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**'HASTEN SLOWLY, YOU WILL SOON  
ARRIVE': SPACE, DIALOGUE AND  
PARTICIPATION IN SUPPORT OF A  
DIALOGICAL CURRICULUM  
FRAMEWORK**

**MELVILLE JOHN STEPHENS**

**A commentary submitted in partial  
fulfilment of the requirements of the  
University of Northumbria at  
Newcastle for the degree of Doctor of  
Philosophy by Published Work**

**January 2019**

## **Abstract**

Contemporary higher education, healthcare and healthcare professional education is changing continuously. In times characterised by change and uncertainty, with increasing opportunities for networking and collaboration, educational curricula with an emphasis on 'process' rather than a more traditional, mechanistic emphasis on 'product' would seem appropriate in looking towards the future. Informed by themes derived from a sample of six published papers that reflect a collaborative (interprofessional) approach to education, an argument for a process-driven *Dialogical Curriculum Framework* is proposed for pre-registration physiotherapy education.

A methodology of symbolic interactionism is employed to frame argument from a broad perspective of impermanence and interdependent arising, in the promotion of space for reflection and dialogue to shape learning and professional identity. Learning and emergent professional identity occurs through individuals' social definitions in turn influenced by knowledge and power relationships. The dialogical curriculum seeks to promote a more even distribution of knowledge and power through participation and co-production, in the pursuit of tolerance and coherence to support learning and identity.

The parameters and dynamics of the *Dialogical Curriculum Framework* are represented through the interdependent relationship between four personal and professional attributes, four professional learning themes, and ten professional learning constructs. The processes of space for reflection, open dialogue, participation and symbolic interactionism drive the curriculum, within the context of UK policy and society. The emphasis on the pursuit of person-centred care makes it important for students to make connections with their own and other professions / disciplines to reflect the complexities of contemporary healthcare – an understanding of the 'whole' rather than fragmented parts.

Implications for other healthcare professions pre-registration curriculum design is discussed within the context of change in higher education and healthcare professional education. Present day learners are recognised as naturally creative, active problem solvers which combined with process driven curricula provides the opportunity to develop the knowledge, skills, values and behaviours required in the education and learning for practitioners of the future.

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A2	Jones D., <b>Stephens J.</b> , Innes W., Rochester L., Ashburn A., & Stack E. (2009) Service user and carer involvement in physiotherapy practice education and research: getting involved for a change. <i>NZ Journal of Physiotherapy</i> , Vol 37, pp 26 – 32. <a href="http://nrl.northumbria.ac.uk/1648/">http://nrl.northumbria.ac.uk/1648/</a>	Paper 2
A3	<b>Stephens J.</b> , Abbott-Brailey H., & Platt A. (2011) Appearing the team: from practice to simulation. <i>International Journal of Therapy and Rehabilitation</i> Vol 18(12) p672-682	Paper 3
A4	<b>Stephens J.</b> , & Parr. (2013) The development of media-driven clinical skills through using the 'e-skills portfolio'. <i>International Journal of Therapy and Rehabilitation</i> . Vol 20(7) p336-342	Paper 4
A5	<b>Stephens J.</b> (2015a) A participatory learning model and person-centred healthcare: moving away from 'one hand clapping'. <i>European Journal for Person Centred Healthcare</i> . Vol 3. Issue 3. 279-287. <a href="http://nrl.northumbria.ac.uk/24193/">http://nrl.northumbria.ac.uk/24193/</a>	Paper 5
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Particular thanks to Alison Machin and Jane Davies and their patience in having to listen to my ramblings and helping to drive me towards some kind of focus and organisation of ideas. Irrespective of outcome, the process has been enjoyable.

## **Declaration**

I declare that no outputs submitted for this degree have been submitted for a research degree of any other institution. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this commentary has been approved.

**I declare that the Word Count for this commentary is  
11,524 words**

Name: John Stephens

Signature:

Date: 7<sup>th</sup> January 2019

## 1. Introduction

The term ‘curriculum’ is frequently used regarding planning and policy in the development, delivery and review of programmes of study, yet any definition is often contentious and reliant on local interpretation (Ornstein & Hunkins, 2009; Fraser & Bosanquet, 2006). For many the curriculum is the content of a particular discipline or subject area, and the outcomes to be achieved on completion of study - a product - whilst for others it also includes elements such as the learner, the approach to learning, and the purpose of learning – a process, (O’Neill, 2015, Fraser & Bosanquet, 2006).

This thesis presents an argument for a process-driven *Dialogical Curriculum Framework* in contemporary pre-registration physiotherapy education. The argument is informed by themes of *space for reflection, dialogue, participation, and personal and professional identity*, emergent themes from the sample of six Papers (Appendices 1 – 6) that support this commentary. Framed by the concepts of complexity (Byrne, 2001) and a methodology of symbolic interactionism (Blumer, 1969) the commentary presents a broad position of impermanence ('things' always change) and interdependent arising ('things' come into existence through socially-based 'meanings'). Symbolic interactionism is summarised as being concerned with the acceptance of symbols as culturally derived social objects having shared meanings, providing the means by which reality is constructed. In keeping with the concept of interdependence. Figure 1 (page 2) represents these theoretical frameworks and themes in the form of nested groups. In order to guide the reader, Figure 1 is reproduced at the beginning of each subsequent chapter with themes pertinent to chapter content highlighted in purple.

This introductory chapter provides a broad background to the commentary in terms of intent, perspective of contemporary society and higher education, and an overview of pre-registration physiotherapy education in the UK. Chapter 2 explores approaches to curriculum design, to provide a rationale for the development of the proposed *Dialogical Curriculum Framework* illustrated by the example of MSc Physiotherapy (pre-registration), Northumbria University that has functioned as the vehicle for the iterative approach to the development and application of the framework. Within Chapter 3, the ontological and epistemological position of the commentary is established to contextualise deconstruction of the stated themes and discuss the theoretical perspectives of methodology. The methodology of Symbolic Interactionism underpins

discussion of the *Dialogical Curriculum Framework* at Chapter 4. Towards the end of Chapter 4 the potential impact of the proposed curriculum framework is highlighted with reference to the development of the MSc Physiotherapy programme leading to revalidation and professional body approval events, Spring 2017. The commentary concludes at Chapter 5 with an exploration of the potential broader impact of the framework with reference to current developments within healthcare profession pre-registration education. In relation to the development of ideas and evidence informing the commentary, Appendix 7 provides a reference list of outputs related to each of the six publications.

