NHS REFORMS AND THE WORKING LIVES OF MIDWIVES AND PHYSIOTHERAPISTS

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by

Frank Wilkinson
CBR
University of Cambridge

Anna Bullock
CBR
University of Cambridge

Brendan Burchell
Faculty of Social and Political Sciences
University of Cambridge

Suzanne J. Konzelmann
Department of Management
Birkbeck College
University of London
Malet Street Bloomsbury,
London WC1E 7HX
Email: s.konzelmann@bbk.ac.uk
(corresponding author)

Roy Mankelow
CBR
University of Cambridge

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Abstract
From 2000 the NHS was subjected to a series of far reaching reforms, the purposes of which were to increase the role of the primary care sector in commissioning and providing services, promote healthier life styles, reduce health inequality, and improve service standards. These were seen as requiring a greater leadership role from health professionals, closer and more cooperative working between health professionals, and between health professionals, social services, and community and other service providers. The project surveyed a random sample of midwives and physiotherapists to investigate their perceptions of the effectiveness of the reforms, and their effects on working lives. The predominant perception was that NHS reforms had negatively affected the funding of their services; and had done little to improve service quality, delivery or organisation. Although the potential existed for the reforms to improve services, the necessary resources and required staffing were not made available and the objectives of the reforms were only partially secured by intensifying of work. The downside of this was a deterioration of the socio-psychological wellbeing of midwives and physiotherapists, especially the former, exacerbating the shortage of skilled and experienced. Shortage of staff and the associated increased work burdens were demoralising and demotivating; morale and job satisfaction declined, and job insecurity and labour turnover increased.

JEL Codes: J44, L84

Keywords: professional work, midwives, physiotherapists, Britain, public sector reforms, job satisfaction and morale

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1. Introduction

From 2000 the NHS has been subject to a series of far reaching reforms including: the NHS Plan; NHS Human Resource Strategy; National Institute for Clinical Effectiveness (NICE) Guidelines; Healthcare Commission's Regulation, Inspection and Standard Setting; Shifting the Balance of Power; National Service Frameworks; and Primary Care Trust (PCT) Commissioning. The expressed purpose of the reforms is to increase the role of the primary care sector in commissioning services, to shift many hospital services into primary care facilities, to promote healthier life styles, to reduce health inequality, and to end variations in the quality of care by improving standards of service and quality control (McBride et. al. 2005; Kirkpatrick and Hogue 2005). Meeting these objectives is seen as requiring a greater leadership role for health professionals, closer working relations and cooperation between health professionals, and partnership working between health professionals, social services, and community and other service providers (Korczynski 2002; McBride et. al. 2005). In addition the reform programme included developing all grades of staff to work more effectively and efficiently within their existing and new job roles. This was a key part of the expanding capacity element of reform aimed at workforce modernisation.

The reform programme has been supported by a significant increase in resources committed to the NHS, including an extra £5 billion for pay modernisation via the Agenda for Change agreement, and a significantly increased year-on-year investment until 2008. The aim of the project reported on here is to investigate the perception of midwives and physiotherapists with respect to the effectiveness of these reforms and how they have affected their working lives.

2. The Survey

The Royal College of Midwives and the Chartered Society of Physiotherapists each provided a random sample of 2500 of their UK members. These were surveyed in June 2005, and a single prompt was sent to non-respondents 2 weeks later. Useable returns were received from 1109 midwives and 1070 physiotherapists, response rates of 46% for both. Of the respondents, 112 physiotherapists and 2 midwives worked wholly outside the NHS, and were excluded from the analysis in this report.

The survey includes questions replicated from the Workplace Employment Relations Survey (WERS 2004), a large scale survey of workplace employment

relations undertaken jointly by the Department of Trade and Industry, Advisory Conciliation and Arbitration Service, the Economic and Social Research Council and the Policy Studies Institute. Fieldwork was conducted between February 2004 and April 2005 and covered 700,000 (37%) of all workplaces in Britain, and 22.5 million (91%) of employees in employment. The use of WERS questions allows comparisons between the midwives and physiotherapists included in the survey reported on here, and a large and representative sample of matching public and private sector employees. For this purpose, the Standard Occupational Classification (SOC) occupational groups Health Associate Professionals (SOC 321) and Therapists (SOC 322) have been selected and combined. The Health Associate Professionals group consists of: nurses, midwives, paramedics, medical radiographers, chiropodists, dispensing opticians, pharmaceutical dispensers, and medical and dental technicians; and the Therapists group is made up of: physiotherapists, occupational therapists, speech and language therapists and therapists not elsewhere classified. There are more than 1000 health associate professionals and therapists in the WERS, including 29 midwives and 31 physiotherapists. To prevent overlap, the midwives and physiotherapists have been excluded from the WERS data used for comparisons in this report.

3. Data analysis and presentation.

The respondents were asked about NHS reforms and their effects, using two (for example: yes, no) three (for example: detailed knowledge, some knowledge, no knowledge) and five (for example: much worse, worse, no change, better, much better) point scales. Tables showing the response frequencies are given in Appendix 1. For most of the tables in the text of this report, an *average* response has been used. This average is calculated by giving each point on the response scales (excluding don't knows) a score, weighting this by the number of responses at that point, calculating a weighted average of the scores and expressing this as a percentage of the highest score. For example, taking the five point scale from much worse to much better the scores are: much worse = -1, worse = -0.5, no change = 0, better = 0.5, and much better = 1. Using the above procedure, if the responses were normally distributed around *no change* the score would be 0. If a higher proportion of the respondents opted for *much worse* or *worse* the average score would be negative and if a higher proportion opted for *better* or *much better* it would be positive. The average scores would be -100 if all the responses were *much worse*, and +100 if all the responses were *much better.*

4. Impact of major policy changes in the NHS since 2000

This section considers: the knowledge the respondents had of the reforms their implementation, their importance for improving services; and the role of midwives and physiotherapists in implementing the reforms.

i. Knowledge of reforms

Table 1 indicates the average degree of knowledge the respondents had of various reforms to the NHS. They were most knowledgeable about NICE guidelines, especially the midwives. They also had some knowledge of National Service Frameworks, but there was less than this for the other reforms. Knowledge was especially sparse for Shifting the Balance of Power and the NHS HR Strategy.

