Chapter 1

The responsibilities of being a physiotherapist

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INTRODUCTION

This chapter aims to provide the reader with an insight into what it means to be a professional (in the context of this chapter, a physiotherapist), focusing on the responsibilities, both ethical and practical, that are inherent in claiming to be a professional working in the UK.

The current status and privilege of physiotherapists as autonomous professionals will be placed in the context of the history of the profession, and the impact of autonomy on clinical practice will be explored. The chapter will reflect on the implications for physiotherapists of the increasing expectations of both the general public and the government for health professionals to deliver high-quality health services. Explanations of how physiotherapists can meet these expectations through clinical governance will be provided. Finally, the reader will be offered a look at the possible future of the profession in light of the changing shape of health services in the UK.

Physiotherapists come into the profession because they have an underlying sense of and commitment to helping others and improving their quality of life. Indeed, Koehn (1994) argues that professionals can be thought of as being defined by a distinctive commitment to benefit the client. Physiotherapists want to be able to use their acquisition of knowledge, skills and attributes from qualifying programmes to benefit people, in whatever specialty or with whichever patient group they wish to work once qualified for example, elite athletes, older people, people with developmental or acquired conditions, people with mental health problems. This chapter will help readers understand how they can make benefiting patients a reality in the context of the expectations of society for the provision of high-quality, safe and effective care.

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While earlier editions of *Tidy's Physiotherapy* may have been popular for their prescriptive descriptions of what physiotherapists should do in particular situations or for specific conditions, this edition demands more from the reader. No two patients are quite the same; each requires the skills of the physiotherapist to carry out a full and accurate assessment, taking account of the individuality of the patient, and then to use clinical reasoning to problem-solve and offer appropriate options for treatment, on which the patient will make a decision. A professional is required to have the maturity to take full responsibility for the privilege of autonomy. This will be by maintaining a competence to practise through career-long learning and through self-evaluation, as well as through the evaluation of present practice; by keeping up to date with the most effective interventions; and by maintaining the trust of patients by doing good. Readers should realise that while this approach is more challenging, it will also be more rewarding.

CHARACTERISTICS OF BEING A PROFESSIONAL

Becoming a professional requires an acceptance, often implied, of certain responsibilities, in return for certain privileges. These responsibilities require certain behaviours and attitudes of individuals in whom professional trust is placed. Broadly, professionalism requires these attributes:

- a motivation to deliver service to others
- adherence to a moral and ethical code of practice
- striving for excellence, maintaining an awareness of limitations and scope of practice
- the empowerment of others (Hodkinson 1995 and Medical Professionalism Project 2002, both cited in CSP 2005b).

To practise in the profession of physiotherapy in the UK, registration with the statutory regulator is required. The Health Professions Council (HPC) sets standards of professional training, performance and conduct for thirteen professions, including physiotherapy (HPC 2006). It keeps a register of health professionals that meet its standards, and it takes action if registered health professionals do not meet those standards. It was created by the Health Professions Order 2001 (HPC 2002). Only those registered with the HPC may call themselves a physiotherapist/physical therapist (HPC 2006). It is the duty of registrants to keep up to date with the processes and requirements decreed by the Regulator; this is particularly important currently because of the changing attitudes to, and legislation of, healthcare professions in recent times.

The professional body for physiotherapists, the Chartered Society of Physiotherapy (CSP), provides a framework for the curriculum of physiotherapy education and approves those physiotherapy programmes that meet the requirements of the framework on behalf of the profession.

The CSP also publishes rules of professional conduct and standards of physiotherapy practice derived from within the profession, which are in harmony with those of the HPC. Anyone on the HPC physiotherapist register may call themselves a physiotherapist; only those who are members of the CSP may call themselves a *chartered* physiotherapist.

The breadth of activity and resources that the CSP undertakes and provides seek to establish a level of excellence for the profession. Its education and professional activity is centred on leading and supporting members' delivery of high-quality, evidence-based patient care. This activity emanates from its status as the professional body for physiotherapy in the UK and therefore as the primary holder and shaper of physiotherapy practice. The CSP works on behalf of the profession to protect the chartered status of physiotherapists' standing, which is one denoting excellence. It is worth noting that the relationship with the HPC is one of *registrant*; with the CSP it is one of *membership*.

While the principles of professionalism should be aspired to by physiotherapists anywhere in the world, the existence and/or role of regulators and professional bodies and the way these characteristics are manifested may vary, depending on political, social and financial factors.

Belonging to an organisation that sets standards and ideals of behaviour

The *Rules of Professional Conduct* (the *Rules*) were endorsed at the very first council meeting of the CSP in 1895 (Barclay 1994) and have been revised and updated at intervals since. The *Rules* define the professional behaviour expected of chartered physiotherapists. The current *Rules* set out a number of principles, the basis for all of which is to safeguard patients (CSP 2002a). They include requirements that chartered physiotherapists should:

- respect the dignity and individual sensibilities of every patient
- work safely and competently
- ensure the confidentiality of patient information
- report circumstances that might otherwise put patients at risk
- not exploit patients
- act in a way that reflects credit on the profession and does not cause offence to patients.

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Although the CSP has had *Rules of Professional Conduct* since its inception, agreed national standards were not published until 1990. The CSP *Standards of Physiotherapy Practice* provides statements about the practical application of the ethical principles set out in the *Rules*. The fourth edition (CSP 2005a) has evolved to place more emphasis than in earlier editions on practitioners:

- involving patients in decision-making
- being fully abreast of the evidence of effectiveness in order to inform patients and offer the most effective interventions
- evaluating their practice and measuring a patient's health gain as a result of treatment.

This reflects the increasing expectations of the public to be active partners in their healthcare, the expectations of clinical governance to provide more effective care, and the growing demands of funders of services, as well as patients, to be able to demonstrate the benefits or 'added value' of physiotherapy. All these will be discussed later in the chapter.

Standards of Physiotherapy Practice is written in a way that offers a broad statement of intent (the Standard statement), which is followed by a number of measurable statements about expected performance or activity by the physiotherapist, student or assistant (known as 'criteria'). For example, Core Standard 2 states 'Patients are given relevant information about the proposed physiotherapy procedure, taking into account their age, emotional state and cognitive ability, to allow informed consent.' The criteria for this standard include the following:

- The patient's consent is obtained before starting any examination/treatment.
- Treatment options, including significant benefits, risks and side-effects, are discussed with the patient.
- The patient is given the opportunity to ask questions.
- The patient is informed of the right to decline physiotherapy at any stage without that prejudicing future care.
- The patient's consent to the treatment plan is documented in the patient's record.

These measurable criteria allow performance to be assessed against them, through clinical audit, described in more detail later.

The content of this standard and accompanying criteria set out the specific actions required in order to conform, in this case, to an aspect of Rule 2 of *Rules of Professional Conduct*: 'Chartered physiotherapists shall respect and uphold the rights, dignity and individual sensibilities of every patient,' which includes guidance on informed consent. This is a good example of how the *Standards* and *Rules* complement each other. They should be used together to ensure compliance with the characteristics and actions required of members of the physiotherapy profession.

Commitment to discipline other members

As of 15 October 2006 the CSP no longer handles complaints concerning the professional conduct or fitness to practise of its members, except those described in the next paragraph. The HPC considers all complaints of this nature.

