CSP-HSORU
COLLABORATIVE RESEARCH INTO PHYSIOTHERAPY ORGANISATION

The Nature of the District Physiotherapist Role

Physiotherapy Organisation: 4

WARREN KINSTON BSc MB BS MRCPsych
Senior Research Fellow

JOHN ØVRETVEIT BSc
Research Fellow

Health Services Organisation Research Unit, Brunel Institute of Organisation and Social Studies, Brunel University, Uxbridge, Middlesex

JOYCE I WILLIAMS BA MCSP DipTP
District Physiotherapist, Doncaster Royal Infirmary

Current reorganisation requires District Health Authorities (DHAs) to review their need for posts at District level. An explicit and generally acceptable understanding of the nature of the work and its level is necessary if physiotherapists are to put a convincing case for retaining or creating such posts. This paper reports and discusses some recent research findings about the District Physiotherapist role.

The Problem

CONVENTIONAL wisdom currently describes the District Physiotherapist as responsible for the development of comprehensive services for the population of a Health District (HD). In terms of the theory of levels of work being used in our research, this model* describes work at stratum IV (Kinston, Øvretveit and Teager, 1981). The definition below was tentatively reported during the initial phase of CSP-HSORU research (Kinston and Øvretveit, 1980).

Early HSORU research (Tolliday and Jaques, 1978) had recognised the possibility of stratum IV work but left most details open and questioned its feasibility on a national scale. The series of research conferences recently held at Brunel University together with discussions with individuals over the past year now lead us to offer a new model of the role of District Physiotherapist.

We have been confronted with problems which must be dealt with if physiotherapy organisation is to make sense. These include the following:

- Different District Physiotherapists have described their work to us in quite different ways. They seem to be working on a variety of levels. Each, however, regards his role undoubtedly and truly as that of 'District Physiotherapist'. The first problem, therefore, is that the term 'District Physiotherapist' seems to carry different meanings and expectations within the profession. This can lead to confusion and even ill-feeling.
- In some HDs there is both a District Remedial Gymnast and District Physiotherapist. It is difficult to believe that the population can need two comprehensive services which have so much overlap. The problem here is one of credibility. Is either District role real? Is the District role a political gambit to increase the prestige of the remedial professions? Is this the District Management Team's (DMT) way of diluting responsibility to stop high-level work being done?
- Some DMTs seem unwilling to recommend or allow the provision of a comprehensive population service, but still seem keen to have someone to 'run the services of the District'. Such a person is, not unnaturally, known as a District Physiotherapist. If such a role and title make sense, then the model describing the work as level IV must be incorrect.
- In some HDs, a District Physiotherapist post at stratum IV would consume a quite disproportionate amount of the total resources available for physiotherapy. Does this mean a District role is not needed in some Districts? If there is a person in post, she finds herself doing a considerable amount of routine or emergency clinical work and is pre-occupied with the shortage of staff. Does this make sense? Is the District Physiotherapist just another clinican? Why are some DMTs concerned about employing a physiotherapist who is not clinically active?

* A model is a simplified representation of some aspect of reality. Models may take various forms, for example pictorial, mathematical or verbal. A model built of words may be referred to variously as a definition, description or formulation. Much of HSORU's work consists of building such models of observed reality and testing them in practice.

A useful model of the role must deal with the findings listed above. It should clear up misunderstandings, both within the profession and outside it, so the people involved can not only answer the question 'What is the role?' but also 'Why do we need it here?'. Defining the role as comprehensive service provision does not seem to do this. One solution would be to assume that the stratum IV model is right and therefore that DMTs, remedial gymnasts and many physiotherapists are wrong in their conception of the role. As these latter groups are unlikely to agree to this, the model ends up not matching real life. People may continue to operate on the basis of such a deficient model, but this tends to produce difficulties, which in the NHS typically manifest themselves as power struggles and misunderstandings.

The solution adopted in the HSORU research approach and to be used here is that defining the role only as comprehensive service provision is wrong. It is wrong because it does not accurately model reality. We will offer a definition which takes account of the questions raised above, meeting both political and professional criteria of acceptability.

The Work of the District Physiotherapist

Physiotherapists at the research conferences described their work in a variety of ways. These descriptions were rarely useful in determining organisational structures. Before we offer our formulation of the model, we will indicate various other types of formulation and why they are unsatisfactory.

'The work is attending committees, visiting all units, etc'. This is unsatisfactory because it is simply a list of observable behaviours, not work. Work implies the pursuit of goals and if these could be achieved with completely different activities then the work (whatever it is) would be regarded as done.