Insights into the apparent ignorance of the reform process came from the responses to open questions. One midwife said that her knowledge was confined to that of NICE guidelines because this was relevant to practice and was sent directly to her via the RCM Midwives Journal. A second participant said that she was too busy to acquire detailed knowledge of reforms, whilst a third said that in her organisation information sharing had low priority.

Table 1. Knowledge of NHS reforms.

Average[1] knowledge of:	Midwives	Physios
Nice Guidelines	80	58
National Service Frameworks	52	61
NHS Plan	41	40
Primary Care Trust		35
Commissioning	32	
Healthcare Commission's Regulations, Inspection and Standard Setting	29	23
'Shifting the Balance of Power'	22	21
NHS HR Strategy	22	16

1. On a scale on which: 100 = detailed knowledge, 50 = some knowledge, 0 = no knowledge

ii. Implementation of reforms

The extent of the implementation of the various reform schemes is shown in Table 2. What is interesting about this table is the high number of midwives and physiotherapists who did not know whether or not the reforms had been implemented at their place of work. Apart from NICE Guidelines and the National Service Frameworks, more than 50% of the respondents did not know whether the reforms had been introduced, and for Shifting the Balance of Power and NHS HR Strategy this proportion rises to more than 70%. In fact, the proportion with detailed knowledge of each reform was much smaller than the proportion who said that the reform had been introduced at their place of work. For example, 90% of midwives reported that NICE guidelines had been introduced where they worked but only 62% had detailed knowledge of this key reform; for physiotherapists these proportions were 68% and 23% respectively.

Table 2. Implementing NHS reforms

Implementation at place of work:	Yes	No	Don't know
	%	%	%
Nice Guidelines			
Midwives	90.4	3.8	5.9
Physiotherapists	68.0	4.0	28.0
National Service Frameworks			
Midwives	50.2	7.3	42.5
Physiotherapists	68.1	4.7	27.2
NHS Plan			
Midwives	43.1	3.4	53.5
Physiotherapists	47.9	2.1	50.0
Primary Care Trust Commissioning			
Midwives	31.5	3.7	64.8
Physiotherapists	42.2	3.0	54.8
Healthcare Commission's Regulations, Inspection and Standard Setting			
Midwives	36.6	3.0	60.4
Physiotherapists	26.4	2.1	71.5
'Shifting the Balance of Power'			
Midwives	16.6	4.6	78.8
Physiotherapists	18.0	3.3	78.7
NHS HR Strategy			
Midwives	26.1	3.2	70.7
Physiotherapists	17.9	2.3	79.8

The midwives and physiotherapists were asked whether there had been no, some or a great deal of progress in implementing the purposes of NHS reforms, i.e. in: enhancing the role of the primary care sector; promoting healthier lifestyles, reducing health inequality, improving the quality of healthcare; and generating increased co-operation in the provision of healthcare. Again, significant minorities answered *don't know* when asked about the extent of progress. This was particularly so for the primary care sector's increasing role in commissioning and providing services, shifting the service provision from hospitals to primary care, and reducing health inequality. More midwives than physiotherapists had no knowledge of the changing role of the primary sector, although relatively fewer midwives were ignorant of the degree of progress in reducing health inequality (see Appendix 1, Table 3).

The average perceptions of the extent of progress in implementing the purposes of the reforms amongst those expressing a view are shown in Table 3. As the scores for each of the purposes in Table 3 are close to 50, the average perception was that there had been *some progress*. Physiotherapists reported more progress in implementation than did the midwives, except for promoting healthier life styles and reducing health inequality. In particular, the physiotherapists reported more progress in the increased role of the primary care sector in commissioning and providing care, and in the shifting of service provisions from hospitals to primary care.

Table 3. Progress in implementing the purposes of NHS reforms

Average[1] knowledge of implementation:	Midwives	Physios
Promoting healthier life styles	57	48
Improving the quality of care	55	56
Increased co-operation between health professions	52	55
Reducing health inequality	51	44
Partnership working between health professionals, social services and other service providers	50	53
Increased primary care sector's role in commissioning services	45	55
Shifting service provision from hospitals to primary care	47	56
Increased primary care sector's role in providing services	42	55

1. On a scale on which: 100 =a great deal of progress, 50 = some progress, 0 =No progress

Responses to open questions showed mixed receptions to reform. The underlying philosophy of the reforms was seen as excellent by one respondent, and others welcomed both the potential of reform to improve services and the emphasis on midwives as the lead professional. On the other hand, one midwife identified the excess of reforms and wide scope for interpretation as a source of incoherence and repetition.

Answers to open questions also revealed that midwives felt that implementation of reforms was impeded by a lack of training, excessive paperwork and meetings, the bureaucracy of the reform process and by staff shortages. They also found it difficult to manage the speed and frequency of change. Some had become cynical and had disengaged from what they perceived to be non-stop reforms, whilst others felt that they lacked information about reforms and were not involved in the reform process. Management's handling of change came in for particular criticism. Managers were criticised among other things for diverting funds intended for reforms, being ineffective at introducing reforms, failing to handle change, lacking the necessary clinical expertise and for failing to consider the effects on staff.

A small number of physiotherapists unreservedly welcomed the reforms. They commented that the reforms helped break down hierarchy in the NHS, gave a bench mark to work from, empowered primary sector carers and had started a revolution in effectiveness and performance management. The multi-disciplinary approach was singled out for praise by others. It was seen as ground breaking and very satisfying, and served to enhance inter-professional relations. More negatively, other physiotherapists thought the reforms had come too thick and fast to be kept up with, were unrealistic, unnecessary, removed from day to day practice, a waste of time and money and resulted in too much bureaucracy, paper work and box ticking.

Physiotherapists agreed with the midwives that resources and staffing were inadequate for the effective introduction of reforms, and that a stronger managerial lead was needed for their adequate implementation. Lacks of support from trusts, resistance to inter-professional working, and the managerial focus on targets were identified by physiotherapists as obstacles to effective reform implementation.

Both professions were critical of trust managements handling of the implementation of the Agenda for Change Agreement, the national negotiation of which had receive the overwhelming support of the midwives and physiotherapists as essential for the reform process.

iii. Importance of reforms for improving services

Table 4 gives the average perception of the improvement in NHS services of those respondents expressing a view (there was a large proportion of don't knows to this question, see Appendix 1, Table 4). Scores of around 50 in Table 4 show that on average, midwives and physiotherapists perceived that the reforms were of some importance in improving the services they provided. Both professions gave the highest improvement rating to the quality of care, with midwives rating this higher than the physiotherapists. Otherwise, differences between the midwives and physiotherapists concerning improvements in services reflect those for implementation shown in Table 3. In particular, midwives gave greater weight to improvement in the promotion of healthier lifestyles and reductions in health inequality and the physiotherapists gave more weight to the increased role of the primary care sector.

