

Austerity on the frontline- a preliminary study of physiotherapists working in the National Health Service in the UK.

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Abstract

Background

Organisational reform has been commonplace in the response to global socio-economic changes. Rising managerialism, consumerism and marketisation has accelerated reforms; providing challenges for the healthcare professions. The latest socio-economic challenge, austerity, and its professional implications have scarcely been researched. This study aims to explore the lived reality of austerity as experienced by physiotherapists working on the frontline of the National Health Service (NHS) in the UK.

Methods

Ethical approval was granted by the University of Nottingham; the study was advertised via the Chartered Society of Physiotherapy online network. Two participants took part; semi-structured interviews were completed, audio record and transcribed. Data was analysed using thematic analysis.

Findings

Three themes arose from the data: fulfilling professional responsibilities, changing organisational landscape and the professional reality of rationalising and accommodating austerity. The clinical implications of austerity included increased length of hospital stay, insufficient community services, constrained resources and understaffing. Participants demonstrated attempts to preserve their professional status and services through re-stratification throughout the intra-professional hierarchy, changing division of labour and re-professionalisation.

Conclusions

Despite claims that austerity is coming to an end, it remained a reality for these clinicians in the NHS. Physiotherapists in this study used similar methods to preserve practice when faced with exogenous constraints as seen in medicine, such as re-professionalisation and re-stratification. However, this attempt to defend professionalism by a non-medical healthcare profession was met with both successes and losses and has implications for the wider healthcare profession ecology, identifying an area for future research.

Background

The history of the National Health Service (NHS) in the UK has been one of repeated organisational reform, particularly following the neoliberalist movement at the end of the 20th century (Ham, 2009; Klein, 2006). More recently, the reforms implemented have focussed on a shift towards marketisation, cost containment and emphases on productivity, secondary to widespread austerity measures which followed the 2008 global financial crisis (Boyle, 2013). The term 'austerity' is used to describe the imposition of significant spending cuts and creation of unfavourable economic conditions to reduce financial deficits (The Economist, 2015).

Internationally, the crisis caused governments to implement cost saving initiatives, profoundly affecting health services across the globe. These initiatives included reduced health budgets, closure of services, introduction of user charges, reduced access to care, pay cuts for staff, reduction of workforce and increased working hours for existing staff (Adams, Jones, Lefmann and Sheppard, 2015; Ellins *et al.*, 2014; Palese *et al.*, 2014).

In the UK, the Prime Minister at the time, David Cameron, described the crisis as '*the age of irresponsibility [is] giving way to the age of austerity*' (Cameron, 2009). With the deficit in the UK standing at approximately 10% of GDP in 2010/2011, the Conservative/Liberal Democrat Coalition government implemented some of the '*most drastic budget cuts in living memory*' (Financial Times, 2010). Despite claims of the '*end of austerity*' by political leaders (BBC, 2018; The Independent, 2018), it remains the daily reality for those working in the public sector (Kerasidou and Kingori, 2019; Tucker, 2017).

Whilst the effect of austerity measures on the socio-economic life and health of the population has been well documented (Stuckler *et al.*, 2017; University College London, 2017, Watkins, 2017); the impact of austerity from the perspective of healthcare professionals in the UK has scarcely been researched (Kerasidou and Kingori, 2019). Beyond the UK, healthcare professionals have likened the austere health setting to a war zone (Kerasidou, Kingori and Legido-Quigley, 2016); identifying increases in workload (Palese *et al.*, 2014), precarious work arrangements (such as zero hour¹ or temporary contracts), reduced job security, low morale, high stress, understaffing and insufficient resources (Adams, Jones, Lefmann and Sheppard, 2015; Burke, Ng and Wolpin, 2015; Ifanti, Argyriou, Kalofonou and Kalofonos, 2013; Palese *et al.*, 2014; Perelman, Felix and Santana, 2015). These factors affect healthcare professionals' ability to fulfil their

¹ Zero hour contracts, also referred to as 'casual' contracts are based on employment where the employee works when requested; work is not guaranteed (the employer does not have to provide work) and the employee does not have to work when asked (Gov.UK, 2012).

professional responsibilities. For example, lacking equipment and the use of cheaper alternatives (at the expense of quality) impacted on quality of care, safety was perceptibly compromised through the employment of nurse aides to registered nurse positions, services were rationed, elective surgery/admissions were reduced and understaffing led to reduced time at the patient's bedside (Palese *et al.*, 2014; Perelman, Felix and Santana, 2015).