'The work is advising the DMT, providing in-service training, counselling junior physiotherapists, etc'. Such a list of tasks is preferable to a list of activities but it is less satisfactory than a list of responsibilities because it glosses over the option of delegation. If deputies were assigned these tasks, would it mean that the District Physiotherapist did no work? Or would it mean that there were really two or more District Physiotherapists?

'The work is identifying needs, planning, priority-setting, etc'. This is true but unsatisfactory because it is necessary to plan and set priorities for all work at all levels (see *Suggestions for Discussion*). In this sense, all physiotherapists are managers or organisers. The crucial differences among District Physiotherapist posts within the NHS is found in the scale, complexity and implications of the work required.

'The work is being responsible for the provision of physiotherapy services'. This definition is confusing because the Health Authority and the Secretary of State are also said to be responsible for the provision of services. Emphasising direct executive or professional responsibility is also unsatisfactory because it would seem to imply that the clinical output of practitioners, patient care, is the responsibility of the District Physiotherapist. This potentially violates the principle of clinical autonomy towards which the profession, or at least a major segment of it, is striving.

'The work is management of physiotherapists, responsibility for a budget, etc'. Authority relations and budgets do not describe work. They are the methods or tools through which work can get done. Once the work is determined there may be a variety of ways of doing it; some tools may be essential, others may be optional, and others, retained perhaps thoughtlessly or for the sake of tradition or prestige, may interfere with the work.

'The work is what you make it'. This ignores the social reality that all work must take place within limits. The role description we are seeking is a description of the limits. A model which denies the existence of limits or the reality of social accountability is unsatisfactory.

Work to be Done

Since 'needs' are not unquestionable realities, but matters of social definition, the issue of whether a District Physiotherapist role is needed is inevitably a political issue. It sometimes appears that the problem can be easily solved by decisions at the national level, but this is rarely so because national formulae are often designed to be politically comfortable. The problem bites locally where the formula has to be applied in a particular District with particular physiotherapists already in post.

Each local post is instituted formally by the DHA on the advice of the DMT. In practice, decisions are likely to be a result of a complex process of accommodation involving the physiotherapists in the District, key doctors, associated professional groups, administrators and possibly others.

Negotiation and resolution will be aided by a clear statement of the work to be done, the consequences of ignoring this work and the necessary tools for the work; and this varies from District to District.

The New Formulation

We sought to define a few key features of the District Physiotherapist role which make the most sense to all concerned. These are as follows: There is a generally felt need for someone *to create and maintain an overview of the whole physiotherapy system within a District.* The prime purpose of the work is *to deal with fragmentation of services,* and the post-holder is primarily responsible for *integrative and co-ordinative activities.*

Partridge and Warren (1977) have observed that the weakest points in physiotherapy services are likely to be the interactions between the parts (hospital, community and domiciliary services), and the inter-relations between the physiotherapy system and the other health and social systems. There seems to be little doubt that this holds true even in the smallest District with the most primitive services and no plans for significant developments. In such Districts, a variety of administrative responsibilities is scattered among administrators and doctors and, in the absence of a designated physiotherapist, rarely pulled together. In the largest Districts with the most developed and developing services and complex large scale administrative and educational activities, the need for a systematic overview and control holds all the more. The work content and activities in the smallest and largest Districts will be different but let us now pursue the similarity in the responsibilities.

According to the model which has emerged from our work with physiotherapists, the core role of the District Physiotherapist in all Districts should be:

- To serve as a means for the DMT and others to communicate to physiotherapists as a group
- To serve as a focus for physiotherapists in administrative, service or educational matters of potential District relevance

- To evaluate activities and bring about necessary changes in the service as a whole
- To co-ordinate and rationalise available resources within the District
- To provide advice to the DMT
- To deal with District crises in physiotherapy
- To ensure cohesion and enhance morale among physiotherapists in the District — to provide leadership.

Level of Work of the District Physiotherapist

Although the core work of the District Physiotherapist is similar in principle in all Districts, there are important differences between Districts. These differences can be attributed to variation in the level of work at which the District Physiotherapist is working. Our model requires an additional explicit statement of the different levels of work to be undertaken and allows this to be flexibly adjusted.

The next key issue, therefore, is how the level of work is to be decided. It is common practice to avoid the issue by tying pay grades, supposedly reflecting level of work, to population sizes and number of subordinates. Such rules of thumb can be extremely misleading. They avoid the variety of factors that affect level of work, in particular the desires of the Authority who is paying for the work, and the needs of the physiotherapists within the District. To deal with this problem we will use the work stratum model outlined in an earlier paper (Kinston, Øvretveit and Teager, 1981).

