63 (55%) in England.

10.3.6 Managers' career span

In England the average time between qualification and taking up a first physiotherapy manager post was 12.7 years of clinical practice, in Wales it was 14.5 years.

In Wales 6 (75%) had been in the same post for >5 years. The service change model in Wales in 2008 gave pay protection for a 10 year period (subsequently removed.) There were no redundancies of the displaced staff, which was different from the NHS England policy of redundancy or two years pay protection for downbanding which could be considered to be much more threatening, impacting adversely on morale.

10.3.7 Contracted hours and organisation type

The only organisation types reported to have a majority proportion of part-time physiotherapy managers were English Community Trusts and Social Enterprises. 100% of physiotherapy managers in Wales worked full-time, compared with 62% of managers in England; 9 (7.8%) working < 17 hours/week. In 1989 all physiotherapy managers worked full-time.

10.3.8 Number of WTE physiotherapists managed

The average size of a physiotherapy service in England was smaller than previous periods, in Wales it was larger.

Seven Welsh LHBs (87.5%) employed > 100 WTE (with one being the overall largest employer with 280 WTE physiotherapists,) and 1 <10 WTE which was the Tertiary Trust giving a standard deviation of 146 WTE, as one Trust was much smaller than the other LHBs.

In England 18 Trusts (16%,) employed >100WTE, with 96 employing >100WTE, (Standard Deviation 90.6 WTE) as there was one large Mixed Trust and 11 organisations without a lead physiotherapist, employing <1WTE physiotherapist. 29 Trusts (25%,) reported employing <10WTE. There was greater diversity of the size of physiotherapy departments in England. Welsh Health Boards employed significantly more physiotherapists.

10.3.9 Management of other staff groups

Managers in both Wales and England reported management responsibility for other staff groups, with many similarities in the groups managed, who were largely other AHPs and support workers, with a few nurses and other smaller professions.

10.3.10 Responsibilities of the post

In England 60 (52%,) reported changes in responsibilities and 4 (50%) in Wales, though in England some organisations had little impact and other major. The changed community service in England was the factor, but some others were influenced by structural changes within organisations, making the physiotherapy managers post either broader in a multidisciplinary context or in fewer instances more physiotherapy focussed.

10.3.11 Seat on organisational strategic groups

Both Welsh and English physiotherapist were well represented on clinical governance, patient safety and workforce committees. They equally lacked representation on finance 10 (8%,) and service prioritisation 11 (9%,) committees. 113 (98%) of English physiotherapy managers, and 8 (100%) in Wales had accountability for ensuring a positive patient experience.

10.3.12 Commissioning/planning

There was inconsistent interpretation of the terms commissioning and planning relating to managers' roles in both countries. Although managers reported that they undertook these elements, further analysis revealed that planning was in relation to service and workforce planning, rather than commissioning functions. There was consistency that managers in both countries did not undertake commissioning, and planning for both was in respect to their service management roles.

10.3.13 Variety of organisations services provided to

In Wales, 7 (88%,) of physiotherapy managers provided all the physiotherapy for their population, with two organisations also providing some tertiary care. The other manager was in a cancer provider Tertiary Trust. In England the pattern differed. Some Trusts provided for multiple organisations, community services were commonly provided by a different organisation from acute care, and others had contracted their physiotherapy services out to a combination of NHS, social enterprise and private sector providers. Some managers were also involved in tendering for services.

10.3.14 Links with regional and national AHP groups

In England 48% (55) of physiotherapy managers did not have regional AHP networks, and no national architecture for advising the DH; their groupings were mostly in mixed AHP networks, not uni-disciplinary. The English regional

network for AHPs had fragmented following the abolition of the SHA AHP lead posts. The English regions did not come into place until April 2013 changing from 10 old SHAs to the new four regions. Consequently, there was substantial disruption in organisational arrangements. The role of the Chief Health Professions Officer for England had also changed, with a different employer and different post, providing professional and clinical advice about AHPs and services, including advising Health Education England. This change also saw the development of the NHS Commissioning Board, and its mode of clinical senates (NHS Commissioning Board, 2012.)

In Wales there was both an active national network for physiotherapy managers, and a network for representation at Welsh government level. The period post 2008 reforms had not been associated with further national strategic framework reform, though there has been three changes in Health Minister and three different NHS Wales Chief Executives. A Green Paper (WG 2015,) launched consultation which may impact on the structure and membership of LHB Boards. In Wales 100% (8) physiotherapy managers had links with a national AHP network, which would have been facilitated by a formal Welsh Government Standing Committee for therapists to advise the Minister for Health (WAG, 2006,) as well as via the all Wales physiotherapy managers group. In both countries there was access to professional virtual networking via the CSP interactive website, and regional networks of boards and branches an active R&D groups.

10.3.15 Morale

Both English 94 (82%) and Welsh 5 (63%) Physiotherapy managers reported reduced morale post 2008. In England, this was related to the significant organisational changes. In Wales, some LHBs were developed by merging several previous Health Trusts. Both sets of managers attributing this as a cause of reduced morale:

SSI 8 “ *Our organisation has merged, our roles have changed, our managers changed, posts downgraded, and more work than ever, it’s hard to keep your spirits up, but it’s the patients that keep us going.*”

10.3.16 Overall impact of the 2008 changes

There were similarities, though changes were still ongoing in England.

Respondents in both countries agreed with the aggregate views:

- The highest **total disagreement** was the statement that there was: “a higher proportion of staff band 7 and above than in 2008.”
- The highest **disagreement** was the statement that there: “is decreased clinical autonomy for physiotherapists compared to 2008.”
- The highest **agreement** was: “there are less clear boundaries between physiotherapy and other professions compared with 2008.”
- The highest **strong agreement** was: “there are reduced career opportunities for physiotherapists - less scope for promotion and development than in 2008.”

10.4 RQ2 Comparison Between England and Wales

The normative elements of the 10 domains of the ATEAHPMS were further analysed with an empirical analysis of the two countries.

The elements marked* demonstrated a statistically significant association.

Table 70 Summary National comparison: Management domains

DOMAINS		
Strategy	Wales	England
Mean	92%	81%
Clinical Governance	Wales	England
Mean	98%	93%
Professional Development	Wales	England
Mean	97%	88%
Operational Management	Wales	England
Staff deployment in all areas across the service(s)	8 (100%)*	57 (48%)*
Networks between physiotherapists across organisations	8 (100%)*	77 (67%)*
Mean	99%	81%
Human Resources	Wales	England
Recruitment Process	7(88%)	44 (38%)*
Responsible officer status for dismissal of staff	7(88%)*	49 (43%)*
Mean	96%	68%
Resource Management	Wales	England
Mean	88%	70%
Information Management	Wales	England
Mean	89%	74%
Commissioning/Service Planning	Wales	England
Mean	94%	80%
Innovation and Service Re-design	Wales	England
Providing 7-day working in some services	8 (100%)*	68 (59%)*
Preparing submissions for national awards/conferences	6 (75%)*	53 (46%)*
Mean	89%	69%
Research, Development and Education	Wales	England
Manage the budget for your service post-graduate education	8 (100%)*	52 (45%)*
Initiate and manage R&D projects	8 (100%)*	61 (53%)*
Mean	88%	58%
All Domain combined:	Total Mean	93%
		76%

(Full Analysis see Appendix 18)

The normative domains of the ATEAHPMS reflected the roles of the large majority of physiotherapy managers in both countries. Managers in Wales scored highest in each of the 10 management domains with a mean of 93% of

the listed elements, whereas in England the mean was 76%. There were only 4/10 (40%) domains, with 8/74 (11%) criteria of statistical significance between the two countries:

Operational management: Responsibility for deploying staff in all areas across the service (100% Wales; 48% England) and networks between physiotherapists across organisations (100% Wales; 67% England.) Networking in England across organisations may have been less due to the competitive environment.

Human resources: Responsibility for recruitment processes (88% Wales; 38% England) and responsible officer status for dismissal of staff (88% Wales; 43% England.)

Innovation and service re-design: Providing 7-day working in some areas (100% Wales; 59% England) and preparation of submissions for awards/conferences (75% Wales; 46% England.)

Research development and education: Managing the post graduate budget (100% Wales; 45% England) and initiating and managing R&D projects (100% Wales; 53% England.)

Management structures affected the support for staff and impacted on patient care. In all the areas of statistically significant association, Wales performed more of the elements than England. Wales had no devolved structures, therefore the difference between England and Wales likely reflected the

difference between the professionally-led and the devolved structures, rather than solely a national comparison.

10.5 RQ 3 Differences Between England and Wales

The effects of professionalisation of the management and provision of services and stratification of the profession due to NHS changes, demonstrated only a small difference between countries. This is probably a reflection of the way the profession operates at national level, and national regulation by the HCPC which is the same in both countries.

The area of greatest difference between England and Wales was the “power” domain and the characteristic “control over the market in which they operate”. The political difference between the two countries had introduced competition in England, which had reportedly impacted adversely on some NHS provider services. This was not a feature in Wales due to policy differences (Chapter 2). It could be argued that the Welsh NHS was closer controlled with more central management of the Welsh NHS, impacting on the power-base of the professions.

The 10 domains of physiotherapy management were undertaken in England and Wales by the majority of managers, but lack of devolved structures in Wales, made their application more consistent. Downward pressure on pay was consistent in both countries being a driver to deprofessionalise. However, there was more recent evidence with a divergence between the countries on terms and conditions of employment, with Wales receiving a pay settlement for AfC

staff outside the former collective agreement, signifying a future change of employment conditions between the countries (CIPD, 2014.)

None of the Welsh respondents provided negative comments about the CSP dual functions of a professional body and TU, possibly due to the Labour run Welsh NHS and partnership arrangements with TUs. Therefore, the only negative comments about the professional body also having a TU function came from respondents in England.

Following an analysis of the data comparing whether there were difference in physiotherapy management structures, support for staff and care to patients a comparison were made between England and Wales. They showed that any differences were related largely to management structure and organisation type rather than national variance.

CHAPTER ELEVEN

DISCUSSION, CRITICAL ANALYSIS AND CONCLUSIONS

In this chapter the empirical findings for the main RQ and the three supplementary RQs are summarised, the limitations of the study are discussed and the conclusions presented, including a revision of the Øvretveit (1992,) schema. An overall evaluation of different management structures is discussed in relation to the impact of health reform and influences on key areas of service provision, including the impact on support for staff and care to patients. The thesis concludes with recommendations for future research and ultimate conclusion.

11.1 RQ1: Organisational changes

Physiotherapy managers identified five different management structures for physiotherapy services (Chapter 6.2):

Professionally-led:

1. AHP Directorate 53 (43%)
2. AHP sub-Directorate 5 (4%)
3. Physiotherapy Directorate 32 (26%)

Devolved:

4. Pathway 23 (19%)
5. Fragmented 10 (8%)

Throughout the periods covered by this research a constant feature of policy was repetitive restructuring of healthcare. In 1989 the impact had been service mergers to consolidate into larger District groupings, these had been well-regarded by physiotherapy managers apart from anxieties about the introduction of general management. In 2005, a few of the District services had fragmented as PCTs developed, with the reforms not generally disliked by physiotherapy managers. Post 2008, the majority of physiotherapy managers reported restructurings; these reforms were widely disliked by physiotherapy managers in England due to their fragmentation of care and requirement for further restructuring on the NHS in England. This was not replicated in Wales as the services had not been fragmented. Therefore reforms that required restructuring which resulted in fragmentation of physiotherapy services were disliked by physiotherapy managers, not reforms in themselves.

Supporting closer integration of health and social care services had been a longstanding policy aim. Moving clinical services from hospitals to the community was reported to have been slow. Post 2008, a large number of Acute Trusts had taken over responsibility for providing community services, potentially strengthening acute providers as they held broader control of patient pathways. Acute Trust physiotherapy managers also reported the requirement to participate in outpatient physiotherapy tendering, with the NHS having a poor

track record of being successful in competing with non-NHS providers, many losing their out-patient physiotherapy provision.

NHS budgets had fluctuated since 1989, growing then shrinking in real terms which had impacted on physiotherapy services. The study informants reported that the impact of cost containment in 2013/14 was widespread, and the main influencer for change affecting 75 (61%,) and felt by respondents to be unprecedented. Cost-cutting pressure was a pre-cursor to the 1989 reforms, but the mid-2000s was an era of NHS investment, although in 2005 there was also a requirement for annual savings. Therefore, organisational restructuring was seen to be of secondary compared to the fiscal challenges of cost containment on physiotherapy budgets which could be considered to be a confounder.

The study informants criticised the *Health and Social Care Act (2012,)* strengthened the role of competition, being criticised for requiring commissioners tender services and reported anxiety about maintaining service provision, given the NHS poor record of winning competitive tendering.

Policy changes affected the hierarchy of decision-making. In 1989 District physiotherapists were involved in decision-making at strategic levels, which was constrained following the introduction of general management resulting in physiotherapy managers having less management autonomy. In 2005 some physiotherapists undertook PEC roles. In 2013/14 managers in devolved models were less involved in decision-making. Where physiotherapy managers were positioned in the organisational hierarchy was defined by management

structures and was reported to have a substantial impact on physiotherapy provision; as the structure determined the level of input physiotherapists had to delivery of startegy and ultimately impacted on physiotherapy provision.

Clinical autonomy had been an important feature of providing clinical practice, valued and reported by physiotherapy managers throughout the periods. In 1989, physiotherapy managers reported the impact of legislation; HC(77)33 (DHSS 1977,) as a milestone for extending physiotherapists' clinical autonomy. In 2005, physiotherapy managers reported policy changes that developed consultant, clinical specialist and extended scope roles, increasing the autonomy of the most advanced practice physiotherapists to take on new roles within their scope of practice e.g. diagnostic ultrasound. Post 2008, a substantial minority of physiotherapy managers reported reduced clinical autonomy impacting adversely on patient care, physiotherapy and its management.

The impact of NHS reforms on physiotherapy managers' morale was constant throughout the periods of reforms, but discontinuous in direction, with lowered morale reported by a large majority in 2013/14. The positive impacts reported by some phsiotherapy managers post 2008, were reduced waiting time and more community care. Reported negative impacts, were reduced quality of care, longer waits and less treatment time, though this was not correlated by organisation type or management structure. The negative impacts were reported by a minority e.g. 63% did not report reduction in quality of care.

NHS policy changes influenced managers' work (Chapter 6). The PCTs, some of which had introduced physiotherapy advisor roles in the mid-2000s, had been dissolved resulting in a decline of advisory non-managerial roles. The career path to becoming a manager throughout the research periods had been preceded by several years of clinical work, though the duration of that clinical work had reduced every decade. Physiotherapy managers had largely become less experienced, with many in their first manager role, and experienced managers changing roles more frequently than in previous periods.

The job titles of the most senior physiotherapist had changed from 1989 "District Physiotherapist", to "Head of AHP/Therapies" being the most frequently occurring title in both 2005 and 2013/14. In 2005 there were 14 different titles for the most senior physiotherapy manager, reducing to eight by 2013/14. The profession had moved away from uni-professional management, with twice as many physiotherapy managers with an AHP-wide role. This had been accompanied by a shift towards more managers working full-time hours.

The majority of managers had both structural authority to manage and sapiential authority as clinical leaders, though the scope of managers' roles varied, during the periods. In 1989 all managers covered a District, managing predominantly physiotherapy staff. In 2005 there was greater variety with some large organisation managers managing up to 10 other professional groups. In 2013/14, some had diversified into a wider multi-professional management function and others narrowed the scope of their role where services were fragmented. This concurred with observation of Bresnen *et al* (2014,) that

management in health care is a complex and variegated with activity that does not map onto clear, unitary and distinct communities of practice.

AfC enabled the clinical career pathway to be better financially rewarded, possibly making a management career path relatively less attractive. There remained a paucity of physiotherapy managers with accredited managerial training. 99% of physiotherapy managers were CSP members, but only 0.2% of them belonging to the profession managers' group; possibly reflecting its relatively low profile, or it not meeting managers' needs.

Nursing remained the profession most likely to represent physiotherapists at Board level throughout the periods, though the number of physiotherapists undertaking this role had increased. One of the benefits reported by physiotherapy managers of AHP structures was the ability to be closer to executive decision-makers, a positively reported impact of manage structure changes in professionally-led models. Uni-professional management posts were normally at least one management tier lower than Board level, and some fragmented models reported at even lower levels in the organisation.

Discontinuities included managers undertaking clinical work, which was performed in 1989, by 76% and in 2005 by 20%, but had risen to 54% in 2013/14, and was apparent in all management structures.

The differences reported by informants between England and Wales related in part to the impact of policy changes, enacted in Wales in 2009 with the establishment of LHBs, but impacting at least three years later in England with

the changes of provider organisations and commissioning arrangements which did not come into place until 2013. The policy impact in both countries led to organisational restructuring affecting roles, responsibilities and functions of many physiotherapy managers. Mergers and fragmentation of services were reported to be greatest in England and ongoing at the time of the research. There were eight significant management domain associations between England and Wales in 2013/14 indicating that managers in both countries undertook largely similar functions. The differences were more between fragmented models and professionally-led models rather than national variance. Strategic decision-making had been affected by policy change. With PCT dissolution in England, PEC Executive roles were disestablished and physiotherapy managers returned to lower levels of strategic influence in community organisations, similar to the acute provider posts of 1994. In England there was no statutory Board post for physiotherapists, though there were 19 Board level roles held by physiotherapists. In Wales Executive Director posts which physiotherapists could apply for, were established by statute in 2009, three of these being held by physiotherapists. Additionally all organisations in Wales were required to have a Head of physiotherapy; whereas 2 (2%.) English organisations reported no Head post. Wales was more homogenous with only two different organisation types and two management structures in its eight organisations, whereas England had nine different organisation types and five different management structures, in its 115 organisations.

Funding was influenced by policy decisions affecting both countries, with a period of reduced NHS budgets in Wales as a result of funding priorities decided by the devolved government. Fiscal constraint was a substantial confounder impacting on the management of physiotherapy, support given to staff and care for patients rather than the different policy intervention between England and Wales.

The physiotherapy managers had on average been in their current post a year longer in England, though those in Wales had more full-time working and more clinical experience before taking up management positions. Both countries had a majority undertaking clinical duties. Outpatient waiting times differed in respect of national “targets” though judging from informants responses not substantially different; possibly due to the adoption of self-referral in many services, which by its operating model would not require a waiting list to be held. Difference existed in the national and strategic links with government departments. Physiotherapy managers in England reported a weakening of regional and national networks following the most recent policy changes, though some AHP groups survived even after the regional AHP post was removed. In contrast physiotherapy managers in Wales reported a national forum for therapy managers. In both countries managers had access to CSP professional networks.

The development of the national advanced practice framework in Wales (NHS Wales, 2012b,) had mandated an education and training profile for these roles, underpinned by level 7 education. In comparison England did not have such a

framework, lacking uniformity of approach and consistent, transferable academic accreditation, though informants in both England and Wales reported valuing academic links for R&D and education. Both countries had criteria for non-medical consultant roles. This illustrated the impact of national reforms which were not influenced by organisational management structure but directly affected on the physiotherapy workforce.

Even though they operated in different legislative frameworks, the impact of organisational changes on physiotherapy managers had many similarities, though a few differences but demonstrated no causal relationship between their roles and the countries in which they were employed. The most significant non-health reform impact on NHS structure was finance, as austerity had affected both England and Wales.

11.2 RQ2: ATEAHPMS

The ATEAHPMS scores reported by informants showed how far managerial roles, within a given organisational structure for physiotherapy services, conformed to physiotherapy managers' opinions about what managerial tasks physiotherapy managers ought to undertake (Chapter 8.) The ATEAHPMS scored 1 for the model rated the highest by physiotherapy managers and 5 for the lowest rated. All management structures were analysed. The descending rank order for fulfilling the management domains was:

1. AHP Sub-Directorate
2. Physiotherapy Directorate

3. AHP Directorate
4. Fragmented
5. Pathway

All physiotherapy managers, in all structures, undertook at least 75% of the identified management tasks, with a mean of 81% of all elements for the total cohort. Physiotherapy managers in the professionally-led structures undertook more tasks than those in devolved structures.

The impacts of the most recent changes were reported by the majority of respondents to be; increased waiting times, more community care, and improved equity of access to physiotherapy. This differed from a survey undertaken in 2012 (CSP 2012c). The scope of services differed between structures in respect of specialisms provided and degree of autonomy. The majority (71%,) of respondents reported reduced career progression opportunities as a result of downward pressure on pay. Physiotherapy managers reported a less clear mission, more service fragmentation and improved quality of care. Informants reported a dislike for devolved structures, least recommending a fragmented one. They preferred being managed by a physiotherapist and working with a group of AHPs, in a structure that they were familiar with. A structure where the physiotherapy manager controlled the budget was strongly preferred; these were observed in the professionally-led management structures. The major confounding factor of physiotherapy budgets needs also to be accounted for, as budget constraints were not necessarily related to organisational reforms.

Physiotherapy managers worked in three different types of management role:

1. Horizontal roles of multi professional leadership/management, with a relatively flat structure
2. Vertical leadership “Silo” roles; where the Head physiotherapist managed the physiotherapy profession only or was a clinical lead, with no broader AHP management function
3. Multidimensional management functions (matrix management role,) delivered from a central service across the organisation using both vertical and horizontal functions interconnecting with other structures; laying one or more forms of departmentalisation on top of an existing form

The factors that appeared to determine which of these three types of management role was used, included some of the confounding factors, such as budget, critical mass of staff and variety of specialisms provided.

The informants’ responses were rated against a framework regarding the structures’ ability to provide an effective and efficient physiotherapy service. The descending rank order for providing an effective and efficient physiotherapy service was:

1. AHP Directorate
2. Physiotherapy Directorate
3. AHP Sub-Directorate
4. Fragmented
5. Pathway

They rated the professionally-led structures higher than the devolved types. A majority of informants identified that the important factors in providing a comprehensive service included; having sufficient staff with a range of skills and sub-specialisms, access to education and training for staff, critical mass being a key factor. Additionally management structures which maintained AHP (even if not physiotherapy) identity, were highly regarded.

Accountability for budgets enabled managers to prioritise resource allocation, but also required them to identify cost savings. This was felt to be preferable to another budget holder making savings which may adversely impact on physiotherapy. Quality of care to patients was rated higher in the fragmented structure than the AHP directorate, possibly due to the impact of austerity measures reported by those in Acute Trusts. This seems to assume:

1. Austerity measures have greater impact in AHP Directorates than in other kinds of structure
2. AHP Directorates were found in most Acute Trusts
3. Informants thought that austerity measures reduced quality of care

There was evidence that recent re-structurings had introduced more devolved structures. The data indicated that the managers were pragmatic in learning to adapt to different structures, but lacked an evidence-base of the differences between them when consulted about re-structuring. The informants thought the most important characteristic in all of the structures was the ability to influence resource allocation, which directly impacted on staffing and therefore the skills available for patient care.

Statistical analysis showed no significant association between structures when analysing the large majority of the findings. The only significance was the AHP Directorate and Physiotherapy Directorate employing larger numbers of staff than the devolved structures. There were more statistically significant associations between organisation types, including 75% of physiotherapy services in Community Trusts being in devolved structures, compared with 25% in Acute Trusts.

A gap analysis showed management structures of elements that scored less than the mean ATEAHPMS scores, including:

Strategy and planning development for their services, interpretation of government policies and input into physiotherapy workforce planning were the elements most consistently undertaken by all structures. The weakest element was contract management, which would only be relevant if external contracts were held.

Clinical governance was the most highly scoring domain for all management structures.

Professional development scored higher in the professionally-led structures, and lowest of all in the pathway structure.

Operational management scored lowest in the pathway structure and the lowest scoring element was working across organisations.

Human resources scored lowest in the pathway structure. The physiotherapy directorate scored highest.

Resource management scored below the mean in all structures, with the pathway structure the lowest of all.

Information management was rated most highly by the AHP directorate and lowest by the devolved structures. Lack of information would impact adversely on efficiency of the physiotherapy service.

Commissioning/planning scored highest in the AHP sub-directorate with the pathway and AHP directorate both scoring lowest.

Innovation/service re-design scored highest in the AHP sub-directorate. Lack of involvement of voluntary organisations and preparation of award submissions were gaps for all structures.

R&D and education scored highest in the AHP sub-directorate. The devolved structures scored lower than the professionally-led structures.

Gaps in elements of physiotherapy management may have indicated non-compliance with ATEAHPMS norms, which respondents thought adversely impacted on quality of care, and/or service efficiency, and/or effectiveness. Some gaps in fulfillment of the elements of the ATEAHPMS were reported to be more relevant to physiotherapy service provision than others. These included lack of physiotherapy manager involvement in recruitment processes, which would not ensure recruitment of staff with the right professional skills to give continuity of a skilled workforce, this would be a concern for patient care and staff development. Lack of a data set for physiotherapy and monitoring of metrics would not give assurance to senior managers in the organisation that

activity is being measured at all. Similarly lack of physiotherapy managers' involvement in R&D/Education would impede progression of the physiotherapy scientific development of evidence and/or translation into practice.

In answer to RQ2 the gaps identified by application of the ATEAHPMS, showed the professionally-led models rated higher than the devolved structures. It also raised the question of whether the managerial activity gaps identified were being filled by someone other than the physiotherapy manager, and if so by whom? And to what extent?

A comparison between England and Wales management structures using the ATEAHPMS identified that the informants rated Wales higher in all domains. This indicated that physiotherapy managers in Wales undertook more of the elements of physiotherapy management than their English comparators. Wales had only two management structures and no devolved types, therefore the difference between England and Wales might reflect the difference between the professionally-led and devolved structures, as well as a national comparison. In England there were five different management structures as well as NHS changes still impacting at the time of the research, indicating less consistency of physiotherapy management functions and some physiotherapy management functions not been undertaken by physiotherapists. The relationship between management structure and reforms was therefore difficult to attribute a causal effect by county, but did show an effect by management structure as the fragmented structures involved the physiotherapy managers less in undertaking physiotherapy management functions.

11.3 RQ3: Professionalisation

The impact of physiotherapy professionalisation was presented in Chapter 9.

This set out how physiotherapy professionalisation has both influenced management structure and in turn been influenced by it. Characteristics of professionalisation were determined following analysis of theorists' propositions.

These were grouped into nine main attributes:

1. Legislation
2. Regulation
3. Occupational Body.
4. Education
5. Professionalism
6. Practice
7. Inter-professional relationships
8. Public recognition
9. Power

Physiotherapy in England and Wales was assessed at three research periods, meeting all of the above attributes and all 50 characteristics. Some changes resulted from legislation e.g. HCPC (*Health and Social Care Act, 2012*) and prescribing (MHMA, 2013,) affecting the whole NHS and some were at organisational level, including inter-professional relationships and jurisdiction such as self-referral to physiotherapy.

The way in which organisations devolved authority and decision-making through their structures directly impacted on levels of autonomy of physiotherapy managers to manage and physiotherapists to use their skills and resources, therefore ultimately impacted on the quality of patient care and support for staff.

The five different management structures were further analysed regarding achievement of the domains using a three point intensity scale, of the professionalisation criteria developed. In addition qualitative data was gathered. Some attributes were nationally influenced and rated the same by physiotherapy managers across all five management structures; these included the professional body, regulation, legislation and public recognition. The other attributes were subject to local variation and were reported not to be consistently achieved across all management structures. The descending rank order of compliance with the list of attributes was:

1. AHP Directorate
2. AHP Sub-Directorate
3. Physiotherapy Directorate
4. = Pathway and Fragmented

There had been a slight decline in professionalisation, in the sense of the extent of compliance with the list of 50 traits, during the 2008-2013/14 period, compared with 2005. Once again, the devolved structures were rated lower by informants than the professionally-led ones, but the devolved structures were all rated equally. The main difference in the devolved models was less support for education from smaller services, suggesting lack of breadth and scope of physiotherapy practice. The informants reported that this also impacted on the physiotherapists' skills to undertake R&D. Physiotherapy managers working in devolved structures reported that they did not have access to physiotherapy expertise from other sub-specialisms to provide holistic patient care and also

reported reduced managerial power, as a result of limitations of their organisational strategic positioning.

Informants from the professionally-led structures, notably the AHP directorate, recorded the highest scores for power, strategic positioning and influencing and inter-professional relationships. The informants believed that this structure enabled a physiotherapy identity to be maintained within an AHP structure, being further developed and more longstanding in both New Zealand (Mueller and Neads, 2005) and Australia (Boyce, 2006).

The development of evidence-based medicine had perhaps demystified knowledge and has enabled jurisdictional changes by physiotherapy at the expense of medicine (Timmermans, 2004.) and could be considered a confounder, given the impact of its influence on the way physiotherapists work. Professionalisation was influenced by management structures and vice versa, with evidence that devolved types had less senior management roles for physiotherapists affecting their autonomy, authority and to an extent physiotherapy professionalisation. A list of characteristics was developed for factors indicating deprofessionalisation, they were:

1. Elements of "semi-professions"
2. Full professional criteria not yet met
3. Difficulty in enacting boundary-spanning roles
4. Itinerant professionalism
5. Employee status
6. Traditional male domination

The profiles of these factors were compared over the three periods of reform. Some traits were nationally influenced, these included: Regulation, HEI training, remuneration and workforce feminisation.

The factors with differences reported by informants from devolved structures, again demonstrated the major constraint of impeding professional interests, norms and practices, they were:

1. Vertical differentiation, with new role development and loss of discrete body of knowledge by delegation of more tasks to support staff and merging of professional boundaries, though not necessarily de-skilling.
2. Vertical substitution: Challenging traditional hierarchy and increasing physiotherapy scope of practice with changes in physiotherapists' status and financial reward reflected by title and banding e.g. consultant physiotherapists; Band 8C.
3. Less breadth of practice, reported where physiotherapists focussed on one clinical specialism only.
4. Performance monitoring, and control being the responsibility and function of non-physiotherapy managers, with lack of physiotherapy specific data sets.
5. Evidence of some traits of semi-professions, such as mandate to control work not fully granted, with more control of work by general managers.
6. More reliance on locum staff due to lack of "critical mass" and the ability to cross cover requiring gaps in staffing to be filled by external contractors.

Identifying causality was complex e.g. it was difficult to identify whether extended roles for physiotherapists were instigated by the profession demonstrating its ability to take on new tasks, or whether the drive was to reduce tasks undertaken by medical consultants in attempts to reduce staff costs. Similarly, the move in some areas to focus physiotherapy on single pathways of care, may have been instigated to ensure the expertise of these clinicians was maximised, though it may possibly have been driven by a desire to “own” all the multidisciplinary staff in one specialism, regardless of the physiotherapist’s expertise.

Professional stratification and policy changes and the underlying political agenda were closely associated with interviewees commenting on the development of extended physiotherapy roles and physiotherapy assistant taking on more tasks. It is debatable whether physiotherapy adopted demarcationary encroachment or consensual delegation tactics. Stratification was observed both intra-professionally and inter-professionally consistent with the Friedson (1985,) schema. Intra-professional stratification tiers were:

1. “Producers”: Front-line physiotherapy clinical staff involved in direct patient care.
2. “Knowledge-elite”: Those engaged in academic physiotherapy including university based educators/researchers, demonstrated by the increasing number of physiotherapy professors and doctorates within the profession.
3. “Administrative elite”: Physiotherapists in strategic managerial positions.

Management structures were analysed using data from respondents assessed against the stratification domains. The descending rank order was:

1. AHP Directorate
2. AHP Sub-Directorate
3. Physiotherapy Directorate
4. Pathway
5. Fragmented

The informants reported that the instances of jurisdictional changes (inter-professional stratification and vertical stratification) were:

1. Diversification: Changing boundaries following identification of new areas of physiotherapy work (advanced practice and extended scope,) adoption of roles normally undertaken by others i.e. physiotherapy extended its jurisdiction.
2. Specialisation: Requiring post-registration qualifications e.g. acupuncture, leading to intra-disciplinary change which was jurisdictional change as physiotherapists took over this role formerly performed in the NHS only by doctors, as well as physiotherapy vertical stratification.
3. Jurisdiction: Resulting from mutually agreed transfer of tasks or negotiated boundary changes between those with similar training and status, such as the sharing of tasks with OTs as well as the development of paraprofessional groups like physiotherapy assistants.

An influence on physiotherapy stratification was pay policy, which changed with the introduction of AfC in 2004. The three salary grades for clinical practice

changed to eight, encouraging expert clinicians, often being remunerated at higher rates of pay than their managers. Another factor influencing stratification was a shortage of medical staff, with physiotherapists stretching the boundary of the profession, extending its jurisdiction. This stimulated the development of advanced practice roles. On-going austerity in England and Wales provided an opportunity for physiotherapists to further vertically substitute.

The role of the “occupational body” was also important in stratification. The CSP, fulfilled this function, which was a cornerstone to professionalisation. Of the 18 different CSP functions rated by informants, 15 were well-regarded, with setting professional codes and standards considered the most important function; though the HCPC has more power than the CSP in these areas. A question about the role of the CSP in professionalisation revealed a majority in favour of the dual function of the professional body and TU. This reflected the contracts of physiotherapists in the NHS, being employees rather than self-employed. It may also reflect the high number of managers using the CSP TU function during reorganisations. The dual role was similar to medicine as the BMA also provides TU functions and professional association, though the Royal Colleges remain discrete and are by far the most important organisations in relation to doctors’ clinical practice, with a requirement of fellowship for consultant appointment.

The changing stratification of physiotherapy, meant the 2013/14 physiotherapy service had high inter-professional and intra-professional stratification, higher

than at any of the other periods. Although the profession as a whole was highly stratified, not all services in all organisations demonstrated the same levels of stratification. In devolved structures, the physiotherapy managers undertook fewer of the 10 domains of physiotherapy management, than those managing professionally-led structures.

Physiotherapy managers reported deliberately seeking to stratify and define professional boundaries. Physiotherapy had engaged in exclusionary strategies aimed at preventing potential competitors from encroaching into task and knowledge domains, “poaching” skills and roles from competing health professions; such as some A&E assessment work taken from medicine. At the same time physiotherapists also gave up former key roles, such as transferring some rehabilitation tasks to assistants, demonstrating re-stratification like nurses and nursing assistants. Professional interests, norms and practices were therefore a major constraint, even possibly a set of confounders of how structural reform gets implemented and its impact.

A comparison of professionalisation between England and Wales demonstrated a majority of similarities between the two countries, due to the UK-wide nature of the profession in terms of education, training, recruitment patterns and regulation. Therefore, the professionalisation process was largely the same, as was the influence of the CSP. Governments’ policy was the area of greatest difference, though management structures were reported to have more impact on managers’ roles.

Downward pressure on pay was reported by informants and consistent in both countries. There was more recent evidence of a divergence between the countries on terms and conditions of employment, with the Welsh Government giving a pay increase outside the former collective agreement (CIPD 2014,) though it is too soon to measure any impact on professionalisation.

None of the Welsh respondents provided negative comments about the CSP having dual functions of a professional body and TU. The only negative comments in this respect came from English respondents, which are evidence that the Welsh physiotherapy managers were more supportive of the TU function than their English neighbours, as both sets of managers supported the professional function equally.

The management structures in which physiotherapists worked and the associated degree of autonomy differed, with Wales not having any devolved types. Wales pursued traditional structures, though England possibly better placed to adapt to structural change with experience of more protracted restructuring. This had required English managers to accommodate changing circumstances being flexible to the effects of NHS change and impacts on professionalisation.

11.4 Limitations of the Study

Study limitations were identified and mitigations were put in place where possible. The researcher does not consider that the limitations detracted from the validity of the findings making them reliable and representative.

Methodological: Details of methodological limitations and actions taken to minimise impact were described in detail in Chapter 5.9. These included:

- Respondent bias: The respondents were all physiotherapists and therefore gave a physiotherapy view of the NHS and its management arrangement. The questionnaire respondents were qualified physiotherapists being aged 26 years and over. The SSI interviewees were all mid to late career having experienced different periods of reforms and consequent changes in management structures and changes in physiotherapy practice. They may have biased their responses as the interviewer was a physiotherapist, though the SSIs were constructed to gather data to semi constructed questions and used prompt cards to ensure consistency for two questions.
- Participant numbers were a constraint as the process for gaining research permission (Appendix 11) was complicated and slow, reducing the number of potential participants for the questionnaire survey.
- The ATEAHPMS norms reflect entirely the normative view of physiotherapy managers as to the roles a physiotherapy manager ought to do. These norms may omit or undervalue important necessary aspects of healthcare management and over-rate others. As yet there is no

evidence showing what compliance with these norms has on clinical quality or the cost of physiotherapy services.

- The question on commissioning/service planning (Q 3.8) could have been reworded to find out which managers undertook commissioning rather than purely service planning.

Statistical analysis: Non-parametric statistical tests were used as these suited the data. Some management structures were few in number and there were only eight Welsh organisations, limiting valid statistical analysis. The valid statistical tests though limited in number were supplemented by qualitative data to enable valid comparisons to be made.

Researcher bias and reflexivity: There was potential for the researcher's background to introduce bias and this has been reflected on; the researcher being a registered physiotherapist, an Executive Director, former physiotherapy manager, former CSP Vice President, Council member and TU Steward. Information shared with participants during recruitment was that the researcher had letters after her name indicating a fellow of the Chartered Society of Physiotherapy. The researcher's current role holds no managerial accountability for physiotherapy services, though having professional and regulatory responsibilities, but working in a corporate function. The CSP roles were all held more than two decades ago and not discussed with respondents.

The implications of the researcher being a physiotherapist are acknowledged. The researcher was familiar with the scope of physiotherapy, its regulatory

requirements and the different areas of NHS practice. However the researcher had not worked in all organisation types and had not managed physiotherapy services for several years. Arguably the background of the researcher as a physiotherapist enabled the interviewees to speak freely, as they knew the researcher understood the environment in which they worked, though it was also possible that this may have influenced some of the responses. The invitation to complete the questionnaire identified the researcher as a physiotherapist; therefore those responding would have expected the researcher to have knowledge of the subject, though this also may have influenced the responses given. It was possible that the researcher identifying her profession may have stimulated the response rate. The potential problems of the researcher bias may have encouraged participants to overstate their views, to emphasise their viewpoint or conversely to understate them for fear of being “judged”. It is possible that some may have answered giving the answer that they thought the researcher was seeking. It may also have dissuaded some from participating.

To the best of the researcher’s ability these possible constraints were both recognised and managed as far as practicable. The large sample size was aimed to reduce the impact of any individual giving a compromised response. The acceptable response rate indicated that not too many were dissuaded from participating. Providing anonymity for the SSI participants ensured their confidentiality, enabling them to speak more freely.

However the implications of the researcher being a physiotherapist are acknowledged as a constraint with both potentially positive and negative impacts.

Geographical bias: At the time of commencement of the research the researcher worked in England but moved to Wales mid-way through the research. She was therefore equally familiar with both health systems reducing any potential imbalance of knowledge about the two.

The study did not include Scotland or Northern Ireland and was therefore not the entire NHS physiotherapy service, but the large majority of it and two different administrations. It did not include any views from non-physiotherapists about the jurisdiction or status of English/Welsh physiotherapy.

Study period: The English system was studied at an awkward juncture, at which informants may have had a particularly jaundiced view of the current English system and a corresponding kinder view of earlier periods. Their statements may possibly be biased towards understating the quality, resourcing and calibre of English physiotherapy, though this was not possible to confirm. However the NHS has been in a period of continuous change cycles, so no period would likely be free from the impact of organisational changes embedding.

Caution needs to be exercised about over-generalisation of the findings, particularly where management structures and organisation types were few in number. Nevertheless the findings add to the evidence-base about

physiotherapy management, supplementing what was known about physiotherapy services prior to this study.

11.5 Implications of the Findings

There were four key findings:

11.5.1 Organisation types

Structure changes had occurred in the NHS with nine different organisation types identified. “Mixed Trusts” identified those which provided services across specialities promoting cross organisational work in provider aspects, similar to Welsh Health Boards. NHS reforms had been the key influencer for organisations changing: e.g. English Community Trusts no longer “providers” of physiotherapy, Social Enterprise organisations in England providing physiotherapy and Welsh Health Boards creating larger organisations consolidating physiotherapy staff across a District. However, there were other influences to structure changes affecting physiotherapy – the most significant one reported being financial constraints, linked to the national austerity agenda for public services. Additional structure changes occurred when organisations were perceived as failing, leading to mergers and new Trusts being established e.g. University Hospitals North Midlands.

11.5.2 Management structure revision

The Øvretveit (1992,) schema described eight different structures for Therapy services. The research findings to RQ1 enabled the Øvretveit schema to be revised in light of the impact of further structural reforms since the 1990s. The comparison of management structures revealed:

- Three were not observed:
 1. Model A, Individual private practitioner
 2. Variation of D1 or D2, The therapy “service agency”
 3. Independent group practice
- Two were observed but needed modification/renaming:
 - D2, Unit-based combined District therapies, similar to a Welsh Health Board
 - D1, Unit based District therapy service, which could be adapted to be an AHP Directorate
- Three were observed and still empirically applicable with small modifications were:
 - Model B, Directorate or locality-managed, which was similar in part to the Pathway and the Fragmented structures
 - C1, Unit-based single-therapy division, similar to physiotherapy Directorate
 - C2, Unit-based combined-therapies division, which was similar to AHP directorate and possibly AHP sub-directorate , though in a sub-directorate there would not be competition with another unit

- Two organisation types:
 - Social enterprise was observed as a specific organisation, though had management structures similar to the NHS. The Welsh Health Board was similar to the District of 1992 in its provider functions, but also responsible for commissioning. Two different management structures in these organisations were reported.

The original schema was revised to reflect the management structures reported:

Table 71 Schema for Physiotherapy management structures

	Organisational Structure	Description
1	<i>AHP Directorate</i>	A grouping on AHPs, as part of a Division or Clinical Board type structure, managed by an AHP manager, working collectively in a business unit, providing services across and sometimes beyond the organisation. Staff may be line-managed by someone from their own profession, or another AHP. Services are provided to other divisions/ directorates, with AHPs being members of clinical teams, but managed from the AHP Directorate
2	<i>AHP sub-Directorate</i>	Similar to 1 above, with an AHP as the manager but differing regarding the scope of service and its accountability. This would not provide the entire AHP service to the organisation, but in a discrete sub-section e.g. trauma service, community service. There may be several AHP sub-Directorates in an organisation. Accountability would be to the relevant Division/Clinical Board e.g. surgery, community.
3	<i>Physiotherapy Directorate</i>	A grouping of physiotherapists as part of a Division or Clinical Board type structure, managed by a physiotherapy manager, providing services across and sometimes beyond the organisation. Staff would be line-managed by a more senior physiotherapist. Services are provided to other Divisions/Directorates, with physiotherapists being members of clinical teams, but managed from the physiotherapy directorate
4	<i>Pathway</i>	Where physiotherapists would be managed and organised as part of a multidisciplinary team grouped around a patient pathway with a defined clinical specialism e.g. stroke, musculoskeletal. The manager would not be a physiotherapist or AHP, most likely a general manager, and resources would be managed as part of the clinical pathway.
5	<i>Fragmented model</i>	Similar to 4 above, but not providing a whole pathway of care. Where physiotherapists would be managed and organised by a specific discrete services e.g. orthopaedic inpatients, rehab ward, A&E. The manager would not be a physiotherapist or AHP, and likely to be a general manager.

Therefore the Øvretveit schema when applied to the NHS physiotherapy service in England and Wales captured all of the current reported management structures (with a few modifications) with three models not observed. The unobserved models remain conceptually coherent, but were not empirically applicable to the research cohort. Some of the Øvretveit models appeared only to apply where certain reform “confounders” were obtained. That is, there were limits to how far reforms were able to change what organisational models were feasible in providers such as for example social enterprise.

The original schema has been transposed to include terminology that more readily reflected contemporary NHS structures, particularly the move away from the term “District”. Although designed to represent NHS physiotherapy, this empirical schema could be adapted for other AHP services and potentially any clinical profession, both within and beyond the NHS and the UK.

11.5.3 Relevance of the ATEAHPMS

The management structure assessment was to give a systematic normative profile of the similarities and differences between different management structures, and the roles of physiotherapy managers in the five different types identified. The empirical findings demonstrated that the ATEAHPMS domains (Appendix 9,) reflected the roles of the large majority of managers. It was validated by the physiotherapy managers, as the only other role they undertook that was not included was reported to be clinical practice. It was sensitive

enough to identify national differences, as well as identifying the same descending rank order of management structures in respect of fulfilment of the ATEAHPMS as for professionalisation, and effective and efficiency (Chapter 8.2,) this was:

1. AHP Directorate
2. Physiotherapy Directorate
3. AHP Sub-Directorate
4. Fragmented
5. Pathway

The findings concurred with those of Buchanan *et al* (2013,) that the managers were deeply committed to provide well-managed NHS services, but faced increasing workloads with reduced resources.

