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Consultant physiotherapist: a career goal achieved

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Abstract
In 2000, the UK Department of Health announced that a new role, that of the consultant allied health professional, was to be developed and that there would be 240 such posts available nationwide by 2004. This followed on from the introduction of the nursing, midwifery and health visitor roles, which had been successfully implemented from 1999 onwards. The posts were created in order to provide better outcomes for patients by retaining clinical excellence within the service, and encouraging the development of innovative ways of working to enhance the patient journey and improve standards of care. The roles were designed to allow clinicians who wished to remain in patient care to benefit from a career structure similar to that of managers and academics. The holders of these new posts were to be clinical experts in their fields who would provide leadership and strategic vision, and also contribute to teaching and research. This paper examines how these consultant roles have developed, and discusses the challenges that the new post-holders face in attempting to encompass such a wide remit, the structures that are in place to help them, and the limited research to date evaluating their impact and the possible ways forward to develop new posts. It also describes the author's personal journey to become the first consultant physiotherapist in women's health in the UK National Health Service.

Keywords: clinical expert, consultant, development of posts, future.

Introduction

The National Health Service (NHS) Plan (DH 2000) announced the creation of a new role, that of the consultant allied health professional (AHP), which would combine the responsibilities of clinical expert, professional leader, educator and researcher. It was envisaged that the post-holders would develop clinical protocols and redesign services, and that the role would provide a pathway for experienced clinicians to advance their career. The Department of Health set a target of 250 consultant AHP posts to be created by 2004. These were envisaged as all-new positions and there was to be no re-grading of existing roles, but no funding was allocated to help develop the posts. This may explain why there were still only approximately 123 consultant AHPs nationwide at the time of writing in 2009. It is difficult to be precise about numbers since posts are continuously being created and lost.

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Role of the consultant physiotherapist

In June 2002, the Chartered Society of Physiotherapy (CSP) outlined the career path that it was believed consultant physiotherapists would follow (Fig. 1). In reality, the post-holders have

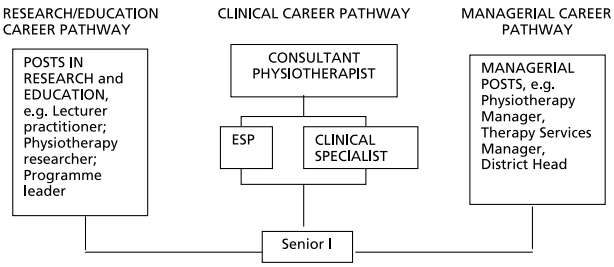

Figure 1. Career options within the National Health Service: (ESP) extended scope practitioner. (Reproduced with the permission of the Chartered Society of Physiotherapy from *Physiotherapy Consultant (NHS): Role, Attributes and Guidance for Establishing Posts*; CSP 2002.)

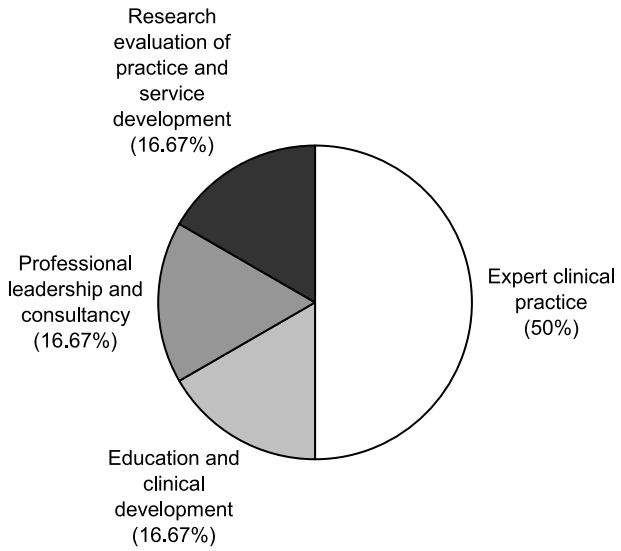

Figure 2. Four main domains envisaged as being encompassed by the role of consultant physiotherapist.

mainly been drawn from those with a clinical or teaching background.

The position of consultant physiotherapist was envisaged as encompassing four main domains (see Fig. 2). The main part of the role was seen as expert clinical practice, with 50% of the consultant AHP's time being spent on this activity and the rest being equally divided between the other three areas. In practice, there is a wide variation between individual practitioners: some do not have their own caseload, but do provide expert advice to clinical specialists in complex cases.