An investigation within the UK suggests that austerity has shaped the functioning of departments and professionals alike; in this case, doctors, nurses and pharmacists working in Accident and Emergency (A&E) (Kerasidou and Kingori, 2019). This study suggested that austerity policy and the weakening welfare system has transformed the role of A&E to 'Anything and Everything', whereby A&E becomes the port of call for those with '*nowhere else to go*' (Kerasidou and Kingori, 2019, p.9). The shifting requirement to focus on procedures, timekeeping and organisation of care is suggested to detract from the empathetic and caring nature of healthcare; furthermore, participants in this study suggested they were unable to 'properly' care for their patients (Kerasidou and Kingori, 2019, p.10). The professions interviewed (nurses and doctors) described a standardisation of their care to conform with targets and to quicken throughput in the department to either admit or discharge; thus freeing space for further A&E attendees (Kerasidou and Kingori, 2019). This focus on quantity and time was described by one doctor as the '*austerity of time*' (Kerasidou, 2019, p.177) where difficult decisions were made in relation to what the patient received and what was withheld; which arguably limits time spent *caring* for the patient, conflicting with the professional ethos of nursing and medicine (Kerasidou, 2019). These findings reflect Hoyle and Grant's (2015) exploration into the increasingly target-driven culture as perceived by nurses working in the NHS. Nonetheless, Hoyle and Grant (2015) suggested that nurses were able to use their professional privilege to resist these targets when they felt they conflicted with their patient's needs.

The reality of austerity for other health professions, such as the allied health professions (AHPs) is unclear. Taking the physiotherapy profession as a case example, this study aims to shed light on the experience of austerity by physiotherapists working in the National Health Service (NHS) in England.

Much like other professional groups, physiotherapists have faced challenges as a result of rising neoliberalism, managerialism, corporatisation and the requirement for increased productivity; for example, physiotherapists have faced encroachment from other occupations (such as exercise technicians and generic rehabilitation assistants) (Jones, 2006; Rolfe *et al.*, 1999; Stanmore, Ormrod and Waterman, 2006) and decommissioning of services (McMillan, 2013; Walumbe, Swinglehurst and Shaw, 2016). The term decommissioning is

used to describe the removal or replacement of healthcare services, often incorporating a reconfiguration of such services, resulting in '*organisational downgrading or closure*' (Harlock, *et al.*, 2018, p. 545). Examples of decommissioning include closure of organisations or departments, replacement with cheaper alternatives and removal of medicines or interventions from funded use (Harlock *et al.*, 2018). Following the publication of the Health and Social Care Act (2012), Primary Care Trusts and Strategic Health Authorities were abolished and Clinical Commissioning Groups (CCG) were formed, mainly made up of local General Practitioners (GPs) (NHS, 2013). These groups take on the responsibility for making decisions for the funding and procuring of health services in their local area (Health and Social Care Act, 2012; Harlock *et al.*, 2018). It is suggested that decommissioning decisions are made not solely on cost effectiveness, but on evidence-based medicine, quality and clinical appropriateness (Harlock *et al.*, 2018). Nonetheless, a national survey of commissioners suggested that cost effectiveness was the most common intended outcome of decommissioning (Harlock *et al.*, 2018).

The rhetoric on austerity (and associated decommissioning) from UK physiotherapists' professional body, the Chartered Society of Physiotherapy (CSP), is one of recognition and mandating response. The CSP described austerity as '*bad for our health*' and encouraged members to be involved in collective action to 'protect' services, jobs, employment conditions, patient care and ultimately, the profession (CSP, 2013).

Austerity is a concept of interest due to its ability to affect the technical nature of the profession's work, for example, where resources, time and staffing is restricted and subsequently, treatment is withdrawn, amended or delayed as a result (Connolly *et al.*, 2014; Tucker, Drummond and Moffatt, 2017). The changing healthcare economy, technological advances and populations growing in age, size and complexity, are threats to the physiotherapy profession in its current state (Nicholls, 2018); mandating a call for the profession to engage with theoretical discussion in order to enhance professional reform (Nicholls, 2018). Therefore, the aim of this study is to commence this discussion by gaining an understanding of the lived experience of austerity by physiotherapists currently working in the NHS in the UK.

Methods

Sample

Physiotherapists working in the NHS in England at the time of the study were eligible to take part. Due to the method of recruitment, only physiotherapists who were members of the CSP took part. No other inclusion or exclusion criteria were applied.

Recruitment strategy

Participants were invited to take part in the study via the CSP online network. An advert was placed upon the news section of the East Midlands and Profession Wide network pages. The online invitation advised those who were interested to contact the principal investigator (RT) who would provide them with the participant information sheet and consent form. At this stage, they were given 72 hours to decide whether they wanted to take part. If they chose to participate, an interview date and time was arranged to suit them. Due to the time constraints of the study, the advert to participate was closed after four weeks; during this time, two participants contacted the principal investigator with interest to take part. The study aimed to achieve a higher participation rate than the two participants recruited, reflecting the difficulties in researching the topic of austerity in the healthcare professions. Although the cohort sampled was smaller than anticipated, the data collected was an important reflection of the current state of austere healthcare and the views of these participants provided preliminary data in a research area which is sparse.