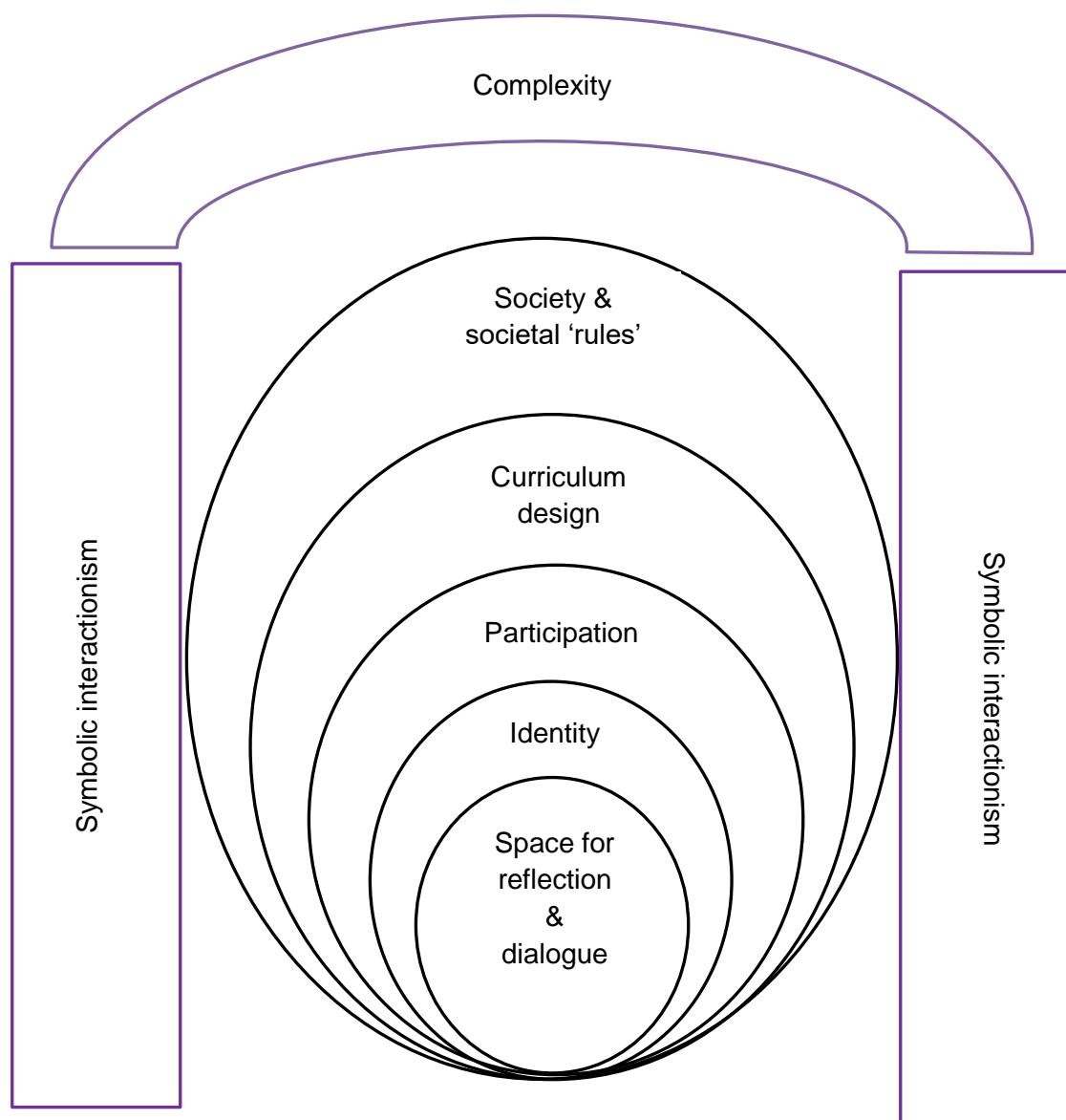


Figure 1. Theoretical Frameworks & Themes

The contribution to originality and knowledge by this work is in the argument for a process driven curriculum framework that focuses on learners' qualities (knowledge, skills, values and behaviours) and emergent professional identity. Underpinning this approach is the view of education as a collaborative, interdependent phenomenon, characterised by impermanence. Education and learning shapes development of professional identity that is dependent on time, space and occasion (Katagiri, 2007); a focus on education for life, rather than consisting of an assemblage of parts to form a product (physiotherapist).

### **1.1 Contemporary higher education in the UK**

From a broad perspective, this commentary is written in 'interesting times' (Kleiman, 2011). The transformation of UK higher education funding has resulted in a shift from publically funded enterprise towards a regulated market in (student) consumer demand. In meeting the educational needs of contemporary society, Kleiman (2011) argues the necessity for disequilibrium through constant change and evolution where creativity is potent – education at 'the edge of chaos' (Figure 2).

