Analysis of education programmes for Advanced Practice Physiotherapists: Queensland, Victoria and Christchurch examples.

Introduction

I have been aware of the scaling up of the advanced practice agenda in the UK has for a number of years with work of Health Education England (HEE) and the Chartered Society of Physiotherapy (CSP) continuing to provide fantastic leadership in this area.

I was first aware of advanced practice in the clinical setting during my first junior rotational position. I was based at St Woolos Hospital in Newport outpatient physiotherapy department. To the right side was the treatment room with standard plinths surrounded by polo-shirt clad physios chattering away to their patients behind wispy curtains. To the left was the physio gym, but only the bravest polo-shirt wearing physios frequented this area as it was the territory of the shirt and tie wearing MPT3 team. At this embryonic point in my career I knew I wanted to be in that room but had no idea how to get there.

Thankfully, I made my way there with the help of some great mentors to point the way but there was certainty no career framework, structured mentorship or education programme to follow. When planning or developing educational frameworks for advanced practice we should remember this mesmerised new grad looking to the years ahead.

How do we develop a programme of education which is meaningful to the participant and their current and future employers? How do we develop a programme which stretches the limits of education and advanced practice? Participants and educators dedicate incredible time and energy into these programmes and so we have a responsibility to ensure that effort is transferable and widely recognised across organisations and geographies.

In this article I will explore the range of educational programmes I came across during my Fellowship and compare these approaches. I will make several recommendations which could be considered when developing or improving the advanced practice educational programme within our organisations.

Queensland, Australia

Patrick Swete-Kelly is the Educational Coordinator for the state-wide Extension Programme. A comprehensive educational programme for aspiring advanced practice physiotherapists. The programme has high standards with participants requiring nomination by their clinical lead and mentor.

Committing to the programme

There is a single intake per year and competition is high, as is the participant commitment. Participants and their managers commit 0.1 FTE to the programme every week for 12 months and the participants themselves are advised to limit their annual leave during this period and to be

prepared for 3-6 hours study outside of work and the programme hours per week. Participants do not typically hold an advanced practice position when they embark on the programme but their managers are required to give them increasing experience of the role and service during their programme. They are also not guaranteed an advanced practice position when graduating from the programme but in a follow-up of programme graduates all clinicians who sought a position in the 12months after their programme were successful.

State-wide roll out

The programme is designed specifically to address potential future workforce problems in the Neurosurgical and Orthopaedic Physiotherapy Screening Clinics (N/OPSC) throughout Queensland. During the state-wide roll out of the N/OPSC the team conducted a workforce analysis which demonstrated that many facilities did not have sufficient capacity to provide backfill for planned or emergent situations or to meet future expansion plans. This was the motivation for developing the Extension Programme which is a centrally co-ordinated and delivered program, supplemented with local support and supervision. The programme also tackles another difficulty many employers face; the retention of skilled staff and sustainability of the recruitment pool.

Using Technology to Bridge the Distance

The Extension Programme is unique and innovative in a number of ways. It is a state-wide educational programme from Cairns in the North to Brisbane in the South. Queensland is seven times the scale of the UK so this endeavour is truly impressive and requires some ingenious developments including extensive use of video-conferencing and telehealth.

Participants sit alone or with their local colleagues in a room with a fully equipped video-conferencing suite which is a requirement of sites wishing to admit clinicians onto the course. They receive the majority of their educational instruction and engage in clinical debate through video conferencing. Participants are also required to attend 3 face to face education sessions, 2 days each and attend a one day annual forum during the 12 month programme.

Observed assessments are an important part of the programme but the distance between sites is clearly a barrier to this. This is overcome by using video-conferencing integrated into clinical observations. Participants and the educational coordinator draw around their screens as the participant being observed carries out their patient assessment. Patients are aware of the benefit which their participation has for the development of the workforce and it offers the opportunity for observing colleagues to pause the assessment at any time to ask questions of the clinician and to reflect in action.