The impact of the most recent NHS changes had resulted in a net loss of 22 (18%) of physiotherapy manager posts,raising the question of who would be undertaking some of the tasks, and whether sufficient focus would be given to physiotherapy management, and whether the tasks undertaken through the lost posts will or should still be undertaken.

11.5.4 Professionalisation and physiotherapy

The findings from the empirical study were assessed against theorists propositions, to determine whether they were valid for physiotherapy in the 21st century. Analysis was also undertaken to consider whether changes in professionalisation resulted from changes in management structure or other

influences. This study found evidence of a transition of growing professionalisation between 1989 and 2005, with a slight decline by 2013/14.

Flexner's proposition (1915) of six traits including intellectual operation, individual responsibility, derived from science and learning, being educationally communicable, self-organising and altruistic was supported by physiotherapy data provided in 2013/14.

The later additions of Carr-Saunders and Wilson (1933,) of prolonged intellectual training, specialised services and the development of an association were evident for NHS physiotherapy. However, the relevant tests of competence and standards of conduct had in the NHS been taken over to a large degree by the regulatory body, the HCPC. Regulation of physiotherapy in the UK had strengthened through the periods, though at the expense of the occupational body with the HCPC being established in 2001 taking greater control away from the CSP. Physiotherapists had become included in a growing group of HCPC regulated professions with the inclusion of social workers and clinical psychologists to the register during the research period. Therefore, this regulatory body had grown in numbers of registrants and arguably also grown in importance due to the focus on safe care following the Mid-Staffordshire inquiry which had criticised the quality of inpatient care in one hospital; demanding tighter regulatory control from all healthcare regulators. Physiotherapy therefore did not conform to all aspects of an "ideal" profession, and the influence of regulation could be considered to be substantial.

The role of the occupational body (the CSP,) remained influential, but had diminished considerably following the HCPC control of education and regulatory control in 2001. The CSP being a TU fulfilled the requirement of a “strong voice”, with some informants commenting that the TU “voice” was stronger than the “professional voice”. The AHPf lacked support from its member bodies and reportedly lacked national impact. Due to the public sector position of the NHS, freedom from state control was not afforded, unlike non-public sector professions. The CSP has maintained a formal code of professional behaviours and values (CSP, 2011b) which had been constant and a requirement of membership. Though it was the regulatory body that set standards of conduct, performance and ethics (HCPC 2008,) and standards of proficiency (HCPC, 2013) by which physiotherapists gained licence to work in the NHS.

Physiotherapy did not demonstrate the historical tradition of professions being occupied by people whose origins lay in the higher social classes and having privilege (Goode 1960,) with the founders of the profession being midwives and nurses. Physiotherapy could be considered to be one of the former non-professional occupations, seeking professional status and its associated goals (Bishop 1997.)

In the NHS during the study period, physiotherapy had the certain professional attributes (Greenwood 1957,): Systematic theory, authority, community sanction, and ethical code and a professional culture of knowledge, behaviour and ethos, with professional “norms” reported as a consistent focus on the quality and safety of patient care.

Physiotherapists were autonomous practitioners sanctioned by legislation, and were able to make independent decisions about treatment options and decisions. An altruistic commitment to service was self-reported; particularly those who were in their mid-late career would not have attracted high levels of pay before 2004. Professional self-judgement of performance was evidenced though all services would be subjected to performance review within their organisational management arrangements, accounting to more senior managers for a wide parameter of key performance indicators. Therefore autonomy was granted by organisations to physiotherapy managers, but accountability was a constraint, shaping the degree of real autonomy held by the profession.

Physiotherapy was reported by respondents to be viewed positively by the population, meeting a need for care and rehabilitation contributing to society. Training schools had been established and a professional association (CSP) with formal codes adopted. One element was not fully observed; reward through high salary, though this had increased post 2004.

Physiotherapy education had strengthened over time becoming an all-graduate university based profession in 1992, with growing attention to R&D which has strengthened, demonstrated by growing numbers of research physiotherapists and post-doctorate appointments. Respondents reported that post-graduate qualifications had increased in number, with HCPC curricula sanction required; though full self-regulation was not afforded. UK physiotherapy had training schools, a professional association and a code of ethics. Attitude attributes

demonstrated by the formation of the CSP as a reference group, orientation to service and autonomy from non-physiotherapists. Not evidenced was total self-regulation, as the HCPC had a mandatory role similar to the arrangements for medicine and nursing.

Professional autonomy (Chapter 3.8.2,) was observed at national, local and individual patient levels but was constrained by regulation. Physiotherapy fulfilled Friedson's (1989, 2001,) assertion of beneficent labour, being a profession being based on work of special value, with knowledge and skill of a specialisation requiring formal learning, education, training and experience as fundamental requirements. It was also reported that professional judgement was a key part of autonomy. Physiotherapy budgets were not fully within the control of physiotherapists and the notions of "trust based on class" and externally imposed rules governing work being minimised, was not observed.

There were reported to be power struggles with other professions. Some physiotherapists were managed in devolved structures, reporting to a non-physiotherapist/AHP where relationships would need to be nurtured by physiotherapists for their contribution to patient care to be recognised by the multi-disciplinary team, being a smaller professional group than nurses and doctors. There was reported to be professional rivalry at two levels; firstly between physiotherapy and the other AHPs, where it was perceived that physiotherapy as the largest profession had to work hard to ensure they were not seen as "bully boys" secondly there was inter-professional rivalry between physiotherapy and the non- AHP professions, with reportedly good relationships

with medicine. The countervailing powers framework (Hartley 2002,) was corroborated, with dominance in the marketplace being countered by other powers, such as government regulation. Medicine remained dominant, though a somewhat fractured relationship with nursing was reported by some. This was illustrated by informants where nurses were afforded privileges due to their numbers, rather than their expertise. It was perceived by these informants that nurses were afforded an unfair advantage in undertaking senior management roles and some rehabilitation roles, positions that were not available for physiotherapists to apply for. "Occupational imperialism" (Larkin 1983,) and the concept of labour market closure presented by Larson (1977,) was evidenced by physiotherapists protecting their professional boundary from encroachment by other therapists and by physiotherapy managers reporting a preference for models of organisation that gave critical mass and occupational dominance over other AHPs and nurses.

Professionalism based on values (Evetts 2012,) was evidenced by physiotherapists dealing with risk and uncertainty, with values based on trust, competence, a strong occupational identity and co-operation. The focus given by Friedson (1971,) of control of work being a primary definer for professions was observed in physiotherapy with the caveat that work was ultimately controlled by managers in the organisation and related to deployment of resources, though at the physiotherapist: patient interface, clinical autonomy was present.

Respondents regarded professionalism as a normative value; worth preserving and highly regarded as a meta-skill of physiotherapy managers. This included their situational awareness and contextual judgement, drawing on the communication, technical and practical skills of physiotherapists (HCPC, 2011.) The observation of Evetts (2005,) of contemporary service occupations, having professions controlled “from above” by the organisational managers and supervisors was observed in physiotherapy. In this scenario organisational objectives define practitioner/client relations, set achievement targets and performance indicators limiting the exercise of discretion. The informants of this study described the impact of budgetary constraints, requiring workforce changes to reduce costs and imperatives for organisational changes impacting on physiotherapists. Additionally the findings related to physiotherapy support Evetts’ concepts of occupational professionalism; with hierarchical structures of authority and decision-making, and accountability with externalised forms of regulation, target-setting and performance review and organisational professionalism with; discretion and occupational control of the work, practitioner trust by both clients and employers and professional ethics.

The physiotherapists in this study said that public recognition for physiotherapy was positive, with sporting events such as the Olympics being seen as giving a strong and positive public image to physiotherapy. The non-sports specialty areas were reported to be often less well-understood by the public and physiotherapists thought that these aspects required ongoing public relations promotion. Patronage by the client was reported to have been seen by patients

welcoming self-referral and easy access to physiotherapy fulfilling Pellegrino's (1983, 1989,) requisite for direct personal contact and morality. Earnings levels had increased since 2004, but still lagged behind medicine.

The power of the profession was the domain that had weakened most over the research periods. This was largely linked to the increasing powers of the state which was observed in several fields, including, regulation, remuneration and legal framework and had strengthened over the periods. The small numbers working in social enterprise organisations where NHS employment terms and conditions were no longer in place were not protected by a national contract. Physiotherapists had largely rejected the "subordination" model and the self-image of being a "paramedical profession" (Chapter 3.8) instead it was reported that they adopted collaborative relationships, strengthen their power-base. This was demonstrated by physiotherapists being grouped together in management structures with other AHPs. Critical mass was reported by informants working in this structure, to strengthen their power-base. Physiotherapy managers reported attempting to control the elements of professionalisation that were within their power to control. Recent changes introducing devolved management structures had threatened their social structure and collegiality. Professional community was reported by informants with a preference for groupings that maintained professional identity.

The concept of "control" (Friedson 1970,) was observed to be synonymous with "power", demonstrated by physiotherapy's autonomy, responsibility, authority and prestige. Financial pressures in organisations had led to opportunities for

some physiotherapists to give up power at the lower levels of practice allowing non-graduate support staff to undertake some functions. Some new roles were undertaken, formerly the domain of medicine; although physiotherapy had strengthened its autonomy, there had not been a decline in aspects of medical dominance, with medicine's authority remaining strong despite governments' attempts to control its power (Allsop, 2006). As medical dominance has not declined substantially it did not explain for the changes which had taken place in physiotherapy, supporting Øvretveit's (1985,) finding.

Friedson's model of power was flawed in that it did not account for the strength of management discretion of the non-medical professions, which were a crucial feature observed in the NHS (Øvretveit 1988,) and evidenced in the professionally-led structures of organisation. In contrast, the sub-ordination models proposed by theorists including (Willis 1989,) were observed in the devolved structures, reducing physiotherapists' power and arguably their professionalisation status.

The evolution of physiotherapy could demonstrate models of power and action (Ritzer and Walczak 2001,) with the CSP having a key role in its political actions to extend professional boundaries and influence. The neo-Weberian concept of social-closure (Walters, 1989) was strongly evident and well regarded by informants, though physiotherapists' ability to control the labour market was limited, due to the public sector nature of the welfare state, and some of its inherent tensions (Osse, 1982).

HC(77)33 was reported by respondents to have given physiotherapy legitimate authority. It had recognised physiotherapists as autonomous practitioners and was a landmark, influencing subsequent physiotherapy practice. It removed medicine's requirement to prescribe physiotherapy, a doctor's signature on a piece of paper not offering any immunity from legal proceedings in the event of mal-practice; fundamentally changing physiotherapists' relationship with patients, giving them authority to receive referrals, clinically diagnose and discharge. Physiotherapy practice had become stronger over the three periods, supported by primary and secondary legislation, and acceptance of the role of physiotherapists as primary care givers. Patients were able to self-refer to physiotherapy, scope of practice was extended to include prescribing from 2014 and regulation was extended. It was reported that physiotherapy had legitimacy based on its positioning in organisations and authority given by tradition. There was no reporting of legitimacy based on charisma.

The title "Chartered physiotherapist" and its membership rules matched the "closed structure" criterion of professionalisation. Problem-solving capabilities affirmed by Murphy (1988,) were found in physiotherapy, being fundamental to clinical practice. These were observed in the forms of HEI level education for physiotherapy clinical practice, though they were largely lacking in physiotherapy management education.

The sequence of professionalisation (Wilensky 1967,) was largely, though not fully observed. New areas of practice had been developed, with training schools established, state recognition and a professional association. UK physiotherapy

saw professional association being formed before the training schools, differing from Wilensky's developmental sequence. The next stage of inter-occupational conflict was evidenced by several informants citing nurses encroaching on the core rehabilitation role of physiotherapy.

Elements of de-professionalisation were reported by physiotherapy managers largely as a result of bureaucratisation, regulation and transfer of education to HEIs. Pay regulation was accomplished by AfC. Performance was monitored and managed and electronic sources making knowledge less discrete. Variance in workforce planning had at times given over-supply of physiotherapists, setting out the conditions in which deprofessionalisation as well as proletarianisation (Mc Kinley and Arches 1985,) could progress. However, physiotherapy in the UK had not seen any great shift towards deprofessionalisation, and could be considered to occupy the "professional-technical" stratum (Navarro 1986.)

Physiotherapy in the NHS demonstrates the impact of becoming a bureaucratised profession, by becoming absorbed into organisational structures. This was most evident in the devolved structures. The polarisation effect between the "professional elite" and "rank and file" physiotherapists was observed (Nadav and Dani 2006,) with many more of the "rank and file" heavily managed.

The theories of professionalisation in contemporary physiotherapy were largely still relevant with some qualifications. A shift of professional activity had taken place with informants reporting changing roles for physiotherapists, similar to

observations of large organisation changes reported by (Brock *et al* 2007).

When the different management structures were compared, several areas of association were identified, challenging the characteristics laid down by earlier theorists. Public-sector employment of professionals introduced an added dimension, questioning whether elements of high financial reward, control of resources and autonomy of all decision-making could ever be achieved, by any publicly employed staff group. The role of the state for all healthcare professions has increased as predicted by Friedson (1994,) by the requirement to assure safe care and to contain costs. Physiotherapy manager informants reported a preference for professionally-led management structures, upholding the pre-requisite for a profession to manage itself, to be considered of higher order. This preference extended to AHP management structures, as well as physiotherapy ones.

The findings therefore only partly confirm the theorists' propositions, as there has been much societal change since Friedson and other theorists of the 20th century commented on professionalisation. Their theories gave insight into physiotherapy's evolution, though societal changes had diminished the importance of a class-based hierarchy of authority and power. The data showed that NHS physiotherapy in England and Wales was part of a clinical hierarchy, with medicine maintaining its influence but its total dominance has diminished. Physiotherapy was reported to be part of a large bureaucracy, though this may differ in other global healthcare systems.

These findings suggest that physiotherapy had survived, elongating professional hierarchies, whilst still giving attention to practice development. Management structures had affected professionalisation and physiotherapists strongly supported social-closure and professional collegiality with other AHPs as a method of maintaining physiotherapy autonomy, at both clinical and managerial levels.

Analysis of the findings showed that compared with the professionally-led models, the fragmented models demonstrated more deprofessionalisation in the elements of: deskilling (working in single specialty pathways losing breadth of physiotherapy skills) , performance monitoring and reporting (lack of profession specific information to monitor and manage), traits of semi-professions (reduced authority, and autonomy), and itinerant professionalism (insufficient critical mass of staff to cross cover requiring locum staff to be employed). In contrast the professionally-led models showed a higher level of professionalisation in the elements of: education (able to influence education providers and also identify training requirements of individual staff to give career progression), practice (providing skills to deliver patient care in a broad variety of specialisms to include specialist practitioners) and power (with physiotherapy manager positioned to strategically influence). The analysis therefore concluded that there was a relationship between management structure and professionalisation, but also recognised that attributing a cause and effect relationship was difficult due to the multifactorial elements that influenced physiotherapy provision.

11.6 Recommendations

The research has contributed to the debate on the different structures of physiotherapy management and the roles and duties of physiotherapy managers, building on the small quantity of published literature on this topic (Chapter 2.) It has also attempted to answer the challenge set out by Parry (1995);

“To provide valid evidence of present and potential contributions to the health of society in order to retain professional independence in the face of the organisational model being imposed on much of the NHS.” (p.310)

On the basis of the evidence presented in Chapters 5-10 the researcher has therefore made a series of recommendations:

11.6.1 Policy

The impact of recent NHS changes resulted in a substantial number of physiotherapy services re-structuring between 2008 and 2013/14 (Chapter 7.1.) Following the evidence provided, I recommend that the NHS needs a period of stability to embed changes without the requirement for future re-structuring in the foreseeable future. Those developing policy would benefit from reviewing these research findings to understand the impact of re-structuring on smaller professions. Physiotherapy managers are also advised to be knowledgeable regarding the impact of policy changes to prepare for future periods of reform.

The impact of divesting PCTs of provider functions resulting in many Acute Trusts taking on community physiotherapy provision strengthening acute

providers. I recommend that policy makers note this consequence, conflicting with their policy to strengthen a community-led NHS in England.

Policy makers are commended to note the impact of protracted austerity on services with revenue budgets that have a high staffing component like physiotherapy (Chapter 10.2.8,) and the workforce reduction that year-on-year budget reduction creates where there is little option to make capital savings.

12.6.2 Management

The evidence provided in Chapter 7.2.5 (Board representation,) and Chapter 7.2.6 (seats on organisational committees,) demonstrates that physiotherapy has scope to extend its functions into more senior organisational decision-making groups. I recommend that executive teams review their involvement of physiotherapists in organisational groups to increase the knowledge and skills of the third largest clinical group, as commended by Lintern (2015.)

Senior managers are advised to carefully consider the impact of reorganisation on relatively smaller services like physiotherapy when contemplating organisational re-structuring (Chapter 6.7.4,) as they do not neatly conform to a “medical model” of care, and have been reported to require a critical mass to provide effective holistic care and efficiency. Being part of an AHP structure was reported to have advantages (Chapter 9.2,) for patient care and physiotherapy services. When reorganisations occur, I recommend that physiotherapy should be combined with other AHPs.

In light of the ATEAHPMS gap analysis (Chapter 8,) I recommend that physiotherapy managers use the normative elements to undertake a self-assessment and gap analysis when faced with organisational re-structuring in order to present an evidence-based approach to discussions and consultations about organisational restructuring impacting on physiotherapy services. Other elements, including clinical outcomes and cost should also be presented.

The findings presented in Chapter 7.2.8 (budget management,) and Chapter 10.2.8 (impact of cost constraints,) detailed the annual revenue savings impact on smaller professions like physiotherapy where staff costs represent >90% of budgets. I recommend that finance directors review the impact of traditional annual savings programmes, and consider as part of integrated workforce planning, the potential to provide better services at lower costs by enabling and supporting smaller services like physiotherapy to vertically substitute for doctors and nurses where appropriate. I also recommend that physiotherapy managers prioritise influencing budget holders as a key requirement of their role, demonstrating the “value” of physiotherapy, its outcomes and economic benefits.

The findings presented in Chapter 7.2 (activities undertaken by physiotherapy managers,) identified the devolved structures rating lower than the professionally-led ones, this was consistent with other findings including fulfilment of professionalisation characteristics (Chapter 9.5); service effectiveness and efficiency (Chapter 8.2); and managers’ preferences corroborating the finding of Øvretveit (1992),(Chapter 6.6.) It was also

consistent with interviewee's observations of fragmented management structures providing poorer patient care than professionally-led structures:

SSI 3 [11] "It's disjointed, with little development opportunity for staff, un-coordinated, limited supervision and worse for patients."

I therefore recommend that physiotherapists in devolved structures develop effective skills for influencing senior managers and other professions, to ensure the contribution of physiotherapy to patient care is maximised, and that physiotherapists are supported to develop their career even when there is no overall physiotherapy manager.

The findings set out in Chapter 10 demonstrated policy changes were drawing England and Wales apart, with the English competitive agenda affecting and influencing the role of the physiotherapy manager and their services. I recommend that physiotherapy managers develop and strengthen their networks for keeping physiotherapy and other AHP managers to be informed of different management structures and about both national NHS systems, ensuring that they maintain skills and knowledge to enable them to adapt to and operate in differing structures and systems.

11.6.3 Practice

The findings regarding roles, responsibilities and functions of managers were presented in Chapter 7. I recommend that physiotherapy managers review their own roles and make comparisons with the functions set out in Chapter 7.2,

identifying areas for possible development of their role. It is particularly recommended that Chapter 7.1.4 (clinical role,) and 7.1.11 (management qualification,) are reviewed, as these areas would be within the scope of the physiotherapy manager to address if gaps were identified.

The evidence of inter-professional relationships presented in Chapter 7.1.13, indicated the responsibility of physiotherapy managers in nurturing these relationships. I therefore recommend that physiotherapy managers review their relationships with other professions and to harness relationships for the benefit of patient care, as identified by the interviewees:

A supportive AHP identity:

SSI6 [10] “More power and understanding of AHP issues. Support for one another.”

The benefits of multidisciplinary working:

SSI1 [12] “By working closer together as a multidisciplinary team we provide better patient care.”

I recommend that physiotherapy managers maintain clinical expertise and practice to enhance credibility with their own staff and the wider healthcare team. I strongly recommend that they prioritise increasing their visibility as clinical leaders, and that their job plans designed to accommodate this function.

The findings in Chapter 10.2.8 (impact of cost constraints), demonstrated that they were a key issue for a large majority of physiotherapy managers. In order to maintain quality of patient care during austerity, physiotherapy managers will have to develop strategies to manage with reduced budgets.

SSI10 “You’ve got to provide better services with less money, we’ve changed some roles, and actually extended our service, it’s better for patients”

These may include integrated workforce re-design demonstrating benefits realisation rather than traditional yearly cash releasing savings.

In light of the findings in Chapter 8.3 (professional stratification,) I recommend that physiotherapists should pay attention to managing the vertical substitution of their profession to improve patient care, or other professions may vertically substitute faster, encroaching on traditional physiotherapy roles such as rehabilitation. Jurisdictional change will need careful management in order to maintain care to patients and physiotherapists’ managerial skills. The data on stratification also identified that maintaining and developing profession academic credibility and intellectual capability is important for promoting vertical stratification of physiotherapy, which in turn offers benefits to patient care as well as the profession itself. I recommend that managers support staff to ensure that they develop opportunities to participate in service improvement activities to extend vertical stratification with appropriate skills and training to perform this function.

11.6.4 Implications for the professional body

The data in Chapter 8.3 (physiotherapy stratification,) suggested that vertical stratification of professions and realignment of professional jurisdictions are

occurring, with economies and flexibility to be realised if there was one therapy profession.

SS17[8] “We’ve been a Therapies Directorate since 2005, I would not want to go back, we need to support each other, together we are strong, we would be even more efficient and effective if we were one AHP profession with subspecialties.”

I recommend that all the AHPs group together as one therapy profession providing the social model of health (Chapter 2.2,) with the CSP taking a lead role to facilitate this; demonstrating leadership from the largest AHP profession to focus on the needs of patient care rather than being professionally protective.

The informants of this study identified an AHP grouping as the most frequently occurring management structure. I recommend that the CSP re-consider its traditional uni-professional focus and have a lead role in working more collaboratively with other AHP organisations, building on the New Zealand and Australian “Allied Health” models. This could be a pre-cursor to developing one AHP profession.

The informants’ views reported in Chapter 7.1.8 (career path,) included the belief that physiotherapy managers’ roles require promoting to the profession in order to ensure physiotherapy’s contribution to patient care is maximised. I recommend that the CSP market management as a career option to ensure there is skilled both management and leadership.

Lack of support from CSP for management training was identified (Chapter 7.1.11.) Medical and nurse managers were better supported in training and

development by their professional bodies. I recommend that the CSP considers the findings and their implications. Given that physiotherapists are increasingly managed in cross-AHP structures, the CSP may consider working with the AHPf members to establish and resource an umbrella group for all AHP managers, rebranding of LaMPs, and providing formal accredited management training like the BMA and RCN do.

The findings in Chapter 9.4 (role of the professional body,) detailed managers significant support for the joint professional body and TU. This support requires recognition by CSP members, of the high regard for its dual functions; though the CSP should also note that 28% took an opposing view, and reflect whether current CSP strategy adequately meets these members' requirements.

The findings in Chapter 9.1 (assessment of physiotherapy professionalisation,) identified the strengthened role of the HCPC post 2001 and the decline in physiotherapy representation. I recommend that the CSP promotes closer working with AHPs and physiotherapists on HCPC committees to ensure that the physiotherapy profession influences the Regulator, and its recently appointed physiotherapy Chair.

11.7 Implications for Future Research

There remains a lack of evaluation of what impact of NHS policy on physiotherapy services means for patients' and carers' experiences of healthcare and into the differences between professionally-led and devolved

management structures. In addition I advise exploration of the views of other managers and other professions to determine whether their views differ from those of physiotherapy managers.

The research included only England and Wales; it would be useful to consider extending the research to include Scotland and Northern Ireland, to verify whether the findings also apply to these parts of the NHS.

The empirical management structure schema could be further tested for its applicability for other AHP services, doctors and nurses.

The gaps identified by the ATEAHPMS could be further explored to find out if they were being filled by someone other than the physiotherapy manager, and if so by whom? And to what extent?

Further research into the professionalisation process of other AHPs would be of value, including an assessment of professionalisation elements.

The revised schema for physiotherapy management structures would be worth testing for applicability in other Beveridge type health systems, for which it is likely to be applicable, as well as social insurance healthcare models.

As social enterprise, Vanguard integrated primary and acute care systems and multi-specialty community providers and other integrated care models develop (NHS England 2015b,) it would be useful to determine whether the management structures identified in this thesis remain still applicable to them

too, and if so what the implications for the theory of the professions, and for health policy and management are.

Although there has been research into Board functions (Endacott *et al*, 2013, Chambers *et al* 2013,) the role and contribution of AHPs has not been researched; further study would provide valuable information regarding the contribution of non-medical and non-nursing professions to Board functions. There would also be benefit to studying physiotherapists' roles in the senior decision-making structures in organisations, where there is not a physiotherapy manager in place.

It would be useful to observe the impact of competition in the NHS and its impact on physiotherapy professionalisation which is currently not researched. Finally I recommend a comparative cost effectiveness analysis of the five physiotherapy management structures found in the NHS.

11.8 Conclusion

This research has filled a gap detailing and analysing the effects of government policy for the NHS on the management, organisation and provision of NHS physiotherapy services in England and Wales, demonstrating growing difference between the countries as well as differences between management structures. This provides information for those making policy and management decisions affecting physiotherapy services as well as the profession itself. It also provides information that will be of relevance to other AHPs.

The study has facilitated a broader understanding about the wider healthcare professions in England and Wales. There was reported to be spread of professionalisation to other AHPs (Clouston and Whitcombe 2009,) as well as nursing which was still not considered to be fully professionalised (Yam, 2004). The dominance of the conflict based paradigm (Freidson 1970,1986,1994; Johnson 1972; Larson 1977), although extremely successful in overcoming the limitations of previous perspectives, has tended, with its focus on occupational dominance and monopoly, obscuring the broader role that professionals exercise (Burrage and Torstendahl, 1990; Halliday, 1987; Halliday and Karpik, 1997; Johnson, 1993; Torstendahl and Burrage 1990). The research identified that traditional approaches in the sociology of the professions did not reflect the shift of professional work to organisational settings. In this context, many existing theories did not reflect the evolution and hybridisation, with the transformation of practices as professional jurisdictions were reshaped by exogenous forces. Therefore an institutionalist perspective of the professions, their work, and organisation gave an institutional approach to the study of the professions, as an alternative to the dominant functionalist and conflict based traditions, drawing on neo-institutionalist concepts (Muzio *et al* 2013.)

The data have enabled an informed perspective on theorists' views relating specifically to physiotherapy in England and Wales. Many of the theories of professionalisation apply to physiotherapy and its five management models, as well as physiotherapy stratification. The data identified physiotherapy conforming to the theory of collegiate control and market closure as key

elements of physiotherapy professionalisation, supporting Etzioni (1969,) Fournier (2000,) theory of occupational closure based on power as a central feature of professionalising goals. This study also found evidence of physiotherapists' strong opposition to attempts to take power away from their profession. The opposition was based on experience of those who had been through cycles of reorganisation and had experienced comprehensive District-wide services of the 1990s fragment and re-structure, weakening professional control and arguably weakening the profession itself in being able to maximise its input into fully achieving its potential contribution to excellent patient care.

The data support some elements of Friedson's theories, emphasising the strategies and structures of professional control and organisation. This demonstrated the continued dominance of medicine, but disproved the concept of medicine being solely responsible for jurisdiction, as physiotherapy had negotiated its own boundary changes, merging with remedial gymnasts and extending scope of practice into some fields formerly occupied by medicine. Friedson's (1970,) concept of medicine's control was shown not to apply to physiotherapy in the UK since 1989 as medicine did not control the work of physiotherapy and the division of labour differed from the technical authority reported by Friedson. State regulation did not assure professional autonomy as physiotherapists' scope of work was determined by themselves. Professional control and autonomy were therefore not considered to be absolute; supporting Øvretveit's (1992,) criticism of Friedson's theories applied to the therapy professions. The data instead suggested medicine's authority rather than

medical autonomy as a key factor in its relationship with physiotherapy, and revealed the continued importance of professional management autonomy for physiotherapy (Øvretveit 1988, 1992). The growth of physiotherapy autonomy had not been dependent of a decline in medicine. The three tiers of intra-professional stratification; producers, knowledge elite and administrative elite, Friedson (1985,) were confirmed by the data as applying to physiotherapy, even though the original classification was intended for the medical workforce, and Friedson identified intra-professional stratification as a way of strengthening professional power for medicine.

The above findings demonstrated changing patterns of professional control and stratification. There were many examples of both vertical and horizontal substitution with jurisdictional change of extended roles, as well as assistants undertaking lower skills tasks and merging of professional boundaries. These changes were influenced by both staffing shortages and economic imperatives.

The evidence falsifies the idea of deprofessionalisation or semi-professionalisation of physiotherapy, as physiotherapists' breadth of practice had grown. Instead the findings encourage us to think of professions like physiotherapy as ecologies or systems rather than fixed entities conceptualised by Abbott (1988,) viewing professionalisation as a sub-set of the broader category of institutionalisation (Dingwall 2004,) demonstrating a focus on the interrelation between professionalisation and institutionalisation as inseparable concepts (Muzio *et al* 2013.) Adopting an institutional lens to study professions

was an issues that was required to add to neo-institutional theory (Suddaby, 2010), and applicable to the NHS.

The study draws out the distinct characteristics that define physiotherapy as a profession. Professionalisation and the traits of physiotherapy have some similarities with other health professions; requiring legal sanction to operate in the NHS; regulation; a professional association; HEI education; and being based on knowledge and learning. However physiotherapy also differed from medicine and nursing in several respects with physiotherapy; having less history, entering UK healthcare during the 19th century; developing its own professional body and gaining legitimate authority. Physiotherapy had vertically extended to grow the boundaries of the profession, and had developed its jurisdiction at the expense of the older healthcare professions. Its scope of autonomous practice (HC(77)33), differentiated it from nursing and some other AHPs, but medicine remains the dominant healthcare profession, with greater autonomy, jurisdiction and public sanction. Jurisdictional change was both a consequence and a confounder of the structural reforms.

In common with earlier research (Jones 1989; 2000 and Jenkins 2005,) the findings found physiotherapists strongly felt that the profession was better at managing itself, rather than leaving this to others outside the AHPs, who in many cases did not appreciate the diversity of the contribution to patient care and the many factors that needed balancing to enable this to happen.

Physiotherapy managers faced with devolved models would need to develop

expert influencing skills to ensure the profession does not revert to one of being “handmaidens” of former years.

To survive the profession will need to embrace workforce changes, mergers, restructuring and changing hierarchies; proactively managing them particularly in devolved models. The profession would be advised to carefully manage professional boundaries and task delegation eroding the “unique” contribution of physiotherapy. Physiotherapy will be “safe” if it can: Retain a high level of demand for its specialised services; retain sufficient control over its own roles; actively compete with existing providers on the basis of cost and quality as well as diversify into new roles. Importantly the research has provided physiotherapy managers with an evidence-base when presented with future re-structuring and reorganisation, which will undoubtedly occur.

An important discussion point for physiotherapy relates to its own identity and whether the changing healthcare environment as well as patient needs are now demanding one AHP profession, should physiotherapy be a sub-specialism of a single AHP profession?, which following the findings of this study, I believe is worthy of consideration.

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APPENDIX 1 Summary of Recent NHS Changes

	POLICY INITIATIVES	BRIEF DESCRIPTION
1984	Griffiths Inquiry	Inquiry lead by Sainsbury's CEO, leading to introduction of NHS general management
1989	<i>"Working for patients"</i>	Ended medical veto
1989	<i>"Caring for People"</i>	Efficiency of resources and patient choice identified, 8 working papers
1990	<i>"The NHS and Community care Act"</i>	Introduced Internal market, money followed the patient
1990	Health Trusts	Established by statute following 1990 act Organisations with responsibilities for providing health care
1991-1997	GP fundholding	Budgets given to GPs
1996	<i>"A service with ambitions"</i>	Focus on quality and seamless services for patients
1997	<i>"New NHS: Modern, dependable"</i>	Services based on partnership, driven by performance
1997	PCGs	Primary and community health services were brought together in a single organisation
1998	<i>"A First Class Service: Quality in the NHS"</i>	Strong quality focus theme emerged
1998	<i>"Better health better Wales" (Wales)</i>	Linked poverty with ill health
1999	Care Trusts introduced	Health and Social care organisations
2000	<i>The NHS Plan</i>	Modernisation, patient protection and patient influence, established new organisations (see below)
2000	Care Trusts	Health organisations, merging health and social care into single organisations.
2000	Children's Trusts	Combining education, social care and health provision for children into single organisations.
2000	Partnership Trusts	One organisation providing mental health services across a wide area typically across a whole county.
2000	Wales Devolution	Wales moving to its own devolved government, including taking responsibility for the NHS in Wales (40% of devolved budget)
2000	<i>"Meeting the Challenge"</i>	DH strategy for AHPs
2001	<i>"Improving Health in Wales- A Plan for the NHS with its partners" (Wales)</i>	Major reorganisation in Wales, 21 Local Health Boards set up, with 13 NHS Trusts and community health council scrutiny
2001-2013	PCTs (PCTs)	Replaced PCGs
2001	Health Professions Council (HCP)	AHP regulator established
2002	<i>"Delivering the NHS Plan: Next steps on investment, next steps on reform".</i>	Instruction regarding reforms
2002	<i>"Shifting the Balance of Power"</i>	More decision-making to front line staff and patients. RHAs become SHAs
2002	Payment by Results	NHS England "tariff"
2002	Foundation Trusts	Independent not for profit public benefit corporation with accountability to local communities rather than central government control.
2002,	Wanless report	Reported the NHS grossly under-resourced (or

2004		extremely efficient)
2003	<i>"Keeping the NHS Local- a New Direction of Travel".</i>	Promoting care closer to home
2004	AfC	Remuneration and terms and conditions for the majority of NHS staff (including AHPs). Leading to blurring of professional boundaries, new roles, and new ways of working.
2004	Monitor	Sector regulator for health services in England
2004	<i>"The NHS Improvement Plan - Putting People at the Heart of Public Services".</i>	Further drive to shift care from hospitals to community
2004	<i>"Standards for Better Health"</i>	Quality initiative setting national standards
2004	<i>" National Service frameworks"</i>	Clinically focussed frameworks to standardise quality improvement for specialist areas
2005	<i>"A Patient Led NHS"</i>	Promoting patients in charge not clinicians
2005	<i>"Our health, our care, our say"</i>	Following consultation a patient led policy
2005	Practice-based commissioning	GP involved again in commissioning
2005	<i>"Health Reforms in England: Update and Next Steps"</i>	SHA and PCT reorganisation. Reduction in numbers consolidating and merging services
2005	<i>"Designed for Life"(Wales)</i>	Focus on lifestyle improvements through the life course
2006	<i>"Our Health, Our care, Our Say: Making it happen"</i>	Update on 2005 policy
2006	<i>Therapy Strategy for Wales (Wales)</i>	10 year strategy
2007	<i>"Our NHS Our Future"</i>	Interim report of the Darzi next stage review
2007	<i>"High quality care for All"</i>	Policy following from review by Darzi
2007	<i>" One Wales-A progressive agenda for the government of Wales" (Wales)</i>	Anti-market policy, stimulating reorganisation setting up 7 Local Health Boards (LHBs) and 2 Trusts from 2009, responsible for population health, commissioning and service provision.
2007	<i>"Trust, Assurance and Safety: The regulation of health professionals"</i>	Regulatory document for health professions
2008	<i>"Framing the contribution of Allied Health Professions (AHPs)"</i>	Department of Health strategy for AHPs
2008	<i>"Transforming Community Services"</i>	DH Strategy to move services closer to patients and away from Acute care
2009	Health Act	Placed a duty on providers and commissioners of NHS services to have regard to a new NHS Constitution, quality accounts and direct payments
2009	Clinical Commissioning Groups	An English NHS commissioning arrangement set up post 2008 reforms
2009	<i>"The European Working Time Directive for trainee doctors - Implementation update"</i>	Contained working hours, requiring other professions to undertake roles formerly done by junior doctors, as well as a drive to increase medical staff number
2010	<i>Procurement guide for commissioners of NHS-funded services.</i>	Guidance re tendering and any qualified provider (AQP)
2010	Social Enterprise	Set up as alterative provider units under the

	organisations	Governments “ Right to provide” agenda
2011	Bevan Commission report (Wales)	Assessing the alignment between NHS Wales and principles of the founded NHS
2012	Health and Care Professions Council (HCPC)	Replacing HCP as regulator of AHPs and Social Workers
2011-2012	NHS Commissioning Board	To design the proposed commissioning landscape and develop its business functions
2012	Special Health Authority, “ <i>The Health and Social Care Act</i> ”	Major change in NHS England removing PCTs from provider functions stimulating major re-organisation in commissioning and provision
2012	The NHS Commissioning Board	An executive non-departmental public body.
2013	“ <i>Liberating the NHS</i> ”	NHS England radical changes post 2013
2014	“ <i>Back to Bevan</i> ” (Wales)	Devolved Welsh government policy to return to the NHS founding principles; anti-market reform
2014	“ <i>Prudent Healthcare: Essential New Approach for NHS Wales.</i> ” (Wales)	Ministerial commitment to promote a prudent approach to healthcare
2014	The NHS (England) Five Year Forward View	“To articulate why change is needed, what that change might look like and how we can achieve it”.

(Changes affecting Wales only, came after 1998 and are shown in brackets)

APPENDIX 2 OVERVIEW OF NHS EVOLUTION UP UNTIL 1989

The development of the NHS reflected the political “mood” of each period, with government policies influencing structures and management practice. An understanding of the developing NHS, as an organisation that has continually updated and remodelled itself, is important in appreciating the impetus for change and its impact. The narrative history sets the context in which AHPs and specifically physiotherapy will be contextualised. Different phases of NHS political evolution were identified:

Pre-1948: Historical influences

1948-74: Administrative command and control

1974-82: Consensus management

1982-89: General management

2.1 Pre-1948: Historical Influences

The genesis of the NHS was in the 19th Century. The 1834 Poor Law Amendment Act was designed to discourage the provision of relief for those refusing the workhouse. By the late 1840s most workhouses outside London housed only:

“The incapable, elderly and sick.” (Fowler 2014, p.73.)

In the 1860s, increasing concern about the state of London's workhouses and their medical facilities, led to pressure for changes. The Metropolitan Poor Act (1867,) was passed and the care of London's sick poor was brought under a new body, the Metropolitan Asylums Board. Responsibility for administration of

the Poor Law passed to the Local Government Board in 1871, with emphasis moving from the workhouse as a receptacle for the helpless poor, to its role in the care of the sick and helpless. The Diseases Prevention Act (1883,) allowed workhouse infirmaries to offer treatment to non-paupers. Hospital charities argued for a state system or an insurance principle, to provide sick care when needed. Several municipalities aspired to run hospitals as well as utilities.

In 1911 the National Insurance Act was passed, providing insurance only for GP services for manual workers, but not their families. This led to the call for services to become more equitable, in both quality and availability to all.

Royal physician Lord Dawson was commissioned whilst he was Chairman of the Consultative Council on Medical and Allied Services in 1919, to produce a report on:

"Schemes requisite for the systematised provision of such forms of medical and allied services as should, in the opinion of the Council, be available for the inhabitants of a given area".

An Interim Report (Ministry of Health (MoH) 1920,) set out detailed plans for a network of primary and secondary health centres, together with architectural drawings including the equipment needed for "massage, electricity, physical culture". The hospitals would refer the most difficult cases to university hospitals. The scheme detailed a new pattern of medical administration. A single Health Authority to unify and control all health services, with administrative medical officers and a medical advisory council. The interim report was published to stimulate debate, though no final report was published.

The 1926 Royal Commission on national health insurance, concluded to separate medical services from the insurance system. In the 1930s, local authorities took over poor law hospitals, becoming municipal hospitals; with some opposition. The quality of healthcare varied widely, with country areas poorly served, having relatively few hospitals compared to city provision.

During the 1930s the BMA wrote reports (1930,1938,) calling for improvements in the provision and organisation of healthcare, though it was not unanimously supported. The Political and Economic Planning survey (1937,) noted that General Practitioners (GPs) carried out most medical and surgical procedures, without checks on their qualification or competence, and with poorer provision in deprived areas. This resulted in the need for more co-ordination and rationality regarding resource distribution.

Consensus determined that public fundraising “topped up” by charges to individuals comprising 50% of costs, was no longer viable. There was, however, tension between GPs and hospital consultants competing for the same resources.

The Chief Medical Officer, MacNalty recommended “nationalisation” in the MoH annual report (1939):

“The voluntary system with all its excellent attributes is unsuited to modern needs of the whole population... may meet with much opposition from the medical profession.” (Public Records Office,1939.)

World War II demonstrated the benefits of co-ordinating health services. The White Paper, “A National Health Service” (MoH 1944,) attempted to reconcile

the views of the coalition partners, (Vickers, 1979). It sought to give a balance between central control and local demands, assigning planning responsibility to the Minister, and executive responsibility to local government. The medical profession was largely strongly opposed to local government control of the health system.

The voluntary sector, was almost bankrupt prior to World War II, but was saved by the government's scheme of paying for stand-by beds for war casualties; confirming that longer-term financial viability required central funding. The landmark Beveridge report "Social Insurance and Allied Services" (House of Parliament, 1942,) did not fully outline the health service funding; stipulating that a nationalised health service was one way Britain could help beat the five great evils of: Want, disease, ignorance, squalor and idleness. The report was based on principles of universality and comprehensiveness; with a desire to help those most in need, to raise standards of healthcare for all regardless of social status. The 1944 White Paper (MoH 1945,) set up central health services council to advise on national health policy, with a hierarchy of public accountability through elected representatives.

In 1945, Aneurin Bevan was appointed as the Minister for Health, his appointment was not welcomed by all Ministers, being junior in both age and experience (Iremonger, 1970). Bevan constructed a scheme to nationalise the network of municipal, voluntary and private hospitals into a single system. There was conflict between Bevan's centralised paternalistic rationalism, and local government's desire to have local control and influence. Minister Morrison, who

had fought for London's takeover of the private voluntary hospitals, was reported as having a "classical confrontation" (Rintala 2005, p.40,) with Bevan, who had more left-wing views; favouring nationalisation of all hospitals. Bevan developed Regional Boards and District committees, creating the separation of medical care and public health.

Following Labour's election victory, Bevan presented his plans for health service nationalisation (Bevan, 1945). He gained Cabinet agreement, though Willink warned the House of Commons (HoC) that the NHS:

"Will destroy so much in this country that we value." (Hewitt, 2006)

The opposition subsequently voted against the first Bill in Parliament 51 times. Bevan specifically ruled out insurance systems, preferring that the NHS would be funded through national insurance. He argued that local councils were too small to run a hospital system, identifying the issue of under-doctored areas. He committed that every person could be assured of getting the advice and treatment they needed.

The main obstacle to overcome was conflict within the medical profession. Doctors demanded representation, but there was deep-seated conflict between GPs and Consultants. The BMA was opposed to turning GPs into "salaried servants of the state". When Bevan later took control of the planning for the NHS, he adopted a strategy to split the medical profession by trying to enlist the support of the Royal Colleges against the BMA. The Royal College of Surgeons (1948,) asked members to vote with their conscience on acceptance of the NHS Act, which was reported as "compulsory co-operation"(Rintala, 2005.)

Several strategies were put in place to gain support from hospital consultants. Teaching hospitals were given special status; the right to private practice using NHS beds was secured, as well as a system of merit awards. The pivotal point of concession for consultants was representation on Regional Boards and Hospital committees, which Bevan was not prepared to extend to other health workers. The lucrative pay deal for consultants led Bevan to comment:

“I stuffed their mouths with gold.” (Abel-Smith 1964, p.480.)

GPs feared the proposal for local authority control and the longer-term transition to salaried status. There followed a bitter disagreement, threatening the launch of the NHS. Bevan conceded to amend legislation withdrawing the salaried GP option, gaining support from the BMA, without making concessions to the other professions (Marmor and Thomas, 1972.)

Opponents of the Bill, cited it as a, “Medical Service Bill” rather than a “Health Service Bill”; as it did more to placate the medical profession than it did to provide a unified health service (Hansard, 1946). Doctors gained strength by gaining a monopoly of legitimacy, blocking changes (Hecló, 1974.)