Ethical approval

Ethical approval was granted by the Faculty of Medicine and Health Sciences at the University of Nottingham (reference number PT200317).

Method of data collection

Data was collected in June 2017; the study used semi-structured interviews which took place in a private room on University premises. One interview per participant was completed, lasting between 40 and 50 minutes. The interviews were recorded using a digital voice recorder and transcribed verbatim. Once the participants had finished their interview, their participation was complete.

The study used hermeneutic phenomenology in the design, conduct and analysis of the interviews. Phenomenology aims to describe and explore the lived world and everyday experiences of an individual; it does not aim to generate theory, but to attach meaning to one's experiences (Finlay, 2011; Smith, 2016). Phenomenology recognises the importance of individual experiences and emphasises the unique understanding of each person (Bevan, 2014); therefore, it was an appropriate methodology for the study.

Data analysis

Once the audio recordings were transcribed, data analysis began. The texts were read and re-read repeatedly by the lead author (RT), who had also carried out the interviews and transcribed the recordings to ensure in-depth familiarisation with the texts. During this

iterative process of repeated review of the transcripts, themes and keywords started to emerge. These preliminary themes were reviewed by the second author (FM); once these themes were established, extracts from the transcripts were organised under these themes to provide exemplars (an extract or statement where the theme is particularly represented or encapsulates the meaning in its statement) (Leonard, 1994). Any deviant statements were also identified to ensure appropriate representation of the participants' viewpoints.

Data management

Data collected during the study was stored securely on a password protected database. All interview transcripts and recordings were kept on the University computer system. The data was anonymised at the point of transcription and any participant identifiable information (such as names or places of work) was removed. Participants were allocated a pseudonym at the point of transcription to protect their identity.

Findings

The participants recruited to the study (Louise and Jane), both worked as physiotherapists in an acute NHS Trust in England. Louise was a senior physiotherapist with over 20 years of experience; she had specialised in neurology for most of her career, working predominantly with patients who have had a stroke. Jane was more novice, having qualified three and a half years ago; unlike Louise, Jane had yet to specialise and was a rotational junior physiotherapist. Jane also currently worked with patients with stroke within the same NHS Trust, though was based in a separate team to Louise. Both Louise and Jane had experienced austerity in their workplaces, citing a reduction of the NHS budget as the main factor. This presented itself in various aspects of their work, which is reflected in the themes drawn from the data.

Themes

Three central themes were drawn from the data. The themes were: fulfilling professional responsibilities, the changing organisational landscape and the professional reality of rationalising and accommodating austerity.

Theme one: Fulfilling professional responsibilities

Both Louise and Jane suggested that there was difficulty in fulfilling their professional responsibilities, duty of care and meeting perceived clinical need. The challenges in fulfilling their professional responsibilities materialised through difficulty in delivering sufficient treatment, providing adequate support on discharge, prolonged hospital stays and involvement in 'difficult' conversations with dissatisfied families.

Jane articulated situations where she felt unable to fulfil the National Institute for Health and Care Excellence (NICE) guidelines for recommended treatment frequency and time for patients who had experienced stroke (45 minutes, five times per week) (NICE, 2013). Jane felt that this was unattainable within the current context and was frustrated by the volume of work and competing demands for her time; which ultimately had ramifications for her treatment sessions:

'Realistically, we are aiming three to four treatments a week, anything over is a bonus....it does feel like we are possibly fighting up against something we are not going to achieve; they're getting shorter sessions and fewer of them...you've got a list of patients that you need to see, so to get through all of them, you've either got to give them less time, or you're just not going to reach everybody.'

The lack of capacity extended into the community with lacking support on discharge. This was an issue that concerned both participants; though Louise was particularly emotionally involved after a community service she had been involved with had recently been decommissioned after the publication of her local Sustainability and Transformation Plan (STP)²:

*'We have patients who can't leave hospital now, because they haven't got any input in the community, and **from a duty of care point of view it's a real ethical/moral dilemma for therapists**' (emphasis added).*

Louise added that there were circumstances where she attempted to reconcile these ethical and moral dilemmas, which were not always present in her work:

'...trying to keep patients in hospital longer while trying to fulfil your duty of care...making sure they get the right treatment within your control... I think every aspect, on every front, there are challenges there that weren't [there] five or ten years ago.'