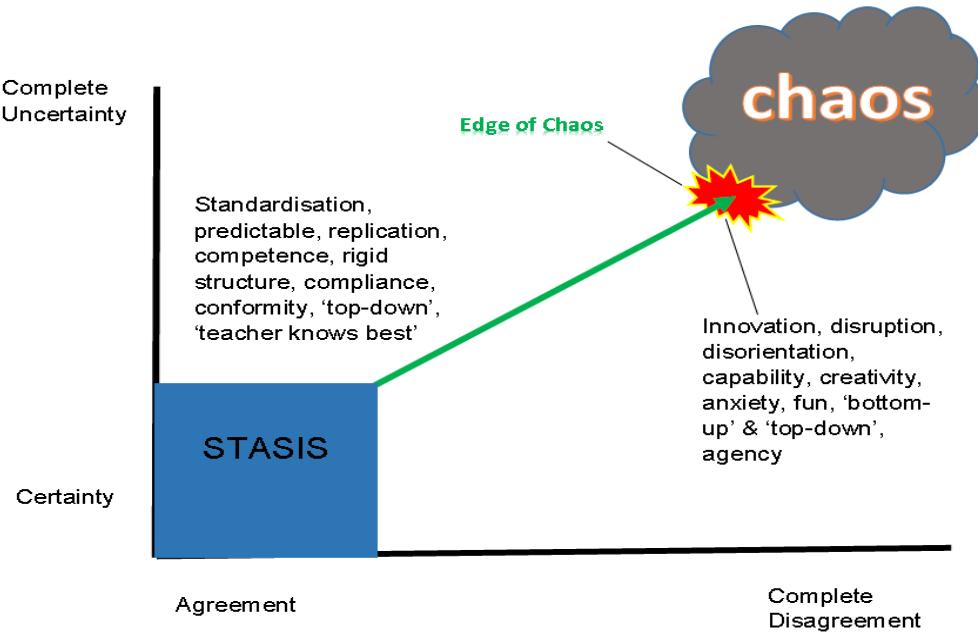


Figure 2. Education on the Edge of Chaos (adapted from Kleiman, 2011)

In times characterised by change and uncertainty coupled with opportunities for networking and collaboration, education and curricula with an emphasis on ‘process’ rather than ‘product’ (O’Neill, 2015; Kleiman, 2011) would seem appropriate.

## **1.2 Contemporary pre-registration physiotherapy education**

Within the United Kingdom (UK), physiotherapy is recognised as an autonomous healthcare profession (HCPC, 2017) being subject to regulation of standards for practice (HCPC, 2013) and education (HCPC, 2014) by the Health and Care Professions Council (HCPC). In addition, the Chartered Society of Physiotherapy, Physiotherapy Framework (CSP, 2013) highlights the knowledge, skills, values and behaviours associated with proficient physiotherapy practice. In adding political context to professional regulation contemporary healthcare policy has recognised the growing levels of complexity and uncertainty within practice (NHS England, 2017; NHS England, 2014; DH, 2012; DH, 2008; DH, 2006; DH, 2000; DH 1999) that has significant implications for pre-registration education and supporting curricula.

As identified by Trede (2012) pre-registration education programmes should not merely promote disciplinary knowledge and technical skills but also skills and intelligence related to team-working, communication with others, learning ways of working through observation and how to socialise into different workplace cultures. The challenges of satisfying a broad range of stakeholders, academic, professional, and public, (Bithell, 2007) are common across an increasing number of health and social care pre-registration programmes.

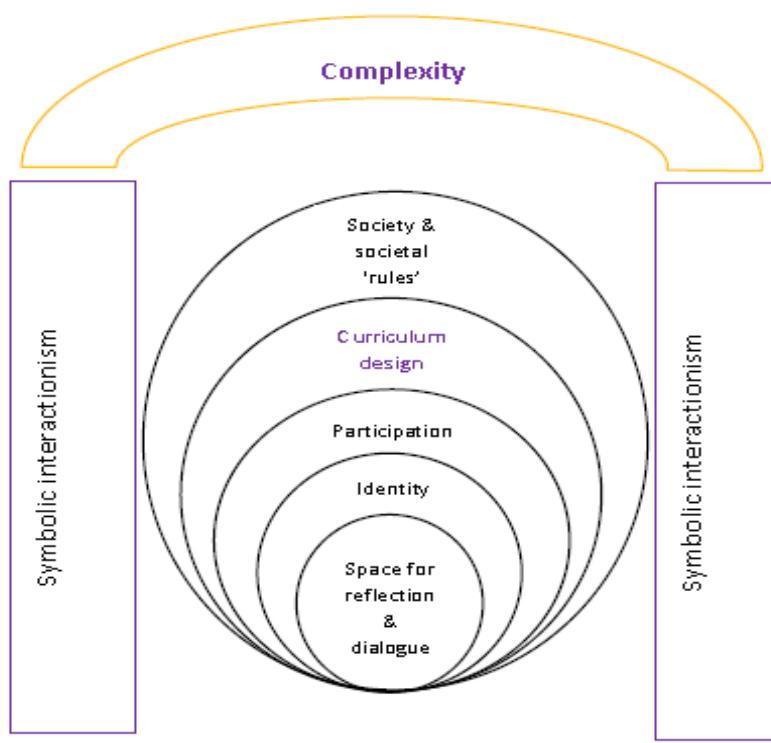
Pre-registration undergraduate and postgraduate Physiotherapy degree courses are offered by thirty-five universities across the UK, a total of fifty-six qualifying programmes (CSP, 2017). Undergraduate degree programmes are three years in duration in England, Wales and Northern Ireland and four years in Scotland, whilst pre-registration Masters degrees are spread over two extended academic years.

Programmes are approved by the HCPC and the CSP, being highly regulated by the HCPC (HCPC, 2014) and Quality Assurance Agency for Higher Education (QAA, 2015). Although programme outcomes are prescriptive, the means of achieving them are less so (Bithell, 2007). The reduced amount of time available and the level of academic study required within MSc routes would, as this thesis proposes, suggest a

different approach to learning and curriculum design being necessary.

Framed by a methodology of symbolic interactionism (Blumer, 1969) and the premise that society shapes self, shapes social interaction (Stryker, 2008) this commentary establishes a clear case for the proposed curriculum framework as an important step in the education of healthcare professionals of the future. The presented argument is rooted in a position of understanding the nature of reality, consciousness, and knowledge as a coherent whole rather than a collection of fragments (Bohm, 2007). It is this position that underpins the rationale for a predominantly process driven approach to curriculum design that is discussed in the next chapter.

## 2. Curriculum Design: product & process, participation, MSc Physiotherapy and enquiry-based learning



This chapter explores approaches to curriculum design within the context of complexity in contemporary (professional) education, to inform discussion of MSc Physiotherapy (pre-registration), Northumbria University and its enquiry-based

learning approach, which has functioned as a vehicle for the development of the curriculum framework. Concepts drawn from the sample of published papers are applied to advance the rationale for the development of the proposed *Dialogical Curriculum Framework*.