The Society does however, handle complaints or consider matters of fitness to practise concerning members of the Society who are not regulated by the HPC. (This includes physiotherapist's physiotherapy treatment of animals, students and the CSP's associate members (CSP 2006).)

Possessing knowledge and skills not shared by others

Any profession possesses a range of specific knowledge and skills that are either unique, or more significantly developed than in other professions. The World Congress for Physical Therapy (WCPT) has described the nature of physiotherapy as 'providing services to people and populations to develop, maintain and restore maximum movement and functional ability throughout the lifespan' (WCPT 1999).

It adds, in a detailed description, that physical therapy is 'concerned with identifying and maximising movement potential, within the spheres of promotion, prevention, treatment and rehabilitation' (ibid, p28).

WCPT identifies the interaction between 'physical therapist, patients or clients, families and care givers, in a process of assessing movement potential and in establishing agreed upon goals and objectives' as crucial and acknowledges that this requires knowledge and skills unique to physical therapists (ibid, p28).

In the UK, one approach to conceptualising physiotherapy has been to focus on three core elements: massage, exercise and electrophysical modalities (CSP 2002a). For physiotherapy, the roots of the profession can be found in massage, the founders of the profession having been a group of nurses who carried out massage. The significance of therapeutic touching of patients still sets physiotherapy aside from other professions. Physiotherapists continue to use massage therapeutically as well as a wide range of other manual techniques such as manipulation and reflex therapy. Therapeutic handling underpins many aspects of rehabilitation, requiring the touching of patients to facilitate movement.

Another description of the profession's knowledge and skills can be found in the *Curriculum Framework*

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for Qualifying Programmes in Physiotherapy (CSP 2002b). This sets out the underpinning knowledge and skills required of newly qualifying physiotherapists, setting this in the context of their application in professional practice areas and environments. These are, in turn, underpinned by a set of professional attributes, identity and relationships, such as understanding the scope of practice and active engagement with patient partnership. Finally, the framework sets out the outcomes that graduates should be able to demonstrate: for example, 'enable individual patients and groups to optimise their health and social well-being' and 'respond appropriately to changing demands'.

Definition

Physiotherapy is a healthcare profession concerned with human function and movement and maximising potential. It uses physical approaches to promote, maintain and restore physical, psychological and social well-being, taking account of variations in health status. It is science-based, committed to extending, applying, evaluating and reviewing the evidence that underpins and informs its practice and delivery. The exercise of clinical judgement and informed interpretation is at its core (CSP 2002b).

Cott et al. (1995) have proposed an overarching framework for the profession: the movement continuum theory of physical therapy, arguing that the way in which physiotherapists conceptualise movement is what differentiates the profession from others. They suggest that physiotherapists conceive of movement on a continuum from a micro (molecular, cellular) to a macro (the person in his or her environment or in society) level. The authors argue that the theory is a unique approach to movement rehabilitation because it incorporates knowledge of pathology with a holistic view of movement, which includes the influence of physical, social and psychological factors in an assessment of a person's maximum achievable movement potential. They argue that the role of physiotherapy is to minimise the difference between a person's current movement capability and his or her preferred movement capability.

Exercising autonomy

Autonomy, or 'personal freedom' (*Concise Oxford Dictionary*, 7th edn) is a key characteristic of being a professional. It allows independence, but is mirrored by a responsibility and accountability for action. Central to the practice of professional autonomy is clinical reasoning, described as the 'thinking and decision-making processes associated with clinical practice' (Higgs and Jones 2000). Clinical reasoning requires the ability to think critically about practice, to learn from experience and apply that learning to future situations. It is the relationship between the physiotherapist's knowledge, his or her ability to collect, analyse and synthesise relevant information (cognition), and personal awareness, self-monitoring and reflective processes, or metacognition (Jones et al. 2000).

This professional autonomy has, however, to be balanced with the autonomy patients have to make their own decisions. Patient-centred decisions require a partnership between patient and professional, sharing information, with patients' values and experience being treated as equally important as clinical knowledge and scientific facts (Ersser and Atkins 2000). Higgs and Titchen (2001) describe the notion of the professional's role as a 'skilled companion'. The professional is characterised as a person with specialised knowledge which can be shared with the patient in a reciprocal 'working with' rather than 'doing to' relationship, and as someone who 'accompanies the patient on their journey towards health, adjustment, coping or death'. This patient-centred model facilitates the sharing of power and responsibility between professional and patient.

A history of how the physiotherapy profession's autonomy evolved in the UK can be found later in this chapter.

Licensed by the state

As previously mentioned, physiotherapists in the UK have to be registered with the HPC in order to use the title *physiotherapist* and therefore to work in any setting in the UK. This is a government measure to protect patients from unqualified or inadequately skilled healthcare providers.

In 2006, the HPC put in place a system requiring re-registration at intervals of two years, linked to an individual's commitment to Continuing Professional Development (CPD), whereby individuals must undertake and maintain a record of their CPD activities and, if required, submit evidence of this and of the outcomes of their CPD on their practice, service users and service. Re-registration is in response to a lessening of public confidence in the National Health Service (NHS) following, for example, the report into children's heart surgery in Bristol (Bristol Royal Infirmary Inquiry 2001). Equally disturbing were the revelations about the murders of so many patients by Harold Shipman, a man who had been a previously trusted general practitioner, where health systems failed to detect an unusually high number of deaths (Department of Health 2004).

This has led the government to introduce a number of measures, including the requirement for all health professionals to re-register at specified intervals, in

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order to be seen to be protecting the public through a more explicit and independent process (Department of Health 2002). It aims to identify poor performers who may be putting the public at risk, as well as providing an incentive for professionals to keep up to date, maintaining and further developing their scope of practice and competence to do their job. Disciplinary processes are in place to remove, ultimately, an individual from the register (HPC 2005). The means by which individuals can maintain their competence are discussed later in the chapter.

Making a commitment to assist those in need

As stated earlier, one of the characteristics of a professional is to want to 'do good'. This is reflected in the ethical principles of the physiotherapy profession, where there is a 'duty of care' incumbent on the individual towards the patient, to ensure that the therapeutic intervention is intended to be of benefit, as set out in Rule 1 (CSP 2002a). This is a common-law duty, a breach of which (negligence) could lead to a civil claim for damages.

More generally, Koehn (1994) suggests, professionals are perceived to have moral authority, or trustworthiness, if they:

- use their skills in the context of the client's best interests and 'doing good'
- are willing to act as long as it takes for assistance to achieve what it set out to achieve, or for a decision to be made that nothing more can be done to help the client
- have a highly developed internalised sense of responsibility to monitor personal behaviour: for example, by not taking advantage of vulnerable patients
- demand from the client the responsibility to provide, for example, sufficient information to allow decisions to be made (compliance)
- are allowed to exercise discretion (judgement) to do the best for the client, within limits.

Koehn (1994) argues that trustworthiness is what stands out as a particularly unique characteristic of being a professional   to do good, to have the patient's best interests at heart and to have high ethical standards. Physiotherapists not prepared to maintain such ethics, even in difficult and stressful situations, run the risk of losing the respect as well as the trust of their patients and the public.

RESPONSIBILITIES OF BEING A PROFESSIONAL

Physiotherapists in the UK are granted the right to make their own decisions, in partnership with patients, about meeting needs. Being a professional is a privilege   in particular the trust that is bestowed by the public   which underpins the patient's ability to benefit from treatment. However, this brings with it weighty responsibilities.