2.2 1948-74: Administrative Command and Control

The NHS (MoH 1944,) born on 5 July 1948, offered free and universal entitlement to state-provided medical care. The inception of a welfare state was welcomed by many in post-war Britain. Health Minister Bevan announced:

“It has not had an altogether trouble-free gestation. There have been understandable anxieties...my job is to give you all the facilities, resources and help I can, and then to leave you alone as professional

men and women to use your skills and judgment without hindrance. Let us try to develop that partnership from now on."(Clark and Briggs, 2005, p.1322.)

The NHS of 1948 mirrored society, with collectivism reconciled to scarcity, believing in the rationality of planning (Klein, 2013). It was financed almost entirely from central taxation, paid for by every working adult; the rich paying more than the poor. Everyone was eligible for care; people could be referred to any hospital, with care being free at the point of use.

The fundamental questions for politicians were: How best to organise and manage the service, how to fund it adequately, how to balance the conflicting demands and expectations of patients, staff and taxpayers and how to ensure the allegedly insufficient resources were targeted where most needed? Bevan foresaw that expectations would always exceed capacity and that the service would be required to change and develop, though others predicted that health problems would diminish (Rivett, 2009). The structure was tripartite:

Hospital services; 1000 hospitals owned and run by voluntary bodies and 540 run by local authorities, were all nationalised and staff salaried. 14 Regional Hospital Boards oversaw local hospital management committees. Teaching hospitals were directly responsible to the MoH.

Family doctors, dentists, opticians and pharmacists; were self-employed under a contract for services from an executive council. GPs acted as "gate-keepers" to the rest of the NHS, referring patients where appropriate to hospitals and

prescribing medicines. Eye tests were provided by opticians. Pharmacists provided over-the-counter medicines and dispensed GPs' prescriptions.

Local authority health services; were managed by a Medical Officer of Health, who had lost command of municipal hospitals but still ran immunisation and maternity clinics with community nurses to support GPs, with responsibility for control of infectious diseases. Additionally there was a school dental service.

Doctors developed a position of dominance by having representation at every level of NHS bureaucracy, with the ultimate tool of veto over the policy agenda.

Bevan reported publicly his frustration in dealings with the medical profession:

“We have never been able yet to appoint a Minister of Health with whom the BMA agree”. (Bevan 1948a, p.41.)

Estimates of the cost of the NHS were exceeded and within three years some fees were introduced; prescription charges of one shilling and £1 for dental treatment, influencing Bevan to resign in 1951.

Increasing expenditure led to the appointment of the Guillebaud Committee (1953,) to enquire into the NHS cost. This was the first major review of the NHS and its workings reporting that the service's record:

“Was one of real constructive achievement” (House of Parliament, 1956, p.110).

In 1956, the NHS launched the national administration training scheme, recognising that managers needed skills and development to undertake tasks required of them.

One of the significant events in the evolution of government health policy was Prime Minister Macmillan's decision in 1958 to accept the Chancellor of the Exchequer's resignation in objection to increased government expenditure, opposing the scale of health spending. The NHS budget increased by 12.8% in real terms (1950-58); then by a further 26% during the 1960s, (Klein, 2006). It was a period of rapid growth in public expenditure, but also a realisation that healthcare costs were rising, from £447M in 1949-50, to £883M in 1960-61 (OHE, 2009). Better medical treatment increased survival rates, requiring more resources. Conflict was recognised, between free healthcare that has no incentive to suppress demand, with the taxpayers desire to control spending. This mirrored the conflict between professionals wanting to develop their skills and provide expertise, and the control of healthcare demand.

1960 saw changes in both the politics and administration of the NHS. Powell's 1961 "Water Tower" speech (Vize, 2008) saw the beginning of a programme of mental health bed closures and the concept of "care closer to home".

Government set up the Public Expenditure Survey Committee in 1961, aiming to achieve stable long-term planning. The MoH's "Hospital Plan"(1962,) was the first attempt to define acceptable standards for hospital services, proposing the development of District General Hospitals (DGHs) for populations of 125,000, based upon a bed norm of 3.3 acute beds/thousand. The aim was to modernise and rebuild many hospitals, integrating them with health and social services. This period saw the NHS developing a momentum of public popularity as treatment improved with medical advances.

The Royal Commission for Doctor's pay, made its first report (Royal Commission, 1968a) to alleviate growing unrest regarding GP pay. This withdrew the requirement for Doctors to use a collective bargaining structure through the Whitley Council. The 1967 the GPs' Charter introduced a new contract, providing financial incentives for practice development.

The Shrewsbury Sheldon mental hospital fire inquiry, set up after the death of 24 patients (Hansard 1968a,) and the subsequent Committee of Inquiry into the Allegations of Ill-treatment of Patients and Other Irregularities at Ely Hospital Cardiff (1969,) exposed the mal-treatment of “institutionalised” mental health patients. Doctors were criticised for outdated, intolerable clinical practices, questioning the balance of power held by doctors and their lack of accountability. While government provided the funds, doctors controlled what happened with the budget:

“Veiled under the shield of clinical autonomy” (Logan et al, 1972.)

In 1969, the Secretary of State for Social Services gave a pessimistic prognosis that the pressure of demography, technology and democratic equalisation, would together be unaffordable (Crossman, 1969). He rejected the option of charging more, opting for an increasing reliance on national insurance contributions. Health Authorities (HAs) were frustrated by government not giving them freedom to manage, while others reported an institution that had little command, and poor control (Klein, 2013). Ministers were frustrated by the lack of implementation of their policies by regional authorities.

NHS structural change was not significant between 1948 and 1974. It was a period of consolidation, though there were several reports where structure was questioned and criticised. The 1960 Porritt report, saw the medical profession calling for unification, and requesting debate on NHS structures (BMA, 1962). The tripartite structure, which was financed centrally but structured and managed separately, was criticised. The MoH report, "First report of the joint working party on the organisation of medical work in hospitals" (1967,) encouraged the involvement of clinicians in management. Hospital activity analysis was introduced to provide better patient-based information. The "Report of the joint working party on the organisation of medical work in hospitals" (MoH 1967a,) aimed to develop the review of clinical work in hospitals, recommending that doctors could and should improve their administrative systems, without waiting for organisational change. The report recommended the creation of hospitals clinical divisions, to ensure effective management and efficient deployment of resources. The Salmon Report (MoH 1967b,) encouraged the development of a senior nursing staff structure to raise the profile of nursing in hospital management.

In 1968, the Crossman Green Paper on NHS (Hansard 1968b,) structure set out its central theme of unified administration, replacing the 700 separate existing authorities. The report recommended 40-50 area Boards in England and Wales, replacing the regions. "NHS: The future Structure of the National Health Service" (DHSS 1970,) proposed a unified administration at all levels of the service and continuity of care with more flexible use of staff. However,

government change prevented these plans being enacted. Joseph, Secretary of State, recommended that the service be reorganised under HAs and outside local government, with the regional tier being maintained. Following a Green Paper (DHSS 1971,) the White Paper was published (DHSS,1972a).

There was a growing mood of militancy among NHS staff, recognising that for most professions the NHS was the monopoly employer. Health occupations' professional bodies and TUs gradually became more assertive, with the NHS becoming increasingly dispute-prone. In the early 1970s inflation and industrial action became significant, with income policies affecting hospital ancillary staff leading to the first major national dispute, "The ancillary workers' strike"(1972), saw 97,000 taking industrial action (Royal Commission,1979), and increasing conflict with doctors and threats to consultants' private practice income.

2.3 1974-82: Consensus Management

This period saw the continuance of industrial unrest from NHS staff and the first major reorganisation of the NHS since 1948. The reorganisation tried to placate opposing views, to bring managerial efficiencies while satisfying the desires of the professions, with "maximum delegation downwards, with maximum accountability upwards", a combination which was incompatible.

Consultation took place prior to the 1974 reorganisation. Key issues included local government reorganisation and the desire to improve the co-ordination of Health and Social Services by matching boundaries. The division between central and local control had political expediency, but lacked effective

administrative capability. Restructuring took place on 1st April 1974, the aim of which was to:

“Provide a fully integrated service in which every aspect of healthcare could be provided by the health professions” (DHSS 1972b, p.9)

The key features of NHS reorganisation (Paton, 1975) included:

- Coterminous health and local authorities
- 14 Regional HAs
- 90 Area HAs and Family Practitioner Committees
- 192 Districts
- Integration of health services in Districts
- Participation of clinicians in management
- Clear allocation of responsibilities of officers
- Consensus decision-making
- Decentralisation of decision-making
- Better use of resources

The resulting arrangements introduced management teams at Regional, Area and District levels. Community services were also affected with the abolition of the Medical Officer for Health post, being replaced by community physicians.

The degree of managerialism was criticised as “terrifying” (DHSS, 1972b).

However, it could be argued that the structure was not inspired solely by a desire for managerial efficiency, and that it fulfilled the need identified by advisory managers to the government to break free from the hegemony of the civil service. The Regions were maintained to keep the civil service with some degree of control, possibly a lost opportunity to divest central control and deliver sustainable reorganisation.

A common feature was consensus decision-making with the aim of promoting centralisation, with the medical profession maintaining its autonomy. Consensus management had been described by Fox (1966,) as both unitary and pluralistic. The unitary rationale being based on the premise that parties involved in the decision-making process had objectives that do not fundamentally conflict with each other, assists consensus. By contrast, the pluralistic rationale allowed for the existence of differing interests within organisations, requiring parties to negotiate and compromise (Harrison,1982). This pluralistic conflict was a feature of the 1974 reforms. The overarching aim of the process was to reach agreement by consensus within management teams. The disadvantages were that the new system was complex and managerially driven. The 1974 reorganisation aimed to give “experts” a voice, most noticeably doctors, providing a complex multi-layered structure which made decision-making remote and slow. This weakened accountability and produced weak decisions (DHSS 1983; Kogan 1978.)

Following the 1974 general election the Labour government set priorities to ban private practice in NHS hospitals, and reduce the bias towards hospital medicine. Also in 1974, the Health Service Commissioner was established; though not managing clinical judgement complaints, ensuring retention of professional autonomy. Resources had been distributed unevenly across the NHS since 1948, therefore Ministers set up a Resource Allocation Working Party (DHSS, 1976). It produced a system of allocation targets based on population, mortality and other factors.

A Royal Commission on the NHS (DHSS 1979b,) was appointed to look into the problem areas surrounding decision-making. The Merrison Report (DHSS 1979c,) strongly supported consensus management (Kogan, 1978). There were both supporters and opponents of consensus, but with DHSS endorsement this model survived longer. The ideal was to meet everyone's desires, reconciling conflicting policy aims, though opponents considered that this ideological and impractical methodology brought about conflict not consensus leading to disillusionment in the later 1970s (Elcock and Haywood, 1980). Disillusionment with consensus coincided with a growth in Trade Union (TU) membership for healthcare workers rising from 40% in 1974, to 60% by 1984 (Sethi and Dimmock 1982). Consultants became increasingly militant and in 1975 the medical profession for the first time took industrial action (BMJ, 1978.) Observers at this time described the "*contradictions of the welfare state*" making indirect normative criticism (Osse,1982).

The financial crisis of 1976, culminated in the UK government borrowing \$3.9Bn from the International Monetary Fund. This resulted in severe cuts in public spending, with cash limits imposed on the NHS (excluding primary care) for the first time. This led to the acceptance of monetarism policies. The two main political parties had opposing views on health policy, leading to confrontation between the values of individualism and collectivism with consensus over the need to control public spending. This fuelled a wave of NHS industrial disputes whereby the ancillary staff unions took strike action during the 1978-79 "Winter

of Discontent” to support their claim for £60/week (BMJ, 1979). The CSP became a combined professional body and TU in 1976.

2.4 1982-89: General Management

The next period was characterised by recession and inflation; “stop-go”, which had been a feature of successive governments through the 50s, 60s and 70s. There was a realisation that the post-war economic growth had ended. The health service increasingly struggled to adapt to the changing economic conditions, leading to conflict regarding the financial boundaries within which the NHS operated. It had become a “victim of its own success”, with new technological developments and life expectancy extending. Despite public expenditure cuts of the late 1970s, the NHS remained relatively protected with annual budget in 1980-81 £644 million higher than it had been in 1975-76; 9.3% increase over this period, (Social Services Committee, 1981) but in real terms, only just over 1% p.a.

From the mid-1970s neo-liberal policies were resurgent, though some right-wing politicians remained anti-NHS. The 1979 election saw both parties prioritising spending on the NHS and commitment to simplify the organisational model. The Thatcher government had many criticisms of the NHS including; its centralised monopoly, excessive bureaucracy, inefficiency, medical emigration, rationing through waiting lists, inflexibility and inability to adopt advanced methods of treatment (Bosanquet, 1983.)

The newly elected government published a consultative document “Patients First” (DHSS 1979b,) following on from the Royal Commission (DHSS 1979a). Its aim was to simplify the NHS structure, moving responsibility for making decisions closer to the localities, proposing that the District Health Authorities (DHAs) should become the key accountable bodies, responsible for planning and service provision (HC(80)8; DHSS 1980). “Patients First” was the platform for the wide ranging series of the next two decades, retaining the dilemma of central versus local control.

One year after the 1982 reorganisation, general management was introduced following the publication of the “National Health Service Management Inquiry” - Griffiths Report (DHSS,1983) and the subsequent HC(84)13 (DHSS 1984a). The Griffiths Inquiry was unique in the history of investigations into the workings and management of the NHS. The team comprised only four members, with no medical (or physiotherapy) interests represented, taking only six months to complete. The report concluded that there was a lack of drive in the NHS because there was no one person held accountable for action; decisions were delayed or avoided, leading to inefficiencies. The main findings were that there was no continuous evaluation of performance, management objectives were rarely set, little output measurement and clinical and economic evaluation was uncommon. An observation was that a clearly defined general management function was absent from the service:

“...If Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge” (DHSS 1983, p.10-12).

The report transformed the management arrangements of the NHS; it blamed consensus policy for making decisions which were weak and of poor quality. Much of the report detailed changes which were needed in attitude, understanding and expectations. It brought about a more assertive style of management, with the NHS mirroring changes on a national scale particularly the relationship with TUs, who opposed government plans.

The introduction of general management, (DHSS 1984,) involved the setting and attainment of objectives and targets for the organisation. There was to be a system of reviews and performance indicators to promote greater accountability and responsibility by doctors and managers in the running of the service and managing budgets. The “Griffiths Report” emphasised the importance of making effectiveness and efficiency the key focus, with rapid decision-making, it:

“Laid down the foundations of a management culture of command and obedience that increased the responsiveness of the NHS to political direction...finally enabled the government to implement its plans for the internal market.”(Butler 1992, p.18.)

The Secretary of State set up and chaired a Health Service Supervisory Board and a full-time NHS Management Board. Below Management Board level, appointments of general managers were made at Regional Health Authority (RHA,) DHA and Unit levels. These posts carried responsibility for improving the organisational efficiency. Responsibility for decision-making was moved closer to the localities, echoing “Patients First”. All day-to-day decisions were taken in the Units of management.

Implementation of the Griffiths Inquiry created a radical and far-reaching culture change, despite their view that the NHS was in no condition to undergo another restructuring. The report brought a change in management style and underlying assumptions about the NHS being a “market”. The new managerialism (Exworthy and Halford 1999,) was an example of the politics of “second best”, in that it was privatised at the margins for example, ancillary services that were tendered out to private companies, but the core of the NHS was not overtly privatised, but made more market-like. This was accompanied by a steady growth of the private health sector (Bartlett and Phillips, 1996). As a result of the reorganisations and the development of the DHAs as key accountable bodies, management posts were gradually introduced for the AHPs at District level and in the case of physiotherapy, there were 180 District management posts out of the 206 DHAs in England and Wales (Jones 1991).

APPENDIX 3 HEALTH AND CARE SYSTEM, ENGLAND APRIL 2013

Source: NHS Choices (2014)

[Figure has been removed due to Copyright restrictions]

APPENDIX 4

AN ALTERNATIVE GUIDE TO THE NEW NHS IN ENGLAND 2015

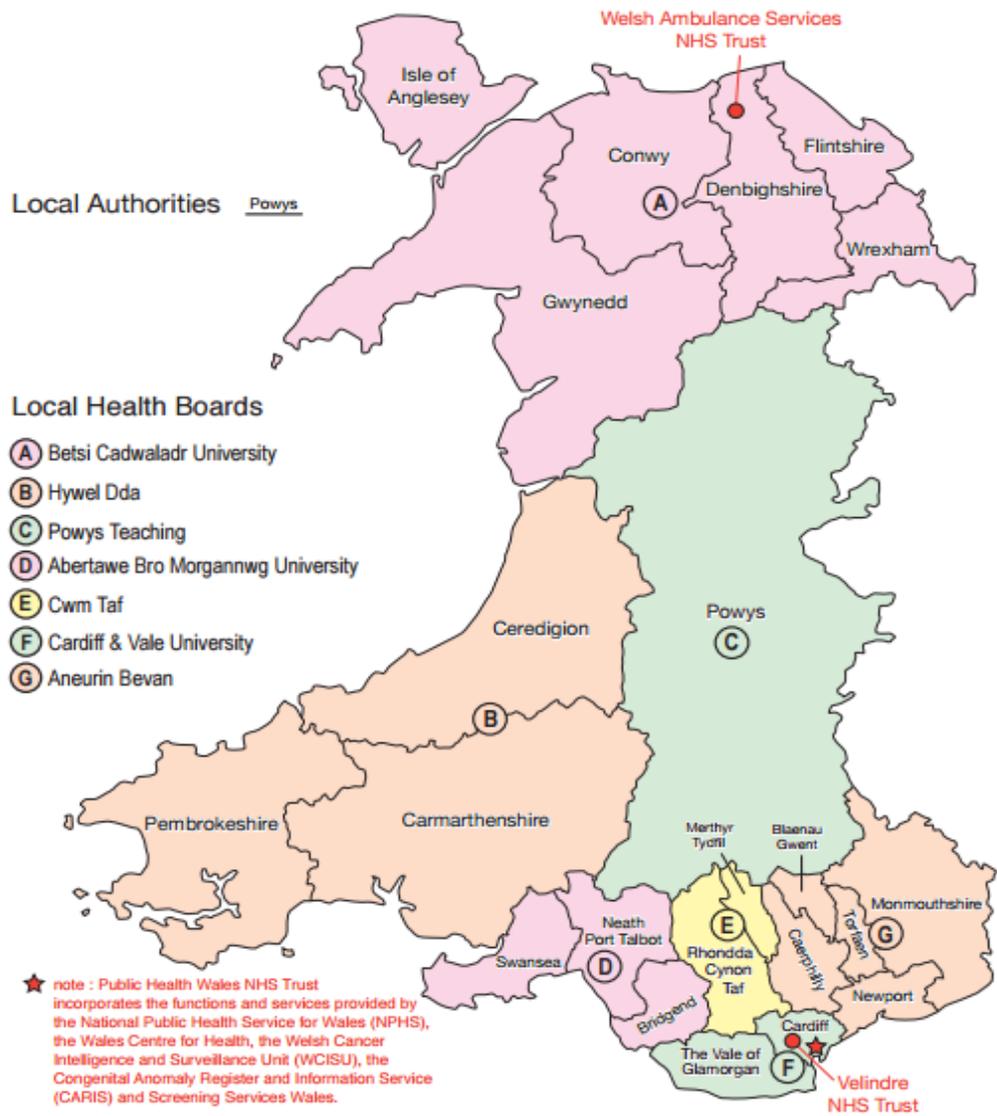
[Figure has been removed due to Copyright restrictions]

Source: Kings Fund (2015a)

APPENDIX 5 NHS WALES ORGANISATIONS, POST 2009

Wales

Local Authorities Local Health Boards



Cartographics
artograffeg

October 2009

Source: NHS Wales (2009)

APPENDIX 6 THE DEVELOPMENT OF PHYSIOTHERAPY

Massage is one of the oldest forms of medical treatment and can trace its origins back to China in 3000BC. It was utilised by both the ancient Greeks and Romans. Hippocrates spoke of the benefit of friction to “*bind a joint that is too loose and loosen a joint that is too tight*” (Bentley and Dunstan 2006, p.5.) “Medical rubbing” grew in popularity in the latter part of the nineteenth century, performed largely by ill-educated but respectable women. An influx of Swedish men and women who had been trained at the central institute in Stockholm led to a great increase in demand for massage which was provided by members of the medical profession and trained nurses.

By 1890 some massage establishments moved from medical rubbing into “houses of ill-fame” (CSP, 2012c). In 1894, the BMJ published an editorial titled “Immoral massage establishments” (BMJ 1894,) in language of moral outrage, claiming that:

“A good many “massage shops,”... are very little more than houses of accommodation” (p.88.)

This report drew comment from the Home Secretary. The implication was that many massage establishments were merely a front for brothels, and many masseurs and masseuses were simply offering massage as a euphemism for prostitution. During 1894, Lucy Robinson, Rosalind Paget, Elizabeth Manley and Margaret Palmer trained midwives/nurses and masseurs at the Royal London Hospital, devised a plan to establish a “Society of Massage”, to ensure the respectability of their work and to:

“Make massage a safe, clean and honourable profession for British women” (Wicksteed 1948, p.14.)

They established as the Society of Trained Masseuses during 1894. One of the founders' first acts was to standardise by examining each other, with further examinations held in 1895. Certificates were issued, and members required signing rules and listening to a lecture by one of the founders.

By discouraging contact between masseuses and male clients and refusing to register male masseurs, the Society reassured the medical establishment of its propriety. There were strenuous efforts of the founders to court medical patronage as it was recognised that medicine had become the principal voice in the political and social campaign to rid the population of illness and disease. By 1896 the Society was inviting patronage from eminent doctors and was seeking medical assistance in qualifying its students. The Society soon developed a code of conduct for its members and thus at this early stage in its development, had accorded with three of the stages in the natural history of professionalisation: The founding of an association based on training, examinations of competence and an ethical code (Friedson, 1983). The establishment of the physiotherapy professional association did not give rise to inter-occupational conflict as the medical profession retained a firm control over the Society. Medical control sought and fostered by the Society was seen as essential to its survival. The ethical code of practice of the profession forbade the treatment of patients other than by direct referral from a doctor. Originally,

physiotherapists carried out doctors' instructions, similar to a pharmacist dispensing a prescription.

Foucauldian discourse analysis regarding the development of the profession undertaken by Nicholls and Cheek (2005,) proposed that power was a creative influence in the formation and transformation of the Society of trained Masseurs; the productive nature of power enabled biomedical, or, more specifically, biomechanical discourses to emerge as a way for the founders to attain social respectability for themselves and their work. This gave physiotherapists license to touch patients, massage, manipulate and treat them, whilst at the same time addressing the vexed questions of legitimacy. They gave Society members a status that allowed them to marginalise other competing organisations, such as the Harley Institute, which could not gain the necessary medical respectability (Barclay, 1994). They also provided a framework around which further advances in physiotherapy could be assimilated.

In 1900, the name of the Society was changed to the “Incorporated Society of Trained Masseuses” with incorporation under the Companies Act. The founders were active in garnering support from high profile doctors, with 79 members of the medical profession giving approval of the aims and principles of the prospectus for the newly “Incorporated Society of Trained Masseuses Ltd.”(1912).

In 1905, male nursing orderlies of the Royal Medical Corps were allowed to take the examinations of the Society, but were not admitted to membership. During the Society's early decades, the willingness of members to be directed by doctors served to reinforce this practice. The tradition of medical patronage remained strong for some years.

The strengthening of the status of physiotherapy was influenced by the 1914-18 war, when war wounded servicemen greatly increased the experience of orthopaedic surgeons. Many more patients survived disabling injuries with surgeons looking to the masseuses for rehabilitation. This increased reliance by the medical profession on trained masseuses, who had extended their range of techniques, resulted in greater public recognition of the profession.

Recognition was symbolised in 1916 by the Queen becoming Patron of the Society and extended in 1920 by the granting of the Royal Charter by King George V, when a merger with the Institute of massage and remedial gymnastics from Manchester was completed. Manual therapy, electrotherapy, exercise therapy and "kindred methods of treatment" were recognised as the central core of physiotherapy practice. On the granting of the Royal Charter, the Society changed its name to the Chartered Society of Massage and Medical Gymnastics and in 1920 men were admitted to membership for the first time and in 1944 changed its name to the CSP.

6.1 Periodisation of professional organisation

During the period of “Historical influences” (Chapter 2.1,) between 1920 and 1939 the Society continued to develop as a national organisation. A structure of Boards and local Branches was established throughout the country. The Second World War created an increased demand for physiotherapy services and the armed forces set up their own physiotherapy schools. A group of male medical gymnasts set up an organisation, the society of remedial gymnasts and recreational therapists.

During the period of “Administrative command and control” (Chapter 2.2,) the founding of the NHS in 1948 allowed physiotherapy to further develop as a profession. Training schools were absorbed into the new NHS, providing financial security. In the newly formed NHS, the CSP continued as the qualifying association and professional body. Following discussions at the CSP in 1948, the World Confederation of Physical Therapy was established in 1951 at an inaugural meeting in Copenhagen, to support international collaboration, peace and stability (WCPT 2015,) now having 130 countries in its membership. In 1968 and 1970 respectively, the Faculty of Physiotherapists and the Physiotherapists Association Ltd. amalgamated with the CSP.

During the 1970s and 80s there were major changes for physiotherapy coinciding with the period of “Consensus Management” (Chapter 2.3.) In 1972 a physiotherapist Lois Dyer, was elected as the first physiotherapist Chairman since 1920, changing the trend from the medical profession. In 1976 the first

degree course in physiotherapy was established at the University of Ulster and following a ballot of membership in 1976 saw the CSP certified as an independent TU. 1977 was a landmark year for the profession, with the recognition of the rights of physiotherapists in clinical diagnosis, and the control of their own clinical interventions (HC(77)33). In 1978 a bye-law change in the Society's statutes finally allowed physiotherapists to treat patients without prior medical referral, getting rid of the outmoded medical dominance (Richardson, 1993).

During the period of "General Management" (Chapter 2.4,) a campaign was run by the CSP to defend District physiotherapy posts (CSP, 1984). The Society of remedial gymnastics and recreational therapy merged with the CSP in 1986, the same year that student physiotherapists were admitted as members.

6.2 Health policy influencing physiotherapy

The beginning of the NHS was a period of optimism for physiotherapists.

Willink, Minister of Health 1943-45, addressed the CSP in 1944, "*Physiotherapy and the nation's health*", praising members for their work and assuring them that a comprehensive health service would offer physiotherapists greater opportunities and responsibilities (Barclay, 1994). In 1945, the CSP Council sent Bevan a memorandum on "*The place of physiotherapy in the NHS*" with particular reference to the fate of private practitioners, he replied that he was:

“Frankly more concerned about the fate of the millions of people who needed treatment than about physiotherapists themselves” (Bevan, 1946, p.87).

In 1946, Physiotherapists as medical auxiliaries, therefore either remained in private practice or moved into the NHS and unlike their medical colleagues had no representation at any level within the NHS, and no compensation for those working in the private sector. 1949 saw a series of eight committees set up by Bevan. The remit was to report on the supply and demand, training and qualification of NHS medical auxiliaries, these included physiotherapists. MoH memoranda (1949,) stated that physiotherapy should be prescribed and directed by a specialist (doctor). These views were reinforced when the Report of the Committee on Medical Auxiliaries, The Cope Report, (MoH 1951,) defined auxiliaries as:

“Persons who assist medical practitioners (other than as nurses) in the investigation and treatment of disease by virtue of some special skill acquired through a recognised course of training” (MoH, 1951).

The dominant role of the medical profession was emphasised. Doctors were seen as taking the lead in the qualifying examinations with half of the examiners being doctors. Auxiliaries were not permitted to validate their own qualifications and felt their views had been ignored. The report also recommended that a statutory body be set up to undertake a review of educational standards, ensuring that the demand for auxiliaries was matched by a well-trained supply. The statutory body envisaged, comprised of two-tiers in which medical

auxiliaries would be in a minority on the policy-making council, but would be allowed a majority on the supervisory council, being subordinate to medicine.

The occupational groups refused to co-operate, so the proposals of the Cope committee (MoH 1951,) were abandoned. Discussion with the medical auxiliaries restarted in 1954 and for the first time, each profession was invited to nominate two delegates to participate.

The “Grey Book”, *“Management arrangements for the re-organised National Health Service”* (DHSS 1972b,) was published a time of reform towards the end of the administrative command and control period, signalling the beginning of the period of consensus management. It described the functions of the new Regional and Area HAs. The importance for AHPs was the acceptance that services would be organised on a District basis. There could be appointments of professional heads at District level and that one of the District Heads could act as convenor.

In 1972, the Tunbridge Report (DHSS 1972c,) was published having the brief:

“To consider the future provision of rehabilitation services in the NHS, their organisation and development, and to make recommendations”.

The Tunbridge Committee members were all doctors. The report reinforced the status quo emphasising the dominance of doctors in the management, and supervision of remedial clinicians. Physiotherapists would have had little, if any, managerial responsibility for the departments in which they worked. Their

clinical practice was prescribed by consultants, including clinical techniques and practice.

As a result of the disquiet caused by the Tunbridge Report, a Working Party, under the chairmanship of McMillan, was set up in 1973. It made recommendations on the future role of the remedial professions (physiotherapy, remedial gymnasts and OT) in relation to other professions and to the patient, and on the pattern of staffing and training (DHSS, 1973). The Working Party recognised that in NHS hospitals the remedial professions had very limited managerial responsibilities associated with their clinical duties. These professions were often represented at management and policy-making levels by nursing or medical colleagues. There opened up opportunities for members of the remedial professions to take up managerial roles. The recommendations fundamentally affected the development of clinical relationships between the physiotherapy and medical professions, as well as the organisation and management of services:

“Only a few doctors would be skilled in the detailed application by therapists of particular techniques... We attach the greatest importance to the doctor/therapist relationship. We think it follows that the therapist can operate more effectively only if given greater responsibility and freedom within a medically orientated team.” (DHSS, 1973.)

McMillan also made recommendations on the management and organisation of the remedial professions was that they should co-ordinate, organise and administer their own services:

“In keeping with the principle that professional people are more properly managed by members of their own profession” (DHSS,1973.)

Furthermore, this approach was strengthened by the recommendation that there should be District level management responsibilities for hospital and community therapy services. These recommendations marked a landmark in the development of therapy services paving the way towards independent status. An often forgotten recommendation was the proposal for the development of one comprehensive and unified therapy profession.

As a result of the 1974 reorganisation and the development of DHAs, management posts were gradually introduced at District level. 180 District Physiotherapy posts out of the 206 DHAs in England and Wales (Jones, 1991). The DHSS designated salary scales to the post of District Physiotherapist, with three different District grades. By placing financial value to the posts, the DHSS endorsed the concept of a self-managing profession at District level. This was further supported by DHSS (1980,) which questioned whether a member of administrative disciplines could take managerial responsibility for non-administrative staff, thereby reinforcing the idea of professions managing themselves. Developments in training and R&D and the establishment of District physiotherapists as well as the appointment of a physiotherapy officer at the DHSS was achieved by 1976.

The DHSS issued a code of practice in September 1977, *“Health Services Development - Relationship between the Medical and Remedial Professions”* HC(77)33 (DHSS 1977,) resulting in part from the McMillan report. This was

arguably the most important document published in the context of the development of autonomy, with three remedial professions being recognised and having rights to make their own decisions on prescribing appropriate forms of intervention for patients referred to their services. HC(77)33 also gave formal recognition of the right to alter or terminate treatment, when appropriate in their professional judgment, paving the way for recognition of the same rights for the other therapy professions. The doctor, in referring patients, was not seen as handing over total control but, in asking for treatment by a physiotherapist, was asking for the expertise of another qualified professional. The circular also stated that the therapist had a duty and a consequential right; to decline to perform any therapy which his/her professional training and expertise suggested was actively harmful to the patient. Further government reports, in 1977 and 1979 strengthened recommendations relating to the management capabilities of Heads of Service HC(79)19 (DHSS,1979d.)

Following the Griffiths report (DHSS 1983,) the appointment of general managers was made. It was the Unit General Management (UGM) function which would at that time be the source of concern for AHP services. In Districts where there were District AHP Managers, managing and co-ordinated across Unit and specialty boundaries. Clinical leadership and management were important aspects of District AHP managers' roles. Under the Griffiths' proposals, UGMs were to be accountable for drawing together planning, implementation and control of performance, with overall responsibility for the total unit budget. With the move towards basing management structures at Unit

rather than District level, a question would arise about the level at which AHP services were to be managed .There was lobbying by the profession to highlight the benefits of District Physiotherapy management and why it “must” stay (CSP, 1984).

Heysell *et al* (1984,) reported that the move towards managed competition and relatively decentralised management units based largely on medical speciality groupings has often been perceived by therapists as a need to “make them fit” with a desire for neat organisational boxes on organisational charts. Underlying the difficulty of incorporating them into decentralised structures includes the failure to realise that the concept of speciality not necessarily being identical for medicine and other professional groupings. Many physiotherapy services follow patients across boundaries, not fitting the structure of either primary or acute care. Developments followed including recommendations for the amalgamation of remedial gymnasts with physiotherapists.

6.3 The Professions

One of the most remarkable developments in healthcare has been the rapid proliferation and growth of new health professions outnumbering doctors, and transforming professionalisation (Baldwin, 2007.) Six of the ten most examined professions in comparative studies of professionalisation are in healthcare (Bourgeault *et al*, 2009.) The “professional” was depicted by Perkin (2002,) as being at the centre of contemporary culture; according to Abbott (1988,) they:

“Heal our bodies, measure our profits and save our souls.” (p.1.)

Professions are reportedly able to solve society's problems, having enabled privileges of self-regulation, monopolies and restrictive arrangements, accompanied by high financial rewards. Professional careers evolved ensuring upward social mobility (Larson, 1977.) Abbott observed that members of a profession try to give it strong legitimacy, so that others would not question their position, with professionals claiming and protecting their right of jurisdiction; diagnosis, inference and treatment.

Flexner (1915,) defined a profession by six traits:

“Professions involve essentially intellectual operations with large individual responsibility; they derive their raw material from science and learning; this material they work up to a practical and definite end; they possess an educationally communicable technique; they tend to self-organization; they are becoming increasingly altruistic in motivation.”(p.156.)

The doctor's professional dilemma (Shaw 1906,) was a satire which described the moral dilemmas of the time, created by limited medical resources and the conflicts between medicine as a business and as a vocation. Early theorists (Carr-Saunders and Wilson 1933,) proposed that a profession was a complex of characteristics, with the “ideal” professions of law and medicine exhibiting all or most of these features. These characteristics included prolonged and intellectual training enabling specialised services, the development of an association imposing tests of competence and the observance of standards of conduct.

Abbott (1991,) proposed that one should not try to define what a profession is, the term “profession” being more honorific than technical, and concluded that:

“To start with definition is thus not to start at all” (p.355.)

Historically, the higher classes occupied the professions and access to them was based on social rank aligned with educational attainment. Perkin (2002,) and Bishop (1997,) observed that as education became more accessible professions were pervading all levels of society, with former “non-professional” occupations seeking professional status and its associated benefits.

Physiotherapy would be in this latter category, as the founders were not from the upper classes (Chapter 3.4.)

The features of “true” professions were defined as a set of attributes or traits (Marshall 1939; Greenwood 1957; Carr-Saunders and Wilson 1933,) though Willis (1989,) argued for a twin focus of both traits and social functionality. Early functionalist and trait theorists drew the relations between professions and organisations as being the differentiation between collegiality and bureaucracy respectively, emanating from a Durkheimian (1964,) and Weberian (1958,) tradition (Evetts, 2004.) They differentiated professions from other occupational groups, focussing on the professions’ function of maintaining social order (Parsons 1968; Millerson 1964.)

Proponents of the functionalist approach, who see the existence of the professions as benign, included Barber (1963,) who claimed that the sociological definition of the professions should differentiate their professional

behaviour in terms of core functions relevant to the social system and to the relationships between the professional and the client. Willis (1989,) noted:

“Professions functioned as a bulwark against the threats to social order, in particular against the growth of large scale bureaucratic organisations.”(p.9.)

Professional groups were viewed as possessing privileged social positions which included self-regulation, in return for non-exploitive use of their high levels of knowledge for the good of society (Larson, 1977.) The converse of this definition was isolation from society, proposed by Dingwall (2004.) Goode, (1960,) introduced the notion of a continuum of occupations, with the professions forming one pole and the least skilled and least organised occupations forming the other pole. Goode’s (1960) characterisation of the “ideal type” profession epitomised a wide consensus of sociological opinion about the basic characteristics of the professions:

“If one extracts from the most commonly cited definitions all the items which characterize a profession... a commendable unanimity is disclosed: There are no contradictions, and the only differences are those of omission” (p. 903).

The differentiating attributes of a “true” profession were perceived by Johnson (1972,) to include: An orientation towards community rather than self-interest; a system of monetary and honorary rewards symbolising achievement; the possession of a high level of knowledge, enabling day-to-day autonomy. Most professions were considered by Johnson to be centred on “problem solving” in a conceptual framework as a defining feature. Collins (1979,) argued in contrast

that knowledge systems served a symbolic purpose functioning primarily to give the holder status, unrelated to their problem-solving capability. Murphy (1988,) criticised Collins for neglecting the importance of the background of problem-solving capacities.

Etzioni, (1969,) defined the basis of professional authority being knowledge and the relationship between administrative and professional authority. Knowledge-based professional groups may be found in different societies and also granted “jurisdiction”, reflecting the importance of social change on the evolution of the professions. Professional experts within bureaucracies develop horizontal connections to other experts and their professional communities. This contrasted with the Marxist viewpoint that modern capitalism was driven above all by the self-expansion of capital. Parsons (2013,) further proposed that professions were motivated by altruism.

Abbott (1988,) theorised how occupational groups achieved power by controlling expert knowledge constructing themselves by forging links between their distinctive occupations. He coined the term “jurisdiction” to denote the right to control the provision of particular services and activities. Morrell (2003,) suggested that the professional values could be summarised in the words: confidence, confidentiality, competence, contract, community responsibility and commitment, concurring with Downie’s (1990,) view of “legitimate authority”, being both moral and legal. Friedson (1988,) gave another dimension, selecting “autonomy” as the central characteristic. Navarro (1986,) however, associated

the professions with the oppressive capitalist classes, and not being for the “greater good” of the majority.

Scott (2008,) presented the concept of professional agency, later developed to include the concept of institutional work (Lawrence *et al.*, 2009.) The broader role of professions in processes of institutional change was reported by Muzio *et al* (2013) , with professionalisation being viewed as a subset of the broader category of institutionalisation, insofar as it represents one of several ways to give order, structure, and meaning to a distinctive area of social and economic life and the production of expertise (Suddaby, 2010).

6.4 Semi-professions

Etzioni (1969,) edited a collection of articles defining “semi-professions” as:

“A group of new professions whose claim to the status of doctors or lawyers is neither fully established nor fully desired...[Their] training is shorter, their status is less legitimate, their right to privileged communication less established, there is less of a specialized body of knowledge, and they have less autonomy from supervision or societal control than “the” professions.”(p.v).

He focussed on teachers, nurses and social workers and reported that their training was shorter, mandate to control their work was less fully granted, their right to privileged communication was less established, and they had less of a specialised body of knowledge with less individual autonomy. An alternative approach proposed the classification of “personal service professions” (Halmos, 1970). The “semi-professional” state was considered by Elzinga (1990,) to be

transitional towards full professional status. This classification was criticised by Friedson (1970,) and Torstendahl, (1990.)

6.5 Professionalisation Process

Five attributes of a profession were proposed by Greenwood (1957):

1. Systematic theory
2. Authority
3. Community sanction
4. Ethical code
5. Culture of professional knowledge, behaviour and ethos

Ritzer and Walczak (2001,) proposed different process models with power and action approaches, drawing on Marx' and Weber's theories, considering how professions acquired a power-base, differentiating them from other occupations, and having acquired it exploited and enhanced it; a theory not dissimilar to the concepts of Jamous and Peloille,(1970); Larkin,(1983); Abbott,(1988.) Two broad perspectives were proposed; the Marxist view concerned with "power" stressing the impact of macro-structural and organisational change, viewing the professions as "hired-hands". Secondly, the Weberian view focussed on "action", being more concerned with the impact of human agency in shaping and influencing organisations and environments, suggesting that professional status was actively pursued through collective action, rather than being a result of macro-structural influences.

Professionalisation has been described as a process of market closure and of the professions gaining monopoly control of work (Larson 1977,) an occupational dominance promoting professionals' own occupational self-interests (Larkin,1983.) Johnson (1972,) and Kalekin-Fishman and Denis (2012,) described it as “dynamic ideological constructs”, with medicine being classified as an “ideal profession”, though legal status may usurp the “ideological” construct.

Professionalisation was defined by Vollmer and Mills (1966,) as:

"A dynamic process whereby many occupations can be observed to change certain crucial characteristics in the direction of a 'profession.' Such characteristics may either be structural or attitudinal."(p.vii.)

Johnson (1972,) summarised the five stages of professionalisation historical development further highlighting that the “bureaucratisation” occurred through the creation of professionally-owned and managed bureaucracies, the direct employment of professionals and state mediation, between a state agency and clientele through a legal framework defining overall allocation of resources.

A developmental sequence of professionalisation proposed by Wilensky (1967,) detailed the first step as being full-time work, followed by separating a new area of practice from other occupational groups, then the establishment of training schools, leading to the consideration of standards and community recognition, and the establishment of a professional association. Wilensky postulated that this would be followed by inter-occupational conflict, between the new practitioners and older established occupations in the same sphere.

This sequence was challenged as in the UK the formation of professional associations emerged before the founding of training schools, supporting the theory proposed by Hall (1968,) of a “sense of calling”, which was extended by Bellah *et al* (1985,) to include “Jobs, careers, and callings.”

Parkin (1979,) described social closure as the usurpation of power by the subordinate groups. Friedson (1984,) further described the changing nature of professional control, arguing that the traditional model of professions became hierarchy-free during the 60s and 70s. He discounted the theories of deprofessionalisation (Haug 1973,) and corporatisation (Esland 1980,) instead proposing a third dimension of professional social control, whereby organised occupations were offered special shelter in the labour market, where members exerted control over their fate. This applied to physiotherapy during this period (Chapter 3.4.1).

6.6 Professionalisation models

Two dominant models of “trait” and “functionalist” were reported, though other concepts including neo-Weberian approach and power was also important. Trait theories collectively comprise a series of different “elements”, which supposedly define a profession. This theory assumes that an inherent quality of occupational activity determines the way in which autonomy develops and how institutions impose control. Later researchers used other process-oriented perspectives, with new frameworks: Adler and Kwon (2008,) proposed “civic professionalism and collaborative community”, Barley and Kunda (2006,)

labelled contract work as “itinerant professionalism”; Bureau (2007,) focussed on “organisational professionalisation”.

The trait approach of defining professionalisation has been criticised (Forsyth 1994; Harrison 1994,) representing professional ideology developed by the professions themselves (Saks, 1983.) Although these researchers refer to very different phenomena, they all rejected the trait approach.

Functional theories include both the symbolism and economic interpretations of professionalisation. Parsons (1952,) developed his sociological theory of the professions to counter Weber’s notion that modern society was becoming rigidly bureaucratic. The professions were argued as being fundamentally important to the maintenance of social order (Parsons 1952, 1968,) part of a structural-functional approach, surmising that professions were:

“The most important single component in the structure of modern societies.”(p. 1.)

Though Sorokin (1966) refuted Parsons’ work as:

“Full of sham scientific slang devoid of clear meaning, precision and elementary elegance.”(p.56.)

6.7 Deprofessionalisation

Johnson (1972,) described concepts of deprofessionalisation and proletarianisation resulting from bureaucratisation and corporatisation. Action approaches demonstrated professionals “shaping” their organisations and

managers reacting. Changing patterns of professional control were observed with occupational groups striving for legitimacy and institutional recognition, (Friedson 1971, 1984; Larson, 1977). Later, Ritzer and Walczak (1988,) defined deprofessionalisation as:

“The decline in the possession, or perception that the professions possess altruism, autonomy, authority over clients, general systematic knowledge, distinctive occupational culture, and community and legal recognition.” (p.6.)

Haug (1973,) concluded that the professions were losing their monopoly over knowledge, autonomy and service ethos, as other occupations grew in strength, organisations managed the health professions and culture evolved. He envisioned a society where professions would lose control due to computerisation and improved educational levels would de-mystify professional knowledge, with the public becoming increasingly aware of their rights. This combined with the self-help philosophy challenged the notion of medicine as the exclusive expert in healthcare.

6.8 The Power of Medicine

Baldwin (2007,) proposed that:

“The particular power and authority of medicine derives basically from people’s fears of illness, suffering, and death, and their dependence on the imputed power and promise of medicine to care and to cure” (p.102).