The design and contents

The curriculum for the programme aligns with the Physiotherapy Career Pathway Competence Framework from the Australian Physiotherapy Association (APA) and International Federation of Orthopaedic Manipulative Physical Therapists (IFOMPT) standards. The programme delivery is based on adult learning principle of doing rather than watching, immediate relevance, active involvement, clear goals and objectives, constructive feedback, opportunities for reflection. The programme can be flexed to suit the needs of the participant using tools such as a Learning Needs Analysis.

The programme provides consistency across a large area, reduces duplication of time and effort by clinicians and their teams and promotes equity of educational provision for all MSK clinicians across the state. The programmes structured requirements of both the learner and their team ensures a robust approach to governance, mentorship and continued professional development. The small

group size and length of the programme encourages peer support and means the programme can be adapted to meet the needs of the learner and the group.

Victoria, Australia

In 2015 a team led by Paula Harding were funded by the Department of Health and Human Services and Health Workforce Australia to develop the Advanced Musculoskeletal Physiotherapy (AMP) Clinical Education Framework (CEF). The team approached this task in a methodological way and published their results in the Australian Health Review Journal.

A step-based approach

They used a step-based approach by conducting literature searches and focus groups. In the focus groups they discussed the key attributes needed as an AMP and the education and training required for AMP roles. The analysis of the scoping review and the focus group led to the teams' decision to develop a competency based training and assessment approach in a workplace setting.

The Clinical Education Framework assumes that clinicians meet the pre-requisite of the Australian Standards for Physiotherapy and builds additional knowledge, skills and behaviours for AMPs on top of this. The key components of the CEF include competency standards, a learning needs analysis, learning and assessment plan, self-directed learning modules and a competency assessment. The competency standards were developed by an experienced team of subject matter experts.

Implementation and evaluation

Once the CEF was developed it was implemented in a small number of test sites and its use and feedback closely monitored and a formal evaluation carried out. Once the CEF had been developed a follow-up focus group with AMPs was conducted for further feedback and verification. The CEF was then adopted across Victoria as a formal assessment component and is used to credential AMPs. It allows prior learning and clinical expertise to be recognised and supports the transferability of staff between organisations.

The CEF consists of a manual which is applicable to a number of AMP roles and services including Rheumatology Screening Clinic, Neuro-Surgery Clinic and Post-op Clinic, Paediatric Orthopaedic Screening Clinic, Joint Arthroplasty Review Clinic, ED Soft Tissue Review Clinic, Primary Contact ED Service, Pain Services and the Osteoarthritis Hip and Knee Service. The attributes identifies from the focus group are summarised into operational, interpersonal skills, attitude and communication, experience and clinical expertise. The pathway was also split into a continuum from pre-entry, supervision, independent to clinical lead. This model provides a simple over-arching structure to the CEF.

Evaluation of the CEF found that clinicians struggled to fully understand the structure initially. During our conversations Paula Harding reflected that some clinicians struggled to identify their specific learning needs and instead could be overwhelmed by the sheer volume of material and options hence the importance of a strong mentorship and supervision element to the programme.

Christchurch, New Zealand

In Christchurch I met with Vince Barry, CEO of Pegasus Health. Pegasus is a charitable organisation which supports general practice and community based health providers in Canterbury. They run an Educational Rounds series to support educational development for their general practice staff. This is not specifically for advanced practice physiotherapists but as it is a different model which may

have application to advanced practice and specifically FCP services in the UK I felt it important to share here.

The Educational Rounds have been such a success they have expanded out of Canterbury and there are now groups in different areas of New Zealand using this methodology. An Educational Round consists of a group of clinicians from different GP practices. They are split into teams and the teams are mixed with clinicians from different practices, different interests and different levels of experience. Clinicians stick with the same team throughout the different rounds. The group decides on a number of "Wicked Issues" which they come across in their practice which they would like to focus on. Wicked Issues have included topics such as, supporting people from and managing illness in the transgender community, talking to men about mental health and coaching for lifestyle choices. These topics are not the most common problems clinicians will come across in their practice but they require deeper discussions and the creation of a safe space within a diverse group of clinicians has been a very productive way to move conversations around these wicked issues forward.