Doing only those things you are competent to do

Every physiotherapist has her or his own personal 'scope of practice' (CSP 2002a)   that is, a range (or scope) of professional knowledge and skills that can be applied competently within specific practice settings or populations.

When a person is newly qualified, this scope will be based on the content of the pre-qualifying Curriculum Framework, but will also be informed by the individual's experience in clinical placements, and the amount of teaching and reflective learning that has been possible as part of those placements.

As a career progresses, and as a result of CPD, some physiotherapists will become competent in highly skilled areas such as intensive care procedures, or splinting for children with cerebral palsy, which are unlikely to have been taught before qualification. Others will extend their skills in areas in which they already had some experience: for example, dealing with people with neurological problems. Others will enhance their communication and life skills, as well as refining their physiotherapy skills by, for example, working with elderly people or people with learning difficulties.

It is the responsibility of the professional to understand his or her personal scope of practice as it changes and evolves throughout a career. To practise in areas in which you are not competent puts patients at risk and is a breach of the CSP's *Rules of Professional Conduct*, and the standards of the profession's regulator, the HPC (2003).

Maintaining competence to practise

An individual's scope of practice and competence are constantly evolving, based on professional and life experiences, learning from reading, from evaluating practice, from reflecting on practice, or more formal ways of learning. It includes undertaking programmes of structured CPD. Clinical reasoning skills are continually refined and further developed throughout a career through evaluative and reflective practice, leading to the ability to deal with increasingly complex and unpredictable situations.

Physiotherapists have a duty to keep up to date with new information generated by research, with what their peers are thinking and doing, and by formally

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evaluating the outcome of their practice. The responsibility for this is dictated by the HPC (2003) and reflected in the *Standards of Physiotherapy Practice* (CSP 2005a). In particular, Core Standards 19 22 are concerned with a requirement that individuals assess their learning needs, then plan, implement and evaluate a programme of CPD based on that assessment.

Responsibility to patients

This chapter has already discussed the importance of the individual physiotherapist as well as the profession as a whole in maintaining the attributes of professionals. Trust is perhaps the most essential characteristic with which to develop a sense of partnership with patients; in turn, this will optimise the benefits of intervention. For physiotherapy, many of the other hallmarks for building and securing trust are set out in the profession's *Rules* and *Standards*. For example:

- to provide safe and effective interventions (safety of application as well as safe and effective) Rule 1 and Core Standards 4, 8, 16
- to treat patients with dignity and respect Rule 2 and Core Standard 1
- to provide patients with information about their options for treatment/interventions Rule 2 and Core Standard 2
- to involve patients in decisions about their treatment (informed consent) Rule 2 and Core Standard 2.

Responsibility to those who pay for services

Physiotherapists have an ethical responsibility to those who finance services, whether these are commissioners of healthcare, taxpayers or individual patients, to provide efficiently delivered, clinically and cost-effective interventions and services, in order to give value in an era when resources for healthcare are limited. This is embedded within Rule 1 of the CSP's *Rules of Professional Conduct* in relation to the establishment of a 'duty of care' towards the patient (CSP 2002a).

Responsibility to colleagues and the profession

A profession has legitimate expectations of its members to conduct themselves in a way that does not bring the profession into disrepute, but rather enhances public perceptions. Physiotherapists have a duty to inform themselves of what is expected of them. Indeed, the *Rules of Professional Conduct* state that knowledge of and adherence to the *Rules* are part of the contract of membership of the CSP. The *Standards of Physiotherapy Practice* make it clear there is an expectation that all physiotherapists should be able to achieve all the core standards (CSP 2005a). Where they do not, programmes of professional development should be put in place to facilitate full compliance, as part of the individual's professional responsibility.

Physiotherapists should not be critical of each other, except in extreme circumstances. However, they do have a duty to report circumstances that could put patients at risk. In the NHS, there are procedures and a nominated officer within each trust from whom advice can be sought. Outside the NHS, advice can be sought from the CSP. Physiotherapists are encouraged to be proactive in supporting each other's professional development and in promoting the value of the profession in local workplace settings, in policy-making forums and in the media.

BECOMING AN AUTONOMOUS PROFESSION

The CSP was founded in 1894, under the name of the Society of Trained Masseuses. This section will not attempt to relate the history of the profession, except in the context of developing autonomy. However, more about the early days of the profession can be found in the book *In Good Hands* (Barclay 1994).

For many years, doctors governed the profession. One of the first rules of professional conduct stated 'no massage to be undertaken except under medical direction' (ibid). Even in the 1960s doctors were asserting that they must take full responsibility for patients in their charge and 'professional and technical staff have no right to challenge [the doctor's] views; only he is equipped to decide how best to get the patients fit again' (ibid). It is hard to believe now that it took more than 80 years to escape the paternalism of doctors, on whom physiotherapists were dependent for referrals. The first breakthrough came in the early 1970s, when a report by the Remedial Professions Committee, chaired by Professor Sir Ronald Tunbridge, included a statement that while the doctor should retain responsibility for prescribing treatment, more scope in application and duration should be given to therapists.

The McMillan report (DHSS 1973) went further, by recommending that therapists should be allowed to decide the nature and duration of treatment, although doctors would remain responsible for the patient's welfare. There was recognition that doctors who referred patients would not be skilled in the detailed application of particular techniques, and that the therapist would therefore be able to operate more effectively if given greater responsibility and freedom.

Eventually, a Health Circular called *Relationship between the Medical and Remedial Professions* was issued (DHSS, 1977). This acknowledged the therapist's competence and responsibility for deciding on the nature

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of the treatment to be given. It recognised the ability of the physiotherapist to determine the most appropriate intervention for a patient, based on knowledge over and above that which it would be reasonable to expect a doctor to possess. It also recognised the close relationship between therapist and patient, and the importance of the therapist interpreting and adjusting treatment according to immediate patient responses.

Autonomy was only achieved by being able to demonstrate competence to make appropriate decisions, building up the trust of doctors and those paying for physiotherapy services. The need to acquire skills of assessment and analysis became a key component of student programmes from the 1970s. Today, qualifying programmes stress even further the development of skills, knowledge and attributes required for autonomous practice.

CLINICAL GOVERNANCE

So far, this chapter has explored the responsibilities of being a physiotherapist from a professional perspective. The focus has been on the individual's personal responsibility as a professional. This section will put all that in the context of a professional's responsibilities to the employer organisation, whether it be in the public or the independent sector.

In the NHS, responsibility for the clinical safety of patients and the quality and effectiveness of services is maintained via a system of clinical governance. It seems probable this will apply equally to the independent sector in the near future. However, even though clinical governance is the responsibility of NHS trusts, its foundation is based on 'the principle that health professionals must be responsible and accountable for their own practice' (Secretary of State for Health 1998). The individual's professional responsibility is therefore still paramount.

What is clinical governance?

> *Definition*
>
> Clinical governance is a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (Secretary of State for Health 1998). (While this definition has been used in England, similar interpretations of the term have been made in Scotland, Wales and Northern Ireland.)

A number of key themes were introduced as part of clinical governance.

The accountability of chief executives for quality

Although some chief executives of NHS trusts claim they were always responsible for quality, this had not been a statutory responsibility in the way it was for a trust's finances. Chief executives now have a statutory responsibility for quality.