It was the first healthcare profession to enter into a partnership with the state placing it in an advantageous position. The rise of the medical profession in the

nineteenth century and its unique closure, contrasted with the array of non-medical groupings that supported practice at that time and who have since challenged the autonomy of medicine. The dominant trait-based functionalist and structural-functionalist perspectives remained unchallenged until Hughes (1963,) Becker *et al* (1962,) and Friedson's professional dominance theories (Friedson,1970,1971,1984,1985,1986.)

Medicine has been pre-eminent in the division of labour in the NHS because of its position of power. The professional power perspective (Friedson 1970,) argued that medicine's dominance in the division of labour was grounded by autonomy and self-regulation underpinned by a legislative framework, institutionalising its relationship with the state on which it relied for political and legislative support to maintain its dominant status.

The "technical autonomy" of individual doctors which freed them from evaluation by other occupations pinned their dominant position. Therefore the state controlled the social and economic organisation, but the important aspect was the maintenance of technical autonomy.

Friedson (1970,) also identified "functional autonomy" as:

"The degree to which work can be carried on independently of organizational or medical supervision, and the degree to which it can be sustained by attracting its own clientele" (p.53.)

APPENDIX 7 PROFESSIONALISATION CHARACTERISTICS

CHARACTERISTIC	TRAIT
<i>Traits</i>	<ul style="list-style-type: none"> • Self-organising formation of an association • Professional body, strong public voice, autonomy from the state • Code of ethics/standards of conduct overseen by a body of representatives • Training schools, systematic theory, specialist body of knowledge • Derived from science and learning • Skill achievement of a certain level (gained through a prolonged period of higher education), which can be used in non-routine situations • Qualifying examinations and tests of competence • Restricted entry • Educationally communicable • Period of professional socialisation • Public, community sanction/ recognition • Full time practice • Support of the law for practice • Large individual responsibility • Authority • Autonomy of clinical practise • Autonomy of the professions' decision-making • An unusual degree of autonomy in work • An altruistic commitment to service • Provision of a crucial social function • Culture and personal identity of professional knowledge, behaviour and ethos that stems from the professionals themselves • High prestige and earnings(relatively, but not the highest).
<i>Professional "attributes"</i>	<ul style="list-style-type: none"> • Systematic theory • Authority • Community sanction • Ethical code • Culture of professional knowledge, behaviour and ethos • Inter-occupational conflict between the new practitioners and older established occupations
<i>Functionalist</i>	<ul style="list-style-type: none"> • Professions seen as a positive force in social development • Meet a genuine human need • Reward through higher socio-economic reward • Emergence of a full-time occupation • Establishment of a training school • Founding of a professional association • Political agitation directed toward the protection of the association by law • Adoption of a formal code
<i>Sociologically Causal</i>	<ul style="list-style-type: none"> • Levels of knowledge for societal benefit • Lengthy and specialised training • Service orientation • Self-regulation in return for not-exploitive control

Structural Attributes	<ul style="list-style-type: none"> • Establishment of full time-occupation • Formation of a training school that develops and transmits a set body of knowledge and theory • Creation of a professional association with standards of membership • Establishment of a code of ethics • Inter-occupational conflict between new practitioners and older established occupations
Attitude Attributes	<ul style="list-style-type: none"> • Formation and use of a professional association as a reference group • Service orientation • Belief in the self-regulation of the profession • Autonomy of the practitioner from those outside of the profession
Professional Autonomy	<ul style="list-style-type: none"> • National level • District level • Individual level
Technical autonomy Socio-economic autonomy The third logic: the beneficent labour of professionals	<ul style="list-style-type: none"> • Right to use discretion and judgment in the performance of work • Ability of the worker to ascertain/ allocate the economic resources needed to complete work • An organised occupation gains the power to determine: <ul style="list-style-type: none"> - Prevent all others from performing that work - Control the criteria by which to evaluate performance - Who is qualified to perform a defined set of tasks
Processual approach	<ul style="list-style-type: none"> • Control resulting from struggles by occupational groups for institutional recognition and struggles within and between occupations • Institutional and contextual conditions • Power differences between professional-subgroups • Interactions among multiple actors in and around the professions • Professionals' subjective interpretations and feelings
Professional Jurisdiction	<ul style="list-style-type: none"> • The tasks must be directly linked to a formal system of knowledge that legitimizes and "expertises" • Health care to "treat and cure" <ul style="list-style-type: none"> - <i>Diagnosis</i>: Assign subjective properties to objective problems - <i>Treatment</i>: To classify empirical data to suggest a prescription - <i>Inference</i>: Inference between diagnosis and treatment is often automatic but sometimes more complex involving expertise i.e. not protocolised - <i>Academic knowledge</i>: A system of formalised knowledge providing legitimation, research and instruction
Professionalism as a value basis	<ul style="list-style-type: none"> • Knowledge based occupations dealing with risk and uncertainty • "Professionalism" being self- controlling concerned with values, attitudes and behaviour • Professions interrelated and mutually balancing • Professionalisation as a continuum
Profession/ client relationship	<ul style="list-style-type: none"> • Collegiate control (by profession) • Patronage (by client) • Mediation (by the state) • Customer orientation, customer is king" • Interrelationship between professions, organisation and client
Collegiality	<ul style="list-style-type: none"> • Collegial social structure • Collective commitment with
Legitimate	<ul style="list-style-type: none"> • Basis of legitimacy lies in:

authority and domination	<ul style="list-style-type: none"> - Rules and those with elevated position of power - Authority given by tradition - Charisma - Confidence - Confidentiality - Competence - Contract - Community responsibility - Commitment
Closed social structure	<ul style="list-style-type: none"> • Structural category, of "status group." where others accord its members prestige
Bureaucratisation	<ul style="list-style-type: none"> • Rational-legal authority with legitimacy seen as coming from a legal order and laws enacted
Knowledge systems to problem solve	<ul style="list-style-type: none"> • Primary concern is with problem solving to help client
Power	<ul style="list-style-type: none"> • Presence of an assessment process for entry to the profession • How power base is developed • privileges and obligations
Knowledge systems to give power	<ul style="list-style-type: none"> • Primarily to give prestige and power to the owner, giving status
Power of the state	<ul style="list-style-type: none"> • Level of control exerted by government
Professional community	<ul style="list-style-type: none"> • Division of labour • Nature of interdependencies • Tie network structure • Values/basis of trust • Basis of legitimate authority • Orientation to others • Orientation to self
Profession related "norms"	<ul style="list-style-type: none"> • Values: <ul style="list-style-type: none"> - Quality - Client care
Territoriality	<ul style="list-style-type: none"> • Professional personhood • Personal integrity in doing one's work • Taking over medical tasks and functions by force or subterfuge • Seeking out newly defined or abandoned territories • Develop a consensus which will enable them to work together with other professions in a harmonious and integrated way • Professional personhood • Personal integrity in doing one's work, and not letting others invade
Process of professionalisation	<ul style="list-style-type: none"> • Occupations observed to change crucial characteristics to become a "profession" <ul style="list-style-type: none"> - Emergence of a full-time occupation - Establishment of a training school - Founding of a professional association - Political agitation directed toward protection of the association by law - Adoption of a formal code - Control of the market in which they operate

APPENDIX 8

DEPROFESSIONALISATION CHARACTERISTICS

CHARACTERISTIC	TRAIT
“Semi - Professions”	<ul style="list-style-type: none"> • Shorter training • Mandate to control work less fully granted • Right to privileged communication less established • Less individual autonomy because more supervision given • Less specialised body of knowledge
Transitional phase <i>(towards full professional status)</i>	Full professional criteria not yet met
Breadth of practice	Less powerful professional groups may find difficulty in enacting boundary-spanning roles
Itinerant professionalism <i>Afforded to contract workers i.e. a lesser status</i>	Contingent (contract) work for professions gives different relationships: <ul style="list-style-type: none"> • Lack of security • Developing skills base • Lack of corporate support
Deprofessionalisation or limited professionalisation	Employee status weakens the ability to perform as a “true” profession
Feminised workforce	Traditional male dominated professions keeping feminine dominated workforces at a distance

APPENDIX 9

ASSESSMENT TOOL FOR EVALUATING AHP MANAGEMENT STRUCTURES

Fiona Jenkins and Robert Jones (Jenkins and Jones, 2011)

Introduction

Management arrangements for the AHPs often lack consistency and clarity as they do not comfortably 'fit' organisational structures within trusts. In this chapter we present our assessment *Tool* (Table 2.2) for use in evaluating AHP management and organisational structures in the context of quality, effective, efficient and economical service provision. We believe that the proposed *Tool* is unique in that it can be used to evaluate a wide range of management functions of AHP services.

The *Tool* has been constructed using evidence-based information from our combined research spanning two decades, which has provided a valuable and rich source of data on AHP managers' roles, responsibilities and duties, together with the views of postholders regarding the management and organisational structures in which they work. Our research has also included comprehensive literature reviews and investigation of organisational models internationally. The *Tool* has been developed primarily to assess AHP structures in England and the terminology used reflects the English NHS although it is designed to be transferable to a range of health systems worldwide; it has been reviewed by AHP colleagues in the UK and Ireland.

The *Tool* assesses AHP management structures under 10 management *Domains* which were identified from our research. The 10 *Domains* are:

- 1 strategic management
- 2 clinical governance
- 3 human resource management
- 4 clinical/professional requirements
- 5 operational/service management
- 6 resource management

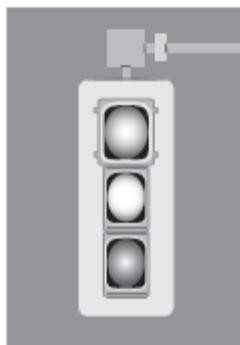
- 7 information management
- 8 education
- 9 commissioning
- 10 service improvement/modernisation.

The *Domains* are not listed in any particular priority order.

Application of the *Tool*

The *Tool* may be used in two ways. Firstly, the current AHP service is assessed using the scoring sheet. Each management *Domain* has several sub-domains or *Elements* which are scored individually using a ‘traffic light’ scoring mechanism. When all the *Elements* of the *Domain* have been traffic light scored, comments and conclusions are recorded. All 10 *Domains* are assessed in this way.

On completion of the scoring the results are analysed, enabling AHP managers to determine strengths and weaknesses of the current management and organisational arrangements, how structure impacts on this and importantly, how the existing management arrangements facilitate or impede the AHP services in providing high-quality, responsive patient care. This enables managers to determine which *Domains* of the service:



- function as near as possible to optimal levels (green traffic lights)
- function less satisfactorily (amber traffic lights)
- function unsatisfactorily (red traffic lights).

If there is an initiative within an organisation to review or change management structures, the AHP manager can use the *Tool* to score the 10 *Domains* and individual *Elements* to assess the likely impact on the service organisation and stakeholders. A comparison between the existing and proposed management structures would then

be possible, enabling conclusions to be drawn and constructive dialogue to take place with senior trust managers and commissioners about the likely advantages and disadvantages of the proposed new arrangements.

Scoring system: assessment *Tool* for AHP management models

We have designed the *Tool* to assess strengths and weakness of different management models. It can be used to assess management arrangements already in place and proposals for new arrangements. The two management models (existing system and proposed new system) may then be compared.

The assessment *Tool* is constructed in tabular form using a separate box for each *Domain* (see Table 5.1, which illustrates a completed example assessment template for one *Domain*). Each *Domain* is numbered: for example, *Domain 1* – Strategic Management, *Domain 2* – Clinical Governance and so on. The *Elements* within each *Domain* are also numbered, with space for comments to be recorded if desired. A Green, Amber or Red score is allocated as appropriate and totalled at the end of each *Domain*. Following this there are text boxes for comments and conclusions about the *Domain*.

The assessment *Tool* is appropriate for evaluating both individual AHP services - unidisciplinary – and clusters of AHP services where these are managed as one large grouping. There are 10 management *Domains*, under which the *Elements* are listed. Not all *Elements* will apply to all services, and therefore these may be left unmarked. Some *Elements* apply to more than one *Domain*, for example, workforce planning which appears in more than one *Domain*.

Example

Domain 1 comprises 10 *Elements*. The traffic light scoring system is completed where:

- Red = No, unable to fulfil this function, unsatisfactory (<25%)
- Amber = Only partially able to fulfil this function
- Green = Yes, able to fulfil this function, satisfactory (>80%).

Comments are made in the element boxes, traffic light scores are totalled, then comments and an overall conclusion about the satisfactoriness or otherwise of the *Domain* are entered in the box at the end of the *Domain*.

We recommend that a separate assessment proforma is used to evaluate each possible or proposed management model.

Conclusion

Our overarching objective in developing this assessment *Tool* has been to ensure –as far as possible – that AHP management arrangements, structures and service organisation are focused on infrastructures that facilitate and support provision of the best possible outcomes for our patients, the service providers themselves and the organisations in which they work.

Change is constant in the NHS and it is essential that we contribute proactively to the process in order to improve services without compromising the legitimate goals of those providing the services, ensuring as best we can that any changes proposed are in the best interests of patient care, are successful and good value for money. There is no simple ‘right’ or ‘one way’ of configuring AHP services; however, it is intended that the assessment *Tool* will be helpful to those AHP managers and others to evaluate their current services or proposed restructuring and changes.

So often we hear of restructuring which takes place without proper consideration of the likely advantages and disadvantages, or put forward on the basis of ‘politics’ or ‘ownership agendas’ of particular organisations or managers. Sometimes, this takes place without proper consideration of how services might be structured to provide optimum high-quality clinical outcomes, appropriate care pathways, patient flows, development for staff, economies of scale, ‘critical mass’, elimination of duplication, excellent communication and networking and many others. The assessment *Tool* incorporates a ‘big picture’ overview, it is evidence based, informed by research and detailed studies of the available literature and examination of a wide range of models – some in place, and some theoretical.

There are approximately 170 000 registrants in the professions within the remit of the Health Professions Council in the UK and a large number of support staff in a wide variety of roles. This represents a very significant percentage of healthcare provision and use of resources. This workforce undertakes many millions of healthcare interventions and patient contacts every year. It is essential, therefore, that decisions about management arrangements, structures and organisation of these services are evaluated using a methodical approach. Our assessment *Tool* may be used to contribute to this process.

Completed example template of assessment *Tool*

	Red	Amber	Green
1 Strategic management <i>Domain</i>			
Mark and comment on each element answering this question: Do the management arrangements enable effective:			
1.1 Contribution to Local Development Process for the whole service <i>Comments: Yes, fully engaged in LDP making recommendations for whole service.</i>			✓
1.2 Medium and long-term planning and service development for whole service (strategic plan for whole service for 1–3 years) <i>Comments: Have a plan for 2 years ahead, not 3 years.</i>		✓	
1.3 Contribution to the SHA workforce plan for the professional group(s) <i>Comments: No, not involved in input to workforce plan for my service, HR do the SHA return without my input.</i>	✓		
1.4 Medium- to long-term workforce planning for the whole service (for 1-3 years) <i>Comments: Yes I have a workforce plan developed within the service.</i>			✓
1.5 Non-fragmented service through effective strategic management of whole service. <i>Comments: Provide both acute and community services, staff managed as one group.</i>			✓
1.6 Clear lines of accountability for the whole service(s) (both management and professional accountability) <i>Comments: All staff have one management and professional line of accountability.</i>			✓
1.7 Management authority for the whole service (s) (full and equitable management authority) <i>Comments: Limited management authority in PCT, locality managers</i>		✓	

<i>hold staffing and training budgets in several areas, which limits management authority.</i>			
1.8 Management responsibility for the whole service(s) (full and equitable management responsibility) <i>Comments: Full management responsibility for Acute Trust staff, but not for all PCT staff.</i>		✓	
1.9 Initiation and management and monitoring of Service Level Agreements (where these are in place) <i>Comments: Do not have any SLAs in place but should have as provide services in other Trusts.</i>	✓		
1.10 Strategic development and partnership working with other organisations such as social services and education <i>Comments: Yes, have well-established senior level strategic mechanisms.</i>			✓
1.11 Initiation and management and monitoring of external contracts (where these are in place) <i>Comments: Yes, have contracts with care homes which I initiated and monitor.</i>			✓
1.12 Implementation of government policies and initiatives across the entire service(s) <i>Comments: Have authority to do this in only part of the service</i>		✓	
1.13 Comprehensive strategic overview for the profession(s), to be fully engaged at strategic level <i>Comments: Head of service not engaged at strategic level, only input is from band 7 clinician</i>	✓		
Traffic light totals	3	4	6
<p>Overall domain conclusion:</p> <p>Mostly positive, however, room to improve strategic workforce planning, develop SLAs and engage head of service.</p> <p>PCT-based staff have less access to training funds as these are held by the locality managers and less flexibility with staff management as staff budgets held by PCT.</p>			

Assessment of management structures: the assessment tool

<i>Assessment criteria</i>	<i>Red</i>	<i>Amber</i>	<i>Green</i>
1 Strategic management domain			
Mark and comment on each element answering this question: Do the management arrangements enable:			

1.1 Effective contribution to Local Development Planning process for whole service <i>Comments:</i>			
1.2 Medium and long-term planning and service development for whole service (strategic plan for whole service for 1-3 years) <i>Comments:</i>			
1.3 Contribution to the SHA workforce plan for the professional group(s) <i>Comments:</i>			
1.4 Medium- to long-term workforce planning for whole service (for 1-3 years) <i>Comments:</i>			
1.5 Non-fragmentation of the service through effective strategic management of whole service <i>Comments:</i>			
1.6 Clear lines of accountability for the whole service(s) (both management and professional accountability) <i>Comments:</i>			
1.7 Effective management authority for the whole service(s) (full and equitable management authority) <i>Comments:</i>			
1.8 Effective management responsibility for the whole service(s) (full and equitable management responsibility) <i>Comments:</i>			
1.9 Initiation and management and monitoring of Service Level Agreements (where these are in place) <i>Comments:</i>			
1.10 Strategic development and partnership working with other organisations such as social services and education <i>Comments:</i>			
1.11 Initiation and management and monitoring of external contracts (where these are in place) <i>Comments:</i>			
1.12 Implementation of government policies and initiatives across the whole service(s) <i>Comments:</i>			
1.13 Strategic overview for the profession(s) to be comprehensive <i>Comments:</i>			
Traffic light totals			
Overall domain conclusion:			
2 Clinical governance domain			
Mark and comment on each element answering this question: Do the management arrangements enable:			

2.1 The provision of effective patient-centred services – including cross-boundary working to deliver care pathways and the involvement of service users in planning and service evaluation <i>Comments:</i>			
2.2 Effective implementation of evidence-based practice equally across whole service(s) <i>Comments:</i>			
2.3 Consistent management of research and development activity across whole service(s) <i>Comments:</i>			
2.4 Consistent management of clinical audit across whole service(s) <i>Comments:</i>			
2.5 Effective management of service risk across whole service(s) <i>Comments:</i>			
2.6 Effective management of health and safety across whole service(s) <i>Comments:</i>			
2.7 Management of equitable staff education and training across whole service(s) <i>Comments:</i>			
2.8 Management of efficient, equitable staffing and staff management across the whole service (s) <i>Comments:</i>			
2.9 Effective communication across whole service(s) <i>Comments:</i>			
2.10 Rapid and equitable management of and response to complaints across whole service(s) <i>Comments:</i>			
Traffic light totals			
Overall domain conclusion:			
3 Human resource management			
Mark and comment on each element answering this question: Do the management arrangements enable:			
3.1 Effective staff recruitment to all grades and all specialties throughout the service(s) <i>Comments:</i>			
3.2 Career progression opportunities and succession planning across the entire service(s) <i>Comments:</i>			
3.3 Flexibility of staff deployment across the service(s) to cover absence, sickness, leave, etc. <i>Comments:</i>			
3.4 Flexible working arrangements such as provision of 7-day working			

<i>Comments:</i>			
3.5 Uniform application of grievance and disciplinary procedures across entire service(s) <i>Comments:</i>			
3.6 Consistent application of HR policies and procedures for all staff across entire service(s) <i>Comments:</i>			
3.7 Equitable and consistent application of Agenda for Change across the entire service(s) <i>Comments:</i>			
3.8 Equitable implementation of Improving Working Lives across entire service(s) <i>Comments:</i>			
3.9 Appropriate high level professional responsibility and authority to recruit and dismiss staff across the organisation <i>Comments:</i>			
3.10 Nationally required regulatory procedures (HPC) to be implemented and monitored across the whole service (s) <i>Comments:</i>			
3.11 Workforce planning for whole service(s) including appropriate skill mix and input to workforce commissioning procedures <i>Comments:</i>			
Traffic light totals			
Overall domain conclusion:			
4 Clinical professional requirements			
Mark and comment on each element answering this question: Do the management arrangements enable:			
4.1 Appropriate high level clinical and professional leadership and consultancy across whole service(s) <i>Comments:</i>			
4.2 'Critical mass' of staff – a broad range of grades and specialisms to be in place across whole service(s) <i>Comments:</i>			
4.3 Effective non-fragmented service provision and good communication across organisations <i>Comments:</i>			
4.4 Professionally relevant and consistent development and implementation of Knowledge and Skills Framework profiles across service(s) <i>Comments:</i>			
4.5 Professionally relevant and consistent Personal Development			

Plans and CPD in place across entire service (s) <i>Comments:</i>			
4.6 A range of appropriate post-registration education to meet staff needs, with expertise in all clinical specialties across service <i>Comments:</i>			
4.7 Comprehensive in-service training and education to meet needs of all staff <i>Comments:</i>			
4.8 Effective management development and relevant professional mentoring across entire service(s) <i>Comments:</i>			
4.9 The management of career progression and succession planning on an equitable basis throughout the entire service(s) <i>Comments:</i>			
4.10 Effective leadership development across entire service(s) <i>Comments:</i>			
4.11 Appropriate professional supervision and support to be in place for all staff across service(s) <i>Comments:</i>			
4.12 Clinical supervision systems in place for staff <i>Comments:</i>			
4.13 Appropriate supervision and support for newly qualified staff including staff rotations across specialties in all core areas across whole service(s) <i>Comments:</i>			
4.14 Undergraduate (student) clinical placements across all core areas <i>Comments:</i>			
4.15 Undergraduate clinical placements across specialist areas <i>Comments:</i>			
4.16 Effective implementation of evidence-based practice across entire service(s) <i>Comments:</i>			
4.17 Implementation, consistent use and monitoring of appropriate validated outcome measures across the entire service <i>Comments:</i>			
4.18 Design and implementation of protocols, procedures and guidelines (managerial and clinical) for the whole service <i>Comments:</i>			
4.19 Consistent implementation of national guidelines and policies across the entire service (s) <i>Comments:</i>			
4.20 Effective clinical and managerial engagement of appropriate			

staff in national, regional and local professional fora <i>Comments:</i>			
4.21 High-quality record-keeping systems, in line with legal and professional standards, throughout the entire service (s) <i>Comments:</i>			
Traffic light totals			
Overall domain conclusion:			
5 Operational/service management			
Mark and comment on each element answering this question: Do the management arrangements enable:			
5.1 Effective and efficient use of staff resources - use of time, skills and expertise in all areas across service (s) <i>Comments:</i>			
5.2 Effective day-to-day management for clinical staff in all areas of service(s) <i>Comments:</i>			
5.3 Appropriate staff deployment in all areas across service(s) - to ensure right skills in the right place at the right time <i>Comments:</i>			
5.4 The elimination of unnecessary duplication of service provision, expertise and resource use <i>Comments:</i>			
5.5 Effective day-to-day management of clinical practice in all areas of service(s) <i>Comments:</i>			
5.6 Effective performance management and monitoring of clinical standards across whole service (s) <i>Comments:</i>			
5.7 Effective day-to-day management of clinical pathways and vertical integration across all areas of service(s) <i>Comments:</i>			
5.8 Continuity for service users between acute hospital and primary care services <i>Comments:</i>			
5.9 Effective networking across services/organisations to facilitate non-fragmented patient care <i>Comments:</i>			
5.10 Effective collaborative working between the service and other agencies such as social, education, voluntary and independent sector <i>Comments:</i>			
5.11 Ensure effective interdisciplinary working across organisation(s)			

<i>Comments:</i>			
Traffic light totals			
Overall domain conclusion:			
6 Management of resources			
Mark and comment on each element answering this question: Do the management arrangements enable:			
6.1 High-level professional input, accountability, responsibility and authority for budget management across entire service(s) <i>Comments:</i>			
6.2 High-level professional input to the budget-setting process for the entire service(s) <i>Comments:</i>			
6.3 Active participation in financial planning and monitoring processes throughout the year for whole service (s) <i>Comments:</i>			
6.4 Achievement of economies of scale - economic use of resources (human and financial) throughout the entire service(s) <i>Comments:</i>			
6.5 Optimum use of facilities and equipment across entire service(s) <i>Comments:</i>			
6.6 Income generation projects including innovative use of NHS facilities across entire service (s) <i>Comments:</i>			
6.7 The most senior AHP manager input to the Payment by Results process to ensure consistent application across entire service(s) <i>Comments:</i>			
6.8 The most senior AHP manager input to the Practice-Based Commissioning process to ensure consistent application across entire service(s) <i>Comments:</i>			
6.9 Equitable management of AHP charitable trust funds across entire service(s) where these exist <i>Comments:</i>			
6.10 Involvement in capital project planning and management relevant to entire service(s) <i>Comments:</i>			
6.11 Effective mechanisms for procurement and shock control for entire service(s) <i>Comments:</i>			
6.12 Effective input to relevant tendering procedures to be in place <i>Comments:</i>			

Traffic light totals			
Overall domain conclusion:			
7 Information management			
Mark and comment on each element answering this question: Do the management arrangements enable:			
7.1 Effective management of clinical and managerial information throughout service(s) <i>Comments:</i>			
7.2 Uniformity of IM&T across service(s) <i>Comments:</i>			
7.3 Proactive input in the development of uniform IM&T across the service(s) including implementation of Connecting for Health <i>Comments:</i>			
7.4 Consistent interpretation of information across entire service(s). <i>Comments:</i>			
7.5 Management of timely, accurate and relevant information across entire service (s) <i>Comments:</i>			
7.6 Consistent data analysis of activity and referral patterns across entire service(s) <i>Comments:</i>			
7.7 The application of uniform data sets and coding across the entire service(s) <i>Comments:</i>			
7.8 The provision of uniform quality information for patients across the entire service(s) <i>Comments:</i>			
7.9 Uniform record keeping across service(s) <i>Comments:</i>			
7.10 Uniform availability of timely and accurate staffing establishment information for entire service (s) <i>Comments:</i>			
7.11 Uniform availability of timely and accurate budget information for entire service(s) <i>Comments:</i>			
7.12 Uniform collection and analysis of data on activity and throughput across entire service(s) <i>Comments:</i>			
Traffic light totals			
Overall domain conclusion:			
8 Education and training			

Mark and comment on each element answering this question: Do the management arrangements enable:			
8.1 High-level professional input to the SHA in pre-registration education contract setting and monitoring for whole service(s) <i>Comments:</i>			
8.2 High-level professional input to post-registration education demand forecasting for entire service (s) <i>Comments:</i>			
8.3 High-level professional input to pre-registration education demand forecasting based on service needs for entire service(s) <i>Comments:</i>			
8.4 Budget management for whole service postgraduate education and training to ensure equity and appropriate use of funding across service(s) <i>Comments:</i>			
8.5 The initiation and management of R&D projects across the entire service(s) <i>Comments:</i>			
8.6 Implementation of appropriate education and training programmes for support staff across entire service(s) <i>Comments:</i>			
8.7 Higher education institutions to have a clearly identified point of contact for the management of undergraduate placements for the entire service(s) <i>Comments:</i>			
8.8 Higher education institutions to have a clearly identified professional senior manager point of contact for input to course evaluation and development <i>Comments:</i>			
Traffic light totals			
Overall domain conclusion:			
9 Commissioning			
Mark and comment on each element answering this question: Do the management arrangements enable:			
9.1 Effective professional senior manager input to the commissioning process for the entire service(s) <i>Comments:</i>			
9.2 Effective involvement of service users in evaluation and development of service(s) <i>Comments:</i>			
9.3 Management of consistent Service Level Agreements across the entire service(s) <i>Comments:</i>			

9.4 Management of professionally relevant service specifications across the entire service(s) <i>Comments:</i>			
9.5 Management of professionally relevant service contracts with non-NHS purchasers, e.g. hospices or voluntary organisations <i>Comments:</i>			
9.6 Active senior professional management engagement in Practice-Based Commissioning for entire service(s) <i>Comments:</i>			
9.7 Active senior professional management engagement in 'Choice' agenda for entire service(s) <i>Comments:</i>			
9.8 Active senior professional management engagement in Payment By Results procedures including costing tariff determination and activity for entire service(s) <i>Comments:</i>			
Traffic light totals			
Overall domain conclusion:			
10 Service improvement and modernisation			
Mark and comment on each element answering this question: Do the management arrangements enable:			
10.1 Management, leadership and implementation of innovative service improvements and modernisation across entire service(s) <i>Comments:</i>			
10.2 Development of consultant AHP posts <i>Comments:</i>			
10.3 Development of extended scope AHP posts <i>Comments:</i>			
10.4 Development of clinical specialist and advanced practitioner AHP posts <i>Comments:</i>			
10.5 Introduction of new ways of working across entire service(s), e.g. 7 day a week working <i>Comments:</i>			
10.6 Active engagement in multidisciplinary service developments, e.g. stroke service redesign for entire health community <i>Comments:</i>			
10.7 Skill mix review and service re-profiling across entire service(s) as appropriate <i>Comments:</i>			
10.8 Appropriate professional senior management input to the development of new types of posts and generic roles <i>Comments:</i>			

10.9 Inclusion of staff of all grades to input to service improvement and innovation <i>Comments:</i>			
10.10 Patient/service user engagement in service improvement <i>Comments:</i>			
10.11 The introduction of expert patient programmes as appropriate throughout the entire service(s) <i>Comments:</i>			
10.12 Involvement of voluntary and public sector organisations in service improvement initiatives across entire service(s) <i>Comments:</i>			
Traffic light totals			
Overall domain conclusion:			

APPENDIX 10 PROCESS FOR GAINING RESEARCH APPROVAL

This was a complex and protracted process with many inconsistencies. To gain the necessary “permission” to proceed with the research, approval was sought via the process required for NHS researchers working in Wales. This procedure was commenced in September 2011 following advice from the National Institute for Social Care and Health Research (NISCHR) co-ordinator, as the permissions co-ordinating process had been reviewed and re-launched in July 2011, changing the governance rules and application procedure.

The NISCHR Research Permissions Coordinating Process (NISCHR PCP) was developed to provide a streamlined, coordinated and consistent review process for gaining NHS research permission from NHS organisations in Wales. The process is coordinated by the NISCHR Permissions Coordinating Unit (PCU,) working alongside NHS organisation in Wales, who hold legal responsibility for research carried out in their organisation.

The aim of the NISCHR PCU (NHS Wales 2011b) was stated as:

- Providing a single point of access, using the Integrated Research Application System (IRAS)
- Giving clear communication channels, providing a single contact point for study-wide queries relating to multi-NHS organisation research
- Reducing in duplication and administration for gaining NHS research permission
- Helping to reduce the time to gain NHS research permission

- Facilitating the granting of NHS research permission for UK wide research studies

Part of the information required for the IRAS submission was a list of organisations to take part in the research. The cohort was designed to include all NHS physiotherapy provider organisations in England and Wales. As the questionnaire survey invitation was to be sent by email invitation it was necessary to include accurate details of:

- Name of NHS physiotherapy provider organisation
- Name of physiotherapy manager/leader
- Email address of Physiotherapy manager/leader

This proved to be a complex task as this coincided with a period where there had been significant changes in NHS England provider organisations. PCTs had largely become commissioners and therefore the community provision of physiotherapy had been moved to different organisations, including acute Trusts, mental health Trusts and social enterprise organisations.

NHS Service directories were searched to give lists on English Trusts.

Community Interest Companies (CIC) providers were highlighted by the PCTs who had adopted this model of provision for their physiotherapy service. 248 organisations were identified as NHS physiotherapy providers (240 England, 8 Wales). As part of this re-organisation many physiotherapy manager posts had also changed and a considerable number of physiotherapy managers changed jobs, retired, moved or had left the NHS. Therefore, identifying which organisations provided physiotherapy services was time consuming. It became

apparent that the term physiotherapy manager was not universally used therefore the target recipient for the questionnaire was the most senior physiotherapy manager or physiotherapy leader where the service was not managed by a physiotherapist.

The researcher knew many of the organisations and physiotherapy managers from professional networks and previous communications. However, to ensure the list of physiotherapy managers' names and addresses was current, every Trust web site was reviewed. Not all of them reflected the recent organisational changes and the vast majority did not give contact details for their physiotherapy service or their physiotherapy manager. Where it was not clear from the web site whether an organisation was still a physiotherapy provider organisation, contact was made by email to the Trust communications team to enquire whether they provided physiotherapy and the contact details for the physiotherapy manager. The responses to this were varied. Some replied that they were uncertain whether they provide physiotherapy, some knew that physiotherapy was provided but not sure which organisation provided it, some organisations did not know who their physiotherapy managers/leaders were and in some cases did not seem to know whether they even had a service, or where it would fit within their structures. The majority were not happy to give out details of the physiotherapy manager email address. Where this was the case, a follow up phone call was made by the researcher to the physiotherapy department to speak to the physiotherapy manager and gather the necessary information. The need to get an up-to-date list of English provider organisations proved to be a

substantial task. By contrast the last re-organisation in Wales had been in enacted in 2009, so these details were largely unchanged.

The finalised information for the IRAS submission was uploaded on 8 January 2012. The research was categorised as “Research administering questionnaires/interviews for quantitative analysis or mixed methodology study”. NISCHR PCU then followed their global governance process of checks and reviews advising on amendments required. Permission was granted to proceed with the research on 12 February 2012 with the requirement for gaining a letter of consent granting NHS Research Permission from each participating organisation prior to commencing research. It was also confirmed that ethical approval would not be deemed necessary as the research was including physiotherapists “by virtue of their profession”. NISCHR PCU then managed the process on contacting the eight Welsh NHS provider organisations’ R&D departments. An amendment to the English research organisations was uploaded to IRAS on 16 February.

The NISCHR PCU was contacted on 17 February 2012, regarding the process for contacting the R&D departments in England. The researcher was advised to contact the National Institute for Health Research Coordinated System for gaining NHS Permission (NIHR CSP) which has the stated aim of standardising and streamlining the process of gaining NHS Permission for commercial and non-commercial clinical research studies in England. This unit advised the researcher that they would need to have contact directly from the Welsh NIRSCH PCU. NISCHR PCU were duly advised and they subsequently

corresponded with the NIHR CSP who further advised on 21 February that they would manage the R&D approval process centrally in England, nominating Northumberland Comprehensive Local Research Network (CLRN) to act as the coordinating unit. Northumberland CLRN then contacted the other 24 CLRNs and asked them to contact R&D departments in their area advising that the researchers' IRAS application had been uploaded on the English IRAS web site.

Communication was received from NIHR CSP on 16 March 2012, informing that the research study had been reviewed and that the initial advice given that they would manage the R&D process had been incorrect as the research did not meet the eligibility criteria for a portfolio study as defined by NHS England (NIHR 2011). Advice was given to contact every English R&D department individually to seek permission.

The NHS National Research and Development Forum web site directory of R&D departments and contact addresses was used (NHS R&D Forum, 2012). Their directory of R&D departments contains two sections; Trusts and Acute Organisations and Primary Care Organisations which covers all the UK. Many of the Primary Care organisations listed on the web site were commissioning organisations not providers. Additionally there were several errors and omissions on this site. For example, it included:

- Ynys Mon (Anglesey) Local Health Board, which has not existed since 2008

- Torbay Care Trust which became Torbay and Southern Devon Health and Care NHS Trust in 2011
- Great Yarmouth and Waveney Primary Care Trust was not included, neither was its current service provider East Coast Community Healthcare CIC.

There were also errors in the contact details for R&D departments. Of the 240 NHS England organisations identified by the researcher of providing physiotherapy services, there was no R&D contact information listed for 17 of these organisations and no information was provided on their Trust website regarding contact details for their R&D department. Therefore 223 English R&D departments were contacted, between 17th – 25th March using names from the National Research and Development Forum directory of R&D departments. 24 emails were not delivered successfully. The “out of office” notifications identified 6 as having left the organisation, 8 being on leave and 10 “bounce backs” as the email address given by the National Research and Development Forum website was not recognised. Attempts were made to re-send to the 24 organisations by trying to identify another R&D manager from the organisations’ web site or where this was not contained the Trusts’ communications department was contacted.

The final method of trying to engage the English R&D departments who either did not have an R&D manager listed or did not accept an email was a direct approach to the physiotherapy manager by the researcher requesting that they ask the R&D department to make contact. 7 of the R&D departments were contacted successfully by this method.

In Wales the approach to R&D departments was handled via NICHHR PCU. All 7 Local Health Board R&D departments gave permission via this route. The one Hospital Trust R&D department had not responded after 3 months. Therefore the physiotherapy manager was asked by the researcher to contact the R&D department, approval was received the following month.

Therefore 214 R&D departments; 8 in Wales, 206 in England, received a request for research permission.

Table 72 Request to R&D departments for research permission

	NHS Wales	NHS England	Total
Physiotherapy provider organisations identified	8	240	248
R&D department contact by email	8	223	231
R&D department emails not successfully delivered	0	24	24
R&D department details provided by physiotherapy manager	0	7	7
Request made for research permission	8	206	214

Responses from R&D departments

NHS Wales

The 8 provider organisations were contacted via the NISCHR PCU. The first R&D departmental approval was received on 20 March 2012. 7 R&D departments had given approval by 24 June 2012. The researcher contacted the physiotherapy manager of the remaining organisation, who contacted her R&D department to speed up their process; this final approval was received on 7 July 2012.

NHS England

The applications forms into the Welsh IRAS system had been uploaded by NIHR CSP when they originally offered to co-ordinate the process in England. Therefore this information was available to R&D departments in England for a period of 4 weeks before it was removed. Therefore the R&D departments who responded quickly to the request for research permission had access to most of the information they required. Unfortunately those departments which were slower to respond required bespoke information to be sent to them, on their own R&D forms, with protocolised checklists. The file size was larger than many of the R&D department email inbox capacity to receive, so often needing sending as 2 or 3 different attachments. There was not one consistent method of application for research permissions.

- 23 Trusts had their own research approval policy, with paperwork and checklists for submission that was bespoke to their organisation, and required completion individually.
- 10 Trusts required Caldicott information governance forms (bespoke to their organisation) completing, even though no patient information was involved
- 126 Trusts corresponded on 2-3 occasions
- 21 Trusts corresponded on 4-5 occasions
- 5 Trusts corresponded on more than 6 occasions
- 1 Trust requested that a substantial amendment be submitted to IRAS to include the name of their R&D Director. This was submitted on the 19 March 12.

The most common request was for the IRAS form that listed all the organisations taking parting the study. However this form was not part of the

IRAS Welsh version, being a sub set of the SSI form, which had been sent as part of the bundle of information. The English R&D departments appeared to not understand the difference in the Welsh IRAS view and the different processes, despite IRAS proclaiming to facilitate cross border research.

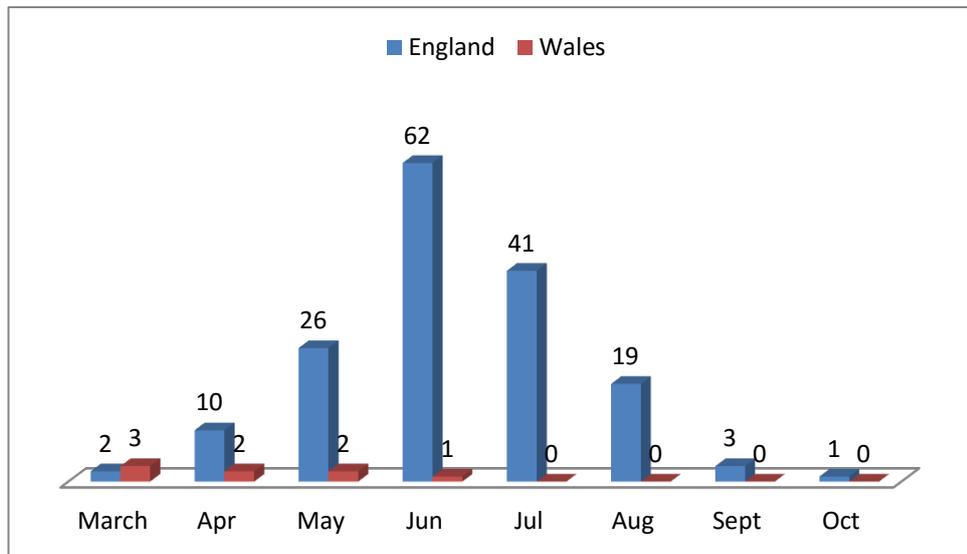
Approval receipt from R&D departments

The first R&D approval from England was received on 22 March 2012. However the responses took several months to be processed by the majority of English R&D departments, with the last one being granted on 30th October, eight months after initial application.

Of the 214 requests for research permission, 42 Trust R&D departments did not grant permission:

- 19 R&D departments did not make any contact even after being contacted on at least 3 occasions.
- 10 R&D departments after having made an initial response neither rejected the application, nor followed through with written consent.
- 6 R&D departments contacted to inform that their organisation no longer provided physiotherapy
- 7 R&D departments did not give permission, citing lack of support for non-portfolio studies as their reason for declining.

Fig. 26 Research Permission Granted by R&D Departments



Research permissions granted from the R&D departments contacted, were 8/8 departments in Wales (100%), and 164/206 R&D departments (79.6%) in England, an overall response rate of 172/214 (80.4%) from the R&D department which received a request for granting research permission.

Type of research approval given

Not all NHS organisations involved in a research study are deemed to act as a Research Site for that study. In some cases an organisation is considered a Participant Identification Centre (PIC). Research sites are defined as organisations responsible for participant-related research procedures specified in the protocol, including recruitment and informed consent,” as indicated by NIHR Introduction to Patient Identification Centres (2011). In Wales R&D approval was given as PIC sites by 7 organisations; 6 Local Health Boards and 1 Trust. 1 Local Health Board was classified as the research site.

Some R&D departments in England classified the application to undertake the study as “Service Evaluation” aiming to judge a service's effectiveness and efficiency through assessment of its aims, activities, outcomes and costs.

Where the application was classified as service evaluation the full R&D process for approval was not required.

In England R&D approval was given as PIC sites by 80 Trusts, and classified as service evaluation by 92 Trusts.

Further communication from R&D departments

Subsequent to gaining research permission several R&D department made further contact with the researcher:

- 98 requested end of research update reports
- 22 requested update information for their annual reports re the status of the research and number of subjects recruited
- 27 followed up to see if their physiotherapy manager had responded
- 8 offered the opportunity to apply for a clinical academic training pathway internship
- 4 added the researcher to their Principal Investigator data base
- 1 followed up to asked more detail about the research which their department considered to be of significant interest, enquiring about the size of the research team for this large project.
- 1 offered free use of inpatient beds in their research ward, which was very surprising given that the research did not include contact with patients or clinical trial.

The process for gaining research approval for this type research is complex and inconsistent between England and Wales. Guidance relating to portfolio studies and the priority that is given to supporting portfolio research from R&D departments made it very difficult to get research permissions from Trusts. The process was far easier and more quickly processed from the researcher's perspective when it was managed centrally as was undertaken by the NISCHR PCU in Wales.

Both the NISCHR PCU and NIHR CSP aim to support research permissions process across the 4 UK countries, this was not enacted in the case of this research project, with both organisations being unclear of the process for Anglo/Welsh research permissions. Additionally the IRAS system appears to be more focused on clinical research, and less tuned to research including the views of NHS staff. R&D departments often did not grasp that the research did not include patients and did not require the researcher to visit their site, this was the subject of many communications with R&D departments.

There was considerable difference of opinion whether the questionnaire survey should be classified as research or service evaluation. Those Trusts classifying the proposal as research required the application for research permission to go through full scrutiny of their R&D procedures. Those Trusts classifying it as service evaluation often just responded by email and made a decision very quickly.

More than 30 R&D departments could not understand why ethical approval was not required, the NISCHR PCU global governance report proved to be a useful source of information.

6 R&D departments indicated that their organisations no longer provided physiotherapy following recent re-organisation, a further 3 reported that they did not provide physiotherapy - but the researcher was able to inform them that they did, and gave the R&D department the name of their physiotherapy manager.