Table 4. Importance of NHS reforms in improving services.

Average[1] perceptions of improvements in:	Midwives	Physios
The quality of care	68	63
Promotion of healthier life styles	64	53
Co-operation between health professions	61	60
Partnership working between health professionals, social services and other service providers	60	59
Reduction in health inequality	60	48
Shifting service provision from hospitals to primary care	52	57
Increased primary care sector's role in commissioning services	47	51
Increased primary care sector's role in providing services	47	52

1. On a scale on which: 100 = Great importance, 50 = Some Importance, 0 = No Importance

iv. Role of midwives and physiotherapists in implementing NHS reforms

The midwives and physiotherapists were asked whether the enhanced roles for their professions were of no, some or a great deal of importance for implementing NHS reforms. Both professions were asked about the importance

of their enhanced role as lead professional; the increased skills and responsibility needed to work cooperatively with other professions; a greater strategic role in service development for higher grades in their profession; and the development of specialists roles with higher clinical and diagnostic expertise. The midwives were also asked about the importance of skills and responsibility to work autonomously. The averages in Table 5 suggest that both professions thought that their enhanced role was more than just of some importance. The midwives put most stress on increased skill and responsibility to work autonomously, and the physiotherapists on the development of specialist roles with higher clinical expertise and diagnostic skills. Both professions put emphasis on increased cooperation with other professionals, and the midwives ranked relatively highly an enhanced role in leading care. On the other hand, the midwives gave less importance to a greater strategic role in developing services for senior practitioners than did the physiotherapists.

Table 5. Importance of enhanced roles for midwives and physiotherapists for the implementation of NHS reforms.

Average[1] perception of the importance for implementing NHS reforms of:	Midwives	Physios
Increased skill and responsibility to work autonomously	71	nk
An enhanced role in leading care	70	64
Increased skills and responsibility to work in partnership with medical and other professionals	69	68
Development of specialist roles with higher clinical expertise and diagnostic skills	63	71
A greater strategic role in service development for leading practitioners.	58	65

1. On a scale on which: 100 = Great importance, 50 = Some Importance, 0 = No Importance

The respondents were in no doubt of the importance of their own and their profession's role in securing the success of NHS reforms (see Table 6). This extended to strengthening their profession by contributing to its body of knowledge, using that knowledge for high quality care, promotion of their profession's philosophy of care, and supporting fellow professionals in developing clinical practice, in education and in management. Members of professions believed strongly in their own and their profession's role in developing and using knowledge, in supporting fellow professionals in developing clinical practice and in education, and in promoting their profession's philosophy of care. Supporting fellow professionals in management was also seen as being of significant importance.

Table 6. Importance for the success of NHS reforms of contributions by midwives and physiotherapists to development of their profession.

Average[1] perception of importance to the success of NHS reforms of:	Midwives	Physios
Strengthening profession by contributing to its body of knowledge	91	91
Using that knowledge for high quality care	94	95
Supporting fellow professionals developing clinical practice	95	92
Promotion of profession's philosophy of care	92	86
Supporting fellow professionals in education	89	83
Supporting fellow professionals in management	84	81

1. On a scale on which: 100 = Great importance, 50 = Some Importance, 0 = No Importance

5. Impact of NHS reforms on professionals' work and service provision

i. Overall effects

The overall effects of NHS reforms on the professional services of midwives and physiotherapists are summarised in Table 7. This table analyses the impact of reforms on the way services are organised and funded, the ability of professionals to fulfil their role, the quality and effectiveness of their service delivery, and work intensity and satisfaction with professional roles. The physiotherapists reported that quality of service, effectiveness of service delivery and organisation had got a little better, service organisation and satisfaction with professional role was largely unchanged, and the adequacy of funding and intensity of work had deteriorated. The midwives ranked the effects in much the same way as the physiotherapists, but they were much more pessimistic about outcomes. They said that the reforms had had little or no effect on the quality, effectiveness of delivery and organisation of their service, or on their ability to fulfil their roles; and that satisfaction with their professional role, adequacy of funding and, especially, work intensity had got worse.

Table 7. Overall effect of NHS reforms on the professional services of midwives and physiotherapists

Average[1] effects of NHS reforms on:	Midwives	Physios
The quality of service you deliver	6	19
The effectiveness of your service delivery	6	16
The way your service is organised	0	14
Your ability to fulfil your role	-1	6
Your satisfaction with your professional role	-17	-5
Adequacy of funding of the your service	-32	-24
Intensity of your work	-45	-28

1. On a scale on which: much worse = -100, worse = -50, no change = 0, better = 50, much better = 100.

ii. Impact on work of reorganisation of service provision, of reorganisation of work and staff shortage.

The impact on the professional work of midwives and physiotherapists of the reorganisation of service provision and of work, and staff shortages is shown in Table 8. Staff shortages had quite a lot of impact, and although the impact of reorganisation of service provision and work had less, it was not much less. The changes had greater impact on midwifery than on physiotherapy.

Table 8. Impact of staff shortages and the reorganisation of service provision on work as professionals.

Average[1] impact of:	Midwives	Physios
Staff shortages	83	73
Reorganisation of service provision	67	57
Reorganisation of work	64	53

1. On a scale on which: none = 0, slight impact = 25, a fair amount of impact = 50, Quite a lot of impact = 75, a huge impact = 100.

iii. Impact of moving towards multi-professional working.

A central plank in the NHS reform process is the planned cultivation of closer working relations and cooperation between health professionals (Kendall and Lissauer 2003). The effects of this are explored in this section. The majority of both midwives and physiotherapists reported that there had been no change (65% and 53% respectively) although very few thought that closeness of working relations had been reduced. The closer co-operation between professionals had gone furthest with the physiotherapists and 45% reported that working relations with other professional had become more or much more close, compared with only 30% of midwives. (see Table 9, Appendix 1).

As measured by the average effect (see Table 9) increases in the closeness of working relationships had little effect on professional identity, job control or involvement in service delivery decision making. Apart from increased involvement in service delivery decision making, where the physiotherapists had a slight edge, there was little difference between the two professions.

