Core concepts of a multiple-perspective conceptual framework for advancing occupational health physiotherapy practice

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Introduction

Occupational health physiotherapy is an evolving clinical speciality which requires advanced clinical practice skills and organisational knowledge. There is a dearth of studies in the literature addressing frameworks for occupational health physiotherapy practice. In response, the Association of Chartered Physiotherapists in Occupational Health and Ergonomics (ACPOHE) developed an Occupational Health Framework for Physiotherapists, however, the development of this framework was limited to the expert opinions of physiotherapists. A doctoral study was, therefore, undertaken to explore the role of occupational health physiotherapy from the perspectives of stakeholders outside the physiotherapy profession in order to develop a multiple-perspective conceptual framework. The aim of this paper is to present a discussion on the core concepts emerging from the conceptual framework. Furthermore, an overview of the legal and policy framework that underpins occupational health physiotherapy practice, the process to develop the framework and the use of the framework in practice is presented.

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Background and context

Historically, there has been a divide between mainstream healthcare and occupational health (Department of Work and Pensions, 2008). In the UK, the government began to take an interest in occupational health around 2006/7 during the Blair/Brown Labour era when Lord Darzi was commissioned to review the NHS and its workforce. This led to the High Quality Workforce report which advocated for a workforce that reflected the needs of the patients (Department of Health, 2008). Also in 2008, the Dame Carol Black (2008) report was published which focussed on Britain's working age population. The Black report was the first report to advocate for a complete restructuring of occupational health services to ensure that it was fit for the future workforce (Black, 2008).

In 2009, the Boorman's report, which was commissioned by the Department of Health to review the health and wellbeing of the NHS workforce, was published. The Boorman's (2009) report took Black's (2008) recommendations and applied it to the NHS workforce. Boorman's (2009) report recommended that organisations should provide health and wellbeing training to all managers and provide early interventions for musculoskeletal and common mental health problems, for which access to physiotherapy and cognitive behavioural therapy were listed as the preferred interventions. In response to this recognition, the Association of Chartered Physiotherapists in Occupational Health and Ergonomics (ACPOHE) developed an Occupational Health Framework for Physiotherapists (ACPOHE, 2012). This framework documented the role of occupational health physiotherapists as autonomous practitioners with professional knowledge and skills, together with skills for interaction and decision making and problems solving to assess the health and wellbeing needs of the workforce in order to deliver personalised interventions that maximise an employee's performance at work (ACPOHE, 2012). In addition, this framework highlighted the complex relationship between occupational health physiotherapists, the employee, the employer and other members of the occupational health team, yet the development of the framework was limited to the expert opinions of physiotherapists (ACPOHE, 2012). In March 2013, an audit conducted by the Chartered Society of Physiotherapy (CSP) on workplace health and wellbeing services for NHS staff found that NHS Trusts had not fully implemented, and in some cases had not even attempted to implement, Boorman's recommendations (CSP, 2013).

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Existing evidence has seen the role of occupational health physiotherapy being limited to clinical (that is, assessment, treatment, generic health outcomes, return to work questionnaires, workplace assessments) and cost-effectiveness analysis (that is, cost/QALY) of managing a musculoskeletal caseload and no researcher have attempted to explore the role of physiotherapy in occupational health from the perspectives of different stakeholders.

Legal and policy framework

ACPOHE is a Professional Network of the CSP and was founded in 1947 to provide a supportive network for physiotherapists working in occupational health and ergonomics (ACPOHE, 2013). According to ACPOHE, occupational health physiotherapy is an evolving clinical speciality which requires advanced clinical practice and organisational knowledge of a senior, experienced clinician (ACPOHE, 2013). However, occupational health physiotherapy has not yet been recognised as a bona-fide clinical speciality by the WCPT and is often grouped with either musculoskeletal physiotherapy or community physiotherapy (Johnson, 2013).