Several Trusts used a consortium approach to R&D with one department administering on behalf of up to 6 organisations, sometimes making it difficult to define which organisation had given permission. Conversely some small organisations which had recently merged to form one larger organisation, still required different R&D approval for different provider parts of their organisation; for example Barts Health had 4 different R&D departments, 3 which gave approval - over a period of 4 months - and one that did not. The offer of access to inpatient beds demonstrated the lack of awareness about the research population and design.

Generally the larger organisations were better at communicating and comprehending the request for research permission, the very small organisations often required copious amounts of paperwork and queries. The least complex route was the social enterprise organisations, which did not have R&D departments and readily agreed to participate.

When research permission was granted the method of communicating this was also inconsistent:

- 51% posted a letter to the researcher's home address only
- 21% posted a letter of approval and also emailed the same letter of approval
- 10% responded by email in an informal manner giving permission to proceed, these departments all classified the research as service evaluation
- 9% posted the approval letter to the researchers work address
- 6% posted a letter to the researcher work address as well as home address
- 3% sent confirmation to the PhD supervisors and the researcher

The inconsistencies between the process for gaining research permission between England and Wales and the differing policies and procedures made the process inefficient in both time and resource. The majority of R&D departments took many months to grant research permission, whereby those organisations classifying the request as service evaluation took significantly less time and resource.

The NHS R&D system is well designed to evaluate clinical research; it is inconsistent in its approach to non-clinical research. The growing focus of support for only portfolio studies indicates that getting approval as PIC sites is likely to be increasingly difficult, whereas service evaluation would appear to be the preferred route in terms of speed and likelihood of approval. There is scope

to reduce bureaucracy and cost of the R&D process, the simplest one being to just email research permissions and not pay the cost of postage.

The research approval was received on 12 February 2012

12 February 2012

Dear Ms Jenkins

**Re: Investigation into NHS reforms on the management of physiotherapy (89355) -
Study-wide / Global governance checks completed**

We are writing to inform you that all the study-wide / global governance checks have been completed for your study for Wales.

Each NHS R&D office will be provided with a full governance report that includes the necessary information about the study-wide / global checks to facilitate the granting of NHS research permission.

Please note that you cannot commence the study at a particular site until you have received a letter granting NHS Research Permission for that site.

Substantial amendments should be notified to the NISCHR Permissions Co-ordinating Unit (PCU) using the appropriate Notice of Substantial Amendment form in IRAS (www.myresearchproject.org.uk) including any supporting documents.

Non-substantial amendments should be notified to the NISCHR PCU by letter (this can be sent as an e-mail attachment) including any supporting documents.

All amendment notifications should be sent to us at NISCHR.PCU.Allwales@wales.nhs.uk.

Kind regards

Gemma Mitchell
NISCHR PCU Facilitator

NISCHR Permissions Co-ordinating Unit (PCU)
Powys Teaching Health Board
Room 12, Monnow Ward
Bronllys Hospital, Bronllys
Brecon, Powys LD3 0LS
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Email / Epost: Gemma.Mitchell@wales.nhs.uk
Fax / Ffacs: 01874 712 719
Website / Gwesafle: www.nischr-ahsc.org.uk

**National Institute of Social Care and Health Research
Permissions Coordinating Process
Research Governance Report – Global Governance Review**

The Global Governance Review has been completed for the below project.

IRAS Project Code	89355
Study Title	Investigation into NHS reforms on the management of physiotherapy
Study Type	Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
Chief Investigator	Ms Fiona C Jenkins
Sponsor	University of Plymouth, University of Plymouth
Funder	
Date and Time	07/02/2012
Report status	Final

Please find to follow the comments raised by the NISCHR Permissions Coordinating Unit during the Global Governance Review of this Project.

C-21. Compliance with any other applicable laws or regulations	Outcome	Not Applicable

C-09. Allocation of responsibilities and rights is agreed and documented	Outcome	Satisfied
6 February 2012 - This is a PhD study, so no contract or delegation of responsibilities log received. The protocol and R&D form explain the research and the NHS sites will only be involved in the identification of participants (NHS staff) as the questionnaires and interviews will take place in non NHS time. The sponsor has signed the R&D form which includes a commitment to arrange the allocation of responsibilities for the management, monitoring and reporting of the research before it commences.		

C-10. Insurance / indemnity arrangements assessed	Outcome	Satisfied
6 February 2012 - Certificate of indemnity received from the University of Plymouth (policy expires 31 July 2012). Document saved in the repository. University of Plymouth indemnity arrangements will apply for the management, design and conduct of the research.		

C-02. Participant information & consent documents and process	Outcome	Satisfied
7 February 2012 - CI confirmed that she has not received a reply/acknowledgement from REC. Advised CI that if she does intend on approaching some retired NHS managers as part of her research, these individuals would not fall under the remit of NHS R&D permissions and she would need to discuss the issue of ethics with the University of Plymouth. Amended patient facing documents received complete with dates and version numbers. Uploaded to ReDA. CI also confirmed that as part of her introductory conversation with telephone interviewees, she		

will ask them whether they mind being taped. If they object, she will not proceed with the recording.

6 February 2012 - No REC approval required as research involves NHS physiotherapy managers in Wales. Copy of letter that CI sent to REC (dated 12 Jan 2012) uploaded informing REC that she would be using NHS managers as participants. Need to clarify whether the CI received a reply/ acknowledgement regarding this from REC.

Also, need to clarify with CI that REC approval would be required if she intends on approaching retired NHS managers.

CI has stated that NHS managers will complete the survey and interview in their own time (outside of work hours).

PIS and consent form received and uploaded to ReDA. Need to request date and version number to be added to documents as good practice.

The Information Sheet does state that interviews will be recorded, then transcribed, but the consent form only asks for consent to undertake the interview and not specifically for consent to be recorded.

This research is being undertaken as part of a PhD study and will look at NHS organisational reform and the ways in which it impacts on how services are managed, patient care and the physiotherapy profession. The study will look at the impact of the most recent NHS reforms and make comparisons with earlier NHS changes.

The research will involve a census questionnaire survey to NHS physiotherapy managers in England and Wales, as well as a small number of in depth semi structured telephone interviews with senior physiotherapy managers some of whom may be retired. There is no conflict of interest as the researcher is also a physiotherapist, an Executive Director, not a physiotherapy manager.

There is a possibility for respondents from research sites where the investigator has worked to feel compromised in their responses. However the potential for this has been minimised as the questionnaire does not make value judgements on individual's capability, but focusses on the impact of organisational change.

The study would involve an in-depth interview (around 30 minutes) with the researcher - an experienced physiotherapy manager.

Potential participants will be approached by an email invitation from the researcher

Questions will relate to the period from 1987 onwards, and will be a semi-structured telephone interview, at a time convenient to participants and not in NHS work time. The interview will be recorded, then transcribed. Participants will be asked questions about physiotherapy management arrangements, the impact of NHS management re-organisations on the provision of physiotherapy, the roles and responsibilities of physiotherapy managers and professionalization of physiotherapy. Participants will be able to see and amend the transcript if they wish.

Informed consent will be part of the recruitment process, sent by email with participants being informed about the research and its purpose as an introductory explanation at the beginning of the questionnaire. By clicking to "proceed" , implied consent will be obtained.

Participants for the telephone interview will be contacted by email where possible or letter, where email is not possible. An explanation of the research will be given and informed consent obtained either by return of email, or mailed reply slip.

Potential participants will have one month to decide whether to take part (with a follow up email after 3 weeks).

C-01. IRAS project filter completed correctly	Outcome	Satisfied
6 February 2012 - IRAS project filter question appears to have been completed correctly.		

C-08. Risks to NHS organisation assessed	Outcome	Satisfied
6 February 2012 - This is a low risk study and will not impact on NHS managers working commitments as the questionnaires and interviews will be conducted in the participants own time (non NHS time).		
There is a possibility that participants may not wish to give their views freely for fear of them not remaining confidential. However, the CI will assure participants of confidentiality.		

Also, there is a possibility that participants from organisations known to the researcher (including current organisation where researcher works), may feel compromised in their ability to answer openly and honestly. This risk will be minimised by not asking questions that make value judgements on individual capability and assuring confidentiality of both individuals and organisations.

The CI has confirmed that there are not any costs associated with the research other than her time and phone calls which she will be funding herself. This was confirmed by email. IRAS question A65. states that no application for external funding has been made.

C-11. Financial management arrangements assessed	Outcome	Satisfied
6 February 2012 - CI has confirmed by email that there is no funding in place for this study as the only costs associated with the research will be the phone calls for interviews which she will fund herself. IRAs question A65. confirms that no application for external funding has been made. No additional NHS costs identified.		

C-15. Compliance with Welsh Language Act assessed	Outcome	Satisfied
7 February 2012 - Discussed with team and it was agreed that the comment regarding the telephone interview selection criteria was acceptable, as long as there was a commitment to translate the written patient facing information into Welsh. We are still waiting for further clarification from Welsh Government regarding this check.		
6 February 2012 - IRAS question A33-2 states that the researcher is prepared to provide / make available participant information in Welsh should it be requested by a participant. Participants preferring to complete the questionnaire in Welsh will be able to contact the researcher who will make available a Welsh language version of the questionnaire.		
A selection criteria for the telephone interviews will be English speaking, as the researcher is not a Welsh speaker.		
Need to clarify with CCJ that the above statement is acceptable regarding the selection criteria for the telephone interviews.		

C-16. Compliance with Data protection and data security issues assessed	Outcome	Satisfied
6 February 2012 - This study will involve the use of audio/visual recording devices. The telephone interview data will initially be taped, the tapes will be kept securely under lock and key until transcription (within 2 weeks) and then destroyed.		
The Information Sheet does state that interviews will be recorded, then transcribed, but the consent form only asks for consent to undertake the interview and not specifically for consent to be recorded.		
The questionnaire data will be stored securely in accordance with information governance requirements. Sites will be allocated a unique number, known only to the researcher, using password protected files on an NHS encrypted PC.		
The email address list for participants will be stored on NHS Wales encrypted laptop.		
Coding will be used for organisations ensuring no individual is identified. Organisations will be coded to identify country and region of origin for later comparison. The researcher will undertake the data analysis maintaining anonymity and confidentiality. At no time will any individual or organisation be identified.		

C-26. Other regulatory approvals and authorisations received	Outcome	Not Applicable

C-22. Research Ethics Committee favourable opinion received	Outcome	Not Applicable
6 February 2012 - Check not applicable as this study involves NHS staff only.		

Contacted CI to make her aware that if she wants to approach retired NHS managers, she will require ethics approval. Advised her to discuss matter with the University of Plymouth (sponsor).

C-06. Arrangements for Disseminating Findings	Outcome	Satisfied
<p>6 February 2012 - The research is part of a PhD and will be published and held in the dissertation library at Plymouth University. IRAS question A51. states dissemination methods that appear appropriate to the study.</p> <p>Participants will not be informed of the results, but they will be published in peer review papers and via presentations/conferences.</p>		

C-04. Protocol assessment	Outcome	Satisfied
<p>6 February 2012 - The objectives, research design and methodology appear acceptable. Gantt chart has been included in protocol to show time lines. No REC approval required as the study involves NHS managers.</p> <p>Protocol summary does not state a version number or date, so need to raise this issue with CI. The sponsor has been identified as the University of Plymouth and the R&D form has been signed by both academic supervisors. Sponsor letter has been received (dated 18 January 2012) and has been saved in the document repository.</p>		

C-05. Scientific quality of research has been assessed	Outcome	Satisfied
<p>6 February 2012 - This research is part of a PhD being undertaken at Plymouth University. The research project and methods were examined at a Transfer Viva in August 2011 and supported as academically suitable to progress, by the lead supervisor (Plymouth University) and secondary supervisor(East Sussex), as well as examined by Viva: Transfer from MPhil to PhD: by a Plymouth University assigned Independent Assessor. Ref statistical aspects of the research: R&D form confirms that 'No review necessary as only frequencies and associations will be assessed –details of statistical input not required'.</p> <p>Copy of transfer report from MPhil to PhD: Report by the Independent Assessor uploaded to ReDA.</p> <p>This is a PhD study.</p>		

Other	Outcome	Satisfied
<p>6 February 2012 - Updated NHS R&D form was signed by the CI and sponsor on 11&12 Jan 2012.</p> <p>This study involves NHS staff only.</p>		



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

Executive Headquarters

Park Road, Whitchurch

Cardiff, CF14 7XB

Sept 2012

Information Sheet

An Investigation into the Effects of National Health Service Reforms on the Management and Provision of Physiotherapy Services in England and Wales- PhD Research

Dear Colleague Physiotherapist,

As a physiotherapist and manager, who has worked in England and Wales, I am interested in NHS organisational reform and the ways in which it impacts on how our services are managed, patient care and physiotherapy as a Profession.

I am undertaking research as part of a PhD to investigate the impact of the most recent NHS reforms and make comparisons with earlier NHS changes. I want to be able to develop the evidence-base to give guidance on the impact of management structures on service provision and provide a resource for managers to draw upon when faced with changes in service organisation.

I would be very grateful if you could spare about 20-25 minutes of your time to complete the on-line questionnaire. It relates largely to the period of NHS reforms since 2008, and asks questions about physiotherapy management, your roles and responsibilities and your views about your professional body,

Your confidentiality is assured. No individual respondent or organisation will be identified in the thesis.

This research has R&D approval from your organisation. The sponsor site is the University of Plymouth.

If you have any questions, or require information in a different format, or in Welsh please do contact me.

Please return the questionnaire by email to: fiona.jenkins3@wales.nhs.uk , or by post to the address above.

The results will be published after completion of the research and they will be available for you to use when asked about where physiotherapy services should sit within the management structure of NHS organisations.

I am very grateful for your support and would like to thank you for taking the time to help me. It would be much appreciated if you could complete this questionnaire within 2 weeks - or sooner if you can! I am extremely grateful for your help with this.

With very best wishes,

FIONA JENKINS MA, FCSP

Questionnaire

Please note that all questions marked with a * are mandatory and must be completed

SECTION ONE : Your Current Role

- *1.1 Your current full job title?
.....
- *1.2 What year did you start in your current post? (please enter year, eg. 1990)
.....
- *1.3 What best describes your contracted hours in your capacity as physiotherapy manager/leader post? *Choose one of the following answers: (Mark with an X)*
- 1 day/week
 - 2 days/week
 - 3 days/week
 - 4 days/week
 - 5 days/week
- *1.4 Is your post: *Choose one of the following answers: (Mark with an X)*
- Managerial
 - Professional lead without managerial responsibilities
 - Fully clinical without managerial responsibilities
 - Other: Please specify.....
- *1.5 Do you undertake any clinical (patient contact) work? **(Mark with an X)**
- Yes
 - No
- 1.6 If Yes:
How many hours per week.....

*1.7 Please indicate which best describes your current role:

(Mark with an X all that apply)

- Provider
- Commissioner
- Planner
- Other: Please specify.....

*1.8 What type of organisation do you work for now (who pays your wages?) *Choose one of the following answers: (Mark with an X)*

- Acute Trust
- Mixed Acute and Community Trust
- Combined primary, secondary and tertiary care
- Community Trust
- Tertiary Care Trust
- Mental Health Trust
- Care Trust
- Partnership Trust
- Social Enterprise
- Welsh Health Board
- Other: Please Specify.....

*1.9 What type of management structure do you work in?
Choose one of the following answers: (Mark with an X)

- AHP directorate
- an AHP model that is not a directorate
- Physiotherapy directorate
- A clinical pathway model
- A fragmented models with physiotherapists managed in different teams in the organisation
- Other: please Specify

1.10 If Yes, please specify.....

*1.11 Job title of the post holder to whom you are currently accountable?

.....

*1.12 What is the occupational group/profession of the post holder to whom you are currently accountable? *Choose one of the following answers: (Mark with an X)*

- Physiotherapist
- Nurse
- Doctor
- Dietitian
- Occupational Therapist
- Podiatrist
- Speech and Language Therapist

- General manager
- Other: Please specify.....

*1.13 Please indicate which organisation(s) you manage physiotherapy services for (whether the staff are employed by your organisation or another): **(Mark with an X all that apply)**

- Acute Trust
- Mixed Acute and Community Trust
- Combined primary, secondary and tertiary care
- Community Trust
- Tertiary Care Trust
- Mental Health Trust
- Care Trust
- Partnership Trust
- Social Enterprise
- Welsh Health Board
- Other, (including private providers under contract to the NHS) please Specify?.....

*1.14 How many different **NHS** organisations do you manage physiotherapy services for:

Choose one of the following answers: (Mark with an X)

- 0
- 1
- 2
- 3
- 4
- 5
- Other: Please specify.....

*1.15 How many different **Non NHS** organisations do you manage physiotherapy services

for: *Choose one of the following answers: (Mark with an X)*

- 0
- 1
- 2
- 3
- 4
- 5
- Other: Please specify.....

*1.16 Please specify the number of Whole Time Equivalent HPC Registered physiotherapists you manage?

1.17 Do you manage staff other than physiotherapists?

(Mark with an X all that apply)

	Yes
Dietitians	
Occupational Therapists	
Orthotists	
Prosthetists	
Podiatrists	
Speech and Language Therapists	
Assistants	
Administration and Clerical staff	
Doctors	
Nurses	

- Other, (please specify).....

1.18 Do you hold a seat on any of the following strategic groups:
(Mark with an X all that apply)

- Organisation's Board
- Foundation Trust, Board of Governors
- Foundation Trust Board of Directors
- Primary Care Executive Board
- Other (please specify).....

*1.19 What is the profession/occupation of the post holder who represents your
 Physiotherapy service at Board level? *Choose one of the following answers: (Mark
 with an X)*

- Physiotherapist
- Nurse
- Doctor
- Occupational Therapist
- Speech and Language Therapist
- Podiatrist
- Dietitian
- General Manager
- Other (please specify).....

*1.20 Please indicate any committee(s) in your organisation you hold a seat on:
(Mark with an X all that apply)

	Yes, I have a seat on this committee	The organisation has a committee, I don't have a seat	The organisation does not have this committee
Organisational operational management board			
Divisional board			
Directorate board			
Clinical board			
Clinical governance			
Service prioritisation			
Quality			
Clinical audit			

Finance			
Workforce			
Research and development			
Health and safety			

- *1.21 Do you have any direct links with a Strategic Health Authority area (in England) National in (Wales) AHP group outside your employing organisation?
(Mark with an X)
- Yes
 - No

SECTION TWO: Provision of Physiotherapy Services Since 2008

- *2.1 What has been the effect of the NHS changes during the last 3 years on your physiotherapy service?

	1 Totally Disagree	2 Disagree	3 Agree	4 Strongly Agree
My physiotherapy service(s) have a clearly stated mission statement compared with 3 years ago				
Physiotherapy services are more fragmented now compared with 3 years ago				
There is more equal access to physiotherapy services across the area compared with 3 years ago				
Quality of physiotherapy care has deteriorated in the last 3 years				
We have a higher proportion of staff band 7 and above than 3 years ago				
There are reduced career opportunities for physiotherapists - less scope for promotion and development than 3 years ago				
Physiotherapy staff morale has improved compared with 3 years ago				
There is decreased clinical autonomy for physiotherapists compared with 3 years ago				
There are less clear boundaries between physiotherapy and other professions compared with 3 years ago				
Other staff have taken on roles previously undertaken by physiotherapists				
Others no longer value the role of the physiotherapy managers compared with 3 years ago				
Physiotherapy has reduced representation and influence at Board level compared with 3 years ago				
The status of Physiotherapy has reduced in the organisation as a whole compared with 3 years ago				

2.2 Has the agenda to provide more services based in the community ie. Transforming community services (in England,) and Setting the Direction (in Wales,) impacted on the management and organisation of your physiotherapy service(s) **(Mark with an X)**

- Yes
- No

2.3 If yes, to above, please give details:

.....

*2.4 Please list the main 3 impacts of the management changes since 2008 on your physiotherapy service:

i.....

ii.....

iii.....

*2.5 Since 2008 has your service been subject to any of the following?: **(Mark with an X, Yes or No)**

	Yes	No
“Any Qualified Provider” initiative		
Part of the physiotherapy service tendered out		
All of the physiotherapy service tendered out		
Currently going through the process of tendering out		
Physiotherapy service expanded to take on providing for a wider geographical area		
Physiotherapy service has decreased in the range of clinical services/specialties provided		
Physiotherapy service re-structured or re-organised in last 3 years		
Physiotherapy service sub-divided between different Divisions/Directorates		
Physiotherapy service merged with that of another organisation		
Physiotherapy service now managed by a physiotherapist (where previously no physiotherapy manager)		
Physiotherapy service not managed by a physiotherapist (where previously there was a physiotherapy manager)		
There has been no change in physiotherapy management arrangements		
No longer any physiotherapy service provided		

*2.6 What has been the general trend for physiotherapy AfC bandings since 2008? Choose one of the following answers: **(Mark with an X)**

- Regrading mainly upwards
- Regrading mainly downwards
- No change

*2.7 Do you have: **(Mark with an X)**

- More management autonomy than in 2008
- Less management autonomy than in 2008

*2.8 What is the reason for your answer to the last question?

.....

*2.9 Since 2008 has the scope of your job changed? *Choose one of the following answers:*
(Mark with an X)

- Scope of the job is less physiotherapy focussed with a broader portfolio
- Scope of the job is more or less the same
- Scope of the job focuses more on physiotherapy

*2.10 Has the physiotherapy budget since 2008 (taking into account inflation) *Choose one of the following answers:* **(Mark with an X)**

- Increased
- Decreased
- Not changed in real terms
- Don't Know

*2.11 In the last year what has been your cash releasing efficiency saving as a percentage of the total physiotherapy budget?

(Please enter a figure)%

*2.12 Have the number of physiotherapy manager posts in your service changed since 2008? *Choose one of the following answers* **(Mark with an X)**

- Decreased
- Increased
- Not changed

*2.13 Have the number of physiotherapy clinical posts in your service changed since 2008? *Choose one of the following answers* **(Mark with an X)**

- Decreased
- Increased
- Not changed

*2.14 Have you lost or had reduced departmental facilities since 2008, such as treatment rooms, hydrotherapy or gymnasias? **(Mark with an X)**

- Yes
- No

2.15 If you have reduced departmental facilities please give the reason for this

.....

*2.16 Please list in priority order the effect of any re-organisation on patient care in your area?

i.....

ii.....

iii.....

SECTION THREE: Your Role, Responsibilities and Duties

Please answer “yes” if you have responsibility for these functions, even if you delegate them to members of your staff

***3.1 Strategy**

Do you have responsibility for: (Mark with an X all that apply)

	Yes
Development of strategy and planning for your physiotherapy service(s)	
Input into physiotherapy workforce planning	
Input into multidisciplinary workforce planning	
Strategic development and partnership working with other organisations	
Interpretation and implementation of Government policies and initiatives across your physiotherapy service(s)	
Management and monitoring external contracts	

***3.2 Clinical Governance**

Are you responsible for: (Mark with an X all that apply)

	Yes
Ensuring positive patient experience	
Implementation of evidence-based practice	
Clinical audit	
Health and safety	
Management of risk	
Response to complaints	

***3.3 Professional Development**

Are you responsible for: (Mark with an X all that apply)

	Yes
Clinical and professional leadership	
Providing consultancy for staff on physiotherapy professional issues	
Ensuring sufficient staff to give “critical mass”	
Ensuring skill mix of physiotherapists to give correct grade mix	
Communication with physiotherapists across the organisation?	
Continued Professional Development linked to staff appraisal across the whole service?	
Post-graduate education to meet service and staff needs	
Comprehensive in-service training programmes	

***3.4 Operational Management**

Do you have overall responsibility for: **(Mark with an X all that apply)**

	Yes
Staff deployment in all areas across the service(s)	
Day-to-day operational management of staff in clinical areas	
Development of physiotherapy policies and procedures	
Performance management and clinical standards monitoring	
Networks between physiotherapists within the organisation	
Networks between physiotherapists across organisations	
Inter-disciplinary working between professions within the organisation	
Capacity and demand management of physiotherapy services	
Performance management of physiotherapy services	

***3.5 Human Resources**

Do you have overall responsibility within your service(s) for:

(Mark with an X all that apply)

	Yes
Recruitment Process	
Appointing officer for physiotherapy recruitment	
Disciplinary policy implementation for physiotherapy staff	
Responsible officer status for dismissal of staff	
Do you have responsibility for ensuring dissemination and implementation of HR policies and procedures across your service(s)	
Skill mix review	

***3.6 Resource Management**

Do you have responsibility for: **(Mark with an X all that apply)**

	Yes
Budget setting ie. agreeing annual budget	
Managing the budget for your service(s)	
Costing and pricing of your service	
Contract monitoring	
Making cash releasing efficiency savings for physiotherapy	
Participation in financial planning and monitoring	
Developing Income generation projects	
Charitable Trust funds	
Purchasing and stock control	
Involvement in capital project planning	
Capacity and Demand management	
Tendering processes	

***3.7 Information Management**

Do you have responsibility for: **(Mark with an X all that apply)**

	Yes
Management of clinical and managerial information throughout your service(s)	
Interpretation and reporting of information	
Monitoring and reporting throughput activity	
Monitoring and reporting case mix	
Uniformity of information for patients across the whole service(s)	

Uniform data sets and coding across the whole service(s)	
Monitoring of compliance with regulatory and professional standard for record keeping of your staff	
Monitoring and reporting of clinical outcomes	

Other: please detail:.....

***3.8 Commissioning/Service Planning**

Do you have responsibility for: **(Mark with an X all that apply)**

	Yes
Managing the provider input to commissioning programmes on behalf of your organisation for your service(s)	
Involving service-users in service development and planning for your service(s)	
Developing Service Specifications for your service(s)	
Capacity and demand planning for your service(s)	
Planning service developments for your service(s)	

***3.9 Innovation and Service Re-design**

Do you have responsibility for: **(Mark with an X all that apply)**

	Yes
Service re-design projects across your physiotherapy service(s)	
Participation in multi-disciplinary service re-design projects	
Introducing higher band roles such as Extended Scope Practitioners	
Providing 7-day working in some services	
Involvement of voluntary organisations in service planning	
Preparing submissions for national awards/conferences	

***3.10 Research, Development and Education**

Do you: **(Mark with an X all that apply)**

	Yes
Input to the pre-registration education contract setting for your service(s)	
Input to post-registration education demand forecasting programme	
Manage the budget for your service post-graduate education and training	
Initiate and manage R&D projects for your service(s)	
Providing Under-graduate physiotherapy training and development placements	
Act as the "point of contact" for Higher Education Institutions with your service(s)	

SECTION FOUR: The Chartered Society of Physiotherapy and your Links

***4.1** Are you a member of the Chartered Society of Physiotherapy? Choose one of the following answers: **(Mark with an X)**

- Yes
- No, I never have been
- No, but I have been in the past

***4.2** If you are not a member of the Chartered Society of Physiotherapy, please indicate why? (Click all that Apply)

- I don't feel it is necessary to belong to the Professional Body
- I don't think its value for money
- It is too trade union oriented rather than profession oriented

- More important to be registered with the Health Professions Council
- Other: Please specify.....

***4.3** How do you rate the importance of being a member of The Chartered Society of Physiotherapy? **(Mark with an X)**

Please rank the importance to you.
 1= low importance
 2 = moderate importance
 3 = important
 4 = very important

	1	2	3	4
Being a member of your professional body				
Setting codes of professional standards and behaviour				
That the profession can withdraw membership rights				
That the profession has opened up membership to include associates (assistants) and students				
Professional advice				
Education and training				
Research and development				
Publications				
Support from professional body on national NHS issues				
Clinical interest groups and occupational groups				
Membership of Leaders and Managers of Physiotherapy Services				
Professional networking				
CSP Boards and Branches				
Annual Congress (Professional)				
Resource centre/library				
Website (iCSP)				
Trade Union functions				
Annual Representatives Conference (Trade Union)				

***4.4** Do you think the proper role of the CSP should be: *Choose one of the following answers (Mark with an X)*

- As a professional body only
- As a Trade Union only
- Both a professional body and a trades union
- Something else:

***4.5** Please indicate why you gave the response above?

.....

SECTION FIVE: Lastly, Some Information About You

***5.1** What year did you qualify as a physiotherapist?.....

***5.2** What Band is this post?.....

***5.3** What management qualifications do you have? **(Mark with an X all that apply)**

- Local organisation training and development with out formal qualification

- Management Diploma
- Institute Health Care Manager qualification
- First degree
- MBA
- Masters level
- Doctorate Level
- Other (please specify)

***5.4** Are you a member of the Institute of Healthcare Management?
(Mark with an X)

- Yes
- No

***5.5** What year did you first take up a managerial post in physiotherapy

***5.6** How many local organisational restructurings have you been through during your career?(**please write a figure**).....

***5.7** Have you ever **(Mark with an X all that apply)**

- Had your job disestablished?
- Been made redundant?
- Been downgraded due to management re-organisation?
- Had your job put at risk?
- Had to reapply for your own job?
- Had your job plan re-profiled?

Other please detail:.....

Can you give some details about the post prior to your current one?

***5.8** What was the name of the post?.....

5.9 What Grade/Band was that post?.....

***5.10** What year did you start in that post?

***5.11** Was it: **(Mark with an X)**

- Full time
- Part time

***5.12** What type of post was it? *Choose one of the following answers:*
(Mark with an X)

- Managerial
- Professional lead without managerial responsibilities
- Fully Clinical without managerial responsibilities
- Other: Please specify.....

***5.13** Please indicate which best described that role **(Mark with an X all that apply)**

- Provider
- Commissioner

- Planner
- Other: Please specify.....

***5.14** What type of organisation was it?: *Choose one of the following answers:*
(Mark with an X)

- Acute Trust
- Mixed Acute and Community Trust
- Combined primary, secondary and tertiary care
- Community Trust
- Tertiary Care Trust
- Mental Health Trust
- Care Trust
- Partnership Trust
- Social Enterprise
- Welsh Health Board
- Other: Please Specify.....

Please can you give some details about the post you held before the one above (ie. two posts ago)?

***5.15** What was the name of the post?.....

***5.16** What Grade/ Band was that post?.....

***5.17** What year did you start in that post?

***5.18** Was it: **(Mark with an X)**

- Full time
- Part time

***5.19** What type of post was it? *Choose one of the following answers:*
(Mark with an X)

- Managerial
- Professional lead without managerial responsibilities
- Fully Clinical without managerial responsibilities
- Other: Please specify.....

***5.20** What type of organisation was it?: *Choose one of the following answers:*
(Mark with an X)

- Acute Trust
- Mixed Acute and Community Trust
- Combined primary, secondary and tertiary care
- Community Trust
- Tertiary Care Trust
- Mental Health Trust

- Care Trust
- Partnership Trust
- Social Enterprise
- Welsh Health Board
- Other: Please Specify.....

YOUR VIEWS

Please write comments about what needs to be drawn to the attention of the researcher as your important observations on the impact of NHS changes and their impact on physiotherapy services during the last 3 years.

***5.21** What are the main advantages of your current management arrangements?

.....

***5.22** What are the main disadvantages of your current management arrangements?

.....

5.23 Please rate your **CURRENT** level of satisfaction with the management arrangements: *Choose one of the following answers (Mark with an X)*

	1 Completely dissatisfied	2 Dissatisfied in some respects	3 Satisfied in some respects	4 Fully satisfied
Your level of satisfaction with the management arrangements for physiotherapy in your organisation				

***5.24** Please rate your level of satisfaction with the management arrangements for your physiotherapy service now compared with 2008 *Choose one of the following answers (Mark with an X)*

- Better
- Worse
- Much the same

***5.25** Please add any final comments or important issue regarding NHS reforms and physiotherapy management since 2008

.....

5.26 The research will also include a few in-depth telephone interviews with experienced physiotherapy managers who were in post in 1987.

Please indicate if you would be happy to be contacted: *Choose one of the following answers (Mark with an X)*

- Yes
- No
- Not Applicable

***5.27** Any other comments:

.....

Your help in supporting this research is very much appreciated.

A copy of the thesis will be held in the CSP Resource Centre. It is also intended that the research findings will be published and presented.

The Questionnaire is now complete.
THANK YOU!

APPENDIX 13 SSI INFORMATION SHEET AND CONSENT



Executive Headquarters
Park Road, Whitchurch
Cardiff, CF14 7XB

XXXX

Dear Colleague,

PhD Research into the Effects of National Health Service Reforms on the Management and Provision of Physiotherapy Services in England and Wales

I am writing to invite you to participate in the above research project investigating the effects of NHS reforms on physiotherapy services in England and Wales. The intended outcome of the research will be to strengthen the evidence base for physiotherapy management and identify the impact of management re-organisation on physiotherapy structures and patient care.

As background to the research this letter aims to explain in a little more detail as to what the study will, and will not, involve in practical terms.

The study would involve you in:

An in-depth interview (up to 30 minutes) with the researcher- an experienced physiotherapy manager.

Questions will relate to the period from 1987 onwards, and will be a semi-structured telephone interview, at a time convenient to you. The interview (undertaken in English) will initially be taped, then transcribed. The researcher will ask questions about physiotherapy management arrangements, the impact of NHS management re-organisations on the provision of physiotherapy and the roles and responsibilities of physiotherapy managers.

Neither individual participants in the study nor the organisations involved will be identifiable in the research report or any subsequent publications. As a non-clinical study this research will have no direct impact on actual service provision and no cost implications for the study site.

This research has ethical approval from (*name of REC*) NHS research Ethics Committee, reference number (*approval number*) and the University of Plymouth. The researcher is a PhD Student, Senior NHS Manager and Fellow of the Chartered Society of Physiotherapy.

If you have any questions please do contact me (email or postal address).

Please complete the attached consent form if you would like to participate in this research, Your support is much appreciated.

Yours sincerely

FIONA JENKINS

CONSENT FORM

An Investigation into the Effects of National Health Service Reforms on the Management and Provision of Physiotherapy Services in England and Wales

Please sign the copy of this consent form and return by email or post.

You may wish to keep a copy for your own records.

1. I confirm that I have read and understand the information sheet dated January 2012 for the above study and have had the opportunity to ask questions.
Please INITIAL box: []
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without any adverse consequences or my legal rights being affected in any way.
Please INITIAL box: []
3. I agree to take part in the above study by undertaking a telephone interview for up to 30 minutes
Please INITIAL box: []

Name of participant	Date	Signature
Name of researcher	Date	Signature

If you would like information in a different format please

indicate:.....



University of Plymouth INTERVIEW SCHEDULE: Physiotherapy Managers

Format and questions for semi-structured interviews

Instruction for interviewing

Before starting interview:

1. Check interviewee has seen PIS
2. Check interviewee has signed and returned consent form
3. Check interviewee has received prompt card
4. Invite interviewee to ask questions about the research and what is expected of him/her
5. Re-assurance re no data personally/organisationally identifiable
6. Ask interviewee permission to audio record (and ensure this consent is also recorded on the audio tape)
7. Offer interviewee opportunity to see and correct transcript

Checklist of topics

Interviewer to select ad hoc which of these to pursue with particular individual informants, according to what appears relevant to the informant's role, the nature of their organisation and information already available to the researcher.

SEMI-STRUCTURED QUESTIONS

1. NHS changes

During your career as physiotherapy manager, how have NHS re-organisations impacted on your physiotherapy service?

If YES: [Supplementary / Probes]

- Can you explain how your work and role has changed over the years due to reorganisations?
- How important has the impact of reorganisations been, compared to other factors (e.g. introduction of Extended Scope Practitioner roles)?
- What period would you describe as being the "Hey day" for physiotherapy and its management ?
 - in what ways?

2. Changes in the profession

During your career, how has the Physiotherapy profession changed?

If YES: [Supplementary / Probes]

- In what way has it changed, can you explain?
- What do you think caused the changes?
- What were the consequences of the changes?
- Which (if any) similar changes have you noticed for other professions?

3. How has the relationship with other professions changed?

If YES: [Supplementary / Probes]

- Why do you think that was?

4. In What ways has the decision-making of physiotherapy managers changed?

[Supplementary]

- How has the hierarchy of decision making for physiotherapy changed?
- Are managers more or less autonomous now than they were?

5. Do you think our status as a profession in the eyes of the general public is getting stronger or weaker?

[Supplementary / Probes]

In which respects stronger, in which weaker?

- Can you explain why?
- Is it important?
 - Why?
- How do you think the other health professions would view the status of physiotherapy as a profession?

6. Management Structure

In my earlier research 5 different management structures were described.

Please look at the prompt card

Can you let me know which of these models you have managed?

	MODEL	DESCRIPTION
A	AHP Directorate	With AHP services managed together, with the different Heads of service working as a collective group
B	AHP Sub Directorate	e.g. trauma AHP team, where the different AHPs are managed as one group of staff by an AHP manager
C	Physiotherapy Directorate	Where there is a Head of physiotherapy managing the whole physiotherapy service, but not grouped with other AHPs
D	Clinical pathway	e.g. respiratory team, where the physiotherapists in that team are managed by a non AHP
E	Fragmented	Physiotherapy dispersed across divisions/directorates with lead physiotherapist providing an advisory non-managerial role, and physiotherapists are managed as part of MDT teams.
F	Other	<i>(If you know of another model I will ask you to describe)</i>

[Supplementary / Probes]

- If you were to recommend one model as the “best” which would it be?
 - Why?

[Probes]

- Is it best for patients, or staff?
 - Is there a difference?
 - Why?
 - If you were to recommend one model as the “worst” which would it be?
 - Why?
- [Probes]**
- Is it best for patients, or staff?
 - Is there a difference between the best and worst, in respect of access, breadth and scope of clinical practice?
 - Why?
 - Are you aware of some other models not shown on the card, would you suggest something else for F?

[Supplementary / Probes]

- could you please describe that model?
- do you think it better than the ones shown?

7. Some physiotherapy services are managed by general managers not physiotherapists, what's your view of this?

[Supplementary / Probes]

- Are there any advantages of this model, over others?
- Are there any problems with this model?
 - such as understanding the clinical role
 - staff deployment
 - specific physiotherapy clinical input to business cases
 - recruitment
 - Staff development
 - R&D
 - staff rotation
 - support for students

8. Management roles and duties (prompt 2)

- 10 different roles and functions of a physiotherapy manager's job have been described. I will go through them individually **and I would like you tell me how important you feel the role is** on a score of 1-10 (1 being unimportant) 10 being extremely important.
 1. Strategy (1-10)
 2. Clinical Governance (1-10)
 3. Professional development (1-10)
 4. Operational management (1-10)
 5. Human resources (1-10)
 6. Resource management (money, equipment, premises) (1-10)
 7. Information management (1-10)
 8. Commissioning/ service planning (1-10)
 9. Innovation/service redesign (1-10)
 10. R&D, education (1-10)
 11. Other (1-10)
- Did you think of any other management role or duty to put into number 11?, what score would you give it?
- Which aspects (functions and roles) of a physiotherapy manager's job do you regard as the most important?
 - Why is that?
- Do you undertake commissioning and /or planning of physiotherapy services?
 - If yes, can you describe?

9. Personal questions

[Supplementary]

These questions to be asked if the participant has not already provided information as a questionnaire respondent.

- How long have you worked as a physiotherapist in the NHS?
- How long have you worked as a physiotherapy manager?
- What type of NHS organisation is your most recent employer?

10. Finally, is there any important aspect of physiotherapy management and organisational change that I have not yet asked you about?

Many thanks for your time, it has been a great help.

APPENDIX 15

PROMPT CARDS

PROMPT 1 Different Models of Structuring Physiotherapy Services

	Structure	DESCRIPTION
A	AHP Directorate	With AHP services managed together, with the different Heads of service working as a collective group
B	AHP Sub Directorate	e.g. trauma AHP team, where the different AHPs are managed as one group of staff by an AHP manager
C	Physiotherapy Directorate	Where there is a Head of physiotherapy managing the whole physiotherapy service, but not grouped with other AHPs
D	Clinical pathway multidisciplinary team	e.g. respiratory team, where the physiotherapists in that team are managed by a non AHP
E	Fragmented	Physiotherapy dispersed across divisions/directorates with lead physiotherapist providing an advisory non-managerial role, and physiotherapists are managed as part of MDT teams.
F	Other	<i>(If you know of another model I will ask you to describe)</i>

PROMPT 2

Management Roles and Duties

	Domain
1	Strategy
2	Clinical Governance
3	Professional development
4	Operational management
5	Human resources
6	Resource management (money, equipment, premises)
7	Information management
8	Commissioning/ service planning
9	Innovation/service redesign
10	R&D, education
11	Other: <i>(If you can think of any other I will ask you to describe)</i>

Interview 1

Acute Trust than has taken in Community services

22 years as a manager, 28 Feb 14.

- *Checked interviewee has seen PIS*
- *Checked interviewee has signed and returned consent form*
- *Checked interviewee has received prompt card*
- *Invited interviewee to ask questions about the research and what is expected of her*
- *Re-assurance re no data personally/organisationally identifiable*
- *Asked interviewee permission to audio record (consented on the audio tape)*
- *Offered interviewee opportunity to see and correct transcript-declined*

8. NHS changes

During your career as physiotherapy manager, how have NHS re-organisations impacted on your physiotherapy service?

Most changes have impacted on physio to increase our staff numbers, there's an increasing need for rehab, 18 weeks RTT for secondary care; also the Trust needed more physio to drive down waiting lists and work in lieu of consultants.

What the changes in your role due to reorganisations:

More emphasis on succession planning, filling gaps, services need providing "come hell or high water" we have to train staff up through competencies as we can't get staff with the skills already e.g. women's health, pain, we advertise, no takers so have to train up in house.

There are bits of posts added onto others, lots of split posts. We used to have 1 WTE in one post, now sometimes we have staff with 1 job with 3 posts in 3 different clinical areas, on different bands in different geographical areas. Managers often don't know exactly what the staff are doing, but it fits the budget and delivers effectiveness. It's VERY different from 10 years ago.

For example they have part time band 6 in rheumatology, and part time band 6 in outpatients then take on a part time band 7 in ESP msk outpatient role. The minority of

the role at higher band, then as more hours come available they increase more senior roles, more flexible, give staff opportunity to know they will progress in their career – but quite hard to manage.

Now we get back fill for mat leave and have to second someone in, then when it finishes move them back – difficult to keep track of who is where and for how long.

How important has the impact of reorganisations been, compared to other factors (e.g. introduction of Extended Scope Practitioner roles)?

It's what you are demanded to do, what you are required to do, rather than the CSP leading the change through the profession, it's within the organisation, there is organisational pressure trying to drive down costs and shift services to primary care.

What period would you describe as being the “Hey day” for physiotherapy and its management ?

Consultant era, can't think it will ever come back; early 2000s raised the profile of the professions, whereas now when our consultant is retiring I didn't even consider to ask to replace like with like.

Why?

It was a big boost to our skills to develop consultant roles to show off our skills and capabilities, - now this is expected....at a lower grade.

9. Changes in the profession

During your career, how has the Physiotherapy profession changed?

Yes it changes more questioning, enquiring doing the right thing, constantly challenged – we used to get away with anecdotal drivell ... I used to go off and read an article – now people know the evidence, they know where more evidence is....a big, big change.

Responsibilities have changed – independent prescribing for example, GPs expectations of the physios taking patients from A to B without going back to them to refer on, advise or medicate. We do much more we are trusted to do it.

Consultants trust us to get on with out their supervision or direction. The profession has certainly evolved, I wouldn't go back.

Which (if any) similar changes have you noticed for other professions?

Nurses, they have consultants and specialists

Radiographers, do reporting whereas previously this was a Dr job

Have Drs changed

[laugh] ... some have, some consultants act as part of a team, others don't think anyone else has much to contribute. GPs are much more aware that there are wider skills in primary care, not just Drs alone.

10. How has the relationship with other professions changed?

Relationships physios and others – I think we covered this – its variable , pockets of isolation, its more about people and personalities rather than the professions themselves

11. In what ways has the decision-making of physiotherapy managers changed?

Physio managers are better at making decisions than before – decide themselves, HR and finance gives advice, but it's down to the manager to decide, the buck stops here.

How has the hierarchy of decision making for physiotherapy changed?

People are more comfortable making decisions, physio manager's better command of the work, more or less autonomous in management decision making.

Are managers more or less autonomous now than they were?

Personally, I am and feel other physio managers are more willing to fight their corner than 15 years.

12. Do you think our status as a profession is getting stronger or weaker?

Status as a profession, stronger or weaker?..with who? General public – how do others perceive physio?

Depends what service they see – people very positive now we have 7 day service, patients and other staff in inpatients, are much more positive. Short appointment waits and self-referral much improved – should we publicise more widely? Worried of shouting too loud and being overwhelmed. We have very favourable patient satisfaction – so favourable we have had to stop doing these events as there were no complaints!

People think we are becoming more useful in terms of rehab – but depends who they come in contact with as to how they perceive us.