Table 9. Effect of change in closeness of working relationship on professional identity, job control and involvement in decision making.

Average[1] effect of reforms on closeness of working relations:	Midwives	Physios
Professional indentity	7	10
Job control	4	4
Involvement in service delivery decision making	9	17

1. On a scale on which: much reduced = -100, reduced = -50, no change = 0, increased = 50 , much increased = 100

This conclusion also applies to the effect of these changes on relations with other occupational groups, working lives and patient/client care. Table 10 suggests that closer working relations have had a greater positive impact on inter-occupational relations, patient/client care and working lives for physiotherapists than for midwives, but even for physiotherapists, this improvement was small.

Table 10. Effects of changes in closeness of working relationships on relations with other occupational groups, working lives and patient care.

Average[1] effect of changes in closeness of working relationships on:	Midwives	Physios
Relations with other professions and non-professional staff	11	20
Patient/client care	8	23
Working lives	-7	8

1. On a scale on which: much worse = -100, worse = -50, no change = 0, better = 50 , much better = 10

Conclusions based on Table 9 and 10 can be explained either by the fact that the increasing closeness in inter-professional relations had had little or no effect, or that there had been an offsetting effect between the different tendencies in inter-professional relations, or some combination of both of these. Table 11 helps differentiate between these conflicting explanations by showing the distribution of improvements in the factors in Tables 9 and 10 based on whether inter-professional relationships had become more close, or whether there had been no change or a lessening of closeness in such relationships.

Table 11 shows that where inter-professional relationships had become closer, a much higher percentage reported improvements. This was especially so for patient care, relations with other staff and involvement in decision making. Perhaps surprisingly, professional identity improved for 60% of midwives and 47% of physiotherapists as a consequence of closer working relationships; and although closer inter-professional working had less influence on job control and working lives, a third or more of those respondents reporting closer relationships said that these had contributed to improvements in job control and working lives. A comparison between the two professions suggests that for physiotherapists closer inter-professional working has a more beneficial effect on patient care and working lives, and for midwives the greater benefits came from improved job control and professional identity. There was a large measure of agreement that closer working improved relationships with other staff and involvement in decision making. Importantly, Table 11 strongly suggests that in large measure the poor showing of the reforms can be attributed to the failure to achieve one of their major objectives: that of encouraging closer working relations between health, and with cognate, professionals.

Table 11 Effects of closer inter- professional relationships

	Working with other professionals have become:			
	Less close or no change		More close	
Improvements in:	Midwives %	Physios %	Midwives %	Physios %
Patient care	13	17	70	80
Relations with other staff	4	8	76	76
Involvement in decision making	13	13	63	68
Professional identity	5	7	60	47
Job control	7	6	48	32
Working lives	4	7	34	46

In their responses to open questions, a few midwives reported improved services and an increasing lead role for midwives. However, the general impression from their comments is that there had been little improvement in midwifery services as a result of the reforms. Midwives reported that a medicalised culture continues to predominate and that nothing seems to change despite all the reforms. Confusion over roles was also identified due to widening their responsibility to include child protection, mental health, diet and smoking, and increased fragmentation of care amongst health care professionals. A shortage of professional back-up was another complaint. Other midwifes identified staff shortages, extended working hours, and deteriorating working conditions as outcomes of reforms. Increasing litigation was also seen as hampering the increased autonomy midwives needed to effectively implement the objectives of reform.

Midwives were pessimistic about the impact of reforms on service delivery and the quality of care. They complained that bureaucracy in the NHS gave low priority to service users and that the priority given to women-centred care had been lost. Others reported that services were poor, standards were falling, hospitals were not clean and that they were unable to do their job effectively and worked in unsafe conditions.

A few physiotherapists identified successful outcomes from the reforms process. These included improvements in service, closer networking between specialisations and better HR practices. A larger number of physiotherapists reported that the reforms had not improved services and many thought that services had worsened. One respondent felt that joint working was not successful because the work of physiotherapists was not appreciated. Others identified the splitting of integrated teams to the disadvantage of specialist treatment as one of the adverse effects of shifting delivery to primary care.

For the physiotherapists expressing a view, reforms had not improved patient care; and for many, care had worsened because reforms wasted clinical time. In their opinion, patient care had failed to improve because of: increased expectations, training in circumstances where there was insufficient staff to provide cover, increased paper work, emphasis on hitting targets and increased managerial staff. New initiatives had also reduced choice, accessibility, and equity for patients; whilst increased throughput had lowered quality, and improvements in quality had been at the expense of quantity owing to staff shortages. The reduction in consultant waiting lists had increased physiotherapists' waiting times, which are not included in government targets due to lack of resources. Cutting waiting times had also led to early discharges from hospital, long journeys by patients for follow-up care, and increases in waiting time in out-patient departments. High quality clinical assessment and treatment has been reduced in the acute sector and cannot be provided in the community; whilst hospital based specialist teams (and specialisation) are not available in the primary sector. Disputes between the acute and community sector had also taken their toll on quality. One respondent said that although they were employed by acute care, their services were bought by the community care trust; and since the two cannot agree, both physiotherapists and patients suffer. In this sea of pessimism about the effects of reforms, there are some notes of optimism, for example, one respondent said that the 'blurring of professional boundaries (with multi-professional teams) has increased satisfaction and we are able to do more for patients'.

Answers to the open questions also linked inadequate service provision and staff shortages. These restricted responses to increased demand, led to reduced services and reduced quality of service, prevented midwives from becoming specialised and gave insufficient coverage for home deliveries. Paradoxically the shortage of midwives encouraged home births by guaranteeing a midwife, no doubt shifting the burden elsewhere. Pressure on midwives had also been exacerbated, especially on the night shift, by the reduction in the hours of junior doctors. Staff shortages were widely compensated for by work intensification.

Shortages of midwives meant that work pressure increased, staff worked excessive hours and during their meal breaks. But for some, the additional hours and effort were not financially rewarded. They complained that heavier work loads, responsibility and stress were not compensated for by increased pay, and others said that they worked overtime without extra pay.

Moreover, staffing shortfalls generated their own dynamics. Intensification of work due to staff shortages adversely affected recruitment and retention, further reducing staff numbers. The loss of experienced midwives added a further twist to the spiral of work intensification and worsening of services because fewer experienced staff were available to provide instruction, guidance and back up for an increased number of inexperienced new recruits.