Attempts have been made by ACPOHE to promote occupational health physiotherapy as a specialist field of clinical practice. In 2010, ACPOHE introduced a registered membership scheme in which physiotherapists could gain recognition as an advanced member (ACPOHE, 2010). There are currently three routes to becoming an ACPOHE registered member, namely, an educational achievement route in which members must complete a certificate, diploma or masters level course that develops knowledge and skills in the work and health fields; a short course and case study route in which members must complete four ACPOHE courses and submit a case study; and an in-depth case study assignment route in which members must submit two in-depth case studies (ACPOHE, 2010). In the UK, there are no Master level occupational health courses specifically for physiotherapists and physiotherapists wishing to gain higher education in this speciality are required to take related courses, for example, the Master of Public Health, Master of Ergonomics or Master of Occupational Health and Safety Management (ACPOHE, 2010).

In 2012, the development of the Occupational Health Framework for Physiotherapists by ACPOHE was seen a landmark direction for occupational health physiotherapy specialisation (ACPOHE, 2012). This framework contained specific information about the behaviours,

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knowledge and skills which are considered integral to the role of occupational health physiotherapists, namely: (a) values; (b) knowledge and understanding of occupational health; (c) practice skills; (d) generic behaviours, knowledge and skills for interacting; (e) generic behaviours, knowledge and skills for problem solving and decision making (ACPOHE, 2012).

In 2012, the recognition of the specialist role of occupational health physiotherapists was acknowledged by the CSP, in conjunction with the College of Occupational Therapy and Society of Chiropodists and Podiatrists, with the launch of the 'Allied Health Professions (AHPs) Advisory for Work' report. This report is an assessment form that allows AHPs to make recommendations to support ill or injured employees back to work earlier or prevent them from going off sick in the first place. It was designed to complement the existing 'Statement of Fitness to Work' form which General Practitioners (GPs) use to determine whether patients can remain in work or need to be signed off (ACPOHE, 2012). However, even though the AHP advisory report can be used by all registered physiotherapists, a study by Gray and Howe (2013), which assessed the beliefs and skills of outpatient physiotherapists related to their management of bio-psychosocial and workplace factors among clients with back pain, found that while most outpatient physiotherapists supported the bio-psychosocial approach, they failed to manage risk factors in the workplace believing that these issues were outside the scope of their professional role. The authors concluded that outpatient physiotherapists were not confident to tackle workplace risk factors in order to aid in the prevention of disability, and that further professional training in the form of occupational health knowledge and practice is required of outpatient physiotherapists as part of their professional development (Gray and Howe, 2013).

From a medico-legal perspective, in 2009 the General Medical Council (GMC) published new guidance on confidentiality, which took effect in April 2010 (GMC supplementary guidance, 2009). In this new guidance, doctors providing a report about an employee to the employer should offer to show the report to the employee or give them a copy before it is sent to the employer (GMC supplementary guidance, 2009). Exceptions include cases where the employee indicates that they do not wish to see the report or if disclosure would cause harm to a third party or if disclosure would reveal information about another person who did not

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give consent (GMC supplementary guidance, 2009). In 2017, the GMC guidance on confidentiality was updated, however, no changes were made to the section on doctors providing a report about an employee to the employer (GMC, 2017). As yet, there is no guidance on confidentiality and consent from the HCPC specifically for physiotherapists working in occupational health who are required to write reports about an employee to the employer. However, the ACPOHE advises that physiotherapists working in occupational health should comply with the GMC guidance (ACPOHE, 2010).

Process of developing the conceptual framework

A qualitative framework underpinned by an interpretative construct was used. The qualitative framework permitted for an exploration of the perceptions of three different stakeholder groups (namely, occupational health clinicians, workforce managers and clients) about the role of physiotherapists working in occupational health departments at a rich and in-depth level. The interpretative construct provided guidance about how the different stakeholders made meaning of the role of occupational health physiotherapy in the context of their natural setting (i.e. the occupational health department). This study used a case study design and was managed according to the principles of case study research. It is considered a robust research approach, particularly when a rich, in-depth appreciation of an issue, event or phenomenon of interest is required (Yin, 2009). From these viewpoints, the central tenet of case study research is the need to explore a phenomenon in-depth and within its natural context. For this project, I used of a multiple case study approach using two occupational health departments situated within different NHS hospitals.