The term 'curriculum' is used by a broad range of individuals, groups and organisations, with wide variations for definition beyond a broad statement relating to the careful systemic use of a well-defined set of ideas (Fraser & Bosanquet, 2006). A useful representation of curriculum is in its consideration as 'Product' - based on the outcomes, structure and content of a programme and as 'Process' - based on students' experience and the interactive process of learning (O'Neill, 2015; Fraser & Bosanquet, 2006). Fotheringham et al (2012) expand on this position in identifying a discipline focused approach that is dominated by professional regulatory requirements, and employability (Product) and what is recognised as a more emergent definition within

contemporary education that prioritises interaction and community (process) over content and structure. A process driven curriculum provides a more holistic approach to education, that relates not just to what is taught, but also to students and academics experiences, and the pedagogical approaches that support this. Table 1 provides a summary of the characteristics of product and process curriculum models relevant to the development of the *Dialogical Curriculum Framework*.

Table 1. Characteristics of Product and Process Curricula (adapted from O'Neill, 2015; Fotheringham et al, 2012; Fraser & Bosanquet, 2006)

<b>Product Curriculum</b>	<b>Process Curriculum</b>
Plans, strict outcomes, and structure	Student and teacher control
Behavioural based	Learning activities
Teacher controlled	Focus on social and life skills, values
Some choice through electives	Context and environmental consideration
Planned by teacher	More student choice

Within this work, a stance is taken that recognises the importance of curriculum in the sense of both product and process. It is not to reject traditional interpretations, but to recognise that the rapidly changing nature of contemporary society and healthcare requires a more liberal approach to education and curriculum design, a shift towards process. Contemporary life is complex and 'liquid' (Bauman, 2005). Change is changing (Bevan, 2017) with movement towards society and healthcare that is characterised by agency and iteration and less reliant on structure and hierarchy. This is evident in the rising impact of technology and networking (e.g. social media), and a movement towards engagement and co-production (Fenwick, 2012) with both students and the public.

A reliance on competency-based education associated with product driven behavioural approaches has been debated for more than two decades. Barnett (1994) argued the limitations of competency-based education, perceiving a drift in higher education towards skills, vocationalism, competence and outcomes, and a retreating into professional regulatory control, with the emphasis on the production of professionals to perform a particular role. The stance of Barnett was softened

somewhat by that of Eraut (1994) who interpreted competence as forming a basis for lifelong learning. However, the culture of contemporary 21st Century healthcare and education has changed beyond recognition since that time. It is becoming ever more evident that a perceived fixed objective reality reflected in product-reliant curricula increases potential to retreat into ‘stasis’ rather than seek the opportunities of complexity / ‘chaos’, (Kleiman, 2011) by passing greater responsibility and autonomy to learners (Edwards, 2016; Fenwick, 2012).

Examples of curriculum models associated with the proposed *Dialogical Curriculum Framework*, are summarised at Table 2 (below) to contextualise the rationale presented.

Table 2. Contextualising the argument for a Dialogical Curriculum Framework

<b>Product Models</b>	<b>Process Models</b>
<i>Discipline-based</i> : centred on the structure of the discipline / profession (O'Neill 2015; Ornstein & Hunkins 2009)	<i>Enquiry-based learning</i> : participation in tasks or scenarios, often open-ended in nature to explore variation of potential solutions. (Kahn & O'Rourke, 2005)
	<i>Dialogue approaches</i> : education as conversation (Laurillard, 2002)
	<i>Reflective approaches</i> : learning from experience, closely linked to process of enquiry, humanistic approach. (O'Neill 2016; Rogers, 1961)
	<i>Negotiation</i> : Negotiation of what will be learnt; pragmatic in terms of resources opening up possibilities for variety in assessment (Ornstein & Hunkins, 2009)

In writing the forward to *A Connected Curriculum for Higher Education* (Fung, 2017), Barnett calls for a vision of ‘well-tuned’ learning that works on a personal, institutional and societal level through connectedness. Although mainly concerned with the links between research and education, proposing 12 dimensions of connectedness within curricula, the comments of Barnett in both 2017 and 1994 (page 7) are equally applicable within the context of healthcare professional education, and the *Dialogical Curriculum Framework*.

Learning is argued as a social activity, driven by context within a complex, socio-material framework (Mulcahy, 2012; Davis and Sumara, 2008; Haggis 2008). In attempting to simplify expression of this complexity the following characteristics for a physiotherapy education curriculum, or indeed any healthcare profession curriculum, are proposed:

- A curriculum which is people-centred; *at whatever level we want to view this, it's a construct, organised, delivered by and for people*
- A curriculum which is context-relevant; *context (environments, people, resources, policies) drives everything*
- A curriculum which is authentic; *informed by evidence across a broad scope, and driven by values*
- A curriculum which is wise; *not just requiring those involved to be intelligent but also to be morally/ethically 'sound', i.e. not just competent but capable*

(adapted from Higgs et al, 2008; Higgs and Titchen 2001)

It is important to understand these characteristics as being an enfolded whole that is constantly changing ie interdependent, rather than a series of individual fragments. As observed by Bohm (2007) human activity is continually divided into specialisms, each seemingly separate from the other. Within curricula this is reflected in modularisation within taught programmes. Over the past three decades, resultant fragmentation within healthcare profession education and the impact on patient care has led to the growth of interprofessional education (IPE, CAIPE 2018). Although intended to unite fragments, IPE arguably carries the threat of merely offering another separate fragment. It was this perspective that stimulated the practice-based approach of the Common Learning Programme North East (CLPNE; Pearson et al, 2006), a more process-driven and contextually relevant approach to education (Papers 1, 3) rather than a generic academic-based, product-driven approach. There is some irony in the English word 'health' being based on the Anglo-Saxon word 'hale' meaning 'whole'.

Fragmentation is often exacerbated by scientific research in taking the content of our thought 'as is', ie an objectively true description of the world (Bohm, 2007; Bohm & Peat, 2000). As human thought tends to discriminate and classify (through distinction

and difference), there is a tendency to habitually look at these as real divisions and the world as broken into fragments rather than a coherent whole.