Insufficient staffing and work intensification was also widely reported by physiotherapists. Staff shortages resulted from a shortage of money, budget cuts, and increasing workloads. Increasing work pressure was coming from NHS reforms because there was less staff and less staff time spent on clinical work ('too much paper work and too many meetings'), growing patient demands and their increased expectations, lengthening waiting times, inter-organisational working, too many targets and 'ridiculous' deadlines. As with the midwives, staffing shortage and work intensity added to difficulties in recruiting and retaining.

For the midwives, service performance was threatened by the shortages of funding and resources. They commented that, amongst other things, resources were inadequate for necessary equipment, extended professional roles, improvement in the quality of care, support staff, antenatal screening, clinical specialisation, breast feeding specialists and other pre- and post-natal services. Resource inadequacy also impacted on management by diverting their attention away from high quality provision to cutting back on services, redundancies and other *economies* to cope with stretched budgets and overspend.

Physiotherapists reported funding constraints on: training, equipment, reducing physiotherapy waiting lists, extra staffing, maintaining current services, implementing reforms, improving patient care, shifting to primary care, meeting expanding demand, recruitment, frontline services, replacing staff, retaining staff and seeing new patients.

6. Training

Education, training and continuing professional development are seen as essential for achieving the improved level, quality and flexibility of services expected of the NHS reforms (Morgan and Allington 2002; McBride et. al. 2005). Table 12 shows the levels of training received by the respondents in the 12 months prior to the survey. The respondents were asked how much training they had had (excluding health and safety training) either paid for or organised by their employer.

Less than 10% of the respondents had no off-the-job training organised or paid for by their employer and a similar proportion received 10 days or more. The highest proportions, 41% of midwives and 37% of physiotherapists, received 2 to 5 days of such training. More physiotherapists than midwives were trained for 5 days or more and fewer received less than 2 days, but these differences were small.

The training question replicated that in the WERS 2004 survey and Table 12 gives separately training for private sector and public sector health associate professionals and therapists. A comparison of the training received by midwives and physiotherapists with WERS public sector employees shows not dissimilar levels of training, except that a higher proportion of the WERS occupational groups received 10 days or more. By contrast, a larger proportion of the private sector WERS occupation received no training.

Table 12. Levels of training.

Length of training:	Midwives	Physios	Health associate professionals and therapists	
			Private	Public
	%	%	%	%
None	8.1	9.4	17.3	9.8
Less than 1 day	5.8	4.7	8.5	5.7
1 to less than 2 days	19.6	15.6	14.6	14.6
2 to less than 5 day	41.4	37.3	32.5	33.5
5 to less than 10 days	16.4	23.3	14.3	20.0
10 days or more	8.7	9.7	12.8	16.4

The midwives and physiotherapists were further asked about any formal on-the-job training they had received, any training necessary for their job or for advancing their career which they had organised and paid for themselves, and whether paid or non-paid time-off was given for the latter. Table 13 shows that fewer midwives than physiotherapists had on-the-job training: 69% of midwives had none or less than 2 days of this type of training compared with 49% physiotherapists, whilst 7% of the former and 24% of the latter were trained on-the-job for 5 days or more. Concerning training necessary for their jobs and careers they had organised and paid for themselves, 44% of midwives and 35% of physiotherapists had no such training, similar proportions had from 1 to 5 days, and 10% of midwives and 13% of physiotherapists provided for themselves education and training which lasted 5 days of more. Of the respondents providing their own education and training, 63% of physiotherapists and 36% of midwives were given time off, and this was paid for by 91% of the former and 80% of the latter.

Table 13. Formal on the job training and self-organised and financed training

	Formal-on-the job training *		Training organised and paid for by trainee*	
Length of training:	Midwives	Physio-therapist	Midwives	Physio-therapist
	%	%	%	%
None	20.1	16.9	44.2	35.2
Less than 1 day	22.3	12.3	7.3	8.0
1 to less than 2 days	26.4	20.1	18.9	18.0
2 to less than 5 day	23.7	26.3	19.3	25.5
5.to less than 10 days	5.2	14.6	4.3	7.2
10 days or more	2.3	9.6	5.9	6.1

Perceptions of the adequacy of the education and professional development received for the increased duties and additional responsibilities required by the NHS reforms are shown in Table 14. There is no significant difference between the two professions in the perceptions of training adequacy; on average, availability and access were just about adequate, and training quality was between just about adequate and adequate.

Table 14. Adequacy of training

Average[1] perception of adequacy of training	Midwives	Physios
Quality	25	25
Availability	7	4
Access	-3	1

1. On a scale on which: totally inadequate = -100, inadequate = -50, just about adequate = 0, adequate = 50 , more than adequate = 100

Thus, training received by the professionals we surveyed was in line with that received by comparable healthcare occupations elsewhere in the public sector, and more than that for similar occupations in the private sector. On average the midwives and physiotherapists felt that availability of and access to training was just about adequate, although the quality of training was perceived as better than this. However, these averages hide a wide range of experiences, and as Appendix Table 14 shows, 30% or more of the respondents found the availability and access to training less than adequate and around 15% had the same view of training quality. The reasons for these different experiences are suggested by responses to open questions.

For some of the midwives questioned, training provision was good; but for most of the respondents, it was not. In criticising compulsory training, midwives said that it was often a paper exercise and that it was not always relevant. Others said that training provision was unreliable, poorly organised and inadequate and that the quality was poor. One recommended better monitoring of training standards in order to secure high quality delivery. Access to training was also restricted for many of the midwife respondents, the most frequently cited reason for which was that staff shortages and work pressure made it difficult to attend training sessions. For some, training in their own time was difficult or

unacceptable for family or social reasons; for others, training needs were not being met because it was not available locally or not supported by managers.

A major determinant of effective training is support given by management. Some midwives found management supportive and their units generous with money and time. But more were dissatisfied. They found no support for training, no incentives to train, no training budget, no development training and inequity in training provision. Financial constraints were a major problem. It was reported by some that all study days, except those mandated, had been cancelled due to budget constraints; and others found that there were no resources or money for training (whether mandated or not). Lack of managerial support and budgetary considerations were reflected in severe limitations on time-off given and financial support; and for some neither were forthcoming. For midwives training in their own time, some were paid at least something, but others were neither paid nor given time-off. As a consequence, at least one midwife was discouraged from training because she could not afford it.