The specifics of how the educational rounds function is also unique. They take place before or after clinic, sometimes 730am sometimes 730pm. All attendees are paid are small amount for their attendance, this amount has not changed in the years that the rounds have been running but Mr Barry feels this has helped attendance even as a token gesture. There is an educations team which supports the organisation and administration for the rounds. This team also provides the research and reading material which is sent in a pack prior to the event. This pack contains brief summaries and longer reading extracts or articles. The pack also proposes questions which should be worked through during the round. A facilitator supports the discussion and debate at the event. Events can be an hour to a few hours depending on the aim of the session and the topic.

Educational rounds and how they address wicked issues using debate, discussion and adult learning principles is unique and an approach which could be of benefit to many aspects of advanced practice education.

Specialisation

In New Zealand and Australia a separate specialisation level has been implemented. I have not approached this topic in line with my discussion about advanced practice education because in the New Zealand and Australian context "specialisation" and advanced practice are not comparable.

In Australia, Specialist is a protected title and the title is accompanied by a 2 year course taught by the Physiotherapy College. I spoke to a number of physiotherapists who had been through the costly course and did not feel it offered them anything over and above their previous title in terms of the roles they could pursue and opportunities available to them. I am sure there are many physiotherapists who hold an opposing view and certainly the breadth and depth of teaching on the specialisation course is excellent but the views that were expressed to me offers the opportunity to debate value and meaningfulness when considering educational developments.

In New Zealand, Specialist is a regulated level of practice which is assessed through a competency based portfolio and a panel interview. This is a very specific title and there are only 9 specialists in New Zealand (at time of writing), all practicing within a derivative of private MSK practice. I spoke to a number of specialists who defined the role as a referral only service in the majority with increased elements of assessment compared to rehabilitation and an increased emphasis on complex patients. Complexity was represented by chronicity of the MSK condition and failed treatments. I would offer that complexity in advanced practice roles in the UK, such as orthopaedic triage and first contact

practitioner (FCP) roles, are also defined by high co-morbidity, mental health concerns, social difficulties and first contact assessments. This difference in complexity and the roles of advanced practice or specialist practice may be due to the differences between the structure of our health systems and how patients access care. Of interest several public health leaders (District Health Boards) offered lack of value and meaningfulness to the specialist title within public health provision as a reason why specialists in New Zealand are largely in private organisations. New Zealand is now looking at regulating Advanced Practice as a separate regulated title as, as well as Specialist, this was being discussed by the Physiotherapist Board of New Zealand when I visited and it will be interesting to see how this conversation evolves.

From a UK perspective the developments in credentialing and regulating different levels of advanced practice in physiotherapy in other countries should lead us to question the benefits of pursuing this line of development. Particularly in terms of meaning and understanding for patients and in terms of value and cost for organisations and clinicians.

Mapping

In the UK we can consistently look to the leadership and support of HEE for guidance around educational requirements for advanced practitioners. HEE has provided us with the MSK core capabilities framework for FCPs and the Multi-professional professional framework for advanced clinical practice in England. These documents provide a framework for local educational developments to align around.

The Queensland Extension Programme provides a centralised coordinated educational programme. They were able to navigate the great distances between staff and services using teleconferencing. This is a fantastic way to coordinate educational programmes and their innovative solutions to peer learning and observational assessments provide an opportunity for UK based programmes.

In the UK there is innovative work being tried and tested around online education. For example, Project ECHO is an online community of practice offering tailored education and case-based learning for participating teams. Another example is TherapyLive, this is a virtual online summit offered by the Physio Matters team streaming debate and conversation around MSK practice free for all registrants. I have also had the great opportunity to complete my Masters in Pain Management with Cardiff University which was offered as an online MSc programme with all cohort discussion and debate through discussion boards and an app and all lectures uploaded onto a portal. These examples show that although virtual education is not the standard offering there are many examples of this work being embraced across the profession.