Hence, it is important to understand the five characteristics underpinning physiotherapy / healthcare profession education (page 9) as an unfolded whole that is constantly changing and that within chaos / complexity (Kleiman, 2011) there is implicate (or enfolded) order. For example, advances in technology and technology enhanced learning (a change in context), will impact on how people learn individually and together, and the evidence, values and ethical frameworks that inform the curriculum. It is in understanding the contribution of implicate order within a complex whole (Bohm, 2007) to the processes that drive the framework, the relationships within and between the *personal & professional attributes*, *professional learning themes*, and *the professional learning constructs* represented at Figure 5 (page 32) that is paramount in the understanding and application of the *Dialogical Curriculum Framework*.

The concept of process-driven activity in the pursuit of a particular goal(s) is not isolated to healthcare education. It was interesting to witness the swimmer Adam Peaty at the 2018 European Multi-Sport Championships attributing his continued success to engagement with process rather than a direct focus on medals or records (products), (Davis 2018).

*Placing focus and attention on processes means you can learn faster, become more successful, and be happier with the outcome.*

Davis (2018)

From a personal perspective, my initial motivation towards process-driven learning stems from a small research project (Stephens and Smith, 2001; see appendix 7) that explored multidisciplinary learning in clinical practice. A quote from a nursing student within a focus group has been a primary motivator towards my work to this day:

*“I came into nursing because I care. You taught me how to care, and now I don’t care anymore.”*

The ensuing dialogue revealed how the student in question had come to dislike what she had become by being ‘taught’ how to behave ‘professionally’, and the strange

juxtaposition of ‘care’ as a value but being taught as a professional competency. My initial frustration in thinking “*bloody hell, is this really the best we can do?*” was very quickly replaced by a realisation that an approach that ‘taught’ professional roles wasn’t good enough for contemporary healthcare. The limitations of ‘teaching’ and product / competency driven curricula were exposed and resulted in a drive to do things differently. Initial thoughts towards curriculum design was further influenced by the work of Eisner (1985) and the concept of explicit, implicit and null curriculum, and although perhaps surprisingly (in terms of subject area) the work of David Bohm (Bohm, 2007; Bohm, 2004; Bohm and Peat, 2000) regarding the connectivity between science, creativity, and order.

Discussion of ‘wholeness’ and enfoldment is further developed at Chapter 3 to inform the ontological / epistemological position of the methodology (Symbolic Interactionsim) and the *Dialogical Curriculum Framework* itself. The following sections (2.1; 2.2) of this chapter seek to apply the issues raised thus far, in relation to MSc Physiotherapy (pre-registration), Northumbria University, the vehicle for the development of the framework. Practical tools useful for curriculum development and delivery - the CPAC Schema and the Participatory Learning Model - are identified to be considered within the context of the enquiry-based learning, and levels of creativity.

## **2.1 MSc Physiotherapy (pre-registration); learners, participation and enquiry-based learning**

The MSc Physiotherapy programme is required not only to shape learning to meet academic requirements, but also to ‘direct’ enculturation of learners to meet the requirements of Professional Statutory Regulatory Bodies (PSRBs; Paper 6) . This ‘shaping of subjectivity’ is achieved through the curriculum and the pedagogy (enquiry-based learning) that supports this (Osberg and Biesta, 2008).

The issues raised at Paper 6 (see overleaf) with regard to pluralism of individual identity are equally applicable at an organisational level (Kraatz & Block, 2008) as Universities (and their curricula) seek to be different things to different people in addressing the challenges surrounding legitimacy, governance, and change. Edwards (2008) cites Osberg and Biesta (2007) in arguing for a reformulation of a discourse for education in general, a pedagogy of invention. Furthermore, I would argue invention as a pedagogy

“The promotion of *structured enculturation* within physiotherapy and healthcare professional education would appear to be endemic amongst policy-makers in particular, often irrespective of the complexity and demands of contemporary healthcare delivery. This, combined with high public expectation in terms of high quality care raises challenges in pre-registration education, particularly across two year accelerated MSc programmes. Obviously *unstructured enculturation*, letting learners just do as they wish, has serious implications for public safety yet in shaping learning to reflect the ‘messiness’ of contemporary healthcare, *structured enculturation* would seem to be undesirable.” (Paper 6, page 456)

of participation through dialogue, reflected in a movement towards emphasis on a process model for curriculum design, rather than reliance on a product model (O’Neil, 2015; Kleiman, 2011). This is of particular relevance within contemporary pre-registration healthcare education, through the proposed development of apprenticeships, two year BSc(Hons) programmes, and doctorates (UK Government, 2017; UK Government, 2016) involving an increasing number of stakeholders.

Within the context of learners and the processes underpinning education, collaborative and co-operative learning has been revitalised and refashioned over the past 20 years through the advent of the internet and burgeoning of multimedia resources and simulation in healthcare professional education (Mason & Rennie 2008; Mohr & Mohr 2017). The learning characteristics of ‘the Millennials’ (individuals born since 1982) and the successive demographical cohort, ‘generation z’, include qualities such as the ability to multitask, along with preferences for networked and collaborative activities that focus on learning from video, images and sound rather than text. However, these qualities also bring disadvantages of questionable quality control with regard to resources, and limited reflection. In addition movement of tutors’ roles away from that of ‘sage on the stage’ to the ‘guide on the side’ (Fox, 2005), a much more open and flexible role has been proposed. The concepts of the spiral curriculum (Bruner, 1960 cited by Johnston 2012) and scaffolding (Pea, 2004), highly prevalent across all levels of education are arguably easier to structure within the 3 year format of undergraduate study (BSc(Hons Physiotherapy) than a 2 year accelerated M-Level programme. There

would therefore appear to be a requirement for a more integrated curriculum and an approach to learning that places much more emphasis on students' previous learning and life experience. It was these principles that informed the development of MSc Physiotherapy (pre-registration) at Northumbria, which will be explored next.