Turning to the physiotherapists, some reported that training was excellent, but others complained about the quality, availability and location of training. In-service training was also found to be of an insufficiently high quality because it was mainly in-house, and training for extended roles was unavailable. A further complaint was that orthopaedic surgeons were not familiar enough with physiotherapy roles to identify learning needs and provide training.

Major difficulties reported by the physiotherapists with respect to training were associated with funding and time off. For a few, however, these were not problems. Several said that they had excellent training with good education budgets and free training days; one reported regular in-service training, a £300 course allowance and 5 days study leave each year. Others said that they were either paid for all training or given time off in lieu for weekend training. Group training and training consortia were used to eke out limited budgets so that funding and study leave posed fewer problems. In other trusts, funding was partial: one paid 75% of the cost of training, one 50%, and one gave one day in lieu for a two day course. However, many physiotherapists reported that little or no funding was available for training; and for two this meant that courses had been cancelled. The number of trusts in which it was reported that funding had been improved was outnumbered by those where it had been cut.

Many of the physiotherapy courses were at the weekend, which raised problems for some, particularly those with families. Several trusts did not provide time off in lieu for such courses. A large number of respondents reported very little financial support for training, and for training carried out in their own time. Training was restricted for others by staff shortages and work pressure. Several respondents reported that they found that the timing of training made it difficult to undertake it, whilst others were unwilling to undertake training in their own time and at their own expense. One said that physiotherapists needed 'protected learning time' supported by the government and Chartered Society of Physiotherapy (CSP).

7. Meeting the challenge of, and getting the support and reward for extended professional role

It is to be expected that the success of the reforms depends on whether the support and incentives are appropriate and that the participants rise to the challenge (Department of Health 2000; McBride et. al. 2005). Table 15 provides information on the degree to which midwives and physiotherapists perceived that these conditions were in place in the case of the NHS reforms. Table 15 shows the confidence midwives and physiotherapists had in getting the support for, meeting the challenges of, and securing career prospects, professional status, pay and grading needed for extended professional roles required of them by NHS reforms. Again the midwives were more pessimistic than the physiotherapists, especially about their ability to meet the challenge of the new roles, and gaining improved career prospects and professional status.

Table 15. Confidence of midwives and physiotherapists in receiving the support, meeting the challenges and getting the rewards for the extended role required by NHS reforms.

Average[1] perceptions of levels confidence in:	Midwives	Physios
Level of support from colleague in same profession	35	43
Ability to meet the challenge of the new roles	10	24
Level of support from other professionals	6	10
Level of support from management	-8	5
Improved career prospects	-25	3
Improved professional status	-25	2
Pay and grading reflecting the requirements of new roles	-39	-36

1. On a scale on which: not at all confident = -100, not confident = -50, neither confident nor not confident = 0, confident = 50 and very confident = 100.

Table 15 shows that both professions had a degree of confidence in support from colleagues in the same profession, but much less in support from other professionals or managers. They had some, if not much, confidence that they could meet the challenge of the reforms. But the midwives had no confidence that their extended role would be recognised by improved career prospects and professional status; and the physiotherapists were confidence neutral in these respects. Both professions had, on average, no confidence at all that pay and grading would reflect the enhanced requirements of their new roles.

8. Relations with management, loyalty, satisfaction and morale.

i. Relations with managers

Table 16 summarises the responses to invitations to agree or disagree with statements about the quality of relations with management, and shows high levels of scepticism in the trustworthiness of management, their ability to understand their workers' views and to treat them fairly. Generally, when the midwives, physiotherapists and health associate professionals and therapists

(from WERS) are compared, each of the occupational groups had most confidence in management's encouragement of people to develop their skills and least in their reliance to keep their promises. It also shows: that midwives had less confidence in management than physiotherapists in each of the ways specified; that physiotherapists are fairly representative of health associate professionals and therapists in the confidence they have in management; and that private sector workers have more confidence in their managers than those in the public sector.

Table 16. Quality of relationships with management

	Midwives	Physios	Health Associate Professional and Therapists	
Average[1] levels of agreement that managers:			Private sector	Public sector
Encourage people to develop their skills	17	28	37	34
Treat employees fairly	-1	21	24	20
Deal with the employees honestly	-3	16	30	19
Understand about employees having to meet responsibilities outside work	-2	23	30	23
Are sincere in attempting to understand employees views	-7	12	27	17
Can be relied upon to keep their promises	-12	2	23	10

1. On a scale on which: strongly disagree = -100, disagree = -50, neither agree nor disagree = 0, agree = 50 , agree strongly = 100.

The paucity of trust in management reveals itself in responses to open questions. A widespread view amongst midwives was that the NHS is over-managed by managers who lack necessary clinical expertise and experience. They variously complained that they were undervalued, unsupported, bullied, and not consulted by managers. Both midwives and physiotherapists were highly critical of the way their trust and its managers implemented the Agenda for Change Agreement. Physiotherapists were also generally critical of both managers and the way their service was managed. They thought that managers were over paid, that management was top heavy and that managerial hierarchy hindered communication. They also experienced too many managerial initiatives and targets, and felt exploited by managers. Others were concerned with managerial capabilities. They found them lacking necessary medical competencies and managerial capabilities, unable to manage change, and unsupportive of their staff. The main target for criticism was trust managers and this was not confined to clinicians. One physiotherapist manager complained that the trust and NHS wasted money, inadequately audited and failed to support line managers.

ii. Loyalties

This lack of confidence in management no doubt helps explain the relative lack of loyalty midwives had for their line managers, employers and the organisations which use their services shown in Table 17. The main loyalties of the two professions were to their clients/patients followed closely by the teams they work with (colleagues, and the people who worked for them), themselves and their profession. Both professions had significantly less loyalty to the organisations which use their services, line managers and their employers. The only difference between the two professions of any significance was the lower levels of loyalty that midwives had towards their line managers.

Table 17. Average[1] loyalty

Loyalty for:	Midwives	Physios
My clients/patients	92	92
My colleagues	90	90
The people who work for me	89	90
Myself	85	85
My profession	84	81
Organisation which uses my services	64	63
My line manager	63	71
My employer	58	56

1. On a scale on which: none = 0, a little = 25, some = 50, a large amount = 75, and a very large amount = 100.

The greatest loyalty, accounting for around 55% in both professions, was to their clients/patients, followed by 18% who gave their greatest loyalty to their colleagues and 10% or so who gave it to themselves (see Table 18). Their profession was afforded greatest loyalty by 7% of midwives and 4% of physiotherapists. Only 1% had greatest loyalty to the organisation which used their service or their employers.