Medical profession – they sometimes think we are too strong, don't like, (no not like) but perhaps more fearful of us – its variable though, some think we should be manipulating everyone....and have a problem when we don't – not a definite answer there.

13. Management Structure

In my earlier research 5 different types of organisational management structure were described.

Please look at the prompt card

Can you let me know which of these models you have managed?

Managed A.

Do you know any others? ..dont think so , it describes all the arrangements that I have come across.

If you were to recommend one model as the “best” which would it be?

If recommend one best A,

Why? Best for patients or staff?

both, *in what respect* more joined up service, transfer between one service and another, and between e.g. OT and podiatry, due to a common organisational niche – whereas if you go from one part to another it breaks down for the patient.

Better for others to contact the service, one point , the principle is right, though the AHP manager needs to be inclusive so this is a vital role... its my only real experience – so I am reflecting my experience – I can't think for patients any others would be superior

If you were to recommend one model as the “worst” which would it be?

E, Fragmented, very difficult model, our neighbour organisation is like this, and it's been a difficult time, I would not recommend, in fact I would warn against it

Why?

The manager is not from a physio background, they don't understand skills physios have to offer – underrate the staff don't use them to their full expertise and potential.

Is there a difference between the best and worst, in respect of access, breadth and scope of clinical practice?

– definitely fragmented model worst, the non-clinician zone managers struggle to see that other services work in other ways - e.g. gap in service where they want an experienced band 5...not realising there is high turnover in these posts going for promotion – so they will get gaps – they need a band 6 but won't pay!

14. Some physiotherapy services are managed by general managers not physiotherapists, what's your view of this?

Not managed by physios- if they can be bothered to understand its ok, it's not though if they can't. I have worked this way many years ago, can be difficult, not out and out a bad thing, could be better than a poor physio manager.

15. Management roles and duties

Which aspects (functions and roles) of a physiotherapy manager's job do you regard as the most important?

Managing staff, HR, feel its most important, if they are **** your service is ****, you are only as good as you lieutenants

Why is that?

If your staff aren't engaged, trained, know what they are doingyou're hopeless, strategy etc. takes a back seat, you need to know you have good motivated staff.

[No Q 9]

Different roles and functions of a physiotherapy manager's job have been described. I will go through them individually and I would like you tell me how important you feel the role is on a score of 1-10 (1 being unimportant) 10 being extremely important.

	Domain	Score
1	Strategy	7
2	Clinical Governance	9
3	Professional development	9
4	Operational management	8
5	Human resources	8
6	Resource management (money, equipment, premises)	10
7	Information management	8
8	Commissioning/ service planning	9
9	Innovation/service redesign	7
10	R&D, education	7
11	Other: <i>Communication externally and internally</i>	6

Is there anything I have missed or forgotten to ask?

Reporting upwards, relationship with other people they can be very important.

Communication inside and outside, we are the public face of the organisation – it's a 6 we need to be role models

Do you undertake commissioning and /or planning can you describe?

Commissioning – work with commissioners. Planning in terms of workforce planning. I am quite reactive to commissioners reacting to service deficits.

10. Finally, is there any important aspect of physiotherapy management and organisational change that I have not yet asked you about?

..not off the top of my head...but we're having another therapies review as we are merging with the community and care trusts – goodness know what that will mean. Frozen posts and growing your own is a problem, links with universities – growing staff is the biggest issue. Can't get band 5s. I wonder whether we should be looking at apprenticeships to grow our own? Commissioned numbers for university numbers are down, they don't know much in advance, but we don't just want locally trained staff either. I wouldn't go back 20 years, but the early 2000s were a dream.

APPENDIX 17

ADDITIONAL TABLES

Table 73 Response rate organisation type as a % of total respondents

	Percentage of total list of physiotherapy providers	Percentage of census survey respondents
Acute Trusts	51%	43%
Care Trusts	2%	2%
Community Trusts	20%	10%
Mental Health Trust	7%	5%
Mixed Trusts	8%	17%
“Other” Trusts	1%	5%
Partnership Trusts	3%	2%
Social Enterprise	2%	4%
Tertiary Care Trusts	3%	6%
Welsh Health Boards	3%	6%

Table 74 Provision of Physiotherapy Services Since 2008

	Totally Disagree	Disagree	Agree	Strongly Agree
Physiotherapy services have a clearer mission statement now compared with 2008	11	53	44	14
Physiotherapy services are more fragmented now than in 2008	22	38	39	23
There is more equal access to physiotherapy services across the area than in 2008	19	43	49	10
Quality of physiotherapy care has deteriorated since 2008	23	63	24	11
Higher proportion of staff band 7 and above than in 2008	45	53	18	6
There are reduced career opportunities for physiotherapists - less scope for promotion and development than in 2008	3	31	45	41
Physiotherapy staff morale has improved compared to 2008	39	65	20	1
There is decreased clinical autonomy for physiotherapists compared to 2008	23	69	22	8
There are less clear boundaries between physiotherapy and other professions compared with 2008	3	48	54	16
Other staff have taken on roles previously undertaken by physiotherapists compared with 2008	13	46	52	10
Others no longer value the role of the physiotherapy managers compared with 2008	23	61	22	14
Physiotherapy has reduced representation and influence at Board level compared with 2008	23	57	30	12
The status of Physiotherapy has reduced in the organisation as a whole compared with 2008	29	59	22	12

Table 75 Impact of government policy on physiotherapy services

Impact of Government Policies	Yes	No
“Any Qualified Provider” initiative	26	96
Part of the physiotherapy service tendered out	19	103

All of the physiotherapy service tendered out	4	118
Currently going through service tendering	12	110
Expanded to take on providing physiotherapy for a wider geographical area	48	74
Physiotherapy service has decreased range of clinical services	25	97
Restructured and re-organised since 2008	79	43
Physiotherapy service sub-divided between directorates/divisions	40	82
Physiotherapy service merged with that of another organisation	40	82
Physiotherapy service now managed by a physiotherapists (where previously no physiotherapy manager)	11	110
Physiotherapy service not managed by a physiotherapist (where previously there was a physiotherapy manager)	33	89
There has been no change in physiotherapy management arrangements	60	62
No longer physiotherapy service provided	5	115

Table 76 The importance of CSP functions to Physiotherapy managers

Functions	Low importance	Moderate importance	Important	Very important
Setting Codes/professional standards	0	6	17	100
Professional advice	1	6	30	85
Support on national NHS issues	3	3	33	76
Being a member of your professional body	5	11	32	75
Profession can withdraw membership rights	9	20	27	67
Clinical interest/occupational groups	1	11	41	62
Research and development	1	10	51	61
TU function	4	8	49	60
Professional networking	6	14	39	59
Membership leaders and managers group	8	15	37	57
Publications	1	10	50	54
Education and training	1	13	50	54
Website	3	19	43	54
Resource Centre (Library)	11	27	35	42
Opened membership to assistants	8	35	39	41
Annual Congress (professional)	13	26	46	31
Representative conference (TU)	27	28	39	28
CSP Boards/Branches	24	31	43	23

Table 77 Themes responses: Views of the CSP roles

Themes	No. Respondents
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Having the TU with the professional body works well, and is needed to survive the changing NHS	36
Need physiotherapists involved in TU function they understand the issues	16
No conflict of interest, there 100% for members	10
Tension in trying to represent what can be two conflicting roles	9
Do not agree with unions in healthcare	6
Good to have both with one subscription	5
Support physiotherapists carers and legal aspects	5
Professional issues have decreased focus at the CSP. Trade Union very important but perhaps should be separated.	5
Having TU as well deprofessionalises us, too political	5
Personal good experience from both arms of the CSP	5
Need the legal cover	5
Other unions too militant	5
Having seen the lack of engagement from professionals whose professional body is not their trade union, this is of concern	4
Other unions more powerful voice	4
Don't understand the issues, no view on this	1

APPENDIX 18

ADDITIONAL FIGURES

Census Questionnaire Survey Findings

Fig.27

Formation of questionnaire response group

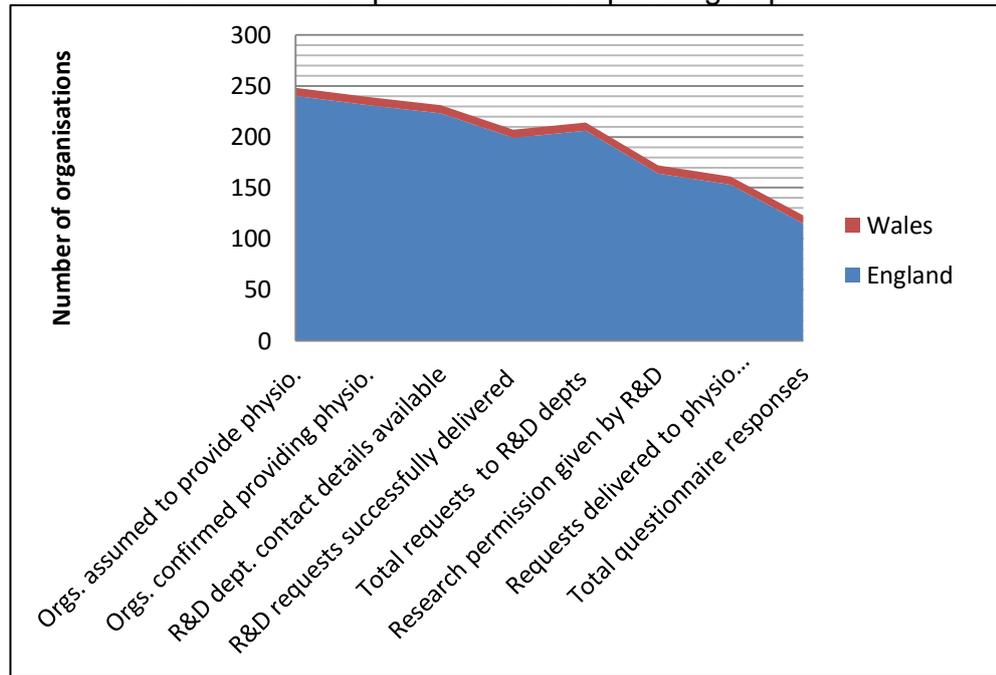


Fig.28 Percentage response of physiotherapy providers giving R&D consent

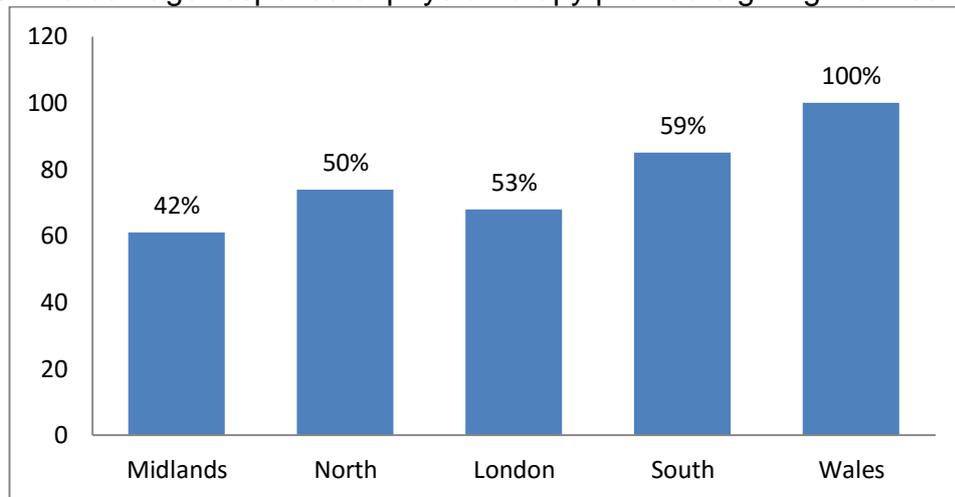


Fig.29 Questionnaire response rate providers by region and responses

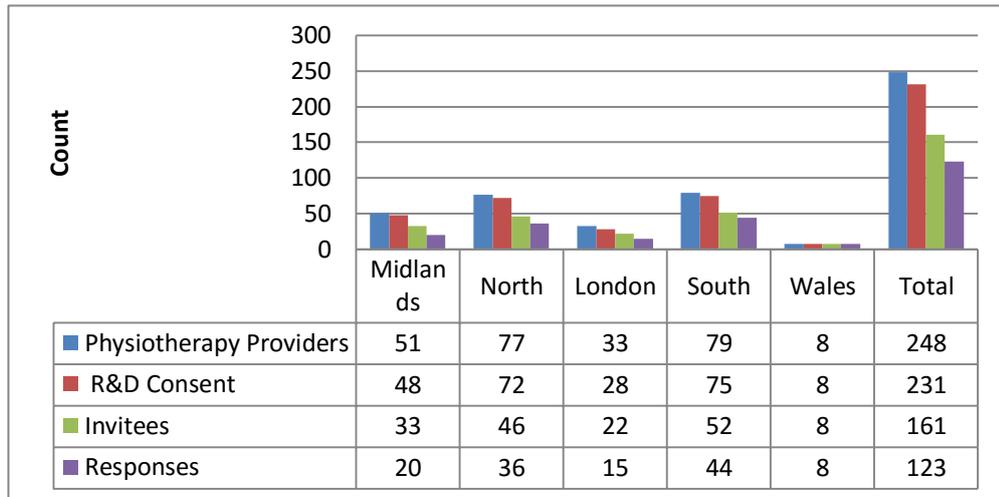


Fig. 30 Percentage responses to delivered questionnaires

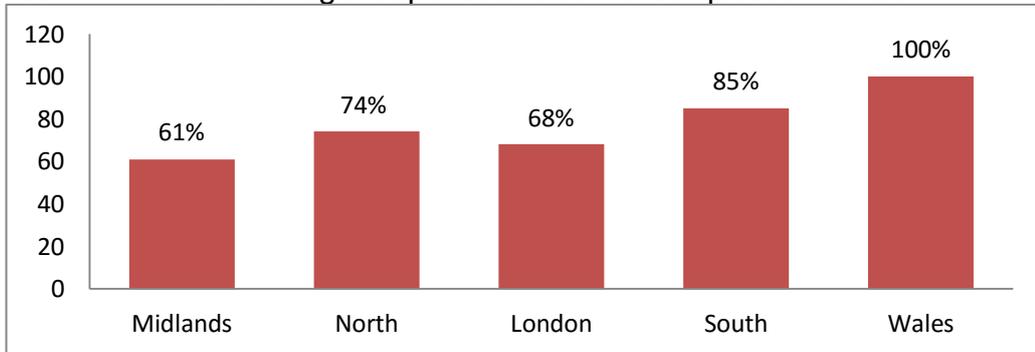


Fig. 31 Respondent organisation type and initial provider list

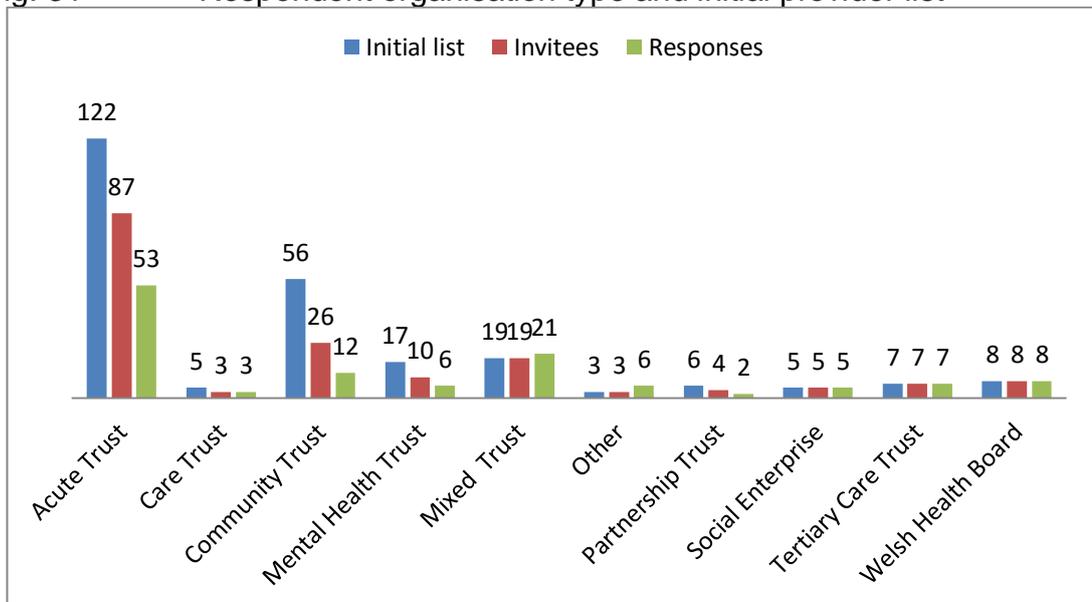


Fig. 32 Physiotherapy providers by organisation type: March 2012

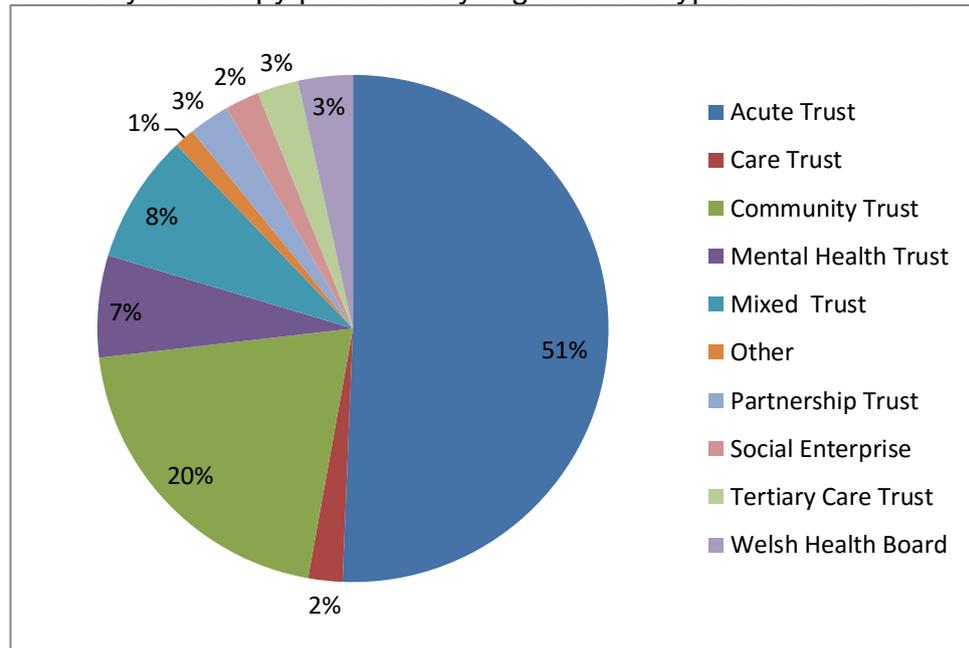


Fig 33 Response rate by organisation type

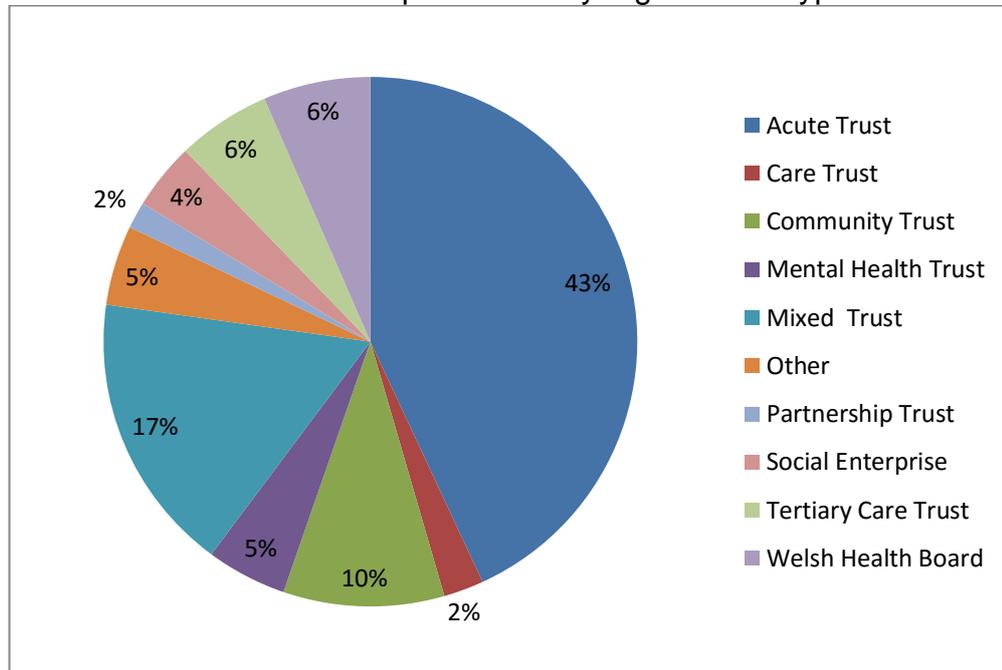


Fig 34

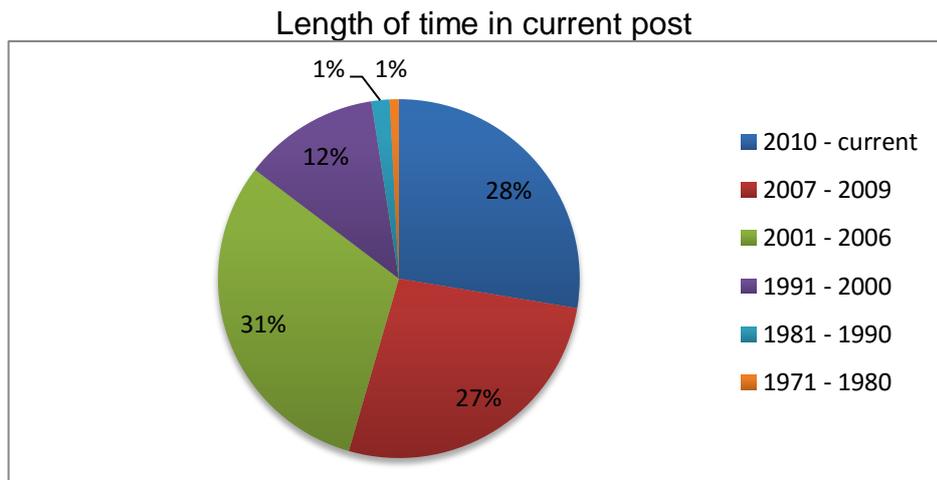


Fig. 35

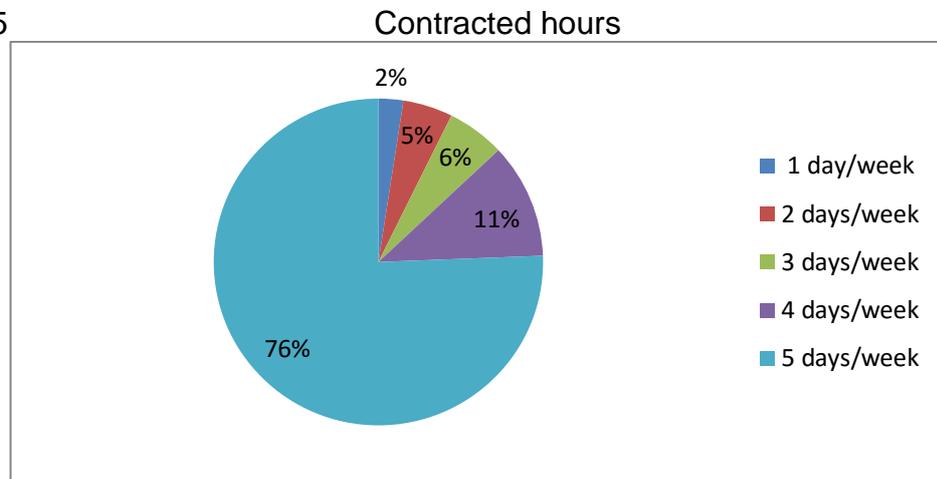


Fig. 36

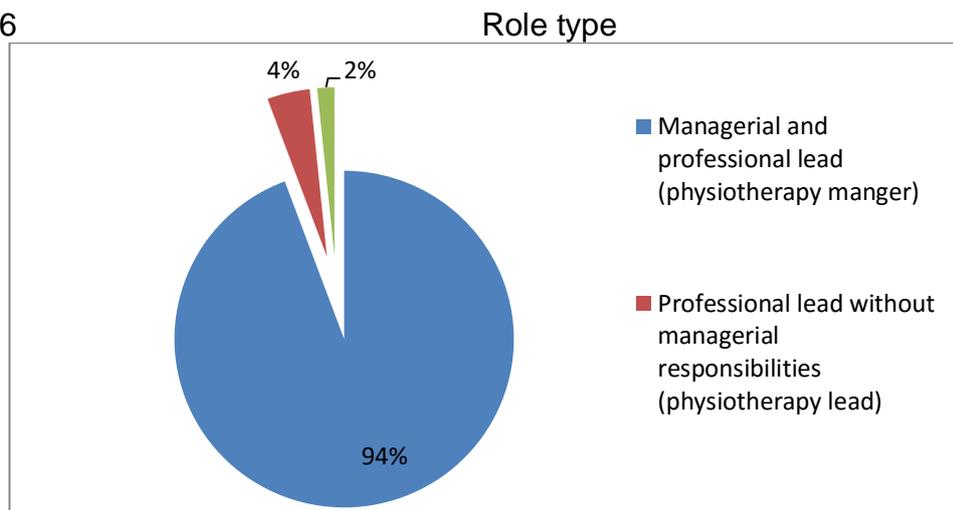


Fig. 37 Physiotherapy managers undertaking clinical work

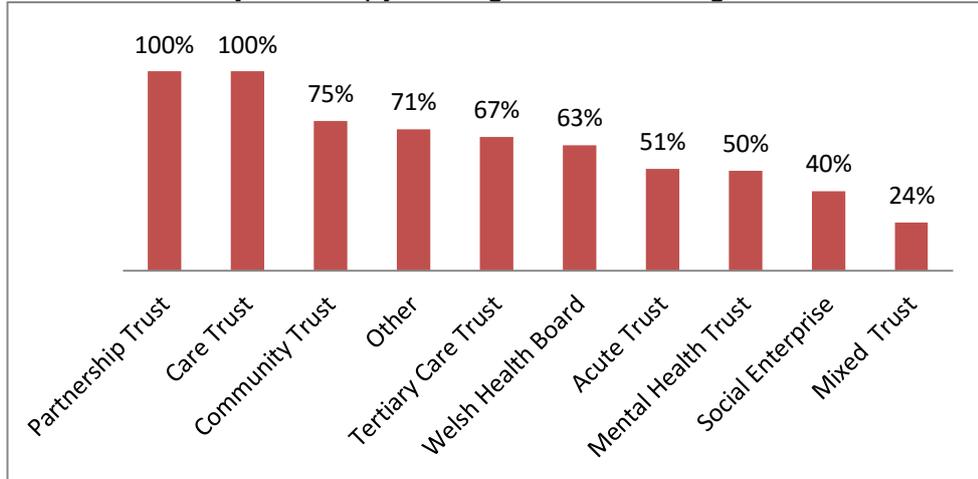


Fig. 38 Mean WTE employed by organisation type

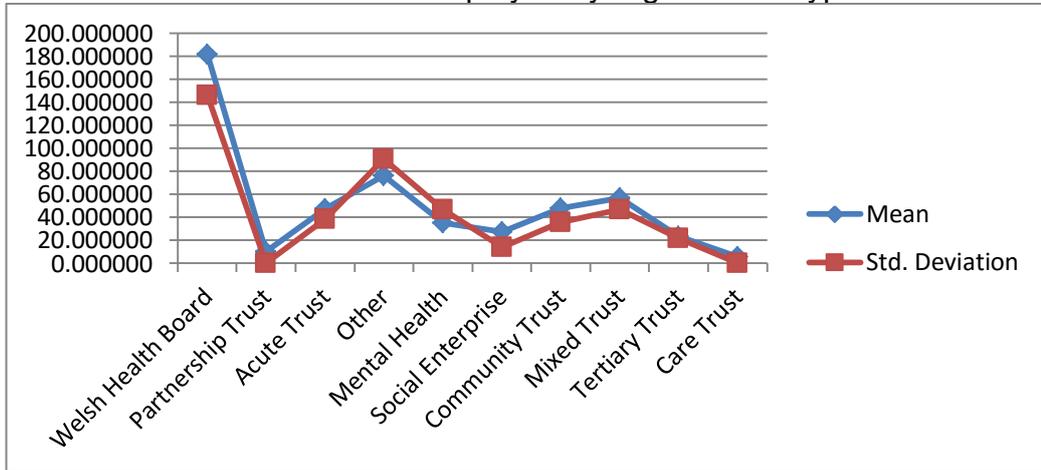


Fig. 39 Management of other staff groups

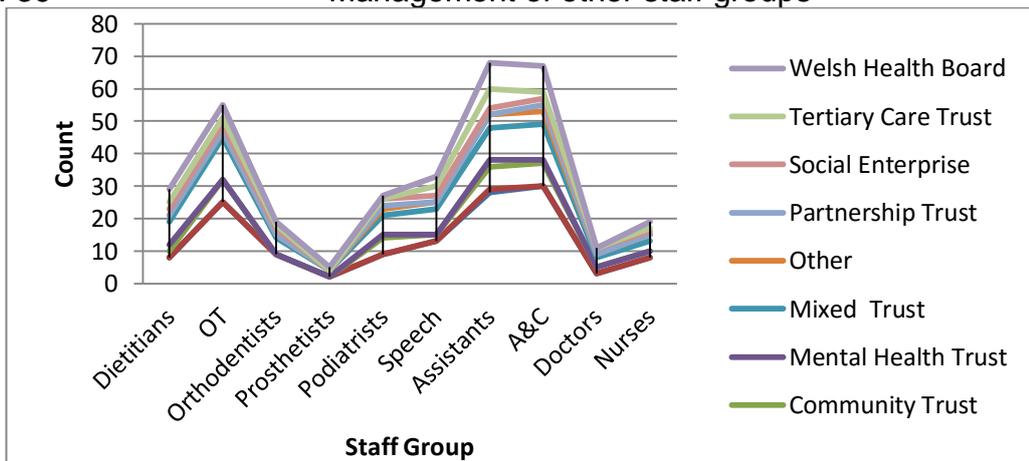


Fig. 40 Impact of move to provide more community-based services

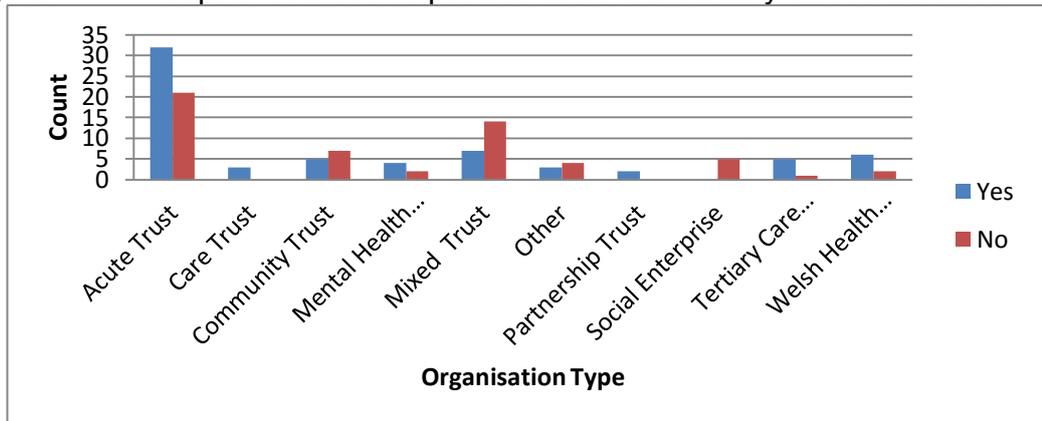


Fig.41 Percentage trend for Agenda for Change bandings since 2008

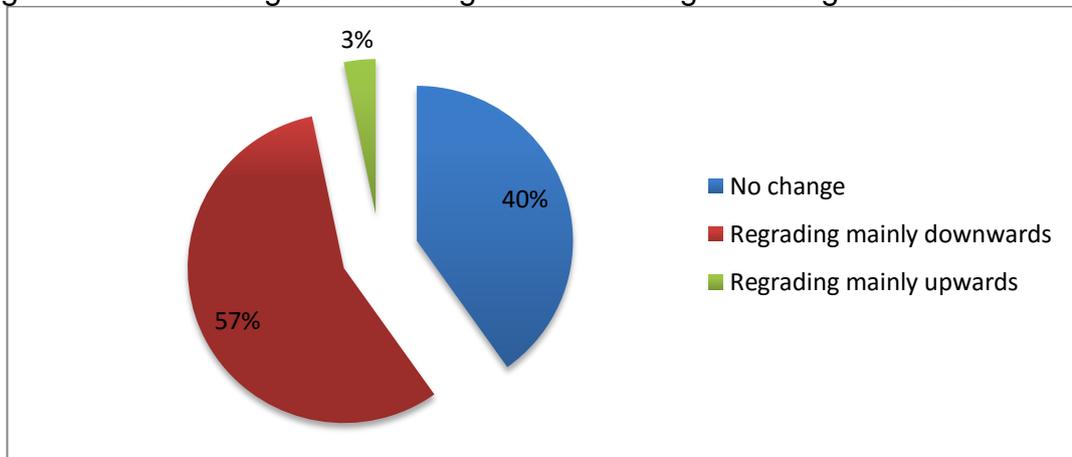


Fig.42 Percentage of physiotherapy budget cash releasing efficiency savings in the last financial year

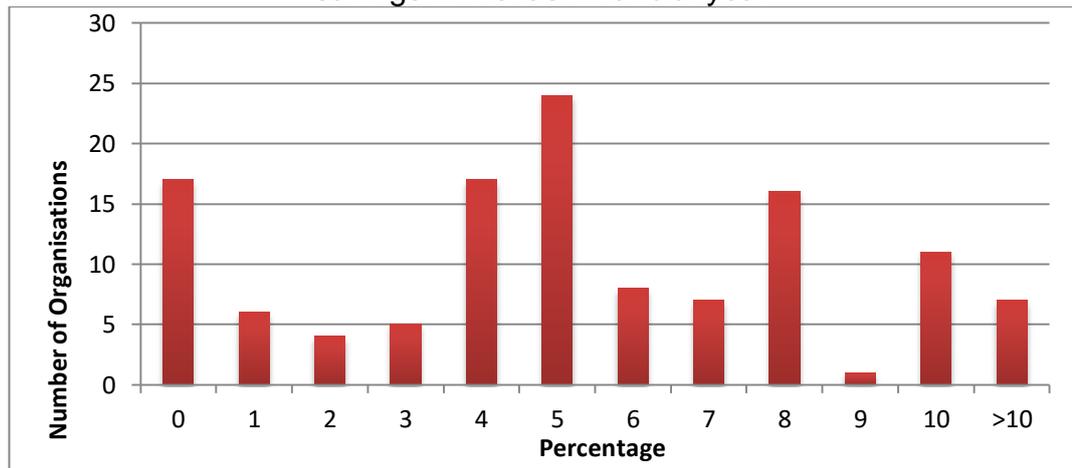


Fig. 43 Change in management autonomy since 2008

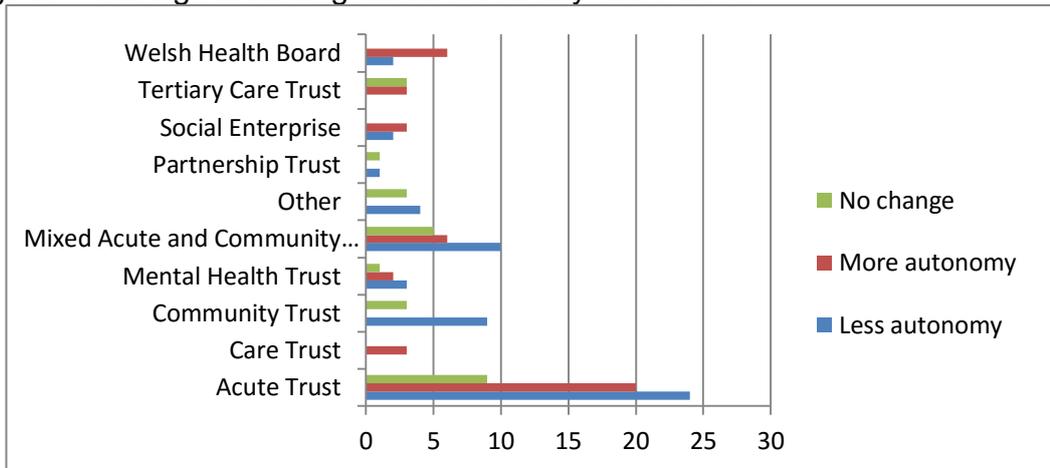


Fig. 44 Change in the Scope of physiotherapy manager's job since 2008

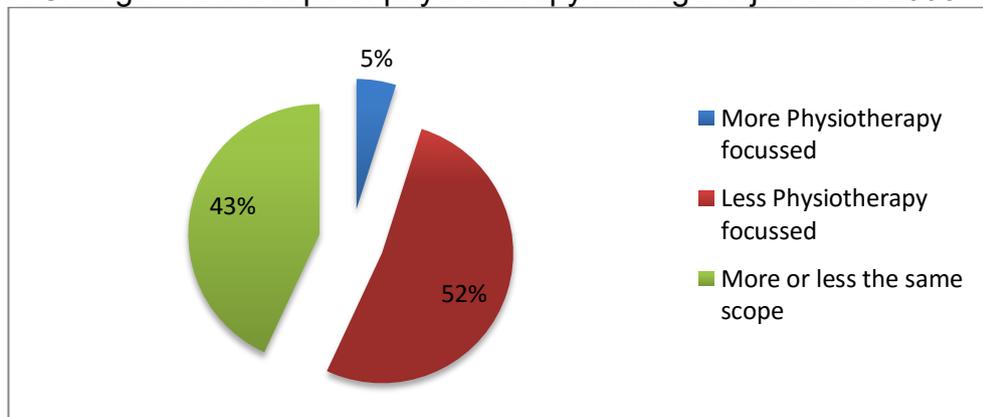


Fig. 45 Change in number of physiotherapy managers since 2008

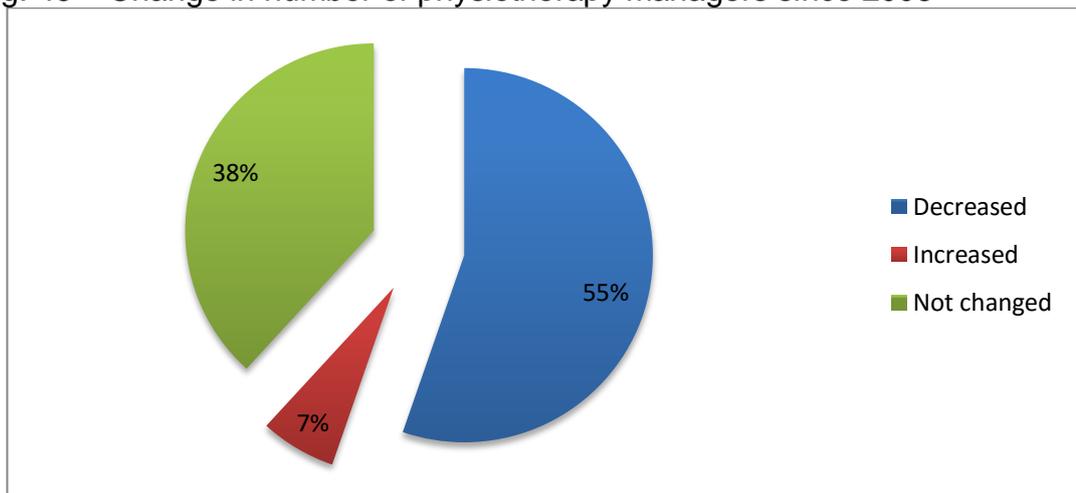


Fig. 46 Change in number of physiotherapy clinical posts since 2008

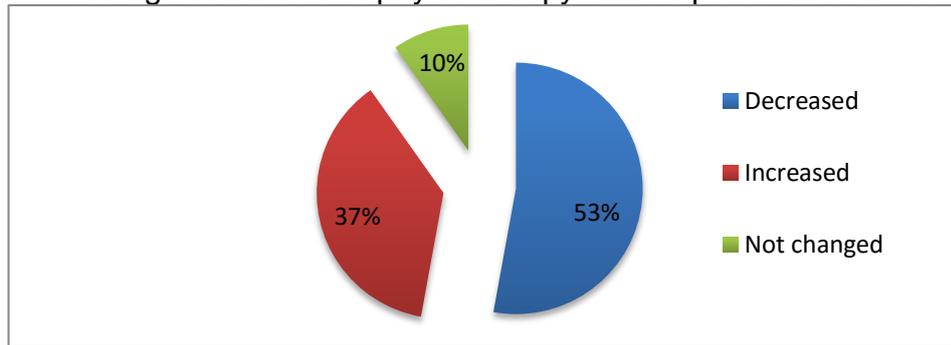
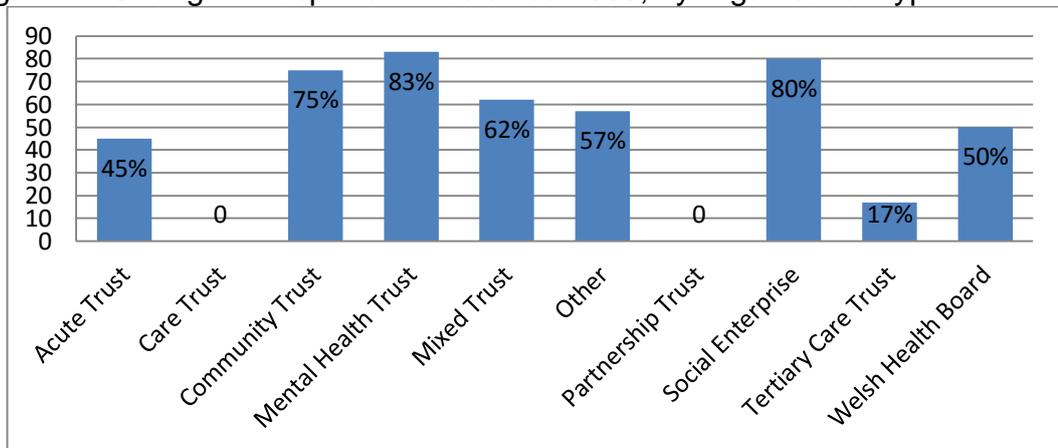


Fig. 47 Change in responsibilities since 2008, by organisation type



Roles, Responsibilities and Duties

Fig. 48 Management domains of physiotherapy managers, rated for importance

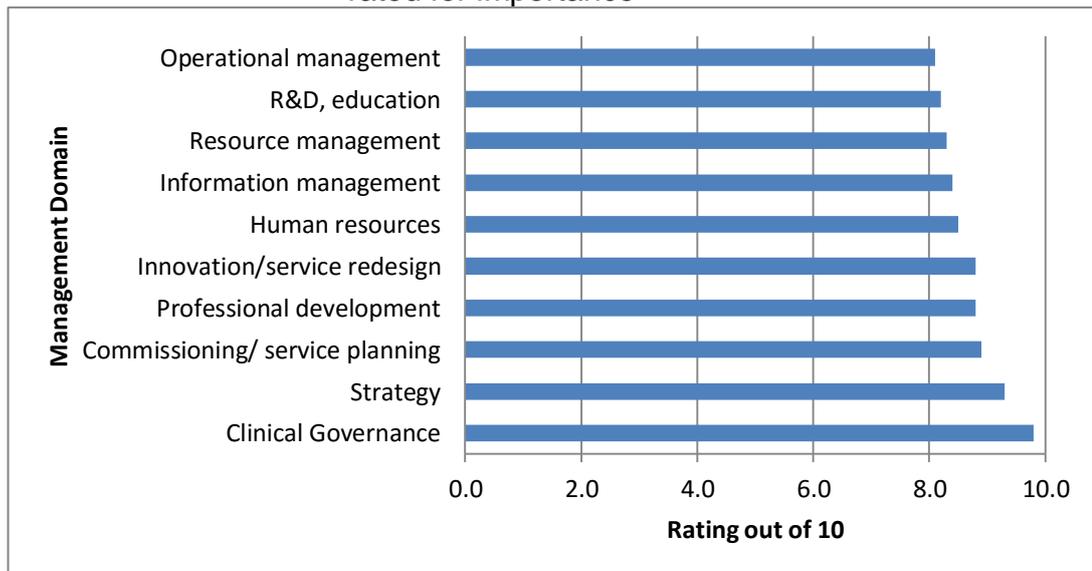


Fig. 49 Welsh Health Boards: Since 2008, has your service been subject to?