## **2.2 Participation, enquiry-based learning and symbolic interactionism**

At Northumbria, an enquiry-based learning (EBL) approach is employed to drive the MSc curriculum through the establishment of tasks that are scenario or skill driven, drawing on students' previous learning / life experience aligned with their developing clinical experience. A relatively small cohort size (n=10-20 students, 2004 - 2017) enables key characteristics of EBL such as the engagement of students as partners in the learning process, that promotes social interaction and cohesion in the learning group (Hutchings, 2007; Kahn and O'Rourke 2005). However, it should be noted that transition in adapting to what is, for the majority if not all students (and initially staff), a much more open-ended approach to learning is challenging and requires support (Paper 6; Stephens & Dawson, 2005).

Table 3. CPAC Schema adapted from Paper 3, p678

<b>CPAC – schema for simulation education</b>
C 'context'—full appreciation of the tasks/case scenario and situation, learning environment, other 'actors' involved, core, and extended team.
P 'participation'—the willingness to be involved with confidence and without fear of not being accepted. Being aware of both professional and social role within the context.
A 'accessibility'—participant ratification. The expectation of and duty to co-operate with others in identification of the role of self and others.
C 'credibility'—having confidence in the respect, professionally and socially, for self and others. Being comfortable with the educational situation (believing it to be purposeful) and individual / team role.

Proposed within the context of simulation at Paper 3, the CPAC schema (context, participation, accessibility and credibility, Table 3 above) has wider application to the role of both students and staff in EBL and their developing personal and professional identities. The focus on meaningful dialogue is to place attention to the process of collaboration, of participatory learning rather than products or things to do. This is

reflected in a broad application of the participatory learning model (papers 2 and 5, Figure 3, below) in shaping the EBL process, and engage participants within a continuous cycle of arrival through dissemination across the curriculum.

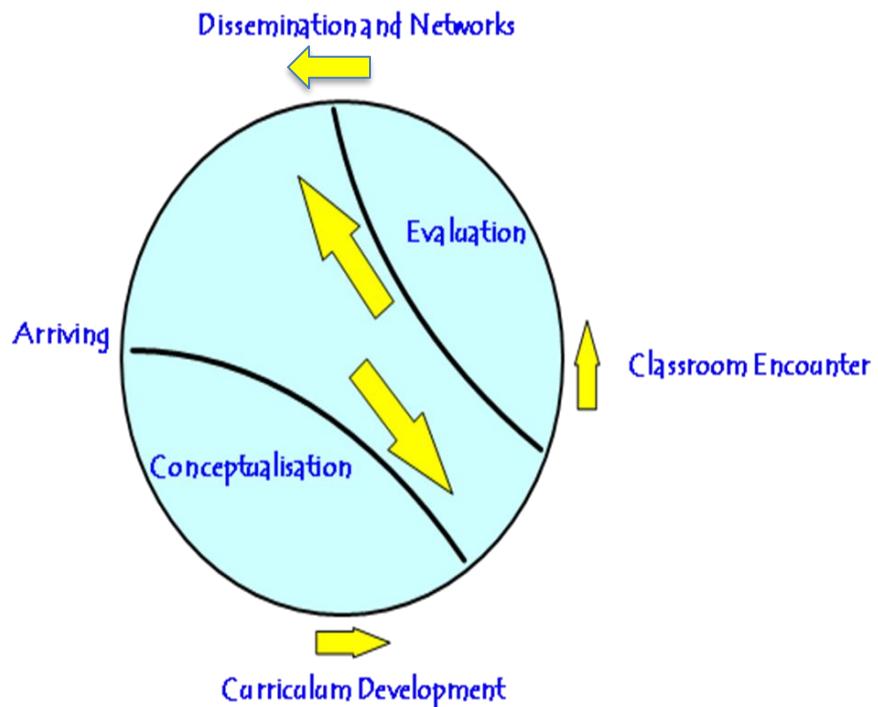


Figure 3. The Participatory Learning Model (Papers 2 & 5)

Senge et al (2010) embrace these concepts with the premise that humans, as living systems, create themselves. People are not merely assemblages of their parts, but continually grow and change within the society in which they function. Thus physiotherapists 'grow' much like a plant rather than being assembled, like a car, in accordance within a set of rules or competencies. Individual and group development represents a process of emergence which requires space (and therefore time) for reflection, in order to facilitate a slowing down and focus for thought. This often necessitates provocation or disruption to provide opportunities for learning, for example the football stadium scenario at Paper 1, the format of the PWE workshop at Paper 5, and the focus on a practical task / deliberate practice (Eriksson, 2004) characteristic of the e-skills portfolio (Paper 4).

*"It was quite, well everyone had a different perspective, I thought it was quite good ..... because ..... from one session to the next ..... where I did see myself had changed ..."*

(Student view) Paper 1, page 382

*The general format of PWE workshops is based on the popular television programme 'Baddiel and Skinner unplanned'*

Paper 5, page 279

*The e-skills portfolio is a vehicle that can be used to facilitate, record and evaluate learning and development of practical skills both within the short and long term, in a relatively simple, focused and robust format.*

Paper 4, page 341

In essence, EBL describes an environment in which learning is driven by a process of enquiry, largely owned by learners (University of Manchester, 2017). Table 4 summarises the characteristics and benefits of EBL, as promoted by the Centre of Excellence for Enquiry-Based Learning (CEEBL).

Table 4. The Characteristics and Benefits of Enquiry-based learning (The University of Manchester, 2017)

<b>Characteristics of EBL</b>	<ul style="list-style-type: none"><li>Learning is essentially student-centred, with an emphasis on group work and use of library, web and other information resources.</li><li>Lecturers become facilitators, providing encouragement and support to enable the students to take responsibility for what and how they learn.</li><li>Students reach a point where they are not simply investigating questions posed by others, but can formulate their own research topics and convert that research into useful knowledge.</li><li>Students gain not only a deeper understanding of the subject-matter, but also the knowledge-development and leadership skills required for tackling complex problems that occur in the real world.</li></ul>
<b>Benefits of EBL</b>	<ul style="list-style-type: none"><li>Fundamentally, students are more engaged with the subject. Learning is perceived as being more relevant to their own needs, thus they are enthusiastic and ready to learn. Working within and communicating to a group are vital for a student's employability</li><li>Students can expand on what they have learned by following their own research interests.</li><li>EBL allows students to develop a more flexible approach to their studies, giving them the freedom and the responsibility to organize their own pattern of work within the time constraints of the task.</li><li>Self-directed learning not only develops key skills for postgraduate study, but also leads to original thought that contributes to larger research projects, papers and publications.</li><li>For teaching staff, developing EBL helps to understand the learning process and the changing needs of students.</li></ul>

Dialogue between staff and students in engaging with, and developing the programme curriculum through EBL is in an understanding of differing levels of creativity, Table 5.