The introduction of a philosophy of continuous improvement

One-off improvements are not enough the NHS has to move to a culture of continuous improvement to achieve excellence. In addition, the emphasis has shifted from improving a particular aspect of care in isolation, to examining the whole system of care, crossing professions, departments, organisations and sectors, to ensure the whole process meets the needs of patients through an integrated approach to healthcare.

An aspiration to achieve consistency of services across the NHS

This is founded on two principles:

- If one trust can provide excellence in a service, then so can all trusts.
- Local services should, where possible, be based on national standards: for example, National Service Frameworks or nationally developed clinical guidelines.

There is some evidence to suggest that nationally developed standards or clinical guidelines are likely to be more robustly developed (Sudlow and Thomson 1997) and that their universal implementation locally will ensure consistency and effectiveness.

An emphasis on continuing professional development (CPD) and life-long learning (LLL)

Clinical governance acknowledges the importance of CPD/LLL for all healthcare workers, in order to keep up to date and deliver high-quality services.

Is clinical governance something new?

Yes and no. Its component parts are all familiar activities, but there is also an underpinning philosophy in clinical governance to reduce risks for patients, a new and more focused emphasis that was not previously articulated. It can be argued that clinical governance is, at least in part, a response to a loss of public confidence in the NHS, as discussed earlier, which has undermined people's perceptions of the NHS as an organisation they can rely on to 'do good' and of the government as a protector of the public. In addition, the public has become more litigious, suing doctors

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and trusts more readily for mistakes, thus drawing money away from front-line clinical services. So clinical governance is about rebuilding the public's confidence in health services, providing high-quality and effective care and, above all, reducing the risk of harm through negligence, poor performance or system failures.

The components of clinical governance

Although clinical governance should be seen as a package of measures that together ensure excellence and a reduction in risk, it can also be viewed as a number of component parts, some of which have been in place for a number of years and are already familiar (Figure 1.1). They include:

- evidence-based practice and clinical effectiveness
- applying national standards and guidelines locally
- evaluating the effectiveness and quality of services
- continuing professional development/life-long learning
- having the right workforce and using it appropriately.

The following sections deal with these aspects.

EVIDENCE-BASED PRACTICE

At the beginning of this chapter, it was asserted that people who want to become physiotherapists have an inherent desire to 'do good'. But how do we know what works what interventions have been shown to be effective? It is hard to comprehend that health professionals have not always sought evidence for the effectiveness of the treatments they use. Perhaps they did but until the early 1990s this 'evidence' was based on personal experience and on opinions derived from that experience, together with the experience of colleagues, or those perceived to be experts and opinion leaders. Is that good enough?

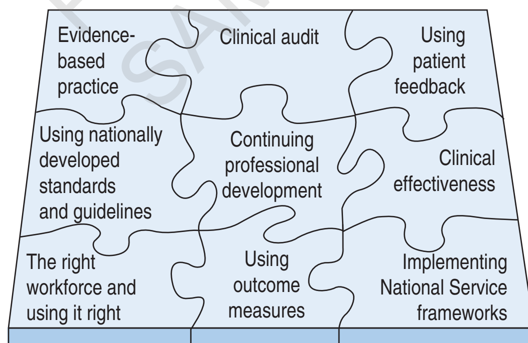

Figure 1.1 Components of clinical governance.

In 1991, Sir Michael Peckham, then Director of Research and Development for the Department of Health, noted that 'strongly held views based on belief rather than sound information still exert too much influence in healthcare. In some instances the relevant knowledge is available but is not being used, in other situations additional knowledge needs to be generated from reliable sources' (Department of Health 1991). At about the same time, a relatively small group of doctors began to write about evidence-based medicine.

> ***Definition***
> An early definition of evidence-based medicine stated that it is the 'conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients' (Sackett et al. 1996).
> A recent definition has updated this, drawing on criticisms of the initial position and stating that evidence-based practice requires that 'decisions about health care are based on the best available, current, valid and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources' (Dawes et al. 2005).

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What do we mean by evidence? Is research the only form of evidence? Certainly for some questions, such as the efficacy of particular drugs, or a particular modality such as exercise programmes for the management of back pain, research studies which compare one intervention with another or a placebo (randomised controlled trials) can provide reliable information about the degree to which an intervention is effective. But other forms of evidence are also important (Figure 1.2). What patients tell us about their condition, which treatments they find effective, the degree to which interventions improve their ability to get on with their lives also provides important evidence. The physiotherapist also contributes evidence in the form of clinical expertise, derived from clinical reasoning experience. Thinking and reflecting on what you are doing, as a practitioner during or after a clinical encounter, will develop such expertise (Jones et al. 2000). Knowledge which arises from and within practice (practice-based and practice-generated knowledge) will become part, along with research evidence, of your rationale for practice (Higgs and Titchen 2001). Sackett and colleagues reflected this in concluding their definition that evidence-based practice requires integration of 'clinical expertise with best available external clinical evidence from systematic research' (Sackett et al. 1996).

A hierarchy of evidence is often described or used in the literature. This ranges from (1) systematic reviews, in which evidence on a topic has been systematically

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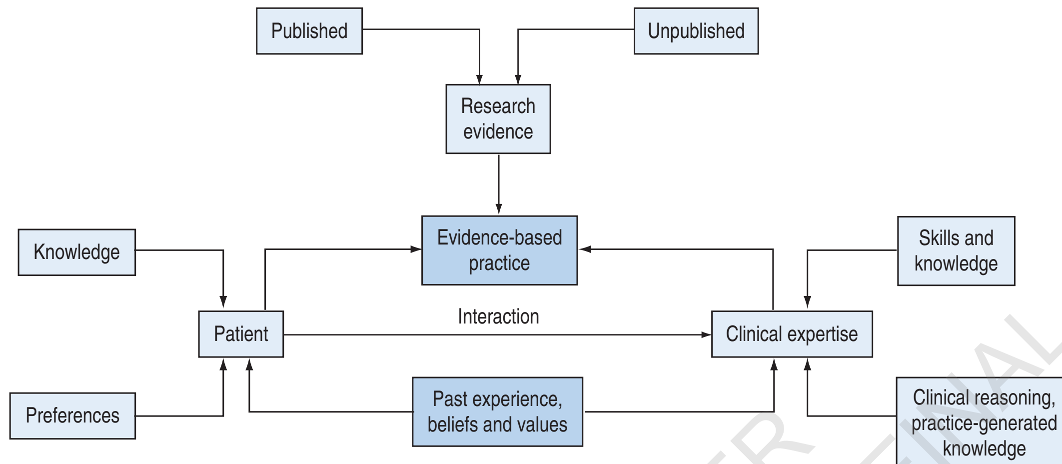

Figure 1.2 What do we mean by 'evidence'? (Adapted from Bury 1998, with permission.)

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identified, appraised and summarised according to predetermined criteria (usually limited to randomised controlled trials) said to be the strongest evidence (the most reliable estimate of effectiveness) to (2) expert opinion, perceived as the least reliable. An example is shown in Table 1.1.

However, such a hierarchy fails to recognise that different research methods are needed to answer different types of question and that, while a qualitative study may be the best research method for a particular question, it still receives a low rating. The hierarchy also fails to recognise the importance of expertise derived from clinical reasoning experience, discussed above. Physiotherapists need to contribute to an ongoing debate to develop a hierarchy that reflects more appropriately a patient-centred approach to practice.