Ethical approval was granted from Middlesex University Health and Social Care Ethics sub-committee. The sampling process was guided by previous qualitative studies to allow for the selection of only those participants that were considered valuable to the study (Bernard, 2002). Fourteen occupational health clinicians, five workforce managers, and nine clients were interviewed using semi-structured interviews across two NHS hospitals. Occupational health clinicians and workforce managers were recruited in the capacity of their professional roles and therefore there could be no substitution for those that chose not to take part or dropped-out. Clients were excluded if they were currently taking formal action or were being formally investigated by the NHS hospital, whose treatment had medico-legal implications,

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and could not adequately understand written and verbal information in English. Participants were excluded if they were unwilling or unable, for any reason, to give their written consent.

Permission to conduct the study was obtained from both senior management and Clinical Governance department at each NHS hospital. The researcher approached each participant individually about recruitment to the study, rather than via senior management, in order to ensure that there were no power relationships influencing the recruitment process that could be perceived as coercion and to uphold the principles of voluntary participation. Each participant was interviewed in a confidential area onsite. Written consent was provided prior to the interview being conducted and interviews were audiotape recorded to permit data analysis at a later point. A flexible, semi-structured interview schedule was used to allow for fundamental lines of enquiry to be pursued with each participant, but flexible enough to allow participants to freely expand on questions, in order to encourage a spontaneous, free-flowing adaptable dialogue (Patton, 2002).

Interviewers were transcribed independently by the researcher and then checked by another researcher who was not involved in the study to ensure accuracy. Any differences in transcription were discussed until a consensus was reached. Data were analysed using the framework analysis technique which emphasised transparency in data analysis and links between the stages of the analysis (Ritchie and Spencer, 1994). Research trustworthiness was established through (a) triangulation of data sources, (b) member checking whereby participants reviewed their interview transcripts, (c) an audit trail to show the process of the emergence of the data, and (d) external peer debriefing sessions to ensure that the researcher reflected on the views of the participants, rather than their own preferences (Shenton, 2004).

Core concepts

This section provides a discussion on the three core concepts about the role of occupational health physiotherapy, namely: (a) risk work, (b) professional identity, and (c) coaching, which emerged from the study (See Figure 1).

Risk work

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Translating risk information into difference contexts for different audiences was central to risk work and reported by all stakeholder groups. Furthermore, risk information must be converted into auditable data for use within the organisation (Gale *et al* 2016). This is consistent with the projects' findings in which stakeholders perceived occupational health physiotherapists as an agent to both the organisational and client. In this context, the occupational health physiotherapist is required to play a dual role by not only identifying the risks involved in a particular case but also linking this information back to the organisation. Flynn (2002) highlighted the issue of epistemological uncertainty for which the health professional must draw on other forms of knowledge about risk in the translation process. In this regard, a variety of terms have been used in the literature, such as tacit knowledge; broad, practical experiences; intuitive expertise and embodied knowledge (Gale *et al* 2016). In the context of the role of occupational health physiotherapy this would imply that the knowledge and skills for problem solving and decision making in risk work would not only require an evidenced-based approach, as reported in the projects' findings, but other forms of knowledge gained through a broad range of experiences and learning.