It was hoped that this initiative would provide a platform that would allow consultants to raise clinical standards by demonstrating best practice and encouraging its implementation, but to date, there has been no research to explore if this has actually been the case. Post-holders were expected to provide education in the field of clinical expertise nationally and internationally, undertake research, evaluate new findings, and if the latter were valuable, disseminate the results and incorporate these into practice. It was also assumed that they would provide professional leadership by developing innovative practice, and by becoming involved in strategic plans to drive change and providing expert input into clinical governance agenda.

The number of consultant AHP posts in the UK is difficult to ascertain precisely. The CSP database, which was in the process of being updated when accessed by the present author in August 2009, had details of 64 registered consultant physiotherapists. The next significant group were radiographers, who have 34 consultant posts. Occupational therapists and dieticians have 10 each; podiatrists, and speech and language therapists have four each; paramedics have two; and orthoptists have one. Therefore, to date, just over 50% of consultant AHPs posts are held by physiotherapists.

Table 1. Distribution of consultant posts in UK physiotherapy

Field of physiotherapy	Number of consultants
Musculoskeletal	29
Respiratory	8
Stroke	5
Elderly care	3
Women's health	2
Cancer care	2
Pain	2
Paediatrics, intermediate care, functional electrical stimulation and prosthetics	1
Not known	6
Total	58

This is a remarkable achievement for our discipline, which only became an all-degree profession in 1994. All of the consultant physiotherapists are educated to Master's degree level at least and many have completed doctorates. Musculoskeletal physiotherapy accounts for half of these posts with 29 consultants (see Table 1).

As can be seen from Table 1, there are two posts within the field of women's health. One is held by Professor Grace Dorey, who has been a consultant physiotherapist at the private Nuffield Health Taunton Hospital, Taunton, UK, since 2004, when she gained her doctorate. The other post is held by the present author, who was appointed to a post at Southampton University Hospitals Trust, Southampton, UK, in June 2008. Her role encompasses all four domains of the consultant AHP post, with 50% of her time being spent on clinical practice, while the other three domains of research, teaching and leadership compete for the remaining 50%.

When you look at the width and depth of the role, it is easy to see why Paul Watson, the first UK consultant physiotherapist, appointed in 2002, believed that the position could have been better devised:

> 'The role should be more about strategic planning rather than administration. [. . .] You need to look at what is important for the service, and there is a difference between using your skills as a consultant usefully, and getting

> bogged down in administration. [. . .] To be a consultant, you need to be able to appraise information . . .' (Clews 2007)

In the same article, Susie Durrell described the two consultant posts that she has held. Her first, at St George's Healthcare NHS Trust, London, UK, was mainly clinical, but her new role at Gloucestershire Hospitals NHS Foundation Trust, Cheltenham, UK, is mainly managerial. Jeremy Lewis, her successor at St George's, felt that the demands of the post mean that he could not devote as much time to research as he would have liked (Clews 2007). These comments show how varied the role of consultant can be, and the way in which the practitioner will influence the various parts of the position, depending on both the role itself and personal preference.

There are many challenges facing consultant AHPs, including variations in scope of practice, achieving a balance between practice and academic work, the post-holders' organizational and professional readiness for these roles, and the lack of training for the post. To this end, the Wessex Deanery, Otterbourne, Hampshire, UK, instigated a consultant practitioner project that has a 3–6-year training programme in expert clinical practice in specialties together with a Master's degree or professional doctorate. The programme offers training across the four domains required at consultant level, and gives AHPs the opportunity to shadow consultants and attend conferences. The first cohort of students will finish the programme in 2010, but it is unclear if any of them will have a consultant post available to them. An interesting research project would be to assess both whether or not they are successful in obtaining a post, and the time scales involved since the sacrifice involved in returning to Band 6 for at least the first half of the training would be difficult for many senior clinicians. However, the programme would be one method of bringing on less-experienced clinicians and training them specifically for the role.

Effectiveness of the post of consultant

Direct research investigating the effectiveness of the consultant post is limited to a single study (Guest *et al.* 2004). This set out to evaluate the impact of the nurse, midwife and health visitor consultant posts that had been available since 1999. A questionnaire survey of all 528 of the consultants in post in 2003 generated 419 replies, a response rate of 79%. Nevertheless, only 8% of respondents were midwives and only one health visitor was identified.

The main aims of the research were to explore the impact of the consultant role on patient care and related outcomes, to assess leadership, and to examine how consultants are 'crafting' the role to remain effective, motivated and committed. The authors also sought to determine whether it is possible to predict later performance at the point of selection.

A range of research methods were used by Guest *et al.* (2004), including in-depth interviews and questionnaire surveys, and both cross-sectional and longitudinal approaches were adopted. The main sources of information were the consultants themselves, although data were also collected from a small number of their sponsors.