There was significant concern surrounding the lack of community services; this resulted in discharges with little support, or 'unnecessary' admission into a residential or nursing home. The misalliance between professional responsibilities and capacity to deliver, created tension for both participants; Louise suggested that these challenges were not present 5-10 years ago. In these circumstances, therapists fought for patients to remain in hospital to

² STPs were introduced by NHS England in 2017 across 44 regions in England; aiming to improve health and social care (NHS England, 2017), though to some extent have become vehicles for cost reduction (Edwards, 2016; Gulland, 2016).

increase their independence, inevitably lengthening their admission. Lacking community services had repercussions for patients who did not meet the required level of independence to be discharged home. Louise suggested that this could have adverse effects on the patients:

'Patients pick up hospital acquired infections, they get chest infections they get c-diff³, they get pressure sores, and they stay in for longer and it appears to be cyclical, those patients that we just can't get out; patients who've got enough cognition, get low mood.'

Louise and Jane's attempts to fulfil their professional responsibilities by optimising the rehabilitation potential of their patients, unavoidably resulted in personal and professional conflict. This was an emotive topic and both participants spoke passionately, articulating situations where they had felt unease or simply disagreed with what they were obliged to deliver. Jane felt particularly distressed from a situation where she could not deliver a certain treatment due to inadequate equipment. A difficult conversation with the patient's family ensued; her feelings towards this are illustrated in the following quote:

'It is really difficult because you're trying to keep your professional face on things, but sometimes I am absolutely with them, I kind of want to walk up to the doors and start screaming 'this isn't fair', but you can't.'

Jane expressed her fatigue and frustration with such situations:

'[It is tiring] particularly if it's not something you believe that you're saying.'

Both Jane and Louise made attempts to rationalise and justify their abilities within the wider constraints:

'You have to think you are doing the best possible job for that person at that moment in time.' Louise

³ C-diff refers to the bacteria *Clostridium difficile*. This is a bacterium affecting the bowels, which can cause diarrhoea; it is often associated with recent use of antibiotics and hospital admissions (NHS Choices, 2016).

'I try and find the silver lining with any situation...it's very difficult to justify at the moment.'

Jane

Jane suggested these difficulties had put physiotherapists at risk of burnout or questioning the occupation entirely:

'I've seen a lot of people questioning or leaving the organisation, purely because it feels like you're knocking your head against a brick wall because you're not able to get on with what you need to get on with, extra pressures being put on you... and I think that has driven people to other lines of work completely.'

These feelings were exacerbated by feelings of guilt, affecting stress levels:

'You can't be seen to be having a break or a drink of water because that's time that could be used for paperwork, a referral, time used to see a patient, so you do feel guilty for taking a breath at times.' Jane

From Louise and Jane's experiences, the role of the physiotherapist appeared to have an increasing element of mutability, adapting to the department's requirements and changing health policy. For some clinicians, this caused distress which resulted in the pursuit of alternative lines of work entirely. The impact of wider constraints on their ability to fulfil their professional responsibilities links with the second theme that arose from the findings, the changing organisational landscape.

Theme two: changing organisational landscape

This theme encompassed the changing organisational landscape through vicissitudes in service provision and the role of the physiotherapist. Both Louise and Jane suggested that the nature of physiotherapy professional work was changing as a consequence of austerity measures. For example, Louise spoke about the increased requirement for senior therapists (referred to as band sixes, sevens and eights) to spend time developing business cases. Louise had experience of obtaining non-clinical skills to assist her in service development:

*'What we are **forced** to do, certainly as band seven physios is to be entrepreneurs and to be business minded; I've taken business courses and financial management courses through the NHS, I can look at tariffs and I can break down, look at bed days, and look at things from a business point of view not just a patient point of view; and from that we have set up new services, and run those from a financial efficiencies point of view '(emphasis added).*

This extract demonstrates a requirement for some of the most senior therapists (band sevens) to engage with business cases and the management of services in order to contribute to cost efficiency savings and the rationing of services; this rationing has become even more prevalent following the 2008 financial crisis and the widespread imposition of austerity measures both in the UK and globally (Ellins *et al.*, 2014; Klein and Maybin, 2012). Louise emphasised the importance of taking into consideration the financial implications of any business case for it to be successful:

'...it teaches you how ruthless things have to be and how big and sparkly things have to be, and how really idiot proof things have to be when you put a business case together, you have to put the numbers at the top, nothing about the quality or the value or the clinical outcomes. It's the numbers at the top and how big they have to be and how big they have to be for somebody here or commissioners, or what money means to them, the capital, those things are really important.'

Louise suggested that the time spent engaging with these business cases created inefficiency:

'We are wasting money and spending so much time wasting, not [assistants], it's band sevens and eights [seniors], costing the commissioners and the NHS a fortune, doing very little for a good chunk of our time in terms of productivity and patient contact because we are now chasing our tail, catching up with the latest change in politics.'