Table 18. Greatest Loyalty

Greatest loyalty to:	Midwives	Physios
	%	%
My clients/patients	58	58
My colleagues	18	18
Myself	13	10
My profession	7	4
My line manager	2	3
People who work for me	1	5
My employer	1	1
The organisations which uses my services	1	1

ii. Working life and patient care

The effect of NHS reforms on important aspects of the working lives of the midwives and physiotherapists are summarised in Table 19. The question offered the respondents a series of statements and asked them to indicate the extent of their agreement, on a five point scale ranging from strongly agree to strongly disagree. The statements can be divided into: 1. increased ease in carrying out work (ease in satisfying the needs of patients/clients, ease of doing the job, and increased feeling of control over work); 2. increased job requirements (increased skills and knowledge required, and increased work load) and 3. socio-psychological indicators of well-being (increased self-esteem, increased self-confidence, raised professional status, increased job satisfaction, increased morale and increased motivation).

Table 19 shows that NHS reforms have significantly increased workloads and added to the required skills and knowledge, but they made it no easier to meet client/patient needs. Moreover, NHS reforms had largely negative effects on the working lives of midwives and physiotherapists. This is particularly so for ease in doing the job, job satisfaction, self-esteem, motivation and morale, and especially so for the midwives.

Table 19. Effect of NHS reforms on working lives and patient care

Average[1] level of agreement that NHS reforms have:	Midwives	Physios
Increased work load	56	44
Increased skills and knowledge required	20	20
Raised professional status	-9	8
Made it easier to satisfy the needs of clients/patients	-11	-4
Increased self-confidence	-15	-5
Increased the feeling of control over their work	-16	-9
Made it easier to do job	-24	-16
Increased job satisfaction	-26	-12
Increased self-esteem	-29	-10
Increased motivation	-29	-14
Increased morale	-41	-24

1. On a scale on which: strongly disagree = -100, disagree = -50, neither agree nor disagree = 0, agree = 50 , agree strongly =100

iii. Work intensity and job insecurity

In view of the increased workload identified above, it is not surprising to find that the work of midwives and physiotherapists had intensified. Table 20 explores the pace of work, the sufficiency of time given to complete work and job security; and gives comparable data from WERS. On average, the midwives and physiotherapists agreed much more strongly than their public and private sector comparators from the WERS survey that they had to work hard and, particularly that they had insufficient time to get their work done. Table 20 also suggests that physiotherapists and the WERS health associate professionals and therapists felt somewhat more secure in their jobs than did the midwives.

Table 20. Work intensity and job security

			Health Associate Professional and Therapists	
Average[1] level of agreement that my job:	Midwives	Physios	Private sector	Public sector
Requires me to work very hard	78	71	56	59
Seems to give me insufficient time to get my work done	57	58	14	27
Is secure in this place:	26	39	41	38

1. On a scale on which: strongly disagree = -100, disagree = -50, neither agree nor disagree = 0, agree = 50 , agree strongly = 100.

iv. Job satisfaction and morale

How satisfied the respondents were with various aspects of their jobs is explored in Table 21, which compares the midwives, physiotherapists and health associate professionals and therapists from WERS. From this, four general points can be made. Firstly, the satisfaction ranking is fairly standard across the occupational groups. For each of the groups, average levels of satisfaction were highest for the sense of achievement from work, the scope for using initiative in the job and the job itself. Then, satisfaction declines from job

security, amount of influence over the job, training received, and involvement in decision making until each of the occupational groups are dissatisfied with pay. Secondly, on every count the midwives were more dissatisfied than the physiotherapists – noticeably so on all job aspects in Table 21 except training and pay. Thirdly, the job satisfactions were very similar for the physiotherapists and the public sector health associate professionals and therapists, except that the physiotherapists were much less satisfied with their training. Fourthly, the public sector health associate professionals and therapists were generally less satisfied than their private sector counterparts, especially with the amount of influence over the job and, perhaps surprisingly, with training received.

Table 21. Job satisfaction

Average[1] satisfaction with:	Midwives	Physios	Health Associate Professional and Therapists	
			Private sector	*Public sector*
The sense of achievement from work	34	43	52	45
The scope for using initiative in job	34	46	50	46
The job itself	30	38	50	46
Job security	23	38	36	33
Amount of influence over job	11	23	38	28
Training received	6	7	32	23
Involvement in decision making	4	11	18	10
Amount of pay received	-21	-17	-5	-8

1. On a scale on which: very dissatisfied = -100, dissatisfied = -50, neither satisfied nor dissatisfied = 0, satisfied = 50, very satisfied =100

The level of morale in midwifery and physiotherapy is indicated by Table 22. The question asked had two parts. The midwives were asked firstly about their own morale as a professional, and secondly about the morale of people in their profession in general. The answers summarised in Table 22 show that on average the morale of the respondents was neither low nor high. But, their perception was that morale in the profession was lower than their own, especially in midwifery where it bordered on low.

Table 22. Morale of Midwives and Physiotherapists

Morale:	Midwives	Physios
Of individual professional	-5	2
Within the profession	-42	-15

1. On a scale on which: very low = -100, low = -50, neither low nor high= 0, high = 50, very high = 100.

The responses to open questions give the reasons for the decline in socio-psychological well-being amongst midwives as a failure to deliver high quality services. Shortage of staff and the burdens associated with it were also demoralising and demotivating. As a result morale and job satisfaction were low, insecurity was high, midwives felt undervalued, unhappy and as a result were leaving the NHS. One summed-up: 'We care for our clients – why does no one care for us'. By contrast, others (very much the minority) were happier with their lot: 'Most midwives in this unit are very pro-active in introducing complementary therapies, aquanatal teaching sessions and anything that might improve client care'.

Reasons for the decline in the socio-psychological sense of well-being amongst physiotherapists included staff shortage and low funding which meant they were unable to deliver quality of care and meet patients' expectations; dirty wards and the risk of MRSA; exploitation by managers and growing workloads. Other factors depressing morale and job satisfaction included: fear of litigation; poor information and lack of power; the threat of changes to the pension scheme; abusive patients and their relatives; no possibility of advancements or chance to specialise; over management and too much bureaucracy; the pace of reform and change; low pay; being unsupported and undervalued.