Minimising risk in practice involves supporting behavioural changes in clients and organisations, healthcare interventions, or developing new policies or procedures (Gale *et al* 2016). The projects' findings, ACPOHE (2012) framework and literature largely support the role of occupational health physiotherapists in minimising risk and maximising safety. Crucially, however, when non health-related risks are at play, such as poor management practices, it is unclear from the ACPOHE (2012) framework and the literature to what extent occupational health physiotherapists have a role of responsibility in mitigating the organisational elements of risk work. With regards to the projects' findings, on one end of the spectrum the occupational health physiotherapist is an agent to the client and responsible for minimising risk through functional capacity evaluations, job demand analysis, work-specific rehabilitation and support for injuries at work. At the other end of the spectrum, the organisation is accountable for any negative impact their practices may have on their employees, and the occupational health physiotherapist as an agent to the organisation is tasked with the responsibility, at least in part, in supporting the organisation deal with their negative practices, such as imposing political or religious views in policy making decisions, bullying and harassment behaviours, or the misinterpretation of health and safety legislation.

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Caring in the context of risk involves supporting clients make informed choices, or preventing undue harm after receiving risk information (Gale *et al* 2016). Providing care for clients can sometimes be hard to reconcile with the organisational aspects of risk work. In other words, there is accountability for occupational health physiotherapists to gather and transfer risk information to the organisation. This accountability to the organisation may threaten the physiotherapist-client trust relationship if clients perceive their department is being 'reported' to the organisation for their risk behaviours. In this regard, the projects' findings indicate that occupational health physiotherapists must maintain an impartial approach. A fundamental challenge, therefore, for occupational health physiotherapists is negotiating with both clients and the organisation about what is 'normal' and 'at risk' behaviours, to demonstrate not only their commitment to risk minimisation, but to do it in a way that is not perceived as 'taking sides' with the organisation and vice-versa.

Professional identity

To date no studies have been published specifically on the professional identity of an occupational health physiotherapist. The traditional interpretation by the physiotherapy profession has been the notion that identity is something that is acquired by novices in the early stages of their training (Davies *et al.,* 2011). The search for professional identity of physiotherapists has been a consistent focus of attention among researchers over the last decade (Roskell, 2013). This effort has led to the notion of physiotherapists engaging in identity work as they seek strategies to enact their professional identity in the workplace (Hammond *et al.,* 2016).

Professional identity in physiotherapy appears to be more complex than traditionally thought. According to Hammond *et al.* (2016) the construction of professional identity by physiotherapists is an ongoing and dynamic process in which physiotherapists make sense and interpret their professional identity based on evolving attributes, beliefs, values and motives. Furthermore, Hammond *et al.* (2016) stated that physiotherapists co-construct their identity of being a physiotherapist within intra-professional and inter-professional communities of practice. The latter is significant because it implies that the professional identity of a physiotherapists' role, image and practice is informed not only by the profession,

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but also by stakeholders outside the profession, and thereby mediated by workplace discourses, boundaries and hierarchies.

In the UK the healthcare system is changing with a national focus on efficiency savings and there is increasing expectations for physiotherapists to articulate their role responsibly and transparently within a clinical governance framework in order to demonstrate the value and contributions of the physiotherapy profession (CSP, 2011). Furthermore, there are societal changes with the integration of different cultures, ethnic backgrounds and religious beliefs and this provides research opportunities for the physiotherapy profession to gain insights on its role through gender and ethnic diversity. In this project the two NHS hospitals were strategically chosen to ensure that each served a very different population. Hospital A (Case 1) is situated in an affluent area serving a largely homogenous population. Hospital B (Case 2), on the other hand, serves a more culturally diverse population and is situated in a relatively deprived area. This strategy promoted the recruitment of a diverse range of participants in order to reflect societal changes and to authentically represent the current NHS healthcare system.

It is remarkable, however, that no participant made reference to the role of occupational health physiotherapists in promoting the equality, diversity and inclusion agenda. One possible explanation for this omission is that participants may have felt that this agenda is beyond the scope of one professional group. In a country of increasing ethnic, cultural and religious beliefs, a profession that can understand, accommodate and assimilate the perspectives of stakeholders from different backgrounds will be in a position to better serve. Greater ethnic, gender and religious consciousness within the physiotherapy profession will help promote its professional identity.