Louise suggested senior staff were working less clinically and reducing the time spent investing in junior members of staff (referred to as band fives); which was reiterated by Jane,

who suggested that senior staff were not available for clinical support and had noticed a change in the workload:

'From my experience, it means the workload gets shifted towards [band] fives, whereas before I think it's been more of a senior level...It can be quite useful to have an experience of doing things that maybe a band six would do, but equally, I think for more newly qualified band fives, it might be intimidating or a bit much.'

Jane suggested physiotherapy assistants (referred to here as band twos/threes/fours) were also adapting their roles:

'I've definitely noticed that twos/threes/fours are possibly doing more than I would expect than in the past. I think work is getting shifted away more from admin or simple mobility practices and a bit more to in depth [treatment].'

Jane expressed concern surrounding the potential deskilling of physiotherapists due to assistants taking on tasks normally associated with qualified physiotherapists. This has financial implications, due to the lower salaries of physiotherapy assistants. Whilst this offers an opportunity for physiotherapy assistants to upskill, this is driven by austerity and is a result of the re-stratification of work throughout the profession; as the senior therapists engage with service management and entrepreneurship to deliver cost efficiency savings on the frontline of care.

Nonetheless, Jane's experience suggested this differed depending on the area of practice, something she had encountered during her rotations. Both Jane and Louise recognised that their role was changing; Louise suggested it was becoming increasingly focussed on discharge planning:

'It's a different profession, so it's more acute, but I wouldn't say we are more skilled in the acute, I would say we are getting more skilled in discharge planning in setting targets and goals really early on.' Louise

As a senior physiotherapist, Louise experienced trepidation regarding the evolving service in which she was situated. She spoke of how this service had made her organisation the envy of others, which attracted clinicians to the area. However, after the decommissioning of this service, pressure was placed upon acute services:

'Whereas now, people would be like no I don't want to come and work for you, you don't do rehab. We're doing less and less rehab.'

Louise suggested that in the current economic climate, her work and ability to make decisions has changed:

'...there were times previously... describe it as the time of milk and honey, you know, if you wanted to go and do some training and implement that; whereas now you really can't make those decisions, there really aren't those value added experiences for staff and for patients because it's obviously more patient orientated, but it's becoming more lean.'

These excerpts demonstrate circumstances where physiotherapists' autonomy was challenged by wider constraints (from the organisation). Such constraints dictated their ability and capacity to perform and deliver their services, suggesting tension between professional autonomy and organisational structure. Consequently, austerity appears to have changed the participants' perception of their autonomy. Their ability to make decisions freely was curtailed by the requirement to meet targets and create cost efficiency savings.

Theme three: professional reality of rationalising and accommodating austerity

The final theme represents the reality of rationalising and accommodating austerity as a professional physiotherapist. The conflict between fulfilling professional responsibilities within organisational constraints, resulted in feelings of powerlessness and subjection. The reality of this was illustrated through Louise's experience. She demonstrates feelings of powerlessness and fatigue whilst undertaking extensive work during the decommissioning of her service. Louise's feelings towards this process are evident in the following excerpt:

*'That's what made me so cross about all these changes, is that **we offered ourselves**, I offered my business case, I presented, **I whored myself around like some cheapskate**, I was banging my drum constantly, I had no shame at all, I didn't care who I presented in front of, I presented to everybody, and still.... they made all these decisions' (emphasis added).*

Louise appeared to feel betrayed by the system; she expressed her disbelief in the feedback she received after presenting evidence and the service was still decommissioned:

'The conversation had been that "they weren't aware of this patient group." And that...that is a lie. That is a lie' (emphasis added).

These excerpts reflect Louise's concern about the decision-making processes of the CCG, who she stated completed audits and service reviews, without consulting the service itself or the clinical staff within it. Louise found this deeply disturbing:

'It felt really upper hand, like they've tried to shut it down or commission to the community or whatever they were doing at the time, without involving us. And it was just very sinister.'

This reflects the common cynicism from healthcare professionals towards CCG decision making (Harlock *et al.*, 2018; Robert, Harlock and Williams, 2014). Whilst Louise clearly felt some anger and distaste towards this situation, she actively encouraged CCGs and governing bodies to seek those with expertise within the service, such as physiotherapists. She suggested that physiotherapists were ideally situated to develop business cases and identify areas for savings, whilst maintaining patient focussed care. Louise stated:

'If that changed, if someone said actually, cards on the table, we need to save this much money...if you came and said exactly how much money you need to save, exactly how much money you have to spend, let us give you a business plan, let's give you some ideas...but they don't, so it's hard.'