9. Conclusions

The NHS reforms introduced since 2000 have had a mixed reception from the midwives and physiotherapists. The average view was that NHS reforms have not been successful and they have done little if anything to improve the quality of service, the effectiveness of service delivery or its organisation. The midwives and physiotherapists we interviewed attributed the failure to achieve many of the objectives of the reforms to the sheer volume of change, its bureaucratic and time consuming nature, the poor quality and reliability of management and the shortage of resources and staff.

The reforms increased the knowledge and skills required by midwives and physiotherapists and significantly added to their work loads; but made no difference to their ability to fulfil their professional roles or to satisfy the needs of patients. Poor implementation of the reforms also made it less easy to do the job and had a detrimental effect on job satisfaction, self-esteem, motivation and morale. The main reasons for this was not the objectives of the reforms which both midwives and physiotherapists supported but lack of support and funding, lack of communication and inter-professional working.

Moreover, whilst the respondents had some confidence that they would receive the support they needed from the members of their own profession, they were much less sure of the necessary level of support from other professions or their managers. They also doubted whether career prospects, professional status, and especially pay, would reflect the increasing demands made upon them.

It has to be said that the averages used in this final report disguise a range of experiences. For more of both professions, satisfaction with professional roles had got worse than had got better; and this was especially so for the adequacy of funding and work intensity. Very few of either profession reported that adequacy of funding and intensity of work had got better.

The findings of this study suggest that the potential exists for the reforms to improve services, but the necessary resources, and especially staffing levels, were not forthcoming. In these circumstances, the objectives of the reforms were partially secured by an intensification of work, which served to prevent deterioration in some, although by no means all, areas of service provision. The downside of intensified work was deterioration in the socio-psychological wellbeing of the professional workers.

Our findings lay stress on the detrimental effect on the service and well-being of midwives and physiotherapists caused by staff shortages. In particular, the perception of many of interviewees was that the shortage of skilled and experienced professional workers exacerbated, and was exacerbated by, the problems caused by the reforms. Pressure on professional workers drained the commitment of many of them to the NHS, and they became increasingly difficult to retain and recruit. This triggered a vicious cycle of a decline in the numbers of professional workers, especially experienced workers, which intensified work pressure and made retention and recruitment more and more difficult.

Overall, there was a large measure of agreement between the midwives and physiotherapists on the progress of implementing the NHS reforms, the importance of NHS reforms for improving services, and the importance for the success of NHS of the enhanced role of professional workers, of developing their professions and of greater inter-professional cooperation. They also largely agreed about the adequacy of training, where their loyalties lay, the extent of work intensification and their own morale. Nevertheless, the midwives were significantly more negative than the physiotherapists about the overall effects of NHS reforms, the impact of staff shortages, the chances of receiving the support for, meeting the challenges of and getting the rewards for their enhanced role, the reliability of management, the effects of NHS reforms on their working lives and on patient care, job satisfaction and morale within the profession.

Comparing the midwives and the physiotherapists with the public sector health associate professionals and therapists reveals a broad measure of agreement between the physiotherapists and the WERS public sector health workers on the quality of relations with managers and job satisfaction. However, the WERS public sector workers perceived their work to be less intensive than both the midwives and the physiotherapists, and their jobs being more secure than those of midwives.

Summing-up, the comparisons above suggest that there is a sectoral effect, which is negative for the public sector, and an occupational effect, which is negative for the midwives for many aspects of their work. Why the midwives should perceive their work lives to be more adversely affected than the physiotherapists, when they have similar views about many aspects of the progress of the reforms and their overall effects, needs further investigation.

It seems appropriate to give the last words to the survey participants who gave not an insignificant amount of their time to filling in the questionnaires. For this

purpose, the comments of three midwives and three physiotherapists to open questions have been reproduced. They were chosen from the very large number of comments made as representing common themes, both positive and negative. The comments of a midwife and a physiotherapist with managerial responsibilities have also been included.

ii. Selected comments of participants

Midwife questionnaire No.3017

Training sessions are available but unable to attend them due to staff shortages. Would only be able to attend in 'own time' which is unacceptable if working 4-5days a week. Find therefore not updated with new trends when implemented

In the unit I work at there are several problems. Our managers do not care for midwives as people. There is no kindness or consideration. Meeting held to give ideas for progress result in no action taken.

Too many chiefs is a major problem – midwives in specialist roles not available for client care within their own field.

Home delivery service not able to cover 2 midwives each night, "bullied" into covering and even when on days off.

We care for our clients deeply – why does no one care for us.

Midwife questionnaire No.1594.

I am a Modern Matron who clearly had a vision for the role, a chance to be a professional lead. Slightly disillusioned that this role has struggled to develop.

Women, acute trusts, PCTs and midwives want and expect a gold service. The resources are just not forthcoming, it is disheartening to see newly qualified midwives leaving within 1 year, despite the best efforts of colleagues to support them

*Physiotherapist questionnaire No.*2040

Too many – nobody is able to follow this many initiatives! The main objective becomes through-put of patients and the staff stop caring about the patients actually getting better….The system has become too management heavy. There

are far too many ‘initiatives’. The waiting lists continue to be unfairly distributed. The staff are at the lowest morale I have ever seen. The management appears to have no idea how to cope so constantly pass the buck to the lower ranks….. Good staff are leaving. There has been no improvement in the service.

Physiotherapist questionnaire No.0576

As a physiotherapy clinical manager with a huge increase in the volume of referrals and with no support from my commissioners I have found my employers have been slow to recognise the need to commission the service. To enable myself and my team to cope with the pressure I have had to develop skills to deal with frustrated, angry, patients. I feel the trust and NHS waste money/do not audit adequately/and do not support clinical line managers like myself who care passionately about our patients and staff. I shall be glad to retire from management (my team keeps me going) but not from physiotherapy as I love my clinical work.

Physiotherapist questionnaire No.1983

The shift to primary care has enabled the community physio’s to work more closely with their hospital based colleagues. The specialists who cut across the two areas enable multi-disciplinary working which must be good for patient care (before the changes the community staff were rather looked down on by some people).

Community physios seem to have a higher profile than they used to. Communication between acute and community based services have also improved and it is not frowned on to encourage health promotion. In the acute sector staff retention seems difficult. The through-put of patients has dramatically increased.

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