Assignation of Level of Work to District Posts

If the core work is to be done and the District Physiotherapist is to be held accountable for it, then she must have some explicit authority over the other physiotherapists and an appreciation of their work and problems. Her decisions will not be recognised as binding unless both conditions hold. This suggests a method of determining the minimum level of work appropriate for the role: it must be at least in the stratum of the most senior existing role, but one grade higher. It can, of course, be one or two strata above. The difference in work level between the District role and other therapist roles will determine whether the requisite authority relation is managerial or co-ordinating (DHSS, 1978).

Using this principle of requisite authority, we can consider three hypothetical Districts where the DMT is considering whom to appoint and at what level to assign the post. This is, of course, rarely done explicitly but we believe some similar process often occurs. We will ignore, for the moment, the way that salaries are pegged.

District A has 11 full-time equivalent (FTE) physiotherapists and three helpers. Only three posts are full-time, two Senior Is and a Senior II. All of these are in the two small hospitals.

If this District appointed a typical Superintendent IV working at upper stratum II she could do useful core District Physiotherapy work. She would carry a service commitment and do quite a lot of direct clinical work. She would be regarded as a leader, helper and instrument of change because of her access to the key doctors, administrators, personnel department and so on. She would have no more than a cash float and probably could move people only to cover on a rota basis or in a crisis. She would not be responsible for anticipating changing work flows but would provide advice when these were evident. We found in one such District that as posts became vacant they would revert to the DMT's central resource pool.

If, however, the post were held by a stratum III physiotherapist (possibly a typical Superintendent II) she would find the inability to plan services irksome. Her presence would be advantageous to physiotherapists there in that she would focus more on District issues rather than local crises; consider the staff as a whole rather than as a collection of individuals; and could put a stronger case for any needed changes to the DMT and others. Nevertheless, she might feel she was not really doing anything useful. If her fight for more responsibility were fruitless, she might leave or settle down, somewhat frustratedly or apathetically, to do mostly clinical work. If she were successful, she would produce continuing improvements. A stratum IV physiotherapist would not apply for a post in this District unless the DMT were determined to upgrade the services substantially.

District B contains a large District General Hospital, other small hospitals and employs 25 FTE physiotherapists and eight helpers. Of the 40 physiotherapists, 18 work in the DGH where there is a Superintendent II. There are two other superintendents.

A stratum II physiotherapist would not apply for this District post. She might be considered too 'junior' and might be found to be of little use to superintendents working in the District.

A top stratum III physiotherapist (possibly a good Superintendent I) could hold the post. She would want to operate where the bulk of the staff were and would probably station herself in the DGH but delegate the running of the hospital to a superintendent. She would use her focus on the District as a whole to develop and maintain systems providing educational and clinical services. Particular problems would be identified and put into the context of her general experience of the service enabling her to issue District-wide guide lines or policy. To do this, she would need to have control over posts, to fill vacancies and deploy staff and thus to reorganise the District. She would expect to appoint staff, plan induction and in-service training programmes, negotiate the conditions of work and develop counselling, discipline, grievance and dismissal procedures. Her influence and leadership style would depend crucially on how many others in the District were working at stratum III and therefore less amenable to her control. Her planning would tend to be incremental — 'We need more here and here and here' — and to be reactive to the expectations of various groups — 'The CSP/DHSS/DMT/my staff expect such and such'.

A stratum IV physiotherapist in post would produce rapid improvement and rationalisation and have fewer problems with stratum III capacity physiotherapists. She might prefer to 'float' rather than to be based in the DGH. However, if the DMT were keeping her to a short timescale, she might find the work unchallenging or frustrating.

District C reflects the more complex Districts, usually large teaching Districts with many medical students. There might be 60-100 FTE staff, mostly full-time, and several Superintendent Is, IIs and IIIs in the various large and small hospitals and health centres.

It is unlikely that a stratum III physiotherapist would be an appropriate candidate for this District post. From the superintendents' point of view, a candidate at least at stratum IV is essential; and since they fear that a District Physiotherapist may do nothing but reduce their own flexibility, they may oppose appointment. The DMT might decide to accept the views of the superintendents and settle for a fragmented service of high but uneven quality.