Table 5. Levels of creativity in EBL (adapted from Kleiman, 2003)

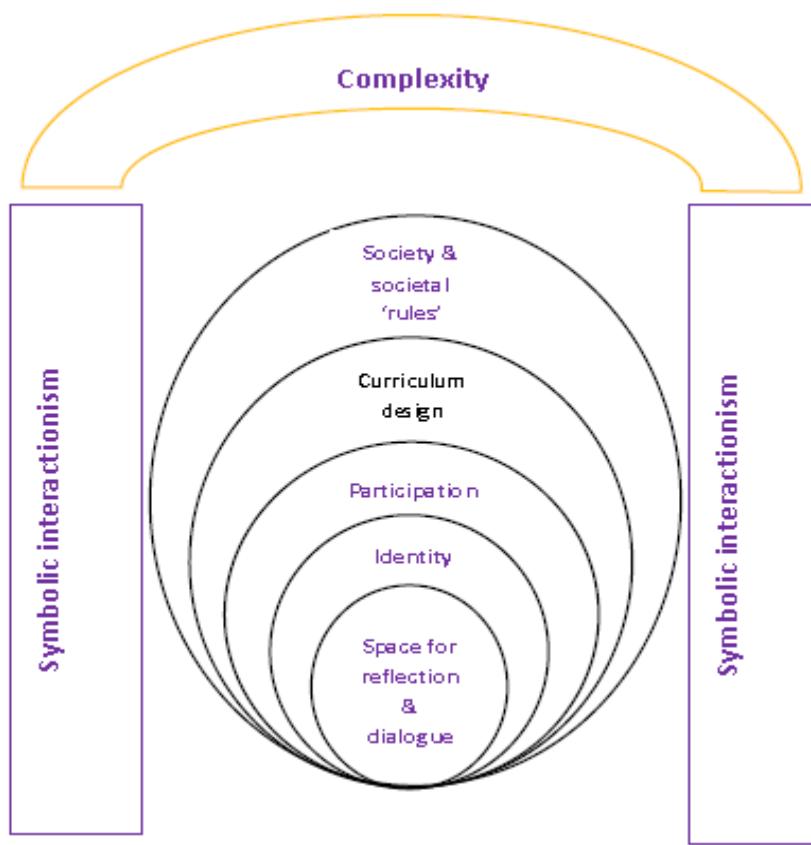
<b>Level of creativity</b>	<b>Descriptor</b>
Replication	I do and you copy. Although at the base of the hierarchy, this very much has a place in the safe and effective application of practical physiotherapeutic skills
Formulation	The principles and rules are clear but there is room for adaptation in terms of the safe and effective application of physiotherapeutic skills to meet individual need, of both the 'patient' and student/physiotherapist
Innovation	Works within the established rules and conventions and responds creatively when there is added complexity in meeting individual need, for example application of physiotherapeutic skills in areas such as palliative care, critical care, community settings
Origination	Ideas and areas of practice that are new, the mould-breakers even. In all probability not for direct application in clinical practice but certainly appropriate in relation to research and also service improvement projects, in which students are involved

Although these levels of creativity are most obvious within Paper 4, in relation to the development of practical physiotherapy skills (e-skills portfolio), they pervade all papers within the published sample. Creating space for reflection enables participants to 'suspend' and 'redirect' attention, for example, facilitated by the practical tasks at the football stadium game (Paper 1), the staged conversation across the PWE workshops (Papers 2 and 5) to enable learning that requires participation and in particular participation through dialogue. The idea of such participatory dialogue is to approach a coherent meaning at a particular time and context, and therefore being and identity (Bohm, 2004),

The *Dialogical Curriculum Framework* is intended to be fluid in terms of 'rules'. It is not there to impose how things must be done but to shape how things might be done within a participatory learning model (Figure 3. Papers 2 and 5). Creating space (and time) for dialogue, is to accept that there is no uniquely imposed truth but merely open dialogue in learning. Participants learn and shape identity through sharing of experience (Papers

3 & 6), through symbolic interactionism, the methodological framework of this commentary.

### 3. Methodological contexts and meanings.



This chapter begins by establishing the ontological and epistemological position of the commentary to inform the methodology, (Symbolic Interactionism). The methodology is discussed from a theoretical position that is plural in nature consistent with concepts of wholeness,

fragmentation, and open dialogue introduced at Chapter 2. This informs deconstruction of the key themes within a societal perspective and the methodology, symbolic interactionism, to support the discussion of the *Dialogical Curriculum Framework* at Chapter 4.

In essence, from an everyday perspective space and time appear separate from 'being', as commodities, having too much or too little of either or both. However, the central tenet of this thesis - space for reflection - is based on the belief that there is no separation of space and time from being (Katagiri, 2010). Space, time and being work together and from this arises identity.

### **3.1. Ontological and epistemological perspectives**

It is important to understand the relationship between space, time and being to provide a clear perspective of the ontological and epistemological position of the commentary and the proposed curriculum framework. As discussed at Chapter 2 (pages 9, 10) the *Dialogical Curriculum Framework* should be understood as an interdependent, constantly changing ‘whole’, the existence of which is brought into being by those who engage with its processes, in a manner similar to that discussed at Paper 3 (‘Appearing the team.....’). From an ontological perspective of existence, primacy is given to the whole, and order within the whole (Bohm and Peat, 2000) that is framed by symbolic interactionism. The appearance of ‘reality’ is based on an epistemology that reflects the ontology, as any underpinning knowledge and thinking is constantly changing through the sharing of meanings via symbols to construct a reality (Symbolic Interactionism, Blumer, 1969).