Table 1.1 A hierarchy of evidence

Level	Type of evidence
Ia	Evidence obtained from a systematic review or meta-analysis of randomised controlled trials
Ib	Evidence obtained from at least one randomised controlled trial
IIa	Evidence obtained from at least one well-designed controlled study without randomisation
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study
III	Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies
IV	Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Adapted from National Institute for Health and Clinical Excellence (2001).

So what does evidence-based practice mean for physiotherapists? Core Standard 4 (CSP 2005a) states that: 'In order to deliver effective care, information relating to treatment options is identified, based on the best available evidence.' A range of sources of information the physiotherapist may need to draw on, including research evidence, patient organisations and clinical guidelines, is listed. What practical steps need to be taken to identify and use research evidence?

- Think about the clinical question you are trying to answer in your information search. Identify the population (e.g. people with multiple sclerosis with symptoms of urinary incontinence), the intervention you are looking for (e.g. neuromuscular electrical stimulation) and the outcome (e.g. a reduction in symptoms), and use this information to formulate a search strategy.
- Work in partnership with an information scientist to get the best results from a literature search (his or her information skills and knowledge combined with your clinical skills and knowledge).
- Look first for evidence that has already been synthesised systematic reviews, nationally developed clinical guidelines or standards. This saves a lot of effort searching for individual studies. If it is a high-quality synthesis, it will also provide a more reliable estimate of effectiveness.
- Know your databases well enough to know which will have the most relevant information on any particular topic.

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- Check the titles and abstracts for relevance.
- Critically appraise any relevant papers you have found to assure yourself of their quality and of the reliability of their conclusions. (A list of appraisal instruments can be found at the end of this chapter.)
- When you find the 'best available evidence', think about it in relation to your patient and your past experience. Is it appropriate for that patient, will you be able to quantify for the patient the degree of likely benefits and harms (if any)?
- Discuss the evidence with the patient and agree the preferred intervention(s) together.
- Implement the preferred intervention(s).
- Evaluate the effect of the intervention(s) and act accordingly.

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> More information about evidence-based practice can be found in Herbert et al. (2005) or at www.nettingtheevidence.org.uk/, a catalogue of useful electronic learning resources and links to organisations that facilitate evidence-based healthcare. See also 'Sources of Critical Appraisal Tools' towards the end of this chapter.

CLINICAL EFFECTIVENESS

Clinical effectiveness, as defined by the Department of Health, sounds very much like evidence-based practice doing things you know will be effective for a particular patient or group of patients. But the fact that an intervention has been proved to work in research studies, in a relatively controlled environment, does not necessarily mean that it will work for a particular patient. Both patients and practitioners are unique beings, and there are many additional factors, practical and behavioural, that need to be considered to ensure the patient gets the maximum benefit from an intervention.

> **Definition**
>
> Clinical effectiveness was defined by the Department of Health in 1996 as 'the extent to which specific clinical interventions, when deployed in the field for a particular patient or population, do what they are intended to do – that is, maintain and improve health and secure the greatest possible health gain from the available resources' (NHS Executive 1996).

- Is the practitioner sufficiently skilled to apply the intervention safely and effectively?
- Is the practitioner an effective communicator?
- Does the practitioner give the patient an opportunity to describe the symptoms fully, to explain the impact of the problem on daily life, and to ask questions?
- Does the patient have enough information to be able to give informed consent?
- Are other options discussed that may have been more acceptable to the patient, even if less effective?
- Would treatment in a hospital setting mean a long, exhausting and expensive journey for the patient?
- Would the patient feel intimidated by a hospital environment?
- Would treatment be more effective if it were provided closer to home: for example, in the GP's surgery or health centre?
- Would treatment be more relevant if it were given in a patient's own home, to be able to develop a programme tailored to the person's lifestyle and environmental needs?
- Wherever treated, does the patient have adequate privacy, warmth and comfort?
- How long has the patient had to wait for treatment and will a delay alter the effectiveness of the interventions?

The answer to each of these questions can have an impact on the patient's ability to benefit from an intervention, however effective the research evidence might suggest an intervention is. This also illustrates the complexity of the clinical reasoning process, where highly skilled judgements have to be made based on a consideration of the whole person, physically, emotionally and within society, as well as the environment, practitioner skills and resources available, in order to provide truly effective treatment.

So while evidence-based practice is a key component of clinical effectiveness, clinical effectiveness also takes account of a range of other influences that could affect the patient's ability to benefit from an intervention based on high-quality research evidence.

APPLYING NATIONAL STANDARDS AND GUIDELINES LOCALLY

Standards

One of the tenets of clinical governance is consistency for the public, being confident that they will experience the same quality of care and have access to the most effective interventions, regardless of where they live. There should be no postcode lottery, where some treatments might be available in some parts of the country

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and not others; the quality of the average and worst services should be raised to that of the best. Where there are high-quality national standards, therefore, these should be used locally. Two examples are set out below.

Nationally developed standards

The CSP's *Standards of Physiotherapy Practice* provides a universal framework for the delivery of services throughout the UK, to which it is expected all physiotherapists will conform. So, for physiotherapy, patients can expect similar values and processes within a healthcare experience.

National Service Frameworks (NSFs)

This government initiative aims to provide the NHS with explicit standards and principles for the pattern and level of services required for a specific service or care group. The NSFs aim to address the 'whole system of care' and each will set out where care is best provided and the standard of care that patients should be offered in each setting. They provide 'a clear set of priorities against which local action can be framed' and seek to ensure that patients will get greater consistency in the availability and quality of services, right across the NHS (Secretary of State for Health 1998).

Table 1.2 lists the NSFs that have been developed. They provide broad statements of expected services. For example, the NSF for older people states: 'Older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention through a specialised falls service.'

Physiotherapists will therefore need to address the implementation of this standard in any services they provide to older people. Implementation will also provide opportunities to promote the value of physiotherapy to this patient population and highlight the contribution physiotherapists can make to a trust's compliance with this particular standard.

Table 1.2 National service frameworks developed by the Department of Health

- Coronary heart disease (including cardiac rehabilitation)
- Cancer
- Paediatric intensive care
- Mental health
- Older people (including falls, osteoporosis and stroke)
- Diabetes
- Long-term conditions
- Renal
- Children
- Chronic obstructive pulmonary disease (2008)

Clinical guidelines

Definition

Clinical guidelines are 'systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific circumstances' (Field and Lohr 1992).

The key factors in the development of clinical guidelines are the systematic process for identifying and quality-assessing research evidence, and the systematic and transparent process used for the interpretation of the evidence in the context of clinical practice, in order to formulate reliable recommendations for practice.

National Institute for Health and Clinical Excellence (NICE)

NICE is a Special Health Authority for England and Wales, established by the government in 1999 to provide health professionals and the public with authoritative information about the clinical effectiveness and cost-effectiveness of healthcare. One of its work programmes is to develop clinical guidelines, which are carried out by a series of collaborating centres. The Department of Health and the Assembly for Wales have given NICE the remit for developing 'robust and authoritative' clinical guidelines, taking into account clinical effectiveness and cost effectiveness. More information about the key principles that underpin the way NICE approaches clinical guideline development can be found on its website.