The District Physiotherapist working at stratum IV would be so occupied in negotiations, planning, administration and the long-term provision and maintenance of the context of care that she would be unlikely to spend any time in direct clinical work. Occasional clinical activity might be possible but routine clinical work would be an inappropriate use of time. The clinical responsibility at District level is to provide and ensure a continuing satisfactory environment within which clinical practice can be carried out effectively and efficiently by others.

Some detachment is necessary for this, so control over what was occurring in the hospitals and community on a day-to-day basis would be mainly indirect, delegated to other physiotherapists. Doctors in the hospitals would sense a source of power affecting their work but out of their daily reach and pressure for some counterbalancing structure, such as a major users group, will grow.

Turnover of staff and the variety of posts is such that it is possible to plan staff development to meet long-term District needs. The awareness of such a centralised long-term influence on their careers will enhance the pressure for representation and unionisation by junior staff.

Integration of services and their development with the other health services and with local authority social services would be necessary and requires close liaison. This work requires a national as well as a district perspective. Long-term social, demographic and technological trends must be identified and the unique features and needs of the District recognised. A strategic and innovative approach to planning becomes essential. Development of articulated policy and District-wide rules and standards becomes a major means of fair co-ordination and integration. This replaces the person-to-person approach that suffices in less complex Districts and feels so natural at stratum III.

It seems likely that there are only a very few physiotherapists capable of working at Stratum V at present and DMTs are unlikely to expect this level of work in the foreseeable future. Such physiotherapists rapidly achieve national prominence for their achievements, and can use their abilities in complex Districts.

Discussion

Reactions of DMTs and Physiotherapists

Within any particular District, the DMT and physiotherapists may have differing perspectives on the model of a core role as offered in this paper.

While a DMT may doubt whether it wants a comprehensive service (the stratum IV role), it may have little choice over solving problems such as service crises and needless waste for which it could be considered negligent. Our research has uncovered Districts where a physiotherapist, isolated in a unit, had had no reply in eight years of writing to the DMT about supply difficulties; where many physiotherapists were unable to establish clearly who was supposed to help them with minor administrative chores; where complex resignation and appointment procedures were necessary for one physiotherapist to move to another hospital a few miles away, and so on. The need for someone to get a grip on District physiotherapy services in a simple and personal way can be difficult to deny. This level of work, at least at upper stratum II, is well within the available finances of even poorly endowed Districts.

Physiotherapists in a particular District may be highly uncertain about the value of a District Physiotherapist. A fragmented service may suit them, particularly if they are in charge of a big fragment, unlikely to apply for the District post themselves, and insulated from the crises elsewhere in the District. Competition within a reasonably well-endowed District can result in large units getting more resources and smaller units becoming poorly-run backwaters with demoralised staff. In one District, the mental hospital with 1,800 admissions annually was staffed by a single half-time physiotherapist and the situation seemed unlikely to change. We have found that staff training and development are limited even in the big fragments and on-call work demands can be excessive. These problems are rarely denied by physiotherapists in confidential discussions.

Morale and Variations in Level of Work

The match of level of work expected by the DMT to the capacity of the person in post will be a major factor in morale as shown in the table.

Matching expectations of levels of work

Expectation of level of work		*District Management Team*	
		Low	*High*
District Physiotherapist	*Low*	Both satisfied	DMT dissatisfied DPt overwhelmed
	High	DMT badgered DPt frustrated	Both satisfied

Deliberate decisions to alter the expected level of work may be blocked by the Whitley rules of thumb. For example, a DMT may wish to develop a neglected service and be willing to inject substantial resources. The best results would come from placing the task in the hands of a person at the highest grading available, but this might not be permissible. Conversely a DMT might wish to cut back development in an established service by using a lower grading but be similarly prohibited. The DMT will use other ways to block development which leaves the high-capacity person, whom they are forced to appoint, feeling disappointed and frustrated.

The level of work called for within a District may fluctuate without any deliberate decision but as a side-effect of large-scale projects within the District or due to activities in surrounding Districts. No amount of guide lines or training courses can prepare someone in post to take on a more complex and long-term view beyond their capacity if this is suddenly expected of them. Such expectations lead to the District Physiotherapist feeling overwhelmed and desiring assistance.

Alternatives to a District Physiotherapist Role

In any District the DMT and physiotherapists themselves will usually agree that there is core District Physiotherapy work (in its new formulation) to be done. We will briefly report on how the work has been attempted in the absence of a District Physiotherapist post.

