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Advancing Practice in Rheumatology Physiotherapy

My Journey from "Senior II" to "Consultant"; travelling from band 6 to 8

The idea of extending the roles of Allied Health Professionals (AHPs) is not a new one. It is worth picking out some elements of the 2001 paper of conference proceedings edited by Alison Carr. This report describes a workshop, run with Consultant Rheumatologists, about extending the roles of nurses and AHPs. It was felt that AHPs "are essential, they underpin future developments in Rheumatology". What's more "Consultant Rheumatologists feel that they have a responsibility to facilitate the professional development of AHPs in extended roles through the provision of education and training and the development of a career structure".

Given that this document details discussions undertaken now 18 years ago it is somewhat surprising how slow AHPs have been to grasp this opportunity. Admittedly, this delay is assumed from what is seen in the literature rather than what may have been happening in clinics, but never got published. A literature review looking at *extended scope practice* and the now far more common *advanced practice* specifically in combination with *rheumatology* gives a brief response. Lots of the work into advanced roles in MSK have been in orthopaedics or triage services. There is very little written about the advanced AHP role WITHIN rheumatology services. So, to add to this I thought I should share my own individual journey from band 6 to 8 in rheumatology. (I've opted not to name names here, but if you are reading this and recognise yourself then please do be assured of how grateful I am for your input in getting me to where I am now!)

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Stage 1 – Taking over Injection Clinic

This part of the journey was fairly strategic. My line manager had identified a need for injection therapy skills across the physiotherapy team and managed to get a few of us onto the course. I was fortunate enough to be able to get clinically supervised training by an excellent Rheumatology Reg at that time. I soon got up to speed on the skills required for the much-varied workload in a rheumatology injection clinic. A few months later, on a new Reg year we ended up short staffed and it was (I think) an easy decision for Rheumatology Clinical Lead / Management to take me on permanently to run the injection clinic. This was in 2008, and at that time it was agreed that a physio doing an injection clinic would be appropriate for band 8 role. I know that Rheumatology Injection clinic is no longer an automatic band 8 role these days; but I would argue it should still be. There is a complexity to the incoming referrals and some higher levels skills needed to triage appropriateness of request on the spot. There is also the added bonus of offering post—injection (or instead-of-injection) specialist physiotherapy / rehabilitation advice there and then. There is a decent amount of a teaching role to the clinic; more often than not there is someone sitting in observing or training under supervision. It is great to be able to offer this training for GPs, for our in-house Regs and for physiotherapists going through the injection course.

Stage 2 – Setting up an AS clinic

I've always seen AS patients in my physio role, but in 2011/12 we put together a business case to see these patients in the rheumatology clinics; and to have this as a role substitution for review by medics. This was around the time we were really starting to see the impact of biologic medications and trying to meet the requirements (at that time) for 3 monthly follow up of those patients taking these treatments. The clinic that I started to run was the first in our Trust to have only AS patients in it. This allowed me to focus on one clinical area; feedback from the first 6 months trial was excellent. I opted to use the Leeds Satisfaction Questionnaire; a lengthy, but thorough assessment of rheumatology specific patient feedback. I did get some pointers of what could be improved; of the three questions with lowest scores one was with regards to medication advice.

The timing of progressions of the physiotherapy advanced role fitted my clinical needs well. It was around the time of the AS clinic patient feedback results that my line manger started mentioning Non-Medical Prescribing (NMP) as a training option. This timing benefit did work well to hit the patient questionnaire feedback, but did mean that I did the original supplementary NMP course; and then a year or so later did the Independent version (which had just been released). When colleagues now discuss how arduous they are finding their own NMP studies I sympathise, bite my lip and try my best not to mention that I had to do it twice!

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Stage 3 – Replacing a Registrar / ST role in general Rheum Clinic

At roughly the same time as the AS clinic set up, we had a chance to trial something different. Again, Reg cover was a little on the light side and my line manager was kind enough to suggest the use of physiotherapy to cover what would have been a Reg role in a general rheumatology clinic. This involved working alongside one of our rheumatology consultants with my own list, but close supervision. This being general rheumatology it covered a broad spectrum of patients. And, yes, the odd one or 2 new patients did slip into what was designed to be a follow up only list.