This was a clear acknowledgement from Louise that austerity measures were an inevitable challenge within which she would have to operate and manage in her work; though alongside this acknowledgement, was the recommendation for funding bodies to listen proactively to clinicians who work on the frontline of care in order to preserve its quality.

This reality instigated Louise and Jane to reconsider the pathway of their careers, which included attempts to become more evidence-based:

'Do I need to move in a different direction clinically? Do I need to diversify and generate some research, some really robust research, to add another string to my bow and be more powerful? Louise

This theme encompasses the challenge to clinicians' autonomy by wider constraints, and the professional and emotional impact this can have.

Discussion

The findings from this study have identified the clinical implications of austerity from the viewpoint of two physiotherapists working in the NHS. The increased length of stay, lack of community services, constrained resources, understaffing and reduced treatment time and frequency were common concerns for the participants. Consequently, patients appeared to rarely receive the care recommended by national clinical guidelines for the treatment of stroke (NICE, 2013).

Not only was the inpatient stay affected, the support on discharge was reported to be profoundly shaken. This seemed to be particularly evident following the publication of the local STP and subsequent decommissioning of a community service.

Policy reform and austerity

Participants explicitly identified examples of where austerity measures had impacted on their practice and their ability to fulfil their professional responsibilities and duty of care.

Participants also described how one of the most recent policy reforms at the time of the interviews (the STPs) were essentially a disguised austerity measure. This conflicts with the marketing of the STPs by NHS England which emphasises collaboration between health and social care, improvement of public health and facilitating access to healthcare (NHS England, 2017).

This disconnection between policy and perception by healthcare professionals is reminiscent of the publication of the Health and Social Care Act 2012 where there was significant disagreement with its content (Pollock and Price, 2011; Pollock et al., 2012; Lister, 2013; Pollock and Price, 2013; Tallis, 2013; Pollock, 2015) with explicit suggestion this policy was a disguised austerity measure (Pownall, 2013). The discontent with these policy reforms appears to be in relation not only to universal access to care and its quality, but also to the challenges and tension it applies to healthcare professionals' values and professionalism itself. This is due to how the policy guides clinicians' decision making in relation to the

resources available and to meet targets; posing a challenge to autonomy and control of one's work, a core component of professionalism (Freidson, 2001; Macdonald, 1995).

The wider literature provides examples of where other healthcare professionals have resisted such measures where they felt it was not in their patient's best interests, demonstrating a strong adherence to professional values, sometimes at odds with managerial and organisational objectives (Hoyle and Grant, 2015; Kerasidou, Kingori and Legido-Quigley, 2016). In this study, participants demonstrated a successful defence of their professional privilege where they felt appropriate, such as the purposeful lengthening of hospital stay to maximise the patient's potential prior to discharge into insufficient community services. However, this defence was not always effective, as observed in Louise's interaction with the CCG.

Professionalism, challenges to autonomy and re-professionalisation

In these circumstances, participants called upon the core tenets of professionalism to defend and preserve their practice. Drawing from the sociology of the professions literature assists in our understanding of the professions, their interactions and methods of response to external constraints, such as austerity. Broadly, professions are occupational groups that possess specialist knowledge, autonomy and control over one's work, have undergone tertiary education (usually to university level) and apply knowledge on a case by case basis (Abbott, 1988; Alvehus, Eklund and Kastberg, 2019; Evetts, 2003; Freidson, 2001; Macdonald, 1995). When autonomy or monopoly over a specialised area of practice is challenged, it can be construed as a process of deprofessionalisation (Haug, 1972, 1975); as the profession loses those components which established them as a profession. Nonetheless, contemporary literature refutes the notion of deprofessionalisation (Waring, 2014) and instead suggests a need to re-professionalise (Evetts, 2011, 2013; Muzio and Fitzpatrick, 2011; Moffatt, Martin and Timmons, 2014; Waring, 2014). The call to re-professionalise has recognised the difficulties in upholding traditional autonomies in a capitalist economy and thus, professions must adapt (Noordegraaf, 2007). An example of this attempt to adapt to capitalist ideology, is Numerato, Salvatore and Fattore's (2012) investigation into medicine. The authors here conceptualised attempts to re-professionalise and reconcile the challenge of top down managerialism to medical autonomy; suggesting this existed upon a continuum from professional opposition → strategic adaptation → negotiation → co-optation → managerial hegemony (Numerato, Salvatore and Fattore, 2012).

In this study, there was evidence of attempts to re-professionalise in response to austerity through the acquisition of business skills, finance management and the pursuit of research.