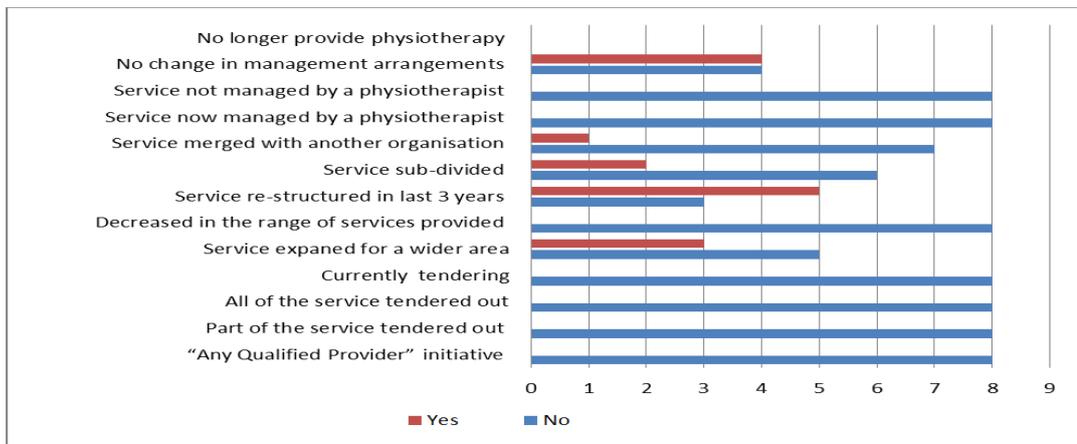


Fig. 50 Acute Trusts: Since 2008, has your service been subject to?

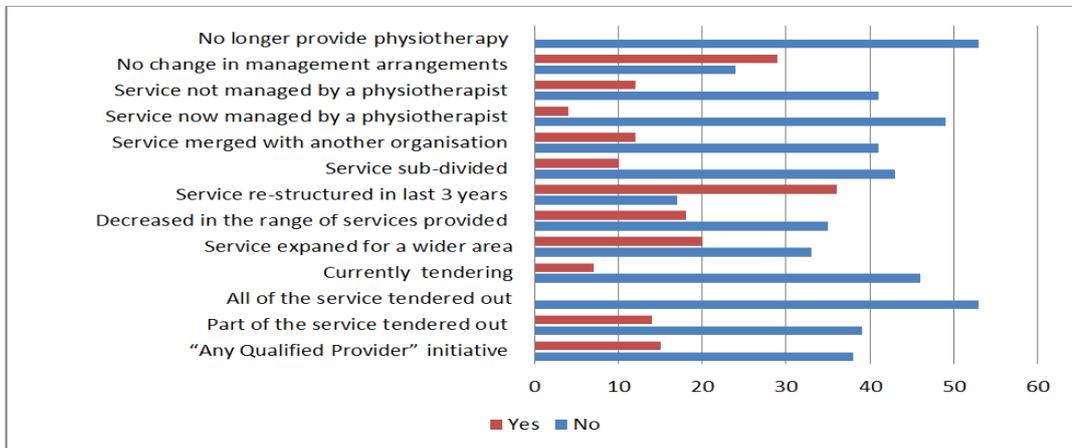


Fig. 51 Mental Health Trusts: Since 2008, has your service been subject to ?

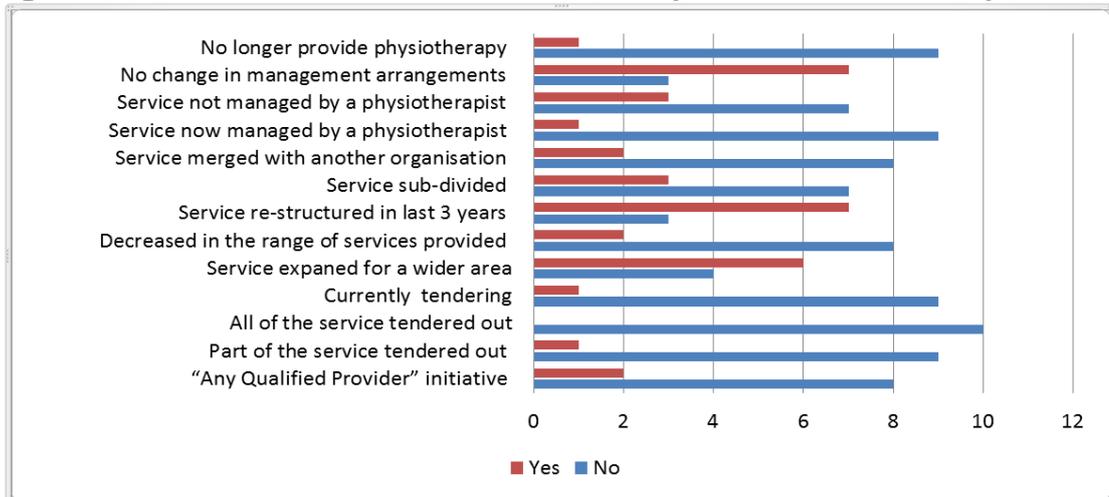


Fig.52 Social Enterprises: Since 2008, has your service been subject to?

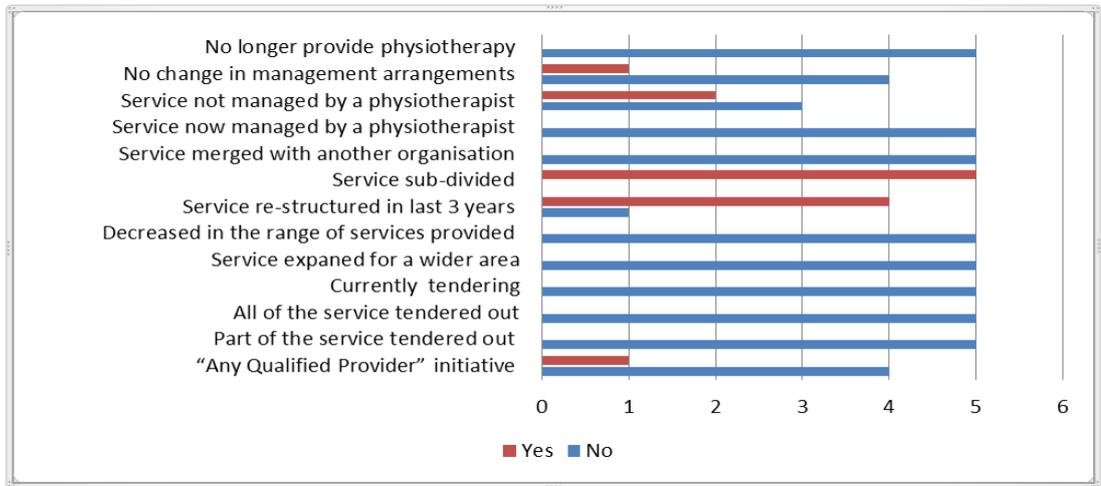


Fig. 53 Community Trusts: Since 2008, has your service been subject to?

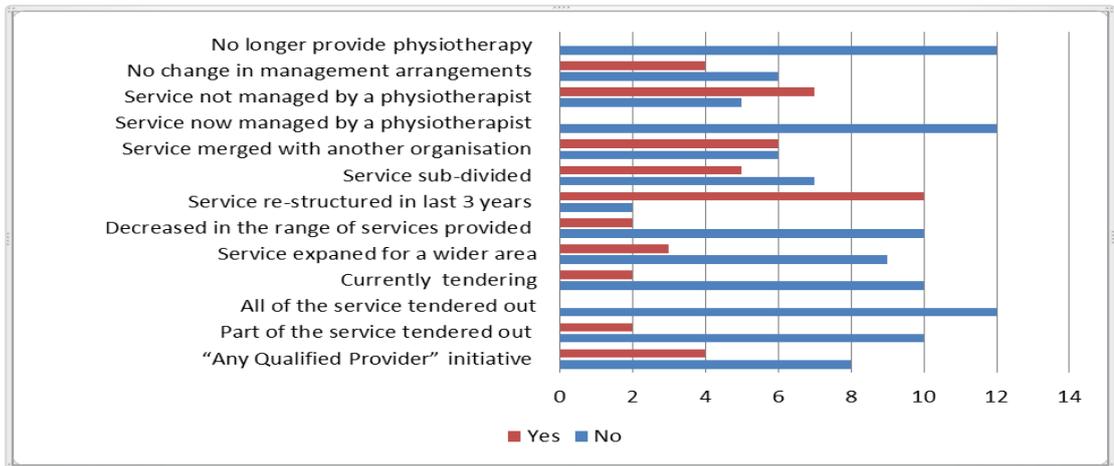


Fig. 54 Mixed Trusts: Since 2008, has your service been subject to ?

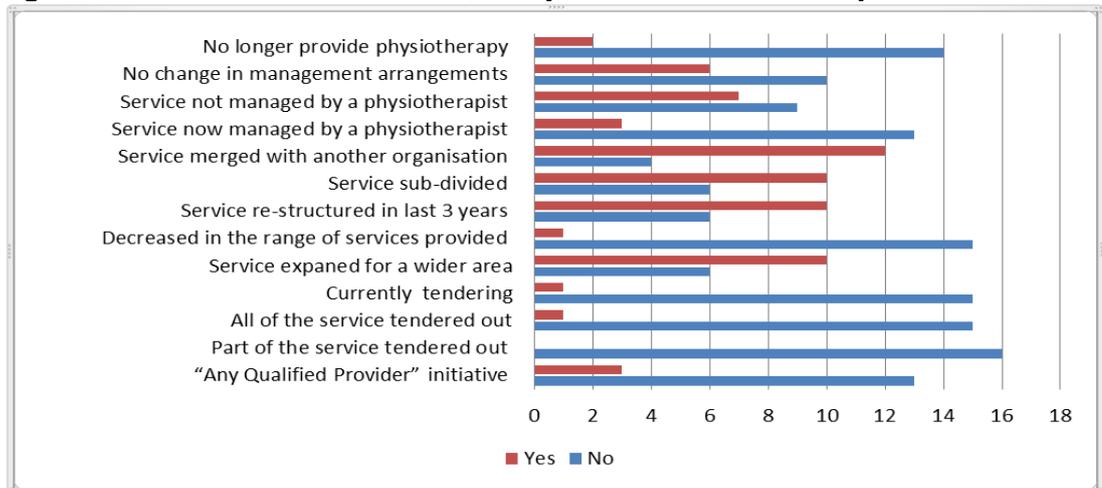


Fig. 55 Tertiary Trusts: Since 2008, has your service been subject to?

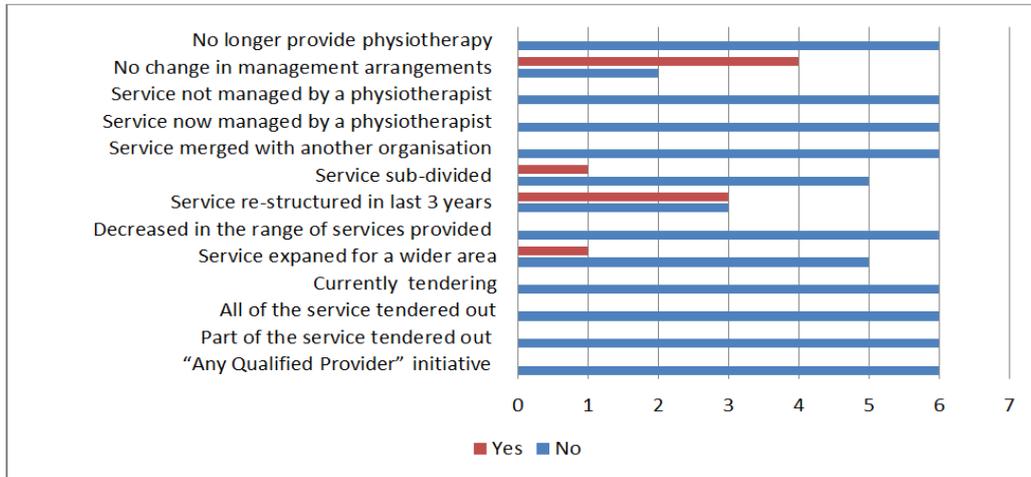


Fig. 56 Care Trust: Since 2008, has your service been subject to?

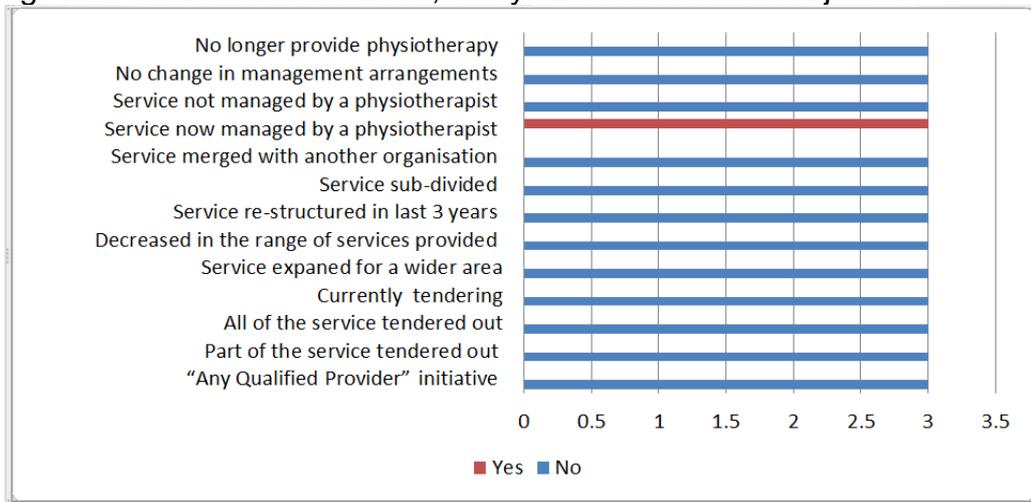
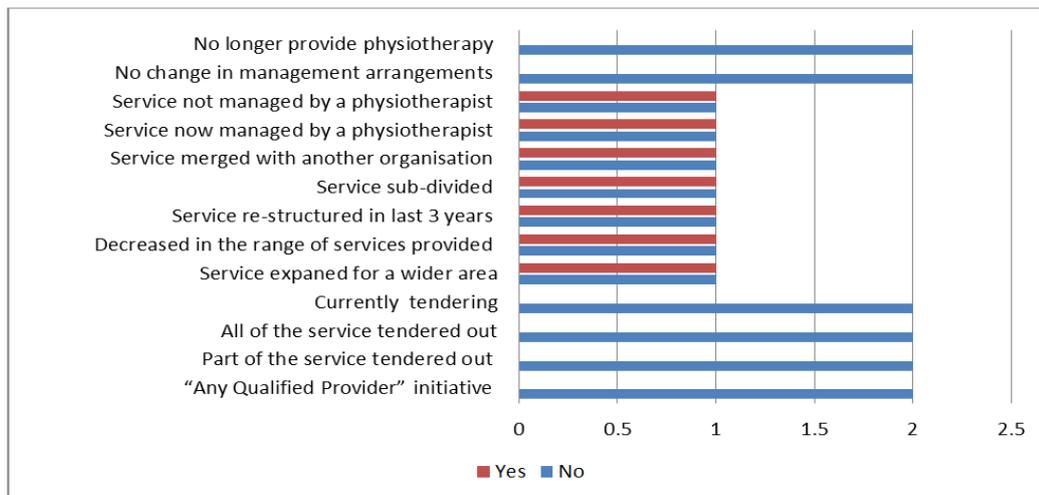


Fig. 57 Partnership Trusts: Since 2008, has your service been subject to?



Respondent Career Information

Fig. 58 Year manager qualified as a physiotherapist

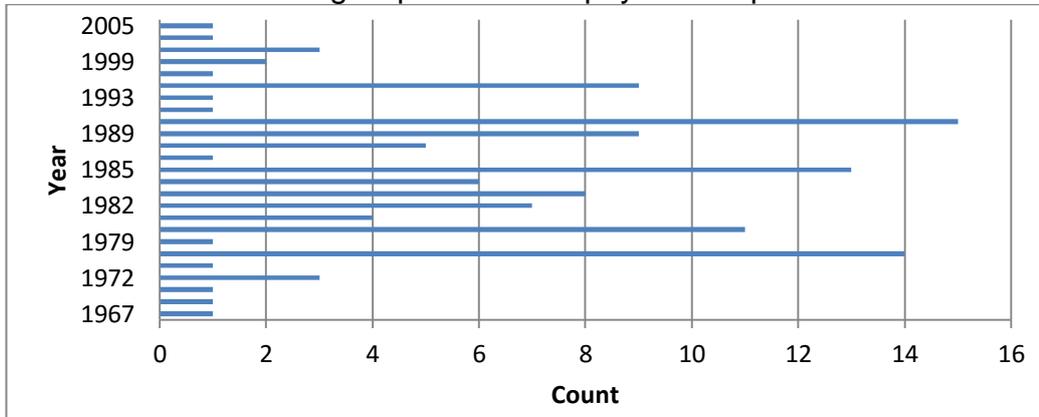


Fig. 59 Physiotherapy managers' pay scale

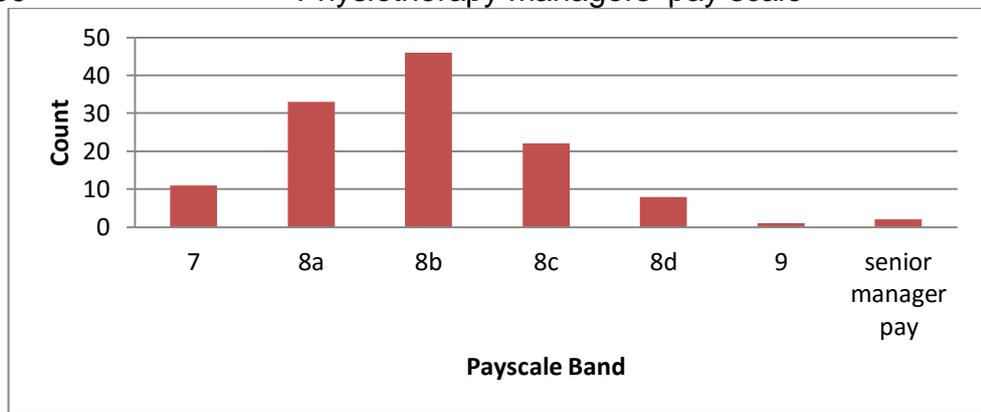


Fig. 60 Correlation: Physiotherapy managers' pay scale and organisation type

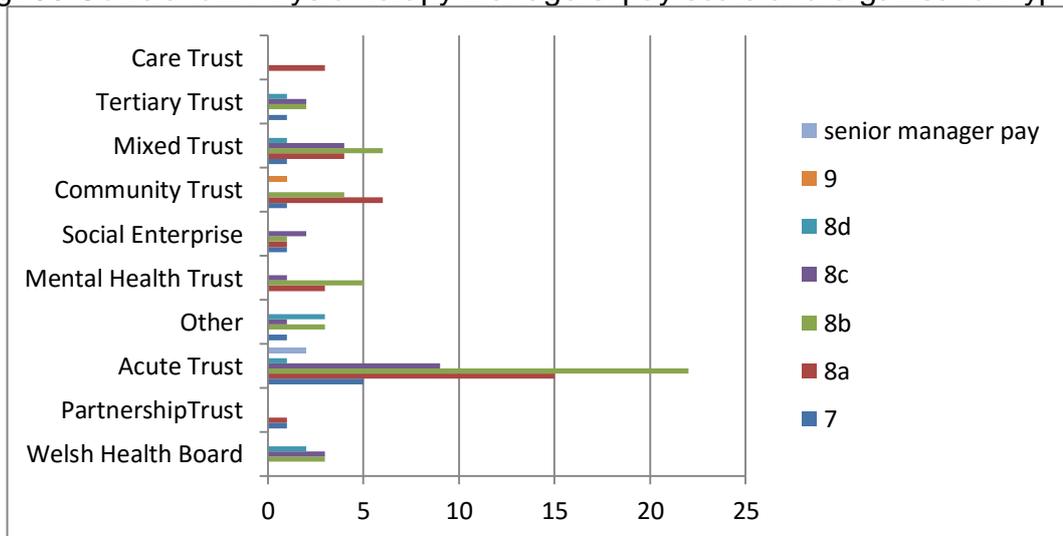


Fig. 61 Year commenced as a physiotherapy manager

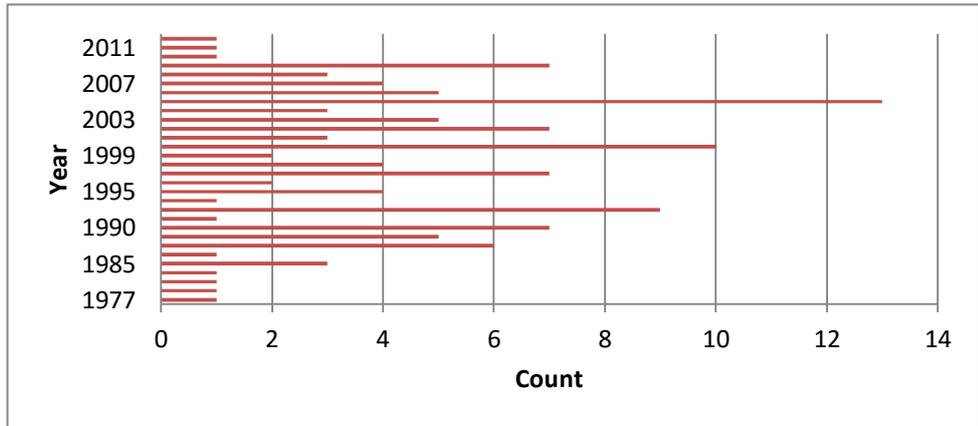
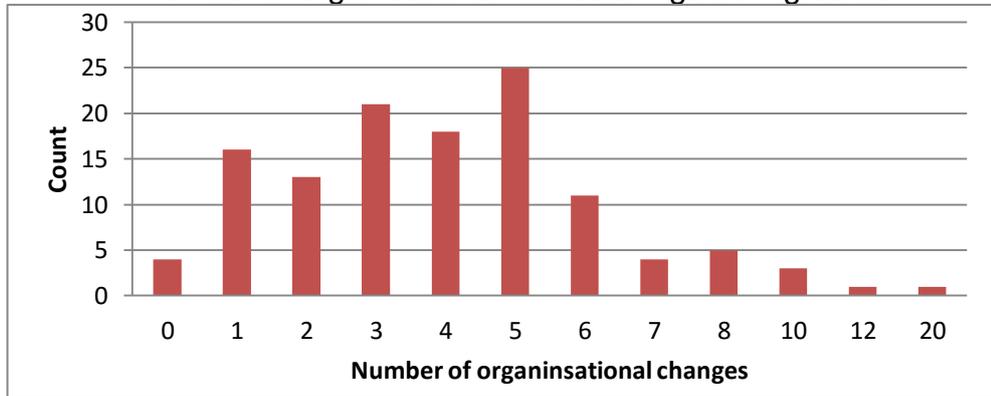
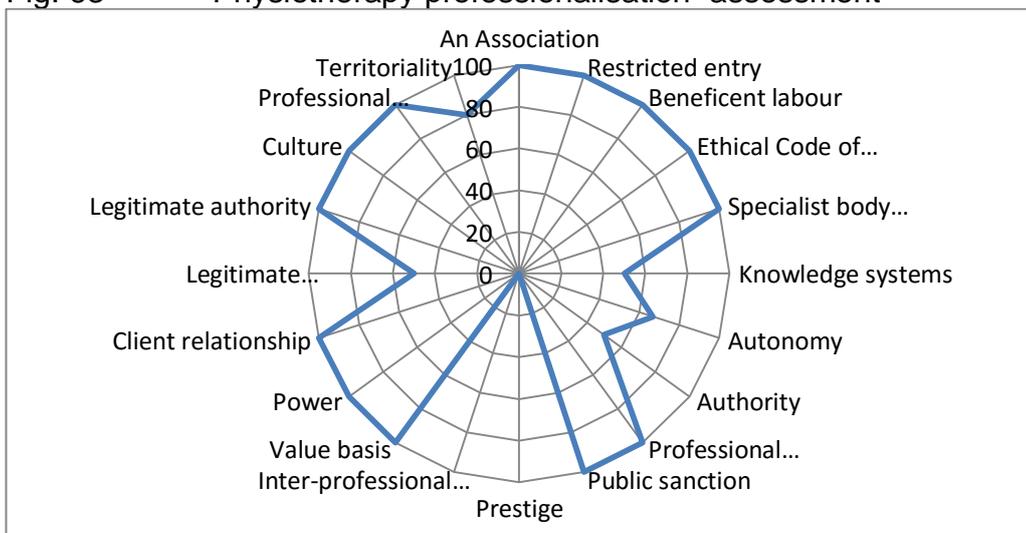