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National Institute for Health and Clinical Excellence (NICE): www.nice.org.uk.

Scottish Intercollegiate Guidelines Network (SIGN)

SIGN was formed in 1993. Its objective is to improve the quality of healthcare for patients in Scotland by reducing variation in practice and outcome, through the development and dissemination of national clinical guidelines containing recommendations for effective practice based on current evidence. Further information can be found on its website.

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Scottish Intercollegiate Guidelines Network (SIGN): www.show.scot.nhs.uk/sign.

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Professionally led clinical guidelines

The physiotherapy profession has developed national, physiotherapy-specific clinical guidelines. To ensure quality and provide confidence for users, the CSP has established a process for the endorsement of these clinical guidelines. The criteria for assessing whether the quality of a guideline warrants CSP endorsement can be found in an appraisal questionnaire developed by a European consortium, known as the AGREE instrument. For users of clinical guidelines, CSP-endorsed clinical guidelines can be considered of high quality and should be implemented locally. Further information about the process for the development of clinical guidelines in physiotherapy is available from the CSP website.

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> AGREE Collaboration (Appraisal of Guidelines Research and Evaluation):
> www.agreecollaboration.org.
> Chartered Society of Physiotherapists (CSP):
> www.csp.org.uk.

EVALUATING SERVICES

How do you know whether you are being effective? Knowing whether you are or not is part of your professional responsibility as a physiotherapist. Rule 1 of *Rules of Professional Conduct* (CSP 2002a) describes the responsibility a physiotherapist has to ensure that any intervention offered to a patient is intended to be of benefit. Several of the CSP's standards of physiotherapy practice include criteria that relate to evaluation, including:

- As part of the assessment process, physiotherapists consider and critically evaluate information about effective interventions relating to the patient's condition (Core Standard 4.1).
- A published, standardised, valid, reliable and responsive outcome measure is used to evaluate the change in the patient's health status (Core Standard 6).
- All physiotherapists participate in a regular and systematic programme of clinical audit (Service Standard 3.2).
- Physiotherapists use the results of audit to assess their learning needs (Core Standard 19.1) and/or as a means to achieve their personal learning objectives (Core Standard 20.3h).

All evaluation is about learning which leads to improvements in the quality and effectiveness of practice. It should be carried out, and the results used, in the context of CPD and reflective practice, to improve an individual practitioner's personal practice and/or the delivery of a whole service. Set out below are four means by which physiotherapists can evaluate their practice. They are not mutually exclusive.

Evaluating the process of care (clinical audit)

In order to evaluate the *process* of care, it is necessary to have a reliable benchmark with which to compare your practice. Earlier, the importance of the local implementation of nationally developed standards and evidence-based clinical guidelines was discussed. These provide such a reliable benchmark. Clinical audit is a tool with which to measure your own performance (or more often, the performance of the service) against standards or criteria based on the 'best available evidence' of effectiveness. This will enable you to identify the extent to which you adhere to those standards or criteria, from which recommendations can be put in place to improve adherence, if necessary.

> **Definition**
>
> Clinical audit is a cyclical process involving the identification of a topic, setting standards, comparing practice with the standards, implementing changes, and monitoring the effect of those changes (CSP 2005a). Further information about clinical audit can be found in an information paper published by the CSP (2002d) and in *Principles for Best Practice in Clinical Audit* published by NICE (2001).

Evaluating the health outcomes of care

This will determine the *impact* of the process of care on the patient's life by using specific measures before and after treatment. The use of a test, scale or questionnaire which records what it aims to record (*is valid and responsive*) and is sufficiently well described to ensure that everyone who uses it does so in the same way (*is reliable*) will help to give physiotherapists the chance to see whether the aims of their intervention have had the impact intended.

A database of outcome measures can be found on the CSP website. This will facilitate the selection of the most appropriate measures for a specific patient or patient group. More information on using measures can be found in a CSP information paper (CSP 2001a).

As well as patients themselves having an interest in an objective assessment of their improvement, it is increasingly important for managers and team leaders to present such information to commissioners of healthcare, to demonstrate the benefits of physiotherapy services and their value for money.

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Using patient feedback

Another mechanism for evaluating practice is to ask the patient for feedback. This could be through the use of a validated patient-assessed outcome measure to provide information about the patient's perception of health gain, or through the use of a structured questionnaire to determine the patient's perception of the quality of the treatment. The CSP's *Standards of Physiotherapy Practice* pack includes a ready-made Patient Feedback Questionnaire, designed to measure criteria in the core standards, for which only patients can judge compliance. Patients are asked to respond to statements that mirror the criteria (Table 1.3).

Responses from the feedback questionnaires can be used by individuals or services to reflect on the extent to which the criteria are being met, and to introduce new processes or development opportunities to secure greater conformance, if necessary.

Another valuable source of patient feedback is patients' complaints. These should be considered positively as opportunities to address the issues contained within them, in order to introduce a service improvement. Any issue that becomes a problem for a patient is a problem for the service, which should be analysed. The involvement of the patient making the complaint in this process, if willing, will facilitate the finding of a solution that can then be embedded into systems and processes.

Peer review

Peer review provides an opportunity to evaluate the clinical reasoning behind your decision-making with a trusted peer. It can be applied most effectively to the assessment, treatment planning and evaluative components of physiotherapy practice, where the reasoning behind the information recorded in the patient documentation can be explored. Guidance on peer review can be found in the clinical audit tools document contained in the *Standards of Physiotherapy Practice* pack (CSP 2005a).

CONTINUING PROFESSIONAL DEVELOPMENT

Definition

Continuing professional development (CPD) is the work-oriented aspect of life-long learning and should be seen as a systematic, ongoing structured process of maintaining, developing and enhancing skills, knowledge and competence both professionally and personally in order to improve performance at work (CSP 2003).

Definition

Life-long learning (LLL) is a theme the government promulgates across all sectors of the population, in order to ensure the workforce is equipped to do the jobs that will contribute to high-quality public services and promote prosperity in the UK.

In healthcare, the connection between CPD/LLL and the quality of services is at the centre of the government's view of a new, modernised NHS. Physiotherapists have always had a strong commitment to CPD evidenced by the clear statement in Rule 1 of *Rules of Professional Conduct*: 'Chartered physiotherapists shall only practise to the extent that they have… maintained… their ability to work safely and competently.' The *Core Standards of Physiotherapy Practice*, with which all physiotherapists should conform, include

Table 1.3 Extract from a patient feedback questionnaire

Criteria	Patient feedback questionnaire	Response option
Core Standard 5.3 The findings of the clinical assessment are explained to the patient	By the end of your first visit, were the results of the assessment explained?	Yes, no, don't know
Core Standard 8.1 Physiotherapists ensure that the patient is fully involved in any decision-making process during treatment planning	I felt involved in deciding about my treatment plan	Strongly disagree, disagree, uncertain, agree, strongly agree
Core Standard 12.3 All communication, written and verbal, is clear, unambiguous and easily understood by the recipient	The physiotherapists used words I didn't understand	Strongly disagree, disagree, uncertain, agree, strongly agree

(Adapted from CSP 2000.)

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standards for the assessment, planning, implementation and evaluation of a CPD programme. Service Standards 6 and 7 require that all physiotherapy services should have a programme of CPD/in-service training for staff.