In both Queensland and Victoria education for advanced practice physiotherapists is focused on the skills and knowledge required by physiotherapists in advanced practice roles and even more specifically in musculoskeletal advanced practice roles. In the UK we do have the MSK Core Competencies for FCP Framework which is specifically designed for FCPs. However, all other work which I have come across seems purposefully generalisable to other advanced practice professions. Perhaps this approach is ahead of the curve in broadening skillsets across professions however it seems pertinent to highlight this as a specific difference between the countries in educational programmes and opportunities for advanced practice physiotherapists.

Recommendations

Frameworks and guidelines

In Queensland they conducted a workforce analysis and found that they would soon be struggling with their workforce numbers. This was the motivation for the development of their Extension Programme. Thanks to the CSPs workforce calculator we are well aware of the possible workforce requirements for FCP if every Primary Care Network (PCN) opts to use the Additional Roles Reimbursement Scheme to implement FCP services and yet we have not used this information to map to the current staffing available for these positions and those ready and waiting to fill them in the years to come. We have the MSK Core Competencies for FCP document but we have not followed this calculator and competency framework to its natural end point in establishing a national curriculum or educational guideline to support the implementation of FCP roles. This is an activity which could be led nationally, regionally or even locally through NHS Trusts, CCGs or groups of PCNs.

Career Pathways

The Victoria model provides a clear pathway from pre-entry to clinical lead advanced practitioner and the Queensland programme supports clinicians prior to achieving a position in their advanced practice teams. I have am not aware of a currently published document for advanced practice physiotherapy which provides this clarity of progression, although I am aware of work being conducted by the advanced practice and consultant practice groups in this area and look forward to their work.

Educational Coordinators

Coordination of educational opportunities outside of Higher Educational Institutes (HEI) is difficult for many reasons including large geographical areas, multiple service providers within the NHS and across the public and private sector and staff retention. However, in Queensland they have overcome some of these barriers and one factor in their success may be the allocation of a specific Education Coordinator role which is funded by the organisation for 0.4FTE in recognition of the benefits to staff experience and retention. This is an approach which I have not come across used in UK advanced practice teams. We are used to a senior member of the team being responsible for collaborative efforts towards continued professional development for the team but what about the CPD of advanced practitioners across a locality or region? Could this be a role supported by commissioners to develop advanced practice services across their jurisdiction or by training hubs to develop and retain staff within a group of PCNs?

Credentialing

The CEF in Victoria is used a credentialing framework. Once a clinician completes their CEF they are credentialed as an Advanced Musculoskeletal Practitioner and these credentials and this title is transferable across organisations which use the AMP CEF. At present we do not have a credentialing process nationally or regionally in the UK. This means that if an organisation works with its partners and clinicians to develop a Clinical Educational Framework or Programme it is not transferable to other roles or organisations. This makes it less desirable for staff as they may find themselves having to complete several service specific educational processes.

This is a barrier which could be replicated in the UK if we are not fully aware of the potential consequences. In England we are fortunate to have a centralised organisation for educational governance in health, HEE. The path towards advanced practice recognition which HEE seem to be exploring is closely linked with universities. This is not a path which was taken by AMP services and organisations which I studied during my Fellowship. Instead they adopted a centrally co-ordinated

and delivered programme in Queensland and a competency based training and assessment approach in Victoria. The lack of similar programmes of HEI supported advanced practice programmes in my Fellowship studies leaves me wondering whether there could be an difficulty with transferability and grandfathering in this method.

Conclusion

Education of advanced practice clinicians could be a burden for many organisations but with some detailed thinking around structures and processes, with some supporting guidelines and frameworks and with robust evaluation advanced practice education is also a fantastic opportunity.

I hope my analysis of some of the educational programmes and approaches observed in other health systems can support some of the thinking and planning around advanced practice development, the increasing need for FCP workforce and the ongoing improvement of our clinical and strategic offering to the wider health system.

I have combined the educational curriculums from the service areas I visited. This combined curriculum offers principles, methods of delivery and assessment and curriculum content for advanced practices education. I would be happy to share this combined curriculum so please email me or reach out on social media if you would like access to this combined curriculum document.

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