Stage 4 – Early experiments in Physios seeing new patients

Around the same time that I was running this follow up clinic, some colleagues from our MSK triage service were trialling a role seeing new patients referred into rheumatology. This was in 2011/12 and perhaps at that stage triage processes were not as tight as they could have been, as this trial ended unsuccessfully. Feedback involved the breadth of potential diagnoses being a problem in this trial as well as the complexity of the cases seen.

Stage 5 – Seeing new patients in the Rheumatology MSK Pain Clinic

Developments took a sharp turn following a change in staffing. The consultant I was supporting each Monday morning left the Trust and I was left potentially losing this band 8 role. I had been happy enough seeing whatever came through the door, but the next step was a little away from AS and other inflammatory arthritis. The opportunity came to work in our Rheumatology MSK Pain clinic, set up by a World-renowned expert in the field, the service saw the non-inflammatory patients. This field of work where pain medications had moderate (at best) effect and problems persisted despite best medical efforts was a ripe place for physiotherapy to be involved. Again, I had been seeing these patients in my physio role since 2004; but this chance nearly 10 years later to see them in clinic did allow different approaches. I was able to really use my NMP skills; both to prescribe and to de-prescribe. The group of patients were also good candidates for non-pharmacological treatment; especially physiotherapy and talking therapies. I had a detailed, lived experience of these treatments and my agreed onwards referrals hopefully reflected this.

After a few years of running this clinic; the lead rheumatologist started to mention his impending retirement. He had a five-year plan so there was no major urgency, but it soon seemed a very logical idea to train me up to see new patients into this service. I have kept data on each new patient I've seen in this service, with the numbers currently sitting in the mid-400s. Within that time, there have been some changes in outcome measures used, in treatments recommended (and the evidence base behind them) and in onwards pathway management; however, my results are fairly consistent over that time. In other words, I think I had a good level of training and those first few "New patients" got as good a service as the new patients coming into the service today continue to get.

Stage 6 – Seeing new patients with inflammatory arthritis

I am very fortunate to have an excellent referral triage team. The advanced practice MSK team review the letters of all incoming rheumatology referrals; they know my service and which patients we like to see and are close to 98% effective at getting the right patient seen by the right clinician at the right time. However, there are of course always some that slip through, or that have a change in presentation from referral letter to consultation. For this reason, and given that fibromyalgia is a diagnosis of exclusion, I have had to get myself trained up and doing full inflammatory arthritis screens. Of the 400 or so new patients seen I have queried an inflammatory diagnosis for 20 or so; by default, I have as such diagnosed an inflammatory arthritis in 14 of these (although strictly speaking I have referred them to colleagues in our Early Inflammatory Arthritis clinic with a high suspicion).

I have always been fantastically supported by radiology and we are fortunate to have a weekly meeting with our MSK radiologists to discuss cases and share learning. Ordering MR scans has become a normal part of the management of the AS patient I see; and taking this on to ordering scans for diagnosis has hence been an easy step.

I now feel I do have the tools to be seeing new patients across our rheumatology service (or certainly in the more commonly seen inflammatory pathologies and of course in our MSK Pain service). Keeping the patient experience central to these developments is massively important and I have been equally challenged and encouraged by our patient user group representatives.

At this stage of more recent changes, I do feel that I have accidently stumbled into a role that could easily support 3 or more staff. In the absence of these staff I have had to make a few choices about which parts of the job role to pursue now, and which to defer. I am very keen that we physiotherapists (and AHPs) as a body working in Rheumatology are able to progress our careers, to improve the patient journey and to be the right person in the right place. For that reason I'll continue to write about my journey from band 7 to 8 and, more importantly, to encourage others to do the same. Of course the nurses are a bit ahead of us AHPs in this; but there is no reason this needs to be a competition. A co-operative push advancing the roles of nurses and AHPs in rheumatology is certainly a sensible strategy and the blurring of professional boundaries has to be a worthwhile goal.

Going back to where I started this blog; I would re-state the 2001 Alison Carr paper that AHPs "underpin future developments in rheumatology"; but also I hope I have shown that they also underpin *current* developments!

This is what I have been up to; please, please do get in touch (@PhysioWillGreg) if you have been doing similar; or especially, if you haven't but would now like to.

Will

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