Coaching

The past decade has seen greater acceptance of coaching as a method of enhancing workplace competence (Ladyshewsky, 2006). Those that have participated in this learning experience often report positive outcomes (Ladyshewsky, 2006). In this project, a new component to the role of occupational health physiotherapy was coaching employees to learn new techniques or adapting current practices to support those with disabilities. It would be

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naïve, however, to assume that every coaching experience is a success. One challenge that can develop in a coaching role is competition and the consequence is disengagement between the coach and learner (Thorne, 2001).

This begs the question as to whether occupational health physiotherapists are adequately prepared for the role of coaching because, as pointed out earlier, putting two people together and asking one to coach the other is not guaranteed to succeed. Sue-Chan and Latham (2004) highlighted that failure to understand the drivers that promote cooperative behaviour is often the reason why so many well-intended coaching programmes fail. According to Ragins *et al* (2000) coaching relationships is first and foremost a social relationship and one that must be managed appropriately. Ragins *et al.* (2000) further stated that once trust is established and coaches acquire the requisite skills to coach and communicate appropriately, only then can the journey be successful for both parties.

The skills required for undertaking a coaching role are numerous. Coaches need to understand basic group processes such as leadership, conflict management and decision making (Bolch, 2001). Furthermore, attributes such as self-assessment, interpersonal skills, communication skills, ability to give and receive constructive feedback, problems solving, critical thinking, professionalism and stress management also needs to be developed (Bolch, 2001). There are no studies focussing specifically on occupational health physiotherapists fulfilling the duties of a coach as part of their role. A recent randomised controlled study, however, on the additional effects of a work-related psychosocial coaching intervention compared to physiotherapy alone, found that the group that received the coaching intervention exhibited a significant improvement of work ability in reference to the physical working demands and work-related wellbeing, which was increased further in the 12 weeks after the intervention (Becker *et al.,* 2017). The results suggest that work-related coaching, beyond physiotherapy, can support the improvement of work ability and work-related wellbeing. While the role of a coach was traditionally undertaken by coaching psychologists (Frisch, 2001), there is no reason why occupational health physiotherapists cannot develop and become competent job coaches.

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One aspect of coaching that may be applicable to occupational health physiotherapists involve developing the knowledge and skills of other employees that relates to their specific competencies (Ciampa, 2005). As such, occupational health physiotherapists will need to clearly outline which features of the employee's job they are competent to coach, potentially even necessitating upgrading their skills or receiving formal coaching qualifications to ensure that they understand and uphold the levels of professionalism, standards and ethics required to be a coach (Renton, 2009).

The conceptual framework and its implications and use in professional practice

The conceptual framework for occupational health physiotherapy practice is depicted in Figure 1. The conceptual framework has been developed to highlight the numerous and varied components of occupational health physiotherapy practice according to the perspectives of different stakeholders. According to O'Meara (2003, p.199) conceptual frameworks are "abstract systems" and in practice are "likely to be amalgams of different frameworks in response to their local context" because "in the real world service delivery is messy and imperfect." The conceptual framework developed in this study, therefore, has not been designed to replace existing frameworks of practice, but to provide a wider context about the role of occupational health physiotherapy.

The structure of the conceptual framework reflects the complexity and the collective components of the occupational health physiotherapy role. All the components are essential to occupational health physiotherapy practice, therefore, no one component can be described as the most important which makes up the defining role of the occupational health physiotherapist, because the individual components that make up the conceptual framework ultimately influences one other in practice. The conceptual framework is, therefore, a real example of the whole being greater than the sum of its parts and supports the viewpoint that the whole is greater than the sum of its parts (Carlson and Heth, 2010).