Fig. 62 Number of organisational restructurings during career



Physiotherapy professionalisation

Fig. 63 Physiotherapy professionalisation assessment



Physiotherapy Manager Roles, Responsibilities and Duties

Fig. 64

Responsibility for strategy



Fig. 65

Strategy domain analysed by management model

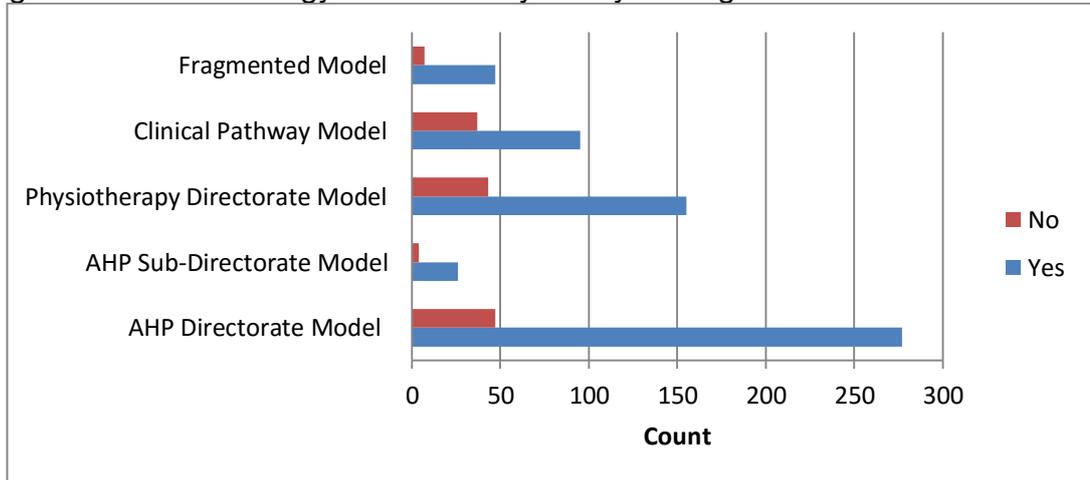


Fig.66

Responsibility for clinical governance



Fig. 67 Clinical governance domain analysed by management model

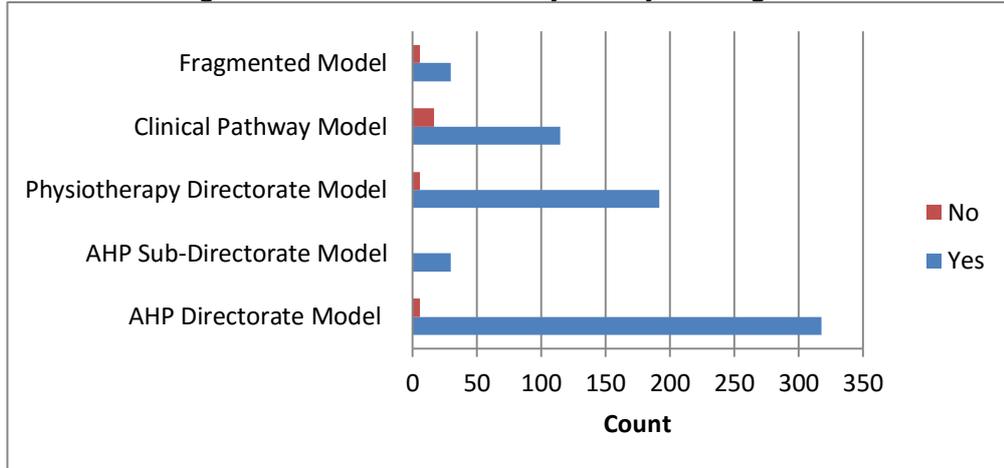


Fig. 68 Responsibility for professional development



Fig. 69 Professional development domain analysed by management model

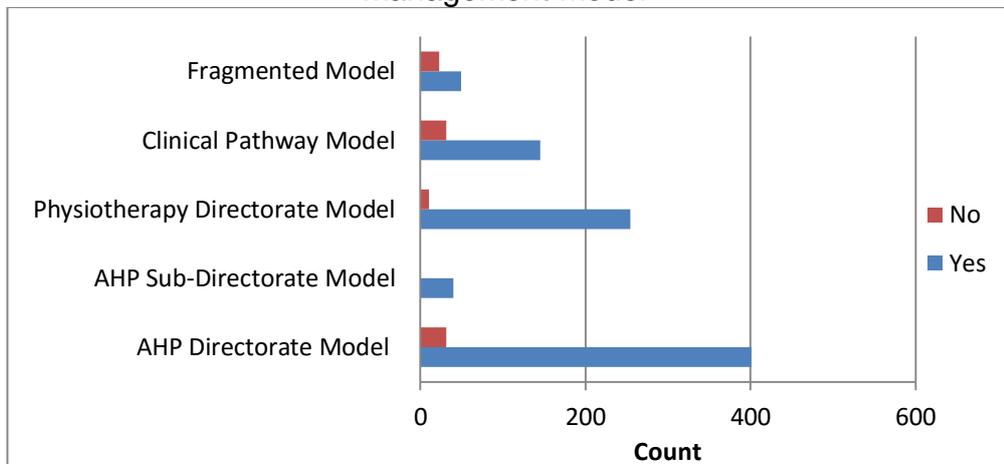


Fig. 70 Responsibility for operational management



Fig. 71 Operational management domain analysed by management model

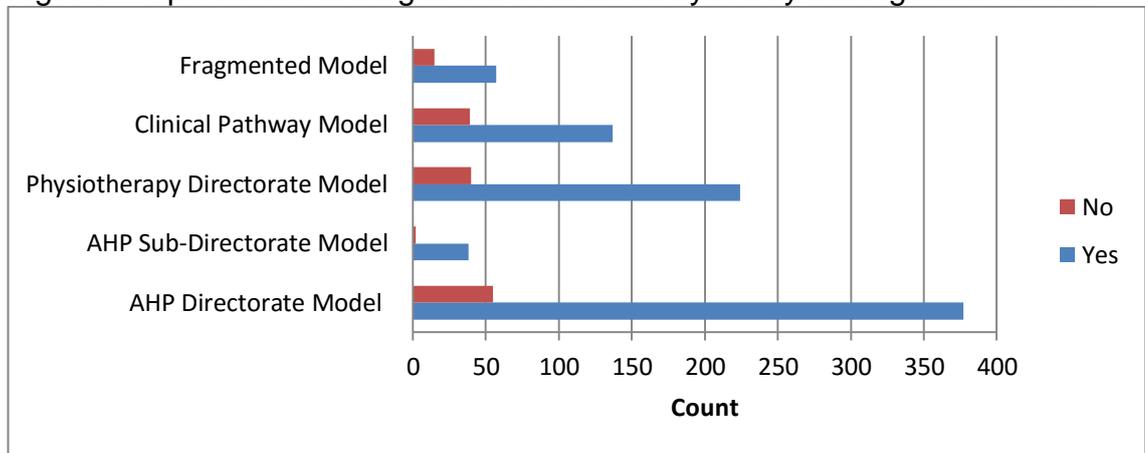


Fig. 72 Responsibility for Human Resources



Fig. 73 Human resource domain analysed by management model

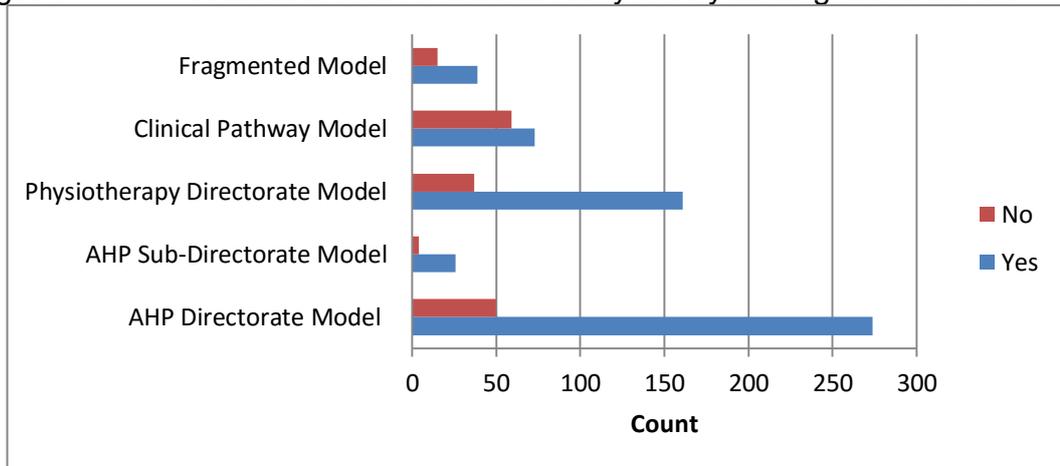


Fig. 74 Responsibility for resource management

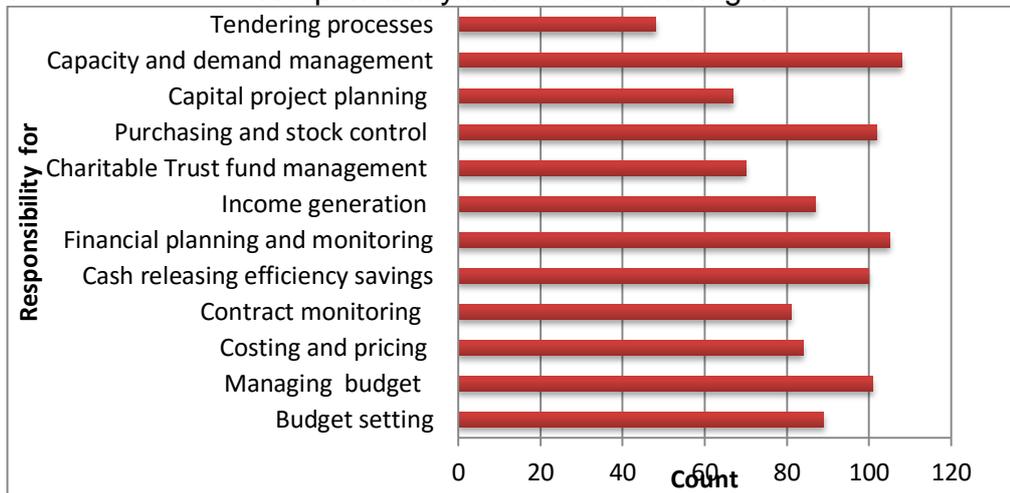


Fig. 75 Resource management domain analysed by management model

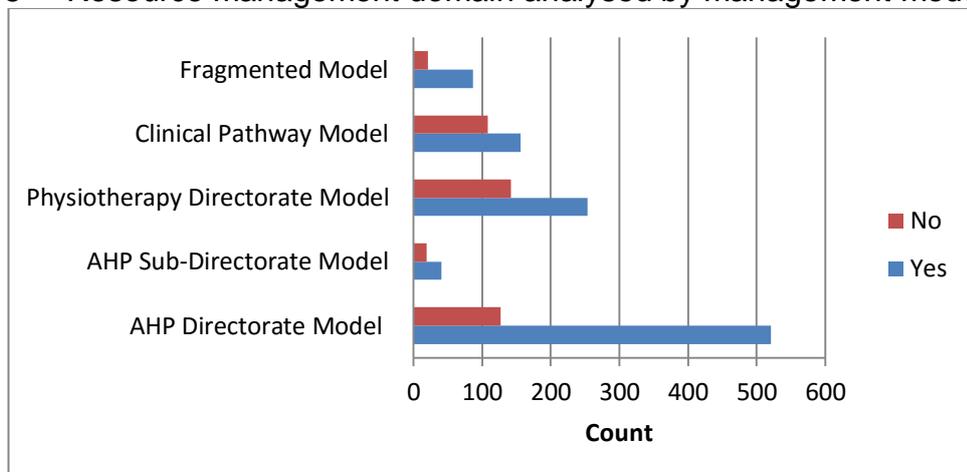


Fig. 76 Responsibility for information management

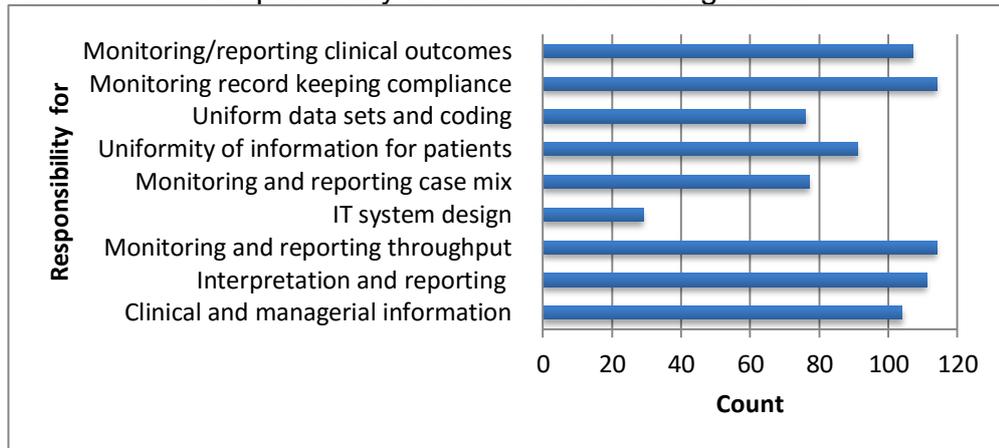


Fig. 77 Information management domain analysed by management model

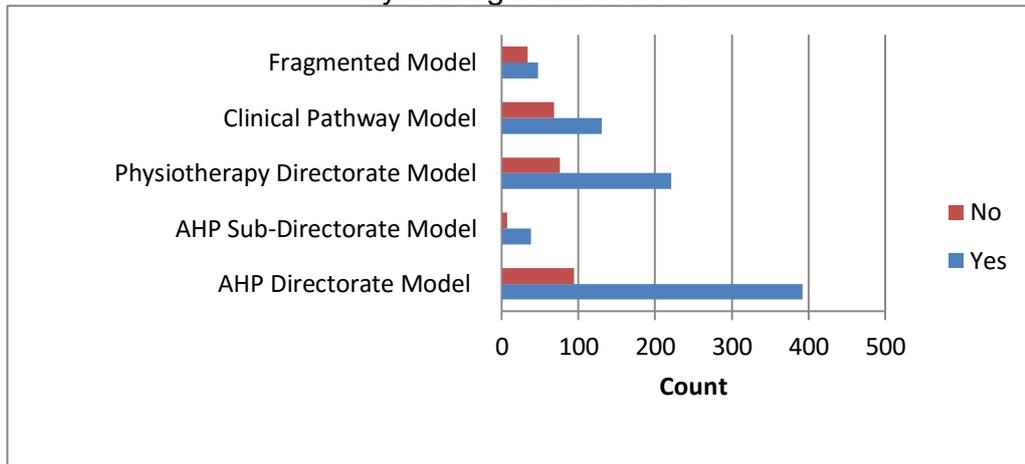


Fig. 78 Responsibility for commissioning/service planning

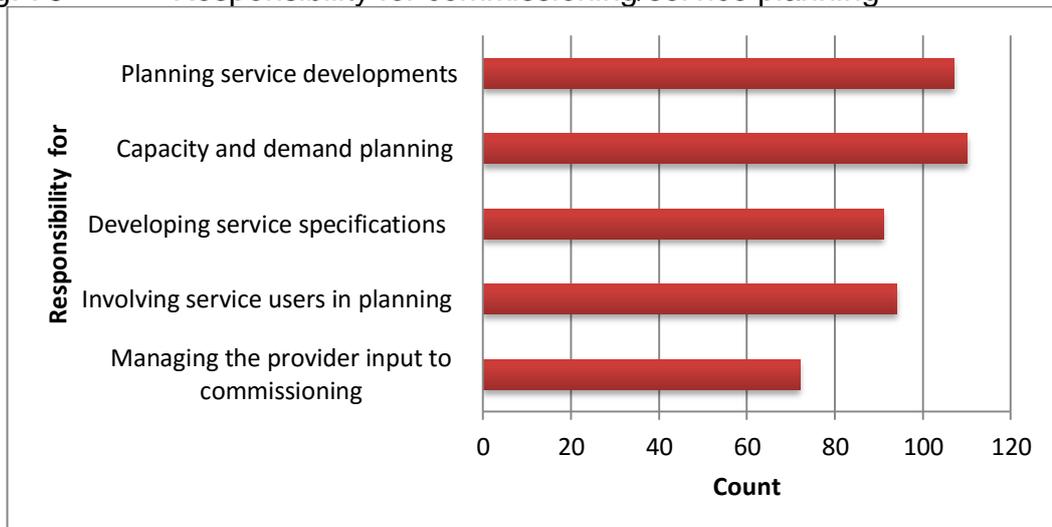


Fig. 79 Commissioning/service planning domain by management model

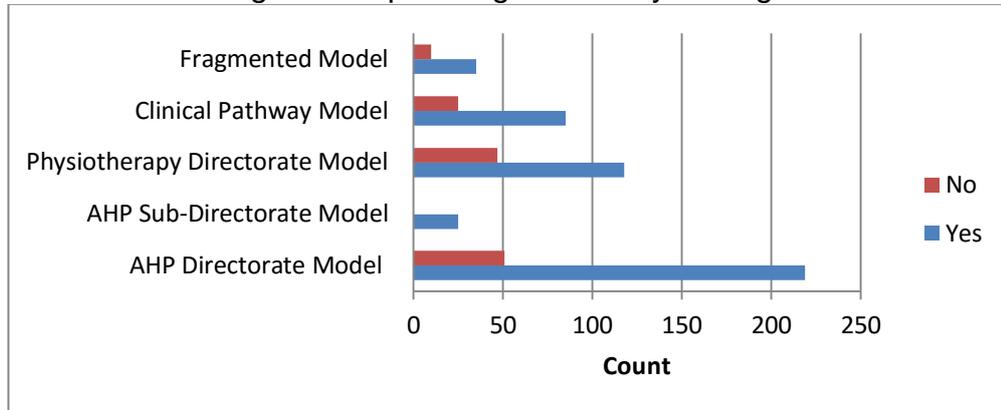


Fig. 80 Responsibility for innovation and service re-design



Fig. 81 Innovation and service re-design domain by management model

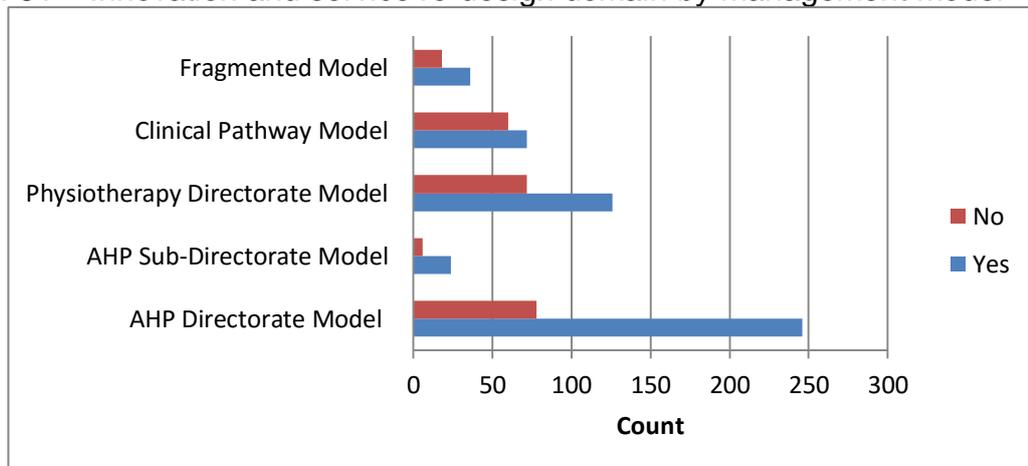


Fig. 82 Responsibility for research, development and education

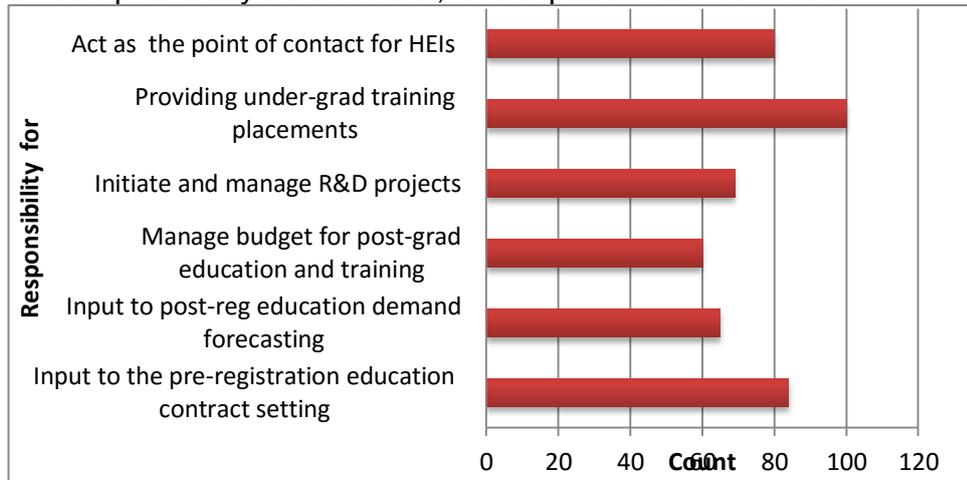


Fig. 83 R&D and education domain analysed by management model

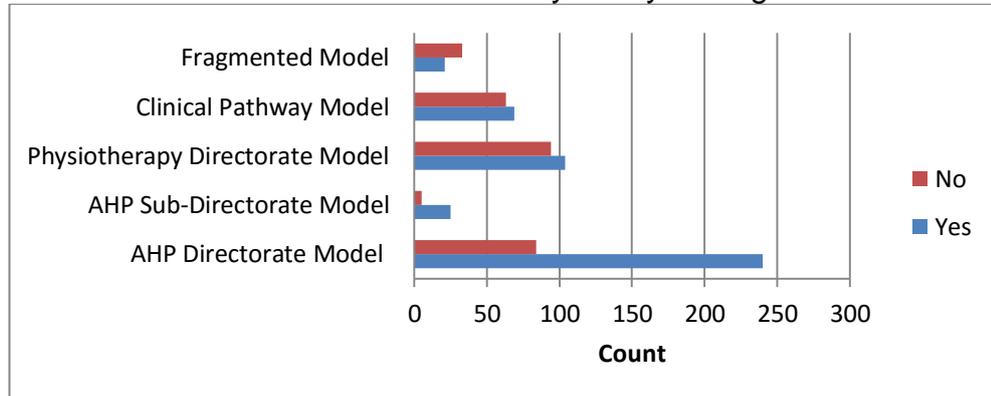


Fig. 84 England and Wales comparison lead roles and organisation type

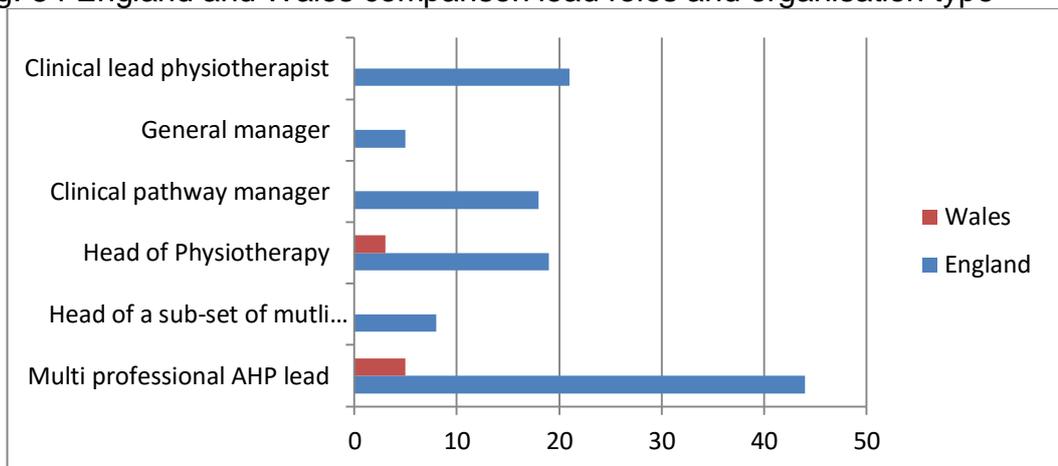
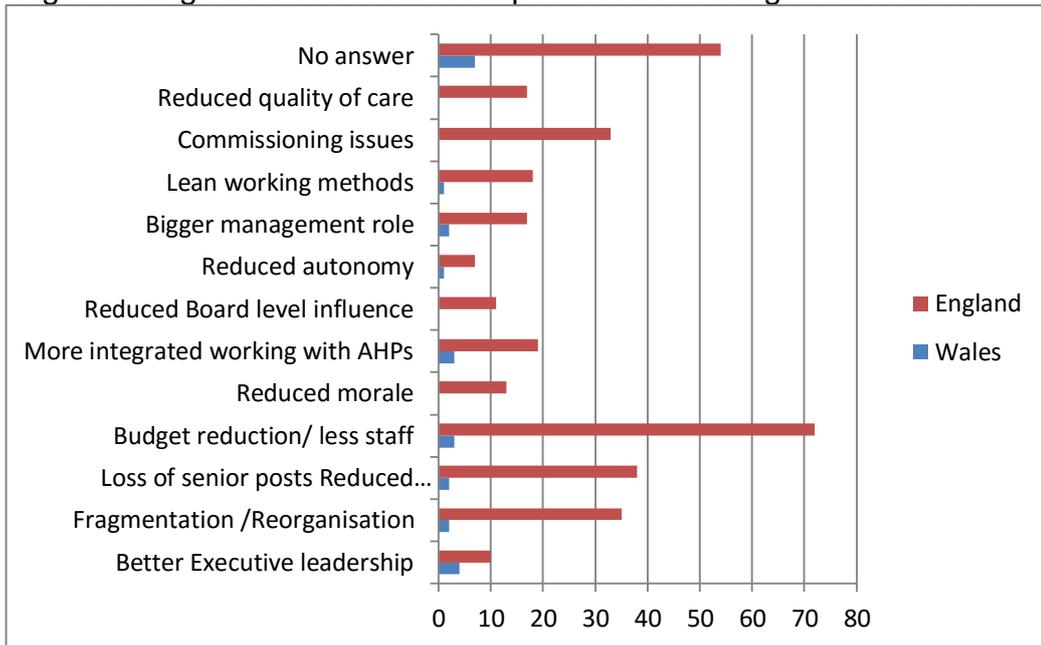
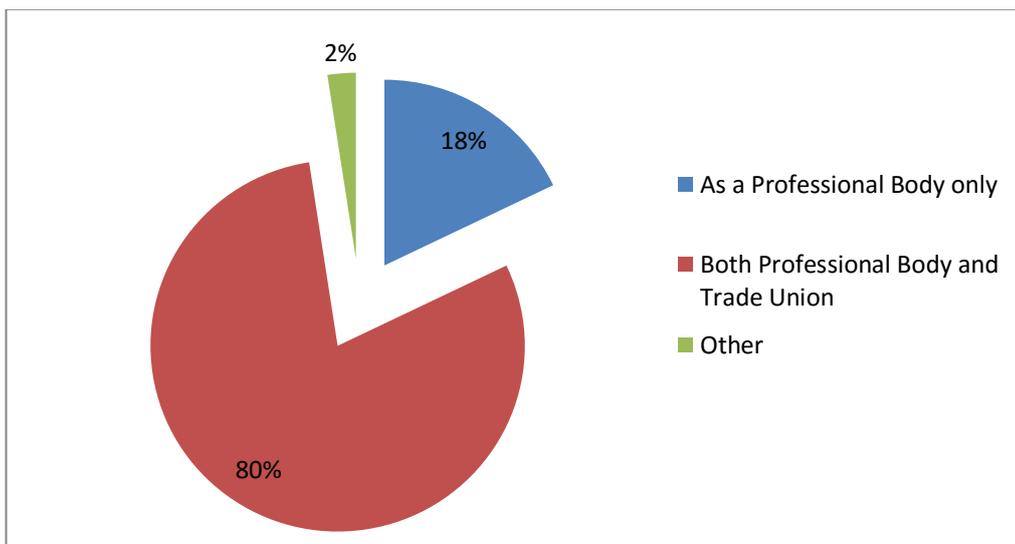


Fig. 85 England v Wales: Main impact of NHS changes since 2008



Views about the Chartered Society of Physiotherapy

Fig.86 What do you think the proper role of the CSP should be?



APPENDIX 19 STATISTICAL ANALYSES

Analysis was undertaken using SPSS V 20 & 21. Findings are set out with reference to the corresponding chapter section of the main thesis. The following includes a selection of the many statistical analyses undertaken, the majority of which did not prove statistical significance.

19.1 Management model and organisation type

A Chi square test for independence was performed to analyse whether there was an association between management model and organisation type (using 2 pooled organisation types (Group C), $\chi^2 (1, n = 123) = 0.51, p = 0.91$, demonstrating no significant association between acute and community organisations with regard to management models and organisation type.

19.2 Improved access

A Chi square test for independence was performed to analyse improved access with longer waiting times (Group D, Professionally-led and devolved structures). $\chi^2 (1, n = 123) = 3.76, p = 0.94$, demonstrating no significant association between management structures with regard to improved access to services.

Table 80 Management models and improved access
*improvedaccess * manstructgroupD Crosstabulation*

		<i>manstructgroup</i>				<i>Total</i>
		<i>AHP</i>	<i>Physio</i>	<i>pathway</i>	<i>Fragmented</i>	
<i>i</i>	<i>Count</i>	15 _a	9 _a	5 _a	3 _a	32
<i>m</i>	<i>% within improvedaccess</i>	46.9%	28.1%	15.6%	9.4%	100.0%
<i>p</i>	<i>% within manstructgroupE</i>	25.9%	28.1%	21.7%	30.0%	26.0%
<i>r</i>	<i>% of Total</i>	12.2%	7.3%	4.1%	2.4%	26.0%
<i>o</i>	<i>Count</i>	43 _a	23 _a	18 _a	7 _a	91
<i>v</i>	<i>% within improvedaccess</i>	47.3%	25.3%	19.8%	7.7%	100.0%
<i>e</i>						

d a c c e s s	% within manstructgroupE	74.1%	71.9%	78.3%	70.0%	74.0%
		35.0%	18.7%	14.6%	5.7%	74.0%
	% of Total					
	Count	58	32	23	10	123
Total	% within improvedaccess	47.2%	26.0%	18.7%	8.1%	100.0%
	% within manstructgroupE	100.0%	100.0%	100.0%	100.0%	100.0%
	% of Total	47.2%	26.0%	18.7%	8.1%	100.0%

Each subscript letter denotes a subset of manstructgroupD categories whose column proportions do not differ significantly from each other at the .05 level.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.376	3	.945
Likelihood Ratio	.381	3	.944
Linear-by-Linear Association	.000	1	.999
N of Valid Cases	123		

19.3 WTE employed

Pooled Group C Acute and Community. $\chi^2 (1, n = 123) = 9.65, p = 0.47$

demonstrating significant difference with acute organisations employing larger staff numbers than community.

Table 81 Scope of service: Number of WTE physiotherapists managed
Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.654 ^a	4	.047
Likelihood Ratio	10.243	4	.037
Linear-by-Linear Association	6.806	1	.009
N of Valid Cases	123		

a. 2 cells (20.0%) have expected count less than 5. The minimum expected count is 3.47.

Pooled Group A. Kruskal-Wallis Test revealed a statistically significant association in the number of staff managed across 4 pooled organisations (Group 1 Welsh Health Boards: n = 8, group 2 Acute Trusts: n = 60, Group 3 Mixed Trusts: n = 33, Group 4 Community Trusts: n = 22) $\chi^2(2, n = 123) = 13.3$, $p = 0.004$. The Welsh Health Boards had the highest median value 210, with the others recording 25.6, 42 and 17.5 respectively.

19.4 Range of specialisms provided by the service

A two sided Fisher Exact test (Group C Acute and Community), reported $\chi^2(1, n = 123) p = 1.000$, determining that there was no significant association between AHP and non AHP management models in respect of decreased range of service.

19.5 Clinical autonomy

A two sided Fisher Exact test (Group D) reported $\chi^2(1, n = 123) = 0.657$, $p = 0.719$, determining that there was no significant association between professionally-led and devolved structures in respect of decreased clinical autonomy.

Table 82 Physiotherapy decreased clinical autonomy

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.198 ^a	1	.657		
Continuity Correction ^b	.069	1	.792		
Likelihood Ratio	.198	1	.657		
Fisher's Exact Test				.719	.396
Linear-by-Linear Association	.196	1	.658		
N of Valid Cases	123				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 27.77.

b. Computed only for a 2x2 table

19.6 Quality of care

A two sided Fisher Exact test (Group B Acute, Mixed and Community) reported $X_2(1, n = 123) = 2.43, p = 0.138$, determining that there was no significant association between acute and community organisations in respect of decreased in quality of physiotherapy care.

Table 83 Quality of physiotherapy care
Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.435 ^a	1	.119		
Continuity Correction ^b	1.888	1	.169		
Likelihood Ratio	2.445	1	.118		
Fisher's Exact Test				.138	.085
N of Valid Cases	123				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 22.81.

b. Computed only for a 2x2 table

19.7 Scope for promotion

A two sided Fisher Exact test (Group C) reported $X_2(1, n = 123) p = 0.834$ determining that there was no significant association between acute and community organisations in respect of reduced career opportunities and scope for promotion.

19.8 Departmental facilities

A two sided Fisher Exact test (Group C) reported $X_2(1, n = 123) p = 0.384$ determining that there was no significant difference between acute and community organisations in respect of lost or reduced departmental facilities.

19.9 Fragmentation

A two sided Fisher Exact test (Group C) reported $X_2(1, n = 123) = 13.4.1, p=0$

Community organisations had significantly more physiotherapy services sub-divided between directorates and divisions than acute organisations

Table 84 Physiotherapy service fragmented
Pooled group C

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	13.417 ^a	1	.000		
Continuity Correction ^b	12.043	1	.001		
Likelihood Ratio	13.898	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	13.308	1	.000		
N of Valid Cases	123				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 19.51.

b. Computed only for a 2x2 table

Crosstab				
		pooledGroupC		Total
		community	acute	
[Physiotherapy service sub-divided between different Divisions/Directorates] Since 2008 has your service been subject to any of the following?	yes	Count 30	Count 10	Count 40
		% within [Physiotherapy service sub-divided between different Divisions/Directorates] Since 2008 has your service been subject to any of the following? 75.0%	% within [Physiotherapy service sub-divided between different Divisions/Directorates] Since 2008 has your service been subject to any of the following? 25.0%	% within pooled2types 100.0%
		% within pooled2types 47.6%	% within pooled2types 16.7%	% within pooled2types 32.5%
		Count 33	Count 50	Count 83
[Physiotherapy service sub-divided between different Divisions/Directorates] Since 2008 has your service been subject to any of the following?	no	Count 33	Count 50	Count 83
		% within [Physiotherapy service sub-divided between different Divisions/Directorates] Since 2008 has your service been subject to any of the following? 39.8%	% within [Physiotherapy service sub-divided between different Divisions/Directorates] Since 2008 has your service been subject to any of the following? 60.2%	% within pooled2types 100.0%
		% within pooled2types 52.4%	% within pooled2types 83.3%	% within pooled2types 67.5%
		Count 63	Count 60	Count 123
Total		% within [Physiotherapy service sub-divided between different Divisions/Directorates] Since 2008 has your service been subject to any of the following? 51.2%	% within [Physiotherapy service sub-divided between different Divisions/Directorates] Since 2008 has your service been subject to any of the following? 48.8%	% within pooled2types 100.0%

% within pooled2types	100.0%	100.0%	100.0%
-----------------------	--------	--------	--------

19.10 Services no longer provided

A two sided Fisher Exact test (Group C) reported $X^2(1, n = 123) p = 0.68$, determining that there was no significant association between acute and community organisations in respect of physiotherapy services being no longer provided

19.11 Government policy: Tendering out

A Chi-square test of independence (with Yates Continuity Correction) examining the relation of tendering for physiotherapy services. Acute organisations were impacted significantly, $X^2(1, n = 123) = 8.184, p = 0.016$.

Table 85 Organisation type and the impact of government policy
Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	8.185 ^a	1	.004		
Continuity Correction ^b	6.819	1	.009		
Likelihood Ratio	8.600	1	.003		
Fisher's Exact Test				.005	.004
Linear-by-Linear Association	8.118	1	.004		
N of Valid Cases	123				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 9.27.

b. Computed only for a 2x2 table

Crosstab

		pooledGroupC		Total
		community	acute	
[Part of the physiotherapy service tendered out] Since 2008 has your service been subject to any of the following?	yes	Count 4	Count 15	Count 19
		% within [Part of the physiotherapy service tendered out] Since 2008 has your service been subject to any of the following? 21.1%	% within [Part of the physiotherapy service tendered out] Since 2008 has your service been subject to any of the following? 78.9%	% within pooled2types 100.0%
	no	Count 6	Count 25	Count 31
		% within pooled2types 6.3%	% within pooled2types 25.0%	% within pooled2types 15.4%
		Count 59	Count 45	Count 104

	% within [Part of the physiotherapy service tendered out] Since 2008 has your service been subject to any of the following?	56.7%	43.3%	100.0%
	% within pooled2types	93.7%	75.0%	84.6%
	Count	63	60	123
Total	% within [Part of the physiotherapy service tendered out] Since 2008 has your service been subject to any of the following?	51.2%	48.8%	100.0%
	% within pooled2types	100.0%	100.0%	100.0%

19.12 Impact on morale

A two sided Fisher Exact test (Group C) reported $X^2(1, n = 123) = 0.681, p = 0.821$ determining that there was no significant association between acute and community organisations in respect of reduced morale.

Table 86 Lowering of morale
Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.169 ^a	1	.681		
Continuity Correction ^b	.034	1	.855		
Likelihood Ratio	.169	1	.681		
Fisher's Exact Test				.821	.428
Linear-by-Linear Association	.167	1	.683		
N of Valid Cases	123				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 11.90.

b. Computed only for a 2x2 table

19.13 Impact of 2008 changes

A Chi square test for independence was performed to analyse whether there was an association with organisation type (using 3 pooled organisation types (Group B), and the primary reported impact of the 2008 changes. $X^2(1, n =$

123) = 0.53, $p = 0.76$, demonstrating no significant association between acute and community organisations with regard to the impact of the 2008 changes.

19.14 Job title and organisation type

A Chi square test (with Yates continuity correction) indicated no significant association in acute and community organisations between job title (Group C pool) $X^2 (1, n = 123) = 0.687, p = 0.53, phi = 0.40$.

Table 87 Pooled organisation type with pooled job title
Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.687 ^a	1	.407	.431	.265
Continuity Correction ^b	.396	1	.529		
Likelihood Ratio	.689	1	.406		
Fisher's Exact Test					
Linear-by-Linear Association	.681	1	.409		
N of Valid Cases	123				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 17.07.

b. Computed only for a 2x2 table

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Phi	-.075	.407
	Cramer's V	.075	.407
N of Valid Cases		123	

jobtitle2pooled * pooled2types Crosstabulation

			pooled2types		Total
			community	acute	
jobtitle2pooled	AHP profession	Count	43	45	88
		% within jobtitle2pooled	48.9%	51.1%	100.0%
	% within pooled2types		68.3%	75.0%	71.5%
	Count	20	15	35	
gen managers type	% within jobtitle2pooled	57.1%	42.9%	100.0%	
	% within pooled2types		31.7%	25.0%	28.5%
Total	Count	63	60	123	
	% within jobtitle2pooled		51.2%	48.8%	100.0%
	% within pooled2types		100.0%	100.0%	100.0%

19.15 Change in number of physiotherapy managers

A two sided Fisher Exact test with Yates' Continuity Correction was performed on 2 pooled organisation types (Group C) to analyse the impact on the reduction of physiotherapy managers posts by organisation type. χ^2 (1, n = 123) = 5.99, $p = 0.019$ demonstrating significant association with acute organisations having a reduction in manager posts compared with community organisations.

Table 88 Impact of reduced numbers of managers

Chi-Square Tests					
	Value	Df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.994 ^a	1	.014		
Continuity Correction ^b	5.143	1	.023		
Likelihood Ratio	6.046	1	.014		
Fisher's Exact Test				.019	.011
Linear-by-Linear Association	5.945	1	.015		
N of Valid Cases	123				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 28.78.

b. Computed only for a 2x2 table

19.16 Clinical role

A Kruskal-Wallis Test (Group A) revealed a statistically non-significant association in hours worked by the physiotherapy managers; Welsh Health Board: $n = 8$, Acute Trusts: $n = 60$, Mixed Trusts: $n = 33$, Community Trusts: $n = 22$, χ^2 (2, $n = 123$) = 3.35, $p = 0.34$. The community Trusts (which included mental health) recorded a higher median score (Md = 6) than the other 3 groups, which recorded median values of 1.5, 0.75 and 0 respectively.

Table 89 Physiotherapy managers' hours undertaking clinical work

Ranks			
	Organisation Type	N	Mean Rank
If Yes, how many hours per week?	WelshHB	8	54.63
	AcuteTr	60	62.00
	MixedTr	33	56.71
	Community	22	72.61
	Total	123	

	If Yes, how many hours per week?
Chi-Square	3.353
df	3
Asymp. Sig.	.340

a. Kruskal Wallis Test

b. Grouping Variable: Organisation Type

Organisation Type	N	Median
WelshHB	8	1.500
AcuteTr	60	.750
MixedTr	33	.000
Community	22	6.000
Total	123	1.000

19.17 Contracted hours and organisation type

A Kruskal-Wallis Test revealed a statistically insignificant association in the contracted hours worked across 4 pooled organisation types (Group A). (Group 1, Welsh Health Boards: n = 8, group 2 Acute Trusts: n = 60, Group 3 Mixed Trusts: n = 33, Group 4 Community Trusts: n = 22) $\chi^2(2, n = 123) = 4.87, p = 0.181$. All groups reported the same median score of 37.5.

19.18 Remuneration

Statistical analysis of pooled organisations types (Pool C) was undertaken. A two sided Fisher Exact test was the appropriate analysis as some cell numbers were small. $\chi^2 (1, n = 72) = 0.399, p = 0.695$ demonstrating no significant association between acute and community organisations with regard to changes in AfC bandings.

19.19 Managerial decision-making

Chi square test for independence indicated significant association in decision-making functions between 2 pooled organisation types (Group C), Acute and Community, in the above domains.

Table 90 Decision-making functions: Pooled group C

Domain	χ^2	<i>P</i>
Human resources domain, responsibility as appointing officer for physiotherapy recruitment	(1, n = 123) = 3.2	<i>p</i> = 0.05
Human resources domain, responsibility for dismissal of staff	(1, n = 123) = 8.81	<i>p</i> = 0.01
Resource Management domain, responsibility for costing and pricing	(1, n = 123) = 6.26	<i>p</i> = 0.04
Resource Management domain, responsibility for contract monitoring	(1, n = 123) = 7.99	<i>p</i> = 0.01
Innovation and service redesign domain, providing 7 day working in some services	(1, n = 123) = 9.27	<i>p</i> = 0.01
Research, development and education domain, initiate R&D projects for your service	(1, n = 123) = 7.43	<i>p</i> = 0.02

Chi square test for independence indicated significant association between 3 pooled organisation types (Group B) and:

Table 91 Decision-making functions: Pooled Group B

Domain	χ^2	<i>P</i>
Operational management: Networks between physiotherapists across the organisation	(1, n = 123) = 5.7	<i>p</i> = 0.19
Resource Management: Responsibility for budget setting	(1, n = 123) = 1.5	<i>p</i> = 0.46
Resource Management: Responsibility for income generation projects	(1, n = 123) = 3.87	<i>p</i> = 0.14
Information Management: Responsibility for clinical and managerial information throughout your service	(1, n = 123) = 3.87	<i>p</i> = 0.14
Information Management: Responsibility for uniformity of information for patients	(1, n = 123) = 2.58	<i>p</i> = 0.27
Commissioning service planning: Managing provider input into physiotherapy commissioning	(1, n = 123) = 0.19	<i>p</i> = 0.90
Innovation and service redesign: responsibility introducing higher band roles	(1, n = 123) = 1.19	<i>p</i> = 0.54
Innovation and service redesign: Preparing submissions for national conferences/awards	(1, n = 123) = 6.67	<i>p</i> = 0.35
Research, development and education: Input to pre-registration education contracts	(1, n = 123) = 0.62	<i>p</i> = 0.73

Chi square test for independence indicated no significant association in decision-making functions, except networks, between 3 pooled organisation types, Acute, Mixed and Community, in the above domains.

19.20 Seats on organisational committees

A Chi –square test for independence between 3 pooled organisation types (Group C), indicated no significant association between acute and community organisations and a seat on 4 key committees.

Table 92 Seats on key organisational committees

Domain	χ^2	<i>P</i>
Clinical audit	(1, n = 123) = 3.75	<i>p</i> = 0.44
Quality committee	(1, n = 123) = 5.85	<i>p</i> = 0.21
Clinical board	(1, n = 123) = 5.95	<i>p</i> = 0.20
Directorate board	(1, n = 123) = 8.33	<i>p</i> = 0.08

A chi–square test for independence indicated significant association between organisation type and a seat on a divisional board. $\chi^2(1, n = 123) = 0.04$

19.21 Budget management

A Kruskal-Wallis Test revealed a statistically insignificant association in the percentage of cost releasing savings across 3 pooled organisation types (Group B) Acute Trusts: n = 60, Group 2 Mixed Trusts: n = 41, Group 3 Community Trusts: n = 22) $\chi^2(2, n = 123) = 4.52, p = 0.104$. The Acute Trusts had the highest median value 5.0, the Mixed Trusts the lowest at 4.5.

This analysis showed that Acute Trusts had the largest mean amount of savings and the Mixed Trusts the lowest mean.

19.22 Management autonomy

A two-sided Fisher Exact test with Yates' Continuity Correction was performed on 2 pooled organisation types (Group C) to analyse the impact on the reduction of autonomy by organisation type. $\chi^2 (1, n = 123) = 1.930, p = 0.25$ demonstrating no significant association between acute organisations and community organisations relating to reduction in management autonomy

Table 93 Management autonomy
Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.930 ^a	1	.165	.205	.113
Continuity Correction ^b	1.459	1	.227		
Likelihood Ratio	1.936	1	.164		
Fisher's Exact Test					
Linear-by-Linear Association	1.914	1	.166		
N of Valid Cases	123				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 26.83.

b. Computed only for a 2x2 table

lessautonomy * pooled2types Crosstabulation

			pooled2types		Total
			community	acute	
lessautonomy	less	Count	32	23	55
		% within lessautonomy	58.2%	41.8%	100.0%
	% within pooled2types		50.8%	38.3%	44.7%
	not less	Count	31	37	68
% within lessautonomy		45.6%	54.4%	100.0%	
% within pooled2types		49.2%	61.7%	55.3%	
Total	Count		63	60	123
	% within lessautonomy		51.2%	48.8%	100.0%
	% within pooled2types		100.0%	100.0%	100.0%

19.23 operational management

Chi Square analysis was performed on 2 pooled organisation types (Group C) to analyse the elements of operational management by organisation type. $\chi^2 (1, n = 123) = 10.23, p = 0.006$ demonstrating a significant association, with physiotherapy managers in acute organisations undertaking more operational management than in community organisations.

Table 94 Operational management

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.231 ^a	2	.006
Likelihood Ratio	8.701	2	.013
Linear-by-Linear Association	4.185	1	.041
N of Valid Cases	123		

a. 1 cells (16.7%) have expected count less than 5. The minimum expected count is 2.68.

Crosstab						
			Poolledtype			Total
			Acute	Mixed	Community	
[Capacity and demand management of physiotherapy services] Operational Management Do you have overall responsibility for:	yes	Count	54	39	15	108
		% within [Capacity and demand management of physiotherapy services]				
		Operational Management				
		Do you have overall responsibility for:	50.0%	36.1%	13.9%	100.0%
		% within Poolledtype	90.0%	95.1%	68.2%	87.8%
	no	Count	6	2	7	15
		% within [Capacity and demand management of physiotherapy services]				
		Operational Management				
		Do you have overall responsibility for:	40.0%	13.3%	46.7%	100.0%
		% within Poolledtype	10.0%	4.9%	31.8%	12.2%
Total	Count	60	41	22	123	
	% within [Capacity and demand management of physiotherapy services]					
	Operational Management	48.8%	33.3%	17.9%	100.0%	
	Do you have overall responsibility for:	100.0%	100.0%	100.0%	100.0%	
	% within Poolledtype					

19.24 Networks between physiotherapists across organisations

A two sided Fisher Exact test with Yates' Continuity Correction was performed on 2 pooled organisation types (Group C) to analyse physiotherapy managers' networking by organisation type. $\chi^2 (1, n = 123) = 3.825, p = 0.47$

demonstrating a significant association with physiotherapy managers in acute organisations undertaking more networking than in community organisations.

Table 95 Networks between physiotherapists

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.825 ^a	1	.050		
Continuity Correction ^b	2.434	1	.119		
Likelihood Ratio	6.158	1	.013		
Fisher's Exact Test				.057	.047
N of Valid Cases	123				

a. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 2.47.

b. Computed only for a 2x2 table

19.25 Human resource

A two sided Fisher Exact test was performed on 2 pooled organisation types (Group D) to analyse the impact of undertaking recruitment processes. $\chi^2 (1, n = 123) = 7.47, p = 0.009$, demonstrating the devolved models undertaking significantly less recruitment processes.

Table 96 Recruitment process

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7.472 ^a	1	.006		
Continuity Correction ^b	5.581	1	.018		
Likelihood Ratio	7.858	1	.005		

Fisher's Exact Test				.009	.009
N of Valid Cases	123				

a. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.32.
b. Computed only for a 2x2 table

19.26 Skill mix review

A two sided Fisher Exact test was performed (Group D) to analyse the impact of undertaking skill mix review. $\chi^2 (1, n = 123) = 7.47, p = 0.009$, demonstrating the devolved models undertaking significantly less than professionally-led.

Table 97 Skill mix review
Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7.472 ^a	1	.006		
Continuity Correction ^b	5.581	1	.018		
Likelihood Ratio	7.858	1	.005		
Fisher's Exact Test				.009	.009
N of Valid Cases	123				

a. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.32.

				Pooledtype			
				Acute	Mixed	Community	Total
[Skill mix review]	yes	Count		52	38	14	104
		% within [Skill mix review]					
Human Resources	Do you have overall responsibility within your service(s) for:	Human Resources		50.0%	36.5%	13.5%	100.0%
		Do you have overall responsibility within your service(s) for:					
	no	Count		8	3	8	19
		% within [Skill mix review]					
Human Resources	Do you have overall responsibility within your service(s) for:	Human Resources		42.1%	15.8%	42.1%	100.0%
		Do you have overall responsibility within your service(s) for:					
Total		Count		60	41	22	123
		% within [Skill mix review]					
	Do you have overall responsibility within your service(s) for:	Human Resources		48.8%	33.3%	17.9%	100.0%
		Do you have overall responsibility within your service(s) for:					
		% within Pooledtype		100.0%	100.0%	100.0%	100.0%

19.28 7-day working

A two sided Fisher Exact test with Yates' Continuity Correction was performed on 2 pooled organisation types (Group C) to analyse provision of some 7 day services by organisation type. $\chi^2 (1, n = 123) = 5.292, p = 0.18$ demonstrating a significant association with physiotherapy managers in acute organisations providing more 7-day services than community organisations.

Table 98 7- day service some areas
Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.292 ^a	1	.021		
Continuity Correction ^b	3.702	1	.054		
Likelihood Ratio	8.045	1	.005		
Fisher's Exact Test				.023	.018
N of Valid Cases	123				

a. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.06.

b. Computed only for a 2x2 table

Crosstab						
		Pooledtype			Total	
		Acute	Mixed	Community		
[Providing 7-day working in some services] Innovation and Service Re-design Do you have responsibility for:	yes	Count	50	25	12	87
		% within [Providing 7-day working in some services]				
		Innovation and Service Re-design	57.5%	28.7%	13.8%	100.0%
		Do you have responsibility for:				
	% within Pooledtype	83.3%	61.0%	54.5%	70.7%	
no	Count	10	16	10	36	
	% within [Providing 7-day working in some services]					
		Innovation and Service Re-design	27.8%	44.4%	27.8%	100.0%
		Do you have responsibility for:				
	% within Pooledtype	16.7%	39.0%	45.5%	29.3%	
Total	Count	60	41	22	123	
	% within [Providing 7-day working in some services]					
		Innovation and Service Re-design	48.8%	33.3%	17.9%	100.0%
		Do you have responsibility for:				
	% within Pooledtype	100.0%	100.0%	100.0%	100.0%	

19.29 Preparing submissions for national award/conferences

A Chi square test was performed for 2 pooled organisation types (Group C) to analyse preparation for award by organisation type. $\chi^2 (1, n = 123) = 9.96$ $p = 0.007$ demonstrating a significant association with physiotherapy managers in acute organisations undertaking this more.

Table 99 Preparing submissions for national award/conferences

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.965 ^a	2	.007
Likelihood Ratio	7.384	2	.025
N of Valid Cases	123		

a. 4 cells (66.7%) have expected count less than 5. The minimum expected count is .13.

19.30 R&D Education

A two sided Fisher Exact test was performed on 2 pooled organisation types (Group D) to analyse the impact of undertaking R&D and Education. $\chi^2 (1, n = 123) = 7.75$, $p = 0.008$, demonstrating the devolved models undertaking significantly less than fragmented models.

Table 100 R&D and education functions

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7.752 ^a	1	.005		
Continuity Correction ^b	6.586	1	.010		
Likelihood Ratio	8.023	1	.005		
Fisher's Exact Test				.008	.005
N of Valid Cases	123				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 13.39.

b. Computed only for a 2x2 table

19.32 Organisational change: Mergers and fragmentation

A two sided Fisher Exact test (Group E) reported $X_2(1, n = 123) p = 0.714$, determining that there was no significant association between England and Wales in respect of merging with another organisation, even though the impact of this was viewed differently by the managers.

19.33 Longer waiting times

A Chi square test for independence was performed to analyse reduced access with longer waiting times (Group E). $\chi^2(1, n = 123) = 0.19, p = 0.74$, demonstrating no significant association between different between England and Wales with regard to reduced access to services.

19.34 More equal access

A Chi square test for independence was performed to analyse more equal access to physiotherapy services across the area (Group E). $\chi^2(1, n = 123) = 2.26, p = 0.376$, demonstrating no significant association between different England and Wales with regard to equal access.

19.35 Cost savings

A Kruskal-Wallis Test (Group E) revealed a statistically non-significant association in percentage of cost efficiency savings between the two nations. Welsh Health Board: $n = 8$, English Trusts: $n = 115$, $\chi^2(2, n = 123) = 1.39, p$

=0.23. The English Trusts recorded a higher median score (Md = 5) compared with Wales (Md = 3.5)

19.36 Structures

A Chi square test for independence was undertaken (Pool D) to determine whether there was any association between AHP and Non-AHP management models and country.

A two sided Fisher Exact test reported $X_2(1, n = 123) p = 0.62$, determining that there was no significant association between England and Wales in respect of AHP and non AHP management models.

19.37 Contracted hours and organisation type

A two sided Fisher Exact test (Group E) reported $X_2(1, n = 123) p = 1.0$, determining that there was no significant association between England and Wales in respect of managers working full time hours.

19.38 Clinical work

A two sided Fisher Exact test (Group E) reported $X_2(1, n = 123) p = 1.00$, determining that there was no significant association between England and Wales in respect of physiotherapy managers undertaking clinical work.

19.39 Remuneration

A two sided Fisher Exact test (Group E) reported $X_2(1, n = 123) p = 0.34$, determining that there was no significant association between England and Wales in respect of alteration of Agenda for Change bandings.

19.40 Scope of service

Table 101 Number of registered physiotherapists managed Pooled group A.

Statistics

Please specify the number of Whole Time Equivalent HPC Registered physiotherapists you manage?

N	Valid	123
	Missing	15
Mean		53.56
Median		35.00
Mode		0 ^a
Std. Deviation		59.095
Variance		3492.245
Minimum		0
Maximum		280
Sum		6588

a. Multiple modes exist. The smallest value is shown

Test Statistics^{a,b}

	Please specify the number of Whole Time Equivalent HPC Registered physiotherapists you manage?
Chi-Square	13.266
df	3
Asymp. Sig.	.004

a. Kruskal Wallis Test

b. Grouping Variable: Organisation Type

Report

Please specify the number of Whole Time Equivalent HPC Registered physiotherapists you manage?

Organisation Type	N	Median
WelshHB	8	210.00
AcuteTr	60	25.61
MixedTr	33	42.00
Community	22	17.50
Total	123	35.00

Kruskal- Wallis one-way analysis of variance analysis indicated a significant association between organisation types in the number of physiotherapists managed, with Welsh Health Boards being most different $\chi^2(1, n = 123)$, $p=0.004$

19.41 Strategic committees

A two sided Fisher Exact test (Group E) reported $\chi^2(1, n = 123) p= 1.00$, determining that there was no significant association between England and Wales in respect of physiotherapy managers involved in any of the strategic committees.

19.42 Morale

A two sided Fisher Exact test (Group E) reported $\chi^2(1, n = 123) p = 0.187$, determining that there was no significant association between England and Wales in respect of reduced morale.

APPENDIX 20 NATIONAL COMPARISON: MANAGEMENT DOMAINS

The elements marked* demonstrated a statistically significant difference.

Table 102 National comparison : Management domains

DOMAINS		
Strategy	Wales	England
Development of strategy and planning	8 (100%)	110 (96%)
Input into physiotherapy workforce planning	8 (100%)	106 (92%)
Input into multidisciplinary workforce planning	8 (100%)	80 (69%)
Strategic development and partnership working	8 (100%)	89 (77%)
Interpretation and implementation of Government policies	8 (100%)	103 (90%)
Management and monitoring external contracts	4 (50%)	68 (59%)
Mean	92%	81%
Clinical Governance	Wales	England
Ensuring positive patient experience	8 (100%)	104 (90%)
Implementation of evidence-based practice	8 (100%)	110 (96%)
Clinical audit	8 (100%)	107 (93%)
Health and safety	8 (100%)	107 (93%)
Management of risk	8 (100%)	109 (95%)
Response to complaints	7(88%)	107 (93%)
Mean	98%	93%
Professional Development	Wales	England
Clinical and professional leadership	7(88%)	83 (77%)
Providing physiotherapy consultancy	8 (100%)	100 (87%)
Ensuring sufficient staff to give "critical mass"	8 (100%)	100 (87%)
Ensuring skill mix of physiotherapists to give correct grade mix	8 (100%)	106 (92%)
Communication with physiotherapists across the organisation	8 (100%)	105 (91%)
Continued Professional Development linked to staff appraisal	7(88%)	102 (89%)
Post-graduate education to meet service and staff needs	8 (100%)	105 (91%)
Comprehensive in-service training programmes	8 (100%)	101 (88%)
Mean	97%	88%
Operational Management	Wales	England
Staff deployment in all areas across the service(s)	8 (100%)*	57 (48%)*
Day-to-day operational management of staff in clinical areas	8 (100%)	99 (86%)
Development of physiotherapy policies and procedures	8 (100%)	104 (90%)
Performance management and clinical standards monitoring	8 (100%)	104 (90%)
Networks between physiotherapists within the organisation	8 (100%)	101 (88%)
Networks between physiotherapists across organisations	8 (100%)*	77 (67%)*
Inter-disciplinary working within the organisation	8 (100%)	91 (79%)
Capacity and demand management of physiotherapy services	8 (100%)	101 (88%)
Performance management of physiotherapy services	7(88%)	106 (92%)
Mean	99%	81%
Human Resources	Wales	England
Recruitment Process	7(88%)	44 (38%)*
Appointing officer for physiotherapy recruitment	8 (100%)	87 (76%)
Disciplinary policy implementation for physiotherapy staff	8 (100%)	93 (81%)
Responsible officer status for dismissal of staff	7(88%)*	49 (43%)*
Ensuring dissemination and implementation of HR policies	8 (100%)	97 (84%)

Skill mix review	8 (100%)	96 (84%)
Mean	96%	68%
Resource Management	Wales	England
Budget setting	8 (100%)	92 (80%)
Managing the budget	8 (100%)	93 (81%)
Costing and pricing of your service	7(88%)	77 (67%)
Contract monitoring	7(88%)	74 (64%)
Making cash releasing efficiency savings	8 (100%)	92 (80%)
Participation in financial planning and monitoring	8 (100%)	97(84%)
Developing income generation projects	7(88%)	80 (69%)
Charitable Trust funds	7(88%)	63 (55%)
Purchasing and stock control	8 (100%)	94 (81%)
Involvement in capital project planning	6 (75%)	61 (53%)
Capacity and demand management	8 (100%)	100 (87%)
Tendering processes	2 (25%)	46 (40%)
Mean	88%	70%
Information Management	Wales	England
Management of clinical and managerial information	8 (100%)	84 (73%)
Interpretation and reporting of information	8 (100%)	103 (90%)
Monitoring and reporting throughput activity	8 (100%)	106 (92%)
Monitoring and reporting case mix	4 (50%)	25 (22%)
Uniformity of information for patients	6 (75%)	84 (73%)
Uniform data sets and coding	7 (84%)	69 (60%)
Monitoring of compliance regulatory/ professional standards	8 (100%)	106 (92%)
Monitoring and reporting of clinical outcomes	8 (100%)	99 (86%)
Mean	89%	74%
Commissioning/Service Planning	Wales	England
Managing the provider input to commissioning	7 (84%)	87 (76%)
Involving service-users in service development	7 (84%)	87 (76%)
Developing service specifications	7 (84%)	84 (73%)
Capacity and demand planning	8 (100%)	102 (89%)
Planning service developments	8 (100%)	98 (85%)
Mean	94%	80%
Innovation and Service Re-design	Wales	England
Service re-design projects	8 (100%)	101 (88%)
Participation in multi-disciplinary service re-design	8 (100%)	101 (88%)
Introducing higher band roles	7 (84%)	82 (71%)
Providing 7-day working in some services	8 (100%)*	68 (59%)*
Involvement of voluntary organisations in planning	6 (75%)	48 (42%)
Preparing submissions for national awards/conferences	6 (75%)*	53 (46%)*
Mean	89%	69%
Research, Development and Education	Wales	England
Input to the pre-registration education contract setting	8 (100%)	59 (51%)
Input to post-registration education demand forecasting	6 (75%)	59 (51%)
Manage the budget for your service post-graduate education	8 (100%)*	52 (45%)*
Initiate and manage R&D projects	8 (100%)*	61 (53%)*
Providing under-graduate training and placements	6 (75%)	94 (82%)
Act as the "point of contact" for Higher Education Institutions	6 (75%)	74 (64%)
Mean	88%	58%
All Domain combined:	Total Mean	93%
		76%

ABBREVIATIONS

AfC	Agenda for Change
AHPf	Allied Health Professions forum
AHP	Allied Health Professions
AQP	Any Qualified Provider
ATEAHPMS	Assessment Tool for Evaluating AHP Management Structures
BMA	British Medical Association
BMJ	British Medical Journal
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CHI	Commission for Health Improvement
CIP	Cost Improvement Plan
CIPD	Chartered Institute of Personnel and Development
CQC	Care Quality Commission
CSP	Chartered Society of Physiotherapy
DGH	District General Hospital
DH	Department of Health
DHA	District Health Authority
DoH	Department of Health
DHSS	Department of Health and Social Security
ESP	Extended Scope Practitioner
FT	Foundation Trust
GP	General Practitioner
HA	Health Authority
HC	Health Circular
HCPC	Health and Care Professions Council
HEI	Higher Education Institute
HMSO	Her Majesty's Stationery Office
HPC	Health Profession's Council
ITA	Inductive Thematic Analysis
LHB	Local Health Board
MHMA	Medicines the Human Medicines (Amendment) Regulations
MoH	Ministry of Health
MSK	Musculoskeletal
NAO	National Audit Office
NHS	National Health Service
NHSI	NHS Institute
NICE	National Institute for Health and Clinical Excellence
OHE	Office of Health Economics
PCG	Primary Care Group
PCT	Primary Care Trust
RAG	Red, Amber, Green
RCN	Royal College of Nursing
R&D	Research and Development

RHA	Regional Health Authority
RQ	Research Question
SDO	Service Delivery and Organisation Programme
SHA	Strategic Health Authority
SSI	Semi Structured Interviewee
TU	Trade Union
UCAS	Universities and Colleges Admissions Service
UGM	Unit General Manager
US	United States
WAG	Welsh Assembly Government
WG	Welsh Government
WHO	World Health Authority
WTE	Whole Time Equivalent

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