Louise actively acknowledged the requirement to expand her professional remit in order to preserve services; this was reflected in her engagement with the CCGs. Louise compared her current work to before the 2008 financial crisis which she described as the time of 'milk and honey', where there was less requirement to engage with finances and she reported feeling freer to attend and implement training. Louise's involvement in the commissioning process reflects both a wider political movement and a professional change. Historically, commissioning was not something that 'frontline' clinicians like Louise would get involved with; though with the publication of the Health and Social Care Act 2012, the government sought to depoliticise healthcare and place commissioning decision-making power in the hands of clinicians via CCGs (Light, 2010; Pollock and Price, 2011; Pollock et al., 2012; Pollock and Price, 2013; Speed and Gabe, 2013). Furthermore, this reflects the requirement for frontline staff to deliver cost efficiency savings, something advocated following the 2008 financial crisis (Appleby, Galea and Murray, 2014; Department of Health, 2010; Nicholson, 2009). This followed what was termed the 'Nicholson Challenge' where David Nicholson (the NHS Chief Executive at the time) in his annual report 2008/09, outlined a requirement to produce £15-20 billion of cost efficiency savings in the NHS between 2011 and 2014 (Nicholson, 2009). Initiatives which mandated healthcare professionals' participation in producing cost savings were introduced (such as the Quality, Innovation, Productivity and Prevention initiative) (Appleby, Galea and Murray, 2014; Department of Health, 2010).

Whilst this suggests that organisational demands, policy reform and rising managerialism imposes a direct challenge to professional values (Ackroyd and Walker, 2005; Dent and Burtney, 1996; Exworthy and Halford, 1999; Kirkpatrick, Dent and Jespersen, 2011; Kitchener, 1999; Potter and Morgan, 1994), it can also provide opportunities for professional groups to defend and even enhance their professional status (Hoyle and Grant, 2015; Kerasidou, Kingori and Legido-Quigley, 2016; McDonald, Campbell and Lester, 2009). Although motivated by a perceived threat, Louise's attempts to re-professionalise and acquire additional skills could be construed as a simultaneous opportunity to strengthen her professional status and in her words, become more powerful. There are examples of this behaviour in the wider profession, such as the encroachment of physiotherapists into the medical field through obtaining rights to injection therapy in 1997 (CSP, 2018) and independent prescribing rights in 2013 (Millett, 2018). More recently, physiotherapists have capitalised on the increasing demand for GP appointments via First Contact Practitioners (FCPs) who are based in GP surgeries, assessing patients who present with musculoskeletal complaints (Goodwin and Hendrick, 2016; Moffatt, Goodwin and Hendrick, 2018).

Changing division of labour and restratification

With more of the senior therapists' time devoted to management and finance, a change in the division of labour and re-stratification within the intra-professional hierarchy followed. The reduced presence of these staff on the 'shop floor', shifted tasks normally carried out by senior members of the team, towards junior (qualified) members of staff; sequentially, tasks normally associated with junior physiotherapists were then delegated to therapy assistants (unqualified) staff members.

This inevitably impacts upon each group's skill acquisition, supervision, competence, experience and the overall nature of their day to day work. Jane spoke of ramifications for those less experienced or newly qualified junior physiotherapists, suggesting performing more specialised tasks may damage the confidence of those members of the profession.

This shift in division of labour is reflective of wider literature, where in response to organisational change, cost containment measures and restricted resources, tasks have been shifted towards assistants and support workers to free up qualified staff to undertake other tasks (Allen, 2001; Ellis and Connell, 2001; Hughes, 2002; Nancarrow and Borthwick, 2005). The allocation of less specialised tasks to assistants/support workers has been described as the transfer of 'dirty work' to lower status individuals (Allen, 2001; Hughes, 1958); subsequently relinquishing qualified staff to carry out more assessment of patients and delegation to other members of staff (Nancarrow, 2004; Nancarrow and Borthwick, 2005). In this study, this transfer of less specialised tasks to therapy assistants included simple mobility practices or treatment and administration related to the patient's hospital stay and therapy.

The shifting division of labour has been linked to Freidson's (1985) re-stratification thesis, whereby some members of the profession become further specialised into professional 'elites' (Alvehus, Eklund and Kastberg, 2019; Freidson, 1985; Waring and Bishop, 2013). These professional elites may acquire autonomy from their 'rank and file' counterparts, though their increased knowledge and power are suggested to be in the collective interest and advance of the profession overall (Alvehus, Eklund and Kastberg, 2019; Freidson, 1985; Waring and Bishop, 2013).

The findings of this study reflect the process of re-stratification within the profession via the development of knowledge elites (Louise) with a reorganisation of division of labour further down the intra-professional hierarchy (Jane and therapy assistants). This technique is a method of increasing and/or reclaiming power in relation to other professions and external influences and is suggestive of not necessarily increased control of the profession, but *by* the profession (Alvehus, Eklund and Kastberg, 2019).