The outcomes stated that 'crafting' was evident, with many respondents adjusting the hours they spent on the four domains over time. Clinical practice varied most widely, with some consultants spending the least amount of time in this area, and research was the domain that expanded the most:

> '86 per cent were heavily engaged in leadership activities, 48 per cent in practice and service development, research and evaluation, 43 per cent in education, training and staff development and 33 per cent in expert practice. 15 per cent reported that they were heavily engaged in all four functions while 11 per cent said they were heavily engaged in none of them.' (Guest *et al.* 2004)

The respondents engaged in all four of the main elements of the job, but typically gave greater priority to leadership and least to expert practice. This may be because, prior to taking up their posts, they had been heavily involved in clinical practice and it was the other roles that needed further development.

Interestingly, not all those involved in the study believed that this was the pinnacle of their career, and some had already left their consultant role to take up a managerial post:

> '60 per cent of consultants intend to stay in the role while 18 per cent are fairly sure that they will not. Looking further ahead, in five years time, 48 per cent expect to be either in their current or in another consultant post. Most of those who have already left have either moved to more senior positions or into roles with managerial authority. It appears that most of those in these consultant posts do not regard

> them as the pinnacle of their career.' (Guest *et al.* 2004)
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> 'The key problems associated with the consultant role and with having an impact were lack of support, lack of resources and lack of authority. 30 per cent of consultants reported high support from senior management and 30 per cent from colleagues while 49 per cent reported low support from senior medical staff, 44 per cent from their professional manager and 41 per cent from their line manager. 19 per cent reported positive resource provision and 52 per cent low provision. Many said that their impact would be much greater if provided with adequate resources and support.' (Guest *et al.* 2004)

It would be interesting to see if these figures remain constant for consultant AHPs since their roles were devised later and, one would hope, with more care.

In summary, most consultants surveyed by Guest *et al.* (2004) believed that they were having a positive impact on service delivery and patient care. They described their jobs as busy and demanding, but also exciting and involving, and most felt satisfied and highly committed to their work. Predictably, they were strong supporters of the initiative to set up the nurse, midwife and health visitor consultants, and believed that this should be continued with stronger local support and resources.

The authors identified several areas for future research, notably an analysis of impact among other stakeholders, and a number of possible messages for policy-makers. Guest *et al.* (2004) concluded that the role had been successful in the majority of cases because it had resulted in improved systems, procedures, and patient service and care.

However, proof was hard to come by and bias was inherent in this study. The authors only questioned the consultants themselves and representatives of their stakeholder trusts, making no comparison with other trusts without consultant practitioners. Furthermore, once best practice is initiated in one trust, another may implement the new pathways without employing a consultant in the role of innovator since only the clinical expertise to run the new pathway is required.

Discussion and conclusion

To date, there has been no research into consultant AHP roles, but this will be required if we are to keep these posts in future. The challenge for existing consultants is to prove their worth, especially now that budgets are being reduced across the board. Post-holders should ensure that succession planning takes place and provide research to support the consultant role. This is a big thing to ask of a small number of people, but without it, the posts may well disappear as the NHS continues to evolve and change in response to changing patient needs and budgetary constraints.

The present author's own journey to her current post involved becoming responsible for the physiotherapy and urodynamic services at a large acute teaching unit. This meant learning many new skills, and building a team of both nurses and physiotherapists to provide conservative management for the client base. The author's current role would not have been possible without the support of her consultant medical team members and the implementation of the NHS Agenda for Change (DH 2004). The road was neither straightforward nor without its challenges, but she eventually attained her current post in July 2008.

The past year has been an interesting one, during which the present author has begun to develop and 'craft' her new role. Her main challenge will be to ensure that the post remains available to future generations of physiotherapists. While this role may not be a career goal realized as such – the author never imagined that such posts would be available when she started out – she very definitely believes that it represents the pinnacle of her career to date.

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Kathleen Vits qualified in London in 1977 and then returned to her native Glasgow to complete a 2-year rotation in a large tertiary unit. She then worked in Spain and Switzerland before returning to the UK in 1983 to move into women's health physiotherapy. Kathleen completed the women's health, continence and urodynamic postgraduate courses, and a Master's degree in Research Methodology in Health including a dissertation on chronic pelvic pain.

She is now the joint editor of the ACPWH Journal *with Linda Boston. Kathleen is an active member of the reflective practice forums for both women's health and urodynamics in the South West region. She has been involved in both commercially and clinically based trials and research projects, and has contributed to several books.*