Some of the work could be done by a non-physiotherapist, for example a doctor or administrator, although this contradicts the principle of self-management (McMillan Report, 1973). More typically, the work is scattered over half-a-dozen or more medical and administrative roles and must be pulled together in some committee or possibly the DMT. These methods are rarely satisfactory owing to lack of knowledge of physiotherapy and difficulties in understanding its unique contribution and needs. Simply adding a 'representative' physiotherapist, elected or appointed, does not help if he lacks an overview of the District.

Alternatively the core work has been attempted by a committee of the most senior or representative physiotherapists in the District. This seems to be preferable, but not (to our knowledge) more successful. Such committees have little cohesion except as inward-looking pressure groups lobbying the DMT for more money. They avoid filling gaps in services when the members must make sacrifices, and painful decisions are usually postponed. There is an inherent conflict between loyalty to their own department and the need for an impartial overview. Often the departure of one member leads to the collapse of the committee.

A third suggestion is that the District Physiotherapist could be elected from the physiotherapists in post. In other words, the District Physiotherapist would be a representative rather than an officer of the Authority as at present. Although some useful work might be done in such a role, it seems unlikely that sufficient authority would be provided to allow unpleasant tasks to be carried out. Long-term work would be difficult to arrange if elections were held every year or two and the level of work done in the role might fluctuate excessively with each new representative. This solution is also unsatisfactory in that it obscures or reduces the responsibility of the Authority.

Conclusion

In this paper we have suggested that the core work of the District Physiotherapist is best described as integrating, rationalising and co-ordinating the various parts of the District's physiotherapy service and being responsible for connections with the remainder of the District health and social care system, as well as physiotherapy education and practice on a national scale. This core work seems to be crucial and seems unlikely to disappear so long as the NHS remains, particularly in the light of developments in the profession. Methods of getting this work done other than through the role of District Physiotherapist have so far been found to be unsatisfactory.

The level of work which will be expected from the role will depend on the stage of development of the District, particularly the level of posts already established, and the wishes of the DHA and others in the District. It can vary from upper stratum II to stratum V, but most Districts are likely to call for either stratum III or stratum IV work.

If the new formulation is valid, then the Whitley pay structure must be seen as a stumbling block to the development of sensible organisation and appropriate career paths. The pay structure should recognise different levels of work, thus overlapping the whole superintendent scale and, if there is a place for a few stratum V posts, extending significantly beyond the level of the current District grades. Grading of District posts as at present is irrelevant to the work expected. The crucial need in the District is for flexibility to pitch the level of work in the role appropriately so as to attract the suitable applicant, and for an organisational mechanism to assess the level of work sensibly and advise on the implications of various options.

Finally, it should be emphasised that the establishment of a key post such as District Physiotherapist inevitably alters the whole structure of NHS physiotherapy organisation. It raises new issues such as requisite authority relations between physiotherapists, participation in physiotherapy management and clinical autonomy and therefore calls for further disciplined investigation.

Suggestions for Discussion

In our conferences about the District Physiotherapist role, we found there was great difficulty in describing work responsibilities. The list below was often thought to be a useful description of the role.

Complete the table with examples which illustrate the similarity of work to be done in three different grades in the three branches of physiotherapy. How does this relate to levels of work?

Responsibilities	Clinical Senior II	Administrative Superintendent II	Educational Principal
Identification of needs			
Identification of resources			
Identification of constraints			
Matching needs, resources, constraints			
Setting priorities			
Developing policy			
Planning			
Monitoring standards			
Personnel work			
Public relations work			
Educational activity			

REFERENCES

Department of Health and Social Security (1973). *The Remedial Professions* (McMillan Report), HMSO, London.

Department of Health and Social Security (1978). *Report of the Sub-Group on the Organisation of the Remedial Professions in the National Health Service*, HMSO, London.

Kinston, W and Øvretveit, J (1980). *First Report to the Chartered Society of Physiotherapy*, HSORU Discussion Document 3119, Brunel University.

Kinston, W, Øvretveit, J and Teager, D (1981). 'Levels of work in physiotherapy'. *Physiotherapy*, 67, 8, 236-239.

Partridge, C J and Warren, M D (1977). *Physiotherapy in the Community*, Health Services Research Unit, University of Kent at Canterbury.

Tolliday, H and Jaques, E (1978). 'Physiotherapy and occupational therapy', in: Jaques, E (ed) *Health Services*, Heinemann, London.

Any questions, criticisms or comments concerning the papers in this series should be addressed to Steering Group (Brunel Project), CSP, 14 Bedford Row, London WC1R 4ED. All letters will be acknowledged and at an appropriate stage issues raised in them will be discussed in the Journal.