There is a paucity of literature directly exploring austerity and the impact on healthcare professionalism. However, there have been observations of restratification as a method of response to New Public Management, corporatisation, consumerism and managerialism by physicians, nurses and podiatrists (Allen, 2001; Alvehus, Eklund and Kastberg, 2019; Carvalho, 2012; Carvalho, 2014; Dent, 2003; Freidson, 1985; Hughes, 2002; Nancarrow and Borthwick, 2005; Waring and Bishop, 2013); and is considered as part of the competitive jostling within the ecology of the professions (Abbott, 1988). In this study, active restratification was observed as a method to preserve the status of the physiotherapy profession when faced with austerity.

The profession in its traditional structure is being challenged by cheaper alternatives, the threat of decommissioning services and the management of austerity; this is explicitly acknowledged by the CSP, where fighting for the preservation of physiotherapy services is advised. In this study, restratification, development and utilisation of knowledge elites, labour substitution, changing division of labour and delegation were all methods of response.

The holistic impact of austerity

Coinciding with active attempts to preserve the profession and its services, were feelings of unrest and apprehension. Louise's emotive use of language is demonstrated in her extracts and her passion was evident. Whilst she felt in a position to react to the challenge austerity posed as a 'professional elite', her rank and file counterpart Jane, described feelings of distress, burnout and guilt. Jane described circumstances where colleagues had left the organisation and even the profession altogether, secondary to the increasing demands, stress and workload. Jane articulated the personal, professional and ethical conflict faced by therapists on a daily basis and the impact on wellbeing; outlining the requirement to emotionally mask (Hochschild, 1983; Wharton and Erickson, 1993) themselves to deliver (or at times, be unable to deliver) care in an austere environment. This provides an empirical example of the intra-professional hierarchy and the disparities between the professional elites and the rank and file members of the profession (Timmons, 2011; Field-Richards, 2017). Rank and file members may not desire to (or be able to) re-professionalise when faced with challenging conditions, where the focus on the frontline is to '*get the job done*' (Field-Richards, 2017, p.225). This recognition of hierarchy and power relations is reinforced and re-enacted through the changing division of labour as discussed.

Limitations

We acknowledge the small sample size and the inability to extrapolate these findings to the wider population of physiotherapists. The sample size was limited due to poor recruitment, reflecting the difficulties in exploring austere (and often understaffed) settings. The

recruitment window was restricted due to time constraints and it is acknowledged that a higher number of interviews may have provided a greater understanding of this phenomena. Furthermore, the participants both worked in an area which had been particularly affected by a recent change in health policy, which may have influenced their responses. Nonetheless, the study obtained some valuable in-depth insights into the reality of working on the frontline of physiotherapy; providing preliminary findings in a research area which is sparse, informing further study. This research has inspired the design of a larger study, aiming to explore these issues in greater depth. The planned study will consist of an organisational ethnography in a large NHS Trust in England. This study aims to complete approximately 150 hours of participant observation, interviews with 30-40 members of staff and document and artefact analysis. This study is currently undergoing the ethical review process and is expected to be complete by 2022.

Conclusion

Despite claims that austerity is coming to an end, it appeared to be a continued reality for clinicians working in the NHS in the UK. This paper has demonstrated how policy reform can be interpreted by clinicians, in this case physiotherapists, and how recent austerity measures have required them to amend their practice, care and professional jurisdiction. Participants demonstrated attempts to reconcile the challenges austerity has posed, such as re-professionalisation and the acquisition of skills to create professional or knowledge elites who worked to defend and preserve the profession. This method of defence had implications throughout the intra-professional hierarchy, resulting in restratification; junior physiotherapists acquired tasks from senior staff and junior staff subsequently delegated their tasks to therapy assistants. The increased pressure to meet targets with limited resources caused feelings of stress, burnout and guilt, with examples of poor retention within the profession as a result.

Examining the physiotherapy profession is of interest, as the sociology of professions literature is heavily embedded in archetypical professions, such as medicine. Although medicine has been inevitably affected by austerity, literature suggests that they have been able to exercise an element of power in their response to maintain their presence at the apex of the healthcare professional hierarchy and their critical place in the delivery of healthcare services. Other professions, such as nursing and the AHPs may not have access to the same resources in order to maintain their place in the healthcare market, where the threat of decommissioning and labour substitution is very real.

The study of this profession has provided an insight into the use of similar techniques to retain professional power (re-professionalisation, restratification, professional elites) as seen

in medicine, but with both successes and losses. Interestingly, the physiotherapy profession appears to be encroaching on professional boundaries in an attempt to compete with other professional groups. This has interesting implications for the inter-professional and inter-disciplinary boundaries, and it is recommended that this is an area for future research.

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