It is clear from the components within the conceptual framework that implementation of any changes to the role of occupational health physiotherapy is beyond the scope of individual physiotherapists. While individual physiotherapists have a responsibility for the quality of their professional practice and the way in which their role within that organisation develops

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(Chetty, 2011), in order to realise the full potential of the conceptual framework, it has been suggested by Garbett and McCormack (2002) that role and subsequent service delivery changes are required at individual and organisational levels. Given the many challenges of implementing a new role or making changes to an existing role, and the attitudinal and organisational barriers that can hinder the implementation process, such as financial constraints, there is a need for both individual physiotherapists and the organisation to consider innovative ways in which the conceptual framework can be used to develop or implement the role of occupational health physiotherapy.

The unique feature of the conceptual framework is that it makes explicit the need for occupational health physiotherapists to move beyond a focus on clinical competence, and requires an engagement with the organisational components of the role. There is potential for occupational health physiotherapists to engage with the conceptual framework, and in particular the organisational components, by firstly acknowledging that these are important and relevant components of their role, and secondly acknowledging that the organisational components of their role are expected not only by the physiotherapy profession but by different stakeholders.

In addition, the conceptual framework can be used:

a) to promote the value of occupational health physiotherapy to a variety of stakeholders (such as, commissioners, policy-makers, service planners, senior executive management, and so on);

b) by organisations (such as, universities, employers) wanting to develop educational courses or postgraduate programmes to support the developmental needs of occupational health physiotherapists;

c) to develop and promote physiotherapy careers in occupational health (such as, new graduates, physiotherapists interested in specialising in occupational health practice);

d) by professional organisations (such as, Association of Chartered Physiotherapists in Occupational Health and Ergonomics, Health and Care Professions Council, International Federation of Physical Therapists working in Occupational Health and Ergonomics) to help inform the standards required to practice occupational health physiotherapy and/or the criteria for advanced membership in the organisation.

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Conclusion

There is a dearth of studies in the literature addressing frameworks for occupational health physiotherapy practice. This study proposed the development of a multiple perspective conceptual framework for occupational health physiotherapy practice using the framework analysis technique developed by Ritchie and Spencer (1994) which is a multilevel analysis framework incorporating five stages. The development of a multiple perspective conceptual framework for occupational health physiotherapy practice is novel and using sound theoretical discourse and evaluation it has the potential to allow the current national framework for physiotherapists in occupational health to evolve from a physiotherapy-only perspective into a multiple professionals collaborative framework to advance the practice of occupational health physiotherapy. This study drew on the convergence of multiple perspectives and hence provides sound theoretical judgement and critique in the development of a multiple perspective occupational health physiotherapy conceptual framework. It is recommended that this conceptual framework be used in the process of amalgamating and facilitating international evidence and expert perspectives when reviewing the current national Occupational Health Framework for Physiotherapists.

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Conflicts of interest

There are no conflicts of interest.

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Figure 1: Conceptual framework for occupational health physiotherapy practice

Key points:

[1]Agent to organisation and client

Create a balance between meeting clinical needs and working within the boundaries of organisational policies and procedures

[2]Impartial approach

Take a neutral approach when dealing with the challenges and problems facing the occupational health service

[3]Direct access care

Recognise that first-line contact with the occupational health physiotherapist could yield better clinical outcomes and organisational benefits

[4]Expert and evidenced-based

Provide specific information to managers compared to traditional occupational health clinicians and outpatient physiotherapists.

Refine and implement evidence-based protocols.

Promote evidenced-based practice to demonstrate the value of the occupational health physiotherapy role.

[5]Role identity

Have a clear perspective of the role and expectations and contributions of occupational health physiotherapy.

Engage with different stakeholders to ensure that they are aware of the role and scope of occupational health physiotherapists.

[6]Specific vocational rehabilitation

Have a vocation-specific rehabilitation focus

[7]Health promotion and training

Participate in health promotion activities.

Train staff members on how to do or adapt the tasks of their job.

Design and implement injury prevention programmes and support the development of job descriptions.

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