The requirement for re-registration of physiotherapists and other healthcare professionals, discussed earlier, makes CPD an essential component of professional life. A philosophy of LLL and individual responsibility for this will be introduced in qualifying programmes, equipping students for a lifetime of learning in order to maintain and continually improve their competence to practise. Written evidence of learning and development, and its impact on improving practice, is now an essential requirement. Every physiotherapist must establish a portfolio containing such evidence, which will need to be maintained throughout a career. Guidance on this can be found in *Developing a Portfolio: a Guide for CSP Members* (CSP 2001b).

Some key characteristics of continuing professional development (CSP 2003)

- It should comprise a broad range of learning activities (courses, in-service education, reading, supervision, research, audit, reflections on experience, peer review — this is not an exhaustive list).
- It is based on individual responsibility, trust and self-evaluation.
- It links learning with enhancement of quality of patient care and professional excellence whilst ensuring public safety.
- It should recognise the outcomes of CPD with a focus on achievement.

The emphasis on the importance of CPD/LLL within clinical governance is a welcome development. The challenges for physiotherapists in keeping up to date are huge, with the fast pace of change in healthcare in particular the rapid increase in the volume of information that has to be evaluated and incorporated into practice. It is hoped that protected time for CPD, including time in the workplace, will become a reality in the NHS, as recommended by the Kennedy Report (Bristol Royal Infirmary Inquiry 2001) and the CSP (2003).

Another form of professional development is reflective practice, a process in which practitioners think critically about their practice and as a result may modify their action or behaviour. 'Reflection enables learning at a sub-conscious level to be brought to a level where it is articulated and shared with others' (CSP 2001b). Learning from experience requires the development of skills such as self-awareness, open-mindedness and critical analysis.

Definition

Reflective practice is the process of reviewing an episode of practice to describe, analyse, evaluate and inform professional learning; in such a way, new learning modifies previous perceptions, assumptions and understanding, and the application of this learning to practice influences treatment approaches and outcomes (CSP 2002b).

HAVING THE RIGHT WORKFORCE (AND USING IT APPROPRIATELY)

Physiotherapists have a professional responsibility to use their skills appropriately. This reflects Rule 1 of *Rules of Professional Conduct*, which states that physiotherapists should 'only practise to the extent that they have established, maintained and developed their ability to work safely and competently'. But there is also a professional responsibility to use resources (human as well as financial) appropriately in delivering healthcare. This means giving consideration as to whether you need to refer a patient on, either because he or she requires a higher level of skill than you possess, or needs a specialist in a different clinical area. Equally, consideration should be given as to whether there are elements of the treatment programme that can be delegated to a physiotherapy assistant or other support worker. (The word 'assistant' is used in the following section to mean both of these.)

The decision about whether to delegate, and which tasks or activities to delegate, is entirely the responsibility of the physiotherapist making that decision. The physiotherapist also takes full responsibility for the application of the tasks or activities carried out by the person who has been delegated. So choosing tasks to be undertaken by an assistant is a complex element of professional activity, which depends on an informed professional opinion.

- *What to delegate?* Physiotherapists need to use their own skills and knowledge to carry out an assessment of a patient in order to formulate a clinical diagnosis and a programme of treatment derived from those findings. This process requires skills of analysis and clinical reasoning, key professional attributes. However, an appropriately trained assistant may well have the attributes required to be able to carry out some or all elements of the treatment programme, based on existing knowledge and skills. This would include the monitoring of the patient's

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condition and progress with the plan, and advising the physiotherapist of any variations in either of these. As there are no hard and fast rules about what to delegate, the physiotherapist should consider carefully the scope and nature of the task and ensure that these are clearly defined and communicated to the assistant.

- *Who to delegate to?* The factors to be considered here are the competence of the assistant and the nature of the task. The competence of the assistant will be affected by the person's length of service, prior experience and training received, coupled with judgements by the physiotherapist about the assistant's ability to deal with that particular patient in those particular circumstances.

The decision about what to delegate and who to delegate to is one that, while ultimately the responsibility of the physiotherapist, also requires the active involvement of the person to whom the task is being delegated. The assistant, therefore, must be allowed to make an assessment of his or her own competence in relation to the particular task. The task should *not* be delegated if either the physiotherapist *or* the assistant is concerned about the assistant's competence. The physiotherapist will then need to decide whether training is required.

Newly qualified physiotherapists should recognise and value the skills and knowledge many assistants possess, particularly those who have long service within the profession, so that effective partnerships between physiotherapists and assistants can contribute to the efficient and effective delivery of physiotherapy services. Physiotherapy assistant members of the CSP have a *Code of Conduct* (CSP 2002c) to which they are expected to adhere in the same way physiotherapists are to the *Rules*. Users of physiotherapy services have a right to expect those who deliver them to be competent to do so. The physiotherapist has the ultimate responsibility to the patient for ensuring this is the case, but also needs to consider competence in the context of effective resource use, in terms of both finance and skills.

MONITORING CLINICAL GOVERNANCE

NHS physiotherapy managers are responsible for devising, implementing and reporting on a departmental clinical governance programme, which should reflect all the aspects of clinical governance discussed in this chapter. Physiotherapists should play an active part in contributing to physiotherapy clinical governance programmes and also participate in relevant multiprofessional clinical governance activities such as clinical audit or local protocol/clinical pathway design.

The Healthcare Commission is an independent statutory body established to raise standards throughout England and Wales. In Scotland a similar function is provided by NHS Quality Improvement Scotland, the Health and Personal Social Services Regulation and Improvement Authority (HPSSRIA) undertakes regular reviews of the quality of services in Northern Ireland. The Healthcare Commission is tasked with assessing the implementation of clinical governance in every NHS trust and making its findings public. Teams of trained reviewers visit trusts every 3 5 years (and can be called in at any time should concerns be raised) to review trust information and data, talk to staff and patients, and consider the trust's performance in specified categories. The Healthcare Commission has added to its existing responsibilities those for inspecting hospitals and care homes in the private sector and carrying out value-for-money studies and performance management within the NHS.

Examples of a physiotherapy manager's responsibilities within a clinical governance programme

- Check staff are currently on the state register.
- Deal with and learn from complaints.
- Carry out programmes for quality improvement, including clinical audit and evaluation, and report how these have led to improvements for patients.
- Ensure that nationally produced, high-quality standards and clinical guidelines are implemented locally.
- Have an appropriate skill mix and staffing level to ensure the safety of patients, making appropriate use of human and financial resources, in order to provide effective care.
- Have a process for identifying and supporting staff members whose competence is in question.
- Provide an in-service training programme and time for individual CPD activities.
- Ensure appropriate participation in multiprofessional clinical audit and quality improvement activities.

So, being a competent physiotherapist who displays the essential characteristics of a professional in the current climate is a complex and demanding process. Figure 1.3 attempts to summarise the elements of professionalism described in this chapter.

THE FUTURE

The health service continues to be a high priority for the government. Change is constant and a key challenge for

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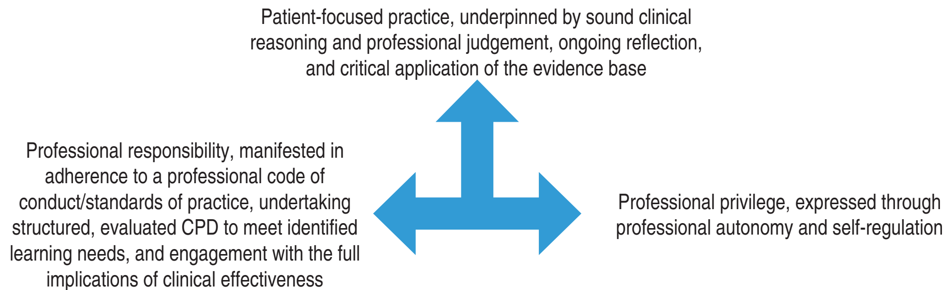

Figure 1.3 Elements of professionalism. (With thanks to Dr Sally Gosling.)

physiotherapists is to respond to the opportunities and risks presented to ensure that high-quality services are delivered to patients. Many of the government's priority health programmes will be dependent for their success on the provision of effective rehabilitation in order to ensure people can continue to lead independent lives, including services for older people, children and those with long-term conditions. Physiotherapists also have a key contribution to make to keeping people fit for work through, for example, the effective management of musculoskeletal problems or the delivery of cardiac rehabilitation programmes. Ensuring ergonomically safe environments in the workplace and offering a rapid work-based response when treatment is needed provide other examples of the value of the profession.

Structural changes

Continued investment in healthcare will bring with it an increase in the expectations of the public whose money is being used, and challenges from the government and the public about the need to change and modernise the way in which healthcare is delivered. Services will need to be more responsive to patients' needs, provided in settings closer to patients' own environments, and delivered more speedily to maximise health benefits and utilise available resources more effectively.

Many more physiotherapy services will be provided in primary care and community settings. Primary Care Trusts (PCTs) will hold 60 per cent of the total budget for healthcare in their local area, and local people will have a much stronger voice in the decision-making process about how those funds are used. In addition, the government has committed itself to increasing integration between health and social care, through Care Trusts, where budgets are pooled in order that they can be used more flexibly to meet the needs of the local population.

More services delivered in primary care and community settings

Physiotherapy already has a track record of delivering responsive and effective services in primary care and community settings. The success of domiciliary and community-based physiotherapy services in avoiding hospital admissions and allowing speedier discharges will be further reinforced through the introduction of intermediate care. The musculoskeletal physiotherapy services delivered in GP practices and health centres, where trust is already established between doctors and physiotherapists, has facilitated more direct access to patients and better referrals, making services more efficient as well as effective.

The challenges, however, will lie with greater team working and delegation of tasks, with physiotherapists having to be prepared to be more flexible, often taking on teaching roles in order to allow other staff such as rehabilitation assistants to deliver services. There will be a need to take on some non-physiotherapeutic roles, such as key worker or case manager, in order to deliver a more consistent approach to care to vulnerable people living in the community.

Another challenge will be the experience of working in more isolated settings, with less easy access to peer support, supervision or shared CPD with colleagues. At a time when clinical governance, the requirement for re-registration and the need for systems to assure patients of practitioners' competence and safety are to the fore, physiotherapists will need to work hard to create systems to support their ongoing learning, while also ensuring their managers accept their responsibilities too. Networking with colleagues with similar interests and case mix at a local and national level will become more important. Where face-to-face contact is not possible, the use of electronic networks for communication and accessing learning resources will need to be embraced.

Delivering clinically effective and cost-effective services

The profession can thrive only if it can clearly demonstrate the 'added value' it offers to patients through increasing their independence, shorter hospital stays, fewer work days lost and so on. In order to achieve this, the profession needs a two-pronged approach. First, it needs to increase its knowledge base about

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the effectiveness of specific interventions, through research. Second, it needs to use information from the evaluation of practice to demonstrate the benefit to patients of those interventions. The profession urgently requires high-quality researchers who can access NHS and other funding in order to increase the knowledge base of the profession. Challenges from commissioners of services, to provide evidence of the effectiveness of physiotherapy for particular patient or diagnostic groups, will not go away and physiotherapy services are in increasing jeopardy without it.

The profession must be brave enough to look critically at the outcomes of interventions. Where research evidenceshows that particular interventions are ineffective, these should cease to be provided. Where patient outcomes are used as a determinant and demonstrate little or no effect, consideration should be given to possible alternative strategies for securing benefit to those patients which may lie outside physiotherapy. For physiotherapists to continue to provide services in areas where there is little benefit weakens the image of the profession to the public and to colleagues from other professions.

There is a growing emphasis in the NHS on working smarter, looking at systems of care from a patient's perspective, breaking down what are perceived as tribal boundaries between professions, and redesigning patient-centred delivery systems rather than 'doing things that way because we always have'. Physiotherapists will need to embrace new ways of working without feeling defensive or appearing to be protectionist. Opportunities will emerge from redesign for physiotherapists to adopt new and highly skilled roles in just the same way as the successful creation of extended-scope practitioner and physiotherapy consultant roles.

Influencing the agenda

To make any of this work, physiotherapists need to be confident about their roles and able to articulate to others the value of physiotherapeutic interventions or approaches from a science-based as well as a holistic point of view. Physiotherapists must adopt a political astuteness that makes them aware of the wider national and local drivers for change in order that opportunities for the profession and for services can be identified and seized positively. They need to be seen to be engaged with and responsive to current agendas through contacts with patient and public representatives as well as senior managers and local politicians.

Characteristics of the profession required to maximise the opportunities being presented

One thing is certain. The delivery of healthcare within organisations, whether funded by the state or privately, will continue to be highly complex, ever-changing and resource-challenged. Qualifying programmes are tasked with equipping physiotherapy students 'with the attitude, aptitude and capacity to cope with change, uncertainty and unpredictability and with a commitment to the concept of quality improvement' (CSP 2002b). Qualifying physiotherapists of today will therefore be better equipped than ever to cope. The NHS is increasingly looking for leaders who are innovative, clear, lateral thinkers and problem-solvers. Physiotherapists are well placed to adopt such roles and should be proactive in looking for opportunities to do so. The skill is to turn challenges and pressures into opportunities to demonstrate the 'added value' of physiotherapy, which in turn will provide job satisfaction, recognition and benefit for patients and the profession.

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SOURCES OF CRITICAL APPRAISAL TOOLS

Critical Appraisal Skills Programme

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Qualitative research:
www.phru.org.uk/~casp/resources/qualitative.pdf
Randomised controlled trials:
www.phru.org.uk/~casp/resources/rct.pdf
Systematic review:
www.phru.org.uk/~casp/resources/reviews.pdf

Scottish Intercollegiate Guidelines Network

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Case-control study:
www.sign.ac.uk/guidelines
Cohort study:
www.sign.ac.uk/guidelines
Diagnostic study:
www.sign.ac.uk/guidelines
Randomised controlled trial:
www.sign.ac.uk/guidelines
Systematic review:
www.sign.ac.uk/guidelines

Users' guide series

Guyatt GH, Sackett DL, Cook DJ 1993 Users' guides to the medical literature. II: How to use an article about therapy or prevention, pt A. JAMA 270(21): 2598 2601
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Bury T, Mead J (eds) 1998 Evidence Based Healthcare: a Practical Guide for Therapists. Butterworth Heinemann: Oxford

Greenhalgh T 2000 How to Read a Paper: the Basics of Evidence Based Medicine. BMJ Books: London

Clinical Guidelines

Weblink

Appraisal of Guidelines for Research and Evaluation (AGREE) instrument: www.agreecollaboration.org

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