Ontology and epistemology are to be viewed as interdependent. To separate each would be to regress to the dated notion of a Cartesian model of reality. The notion of two kinds of ‘substance’, mental and physical, that somehow interact is an extremely limited view and not reflective of a functional whole. As argued by Bohm (2007), historically Descartes proposed that although separated, a relationship between matter and consciousness was possible through the existence of God - being beyond the two and the (independent) creator of both. However, in more recent times the notion of God as an independent creator facilitating the relationship has largely been abandoned, making it completely illogical to maintain this perspective of reality.

Notions of implicate (or enfolded) order is argued to apply to both matter (living and non-living) and consciousness and seen as a deeper and more fundamental order of reality. In contrast the explicate or unfolded order includes the abstractions that humans perceive, communicate, and understand as manifest ‘things’. Communication and language are promoted as an undivided field of movement (Bohm, 2007; Bohm and Peat 2000). This movement involves sound, meaning-making, attention-calling, emotional and physical activity that within this commentary is understood as a form of order within Symbolic Interactionism (Blumer, 1969).

Reality, learning and (professional) identity, is proposed as a social phenomenon, continually interpreted and re-interpreted from a position of liquidity and complexity (Bauman, 2010). Bauman's ideas are acknowledged as being influenced by Goffman (Jacobsen & Kristiansen, 2014), whose dramaturgical turn frames ideas developed within Paper 3 in relation to simulation practice. Individual and group identities are continually shaped by meaningful dialogue, hence the concept of 'appearing the team'. People work to understand themselves through dialogue, to make sense of the stories of their lives, through symbolic interaction(ism) (Blumer, 1969).

*What became apparent to the students as this process unfolded was the ever changing, impermanent nature of 'the team'. It didn't exist in a fixed, independent manner, but was dependent upon tasks and context of those tasks to meet individual patient need.*

Paper 3. Pages 675-676

### **3.2 Symbolic Interactionism; from Goffman and Heidegger to Foucault through Buddhist dependent arising**

Symbolic interactionism is derived primarily from the work of George Herbert Mead (1863-1931) a psychologist, philosopher, and sociologist largely affiliated with the University of Chicago. Herbert Blumer (1900-1987) a student of Mead actually coined the phrase 'symbolic interactionism'. People's selves are regarded as social products that are purposive and creative (Mead, 1992), purposive in this case towards the fulfilment of criteria for the award of a pre-registration academic award, and PSRB registration. Blumer (1969) identifies three premises of symbolic interactionism:

1. Humans act towards 'things' dependent on the meanings 'things' have for them
2. Meanings arise from social interaction
3. Meanings are handled and modified through an interpretive process by the person(s) interacting with 'things'

Symbolic interactionism presents an illustration of human life in action through social interaction, a common thread across all six published papers and the proposed dialogical curriculum. For the curriculum to be legitimate, it must be consistent with the nature of social action of physiotherapists. The complexity of ongoing action establishes structure and organisation of the profession, fitting together the activities of

its members. Hence Standards of Proficiency for Physiotherapists (HCPC, 2013) and a Framework for Physiotherapy (CSP, 2013), arise from and inform the role and purpose of physiotherapy, and the associated Standards of Education and Training (SETS), (HCPC, 2013) the identity and role of physiotherapy education. Blumer (1969) argues social interaction as a medium through which to pass to a particular set of behaviours. Within the sample of papers and argument for the *Dialogical Curriculum Framework* presented here, symbolic interactionism functions as a process that FORMS human behaviour rather than merely the means to release behaviour.

No apology is made in offering a deconstruction of key themes across the following sub-sections (3.2.1 – 3.2.3) within a broad framework (symbolic interactionism) that offers a plurality of theories and cultures for consideration, encompassing the work of Goffman (Paper 3), and Heidegger (Paper 6) along with that of Foucault, Bohm and Buddhist philosophy. In considering human pursuit of thought as theory, it is worth appreciating the origins of the word ‘theory’; derived from the Greek ‘theoria’ – having the same root as ‘theatre’ – meaning ‘to view’ (Bohm, 2007). Therefore, theory is argued here as a form of insight, ways of looking at the world and not merely a singular form of knowledge of how things are.

Within this work, the process of looking at the world is proposed as dialogue (not just words but ideas) shared across groups, ie symbolic interactionism. Language not only calls attention to order, but is an order of sounds, words, phrases and gesture. The *Dialogical Curriculum Framework* is proposed as a vehicle that assists to order and shape, in this specific case, physiotherapy education.

### *3.2.1 Symbolic interactionism; Goffman and Heidegger*

The dramaturgical turn of Erving Goffman (Paper 3) is logical with respect to exploring interpersonal activity and dialogue to shape meaning and identity (Goffman, 1990) but somewhat limited in terms of societal influences. A broader scope of ‘being’ is provided in the work of Martin Heidegger (Paper 6), and in particular his best-known work, ‘Being and Time’ (Heidegger, 2008). Personal understanding of this work is based on three assumptions as to Heidegger’s meaning of ‘being’. Firstly, ‘being’ as the most universal of concepts; secondly as undefinable because of its scope as universal; finally, that ‘being’ of all concepts / objects is the one that is evident to self. Heidegger argues that

to describe experience authentically entails finding a ‘being’ for whom such description might matter. This description of experience is given with reference to ‘Dasein’, the person for whom ‘being’ is a question. ‘Being’ is thus conceived in terms of time, and therefore space and concerns interdependence in negating a ‘subject-object’ division (von Eckartsberg & Valle, 1981), or dualistic thinking. The implications of ‘Dasein’ not only support ideas related to enculturation at Paper 6, but also arguably the entire sample.

### *3.2.2 Symbolic Interactionism; Heidegger and Mahayana Buddhism*

Of particular relevance to this work is Heidegger’s association with the Kyoto School of thought, a group of Japanese intellectuals that assimilated western philosophy and eastern religious ideas. From my own experience in having studied a number of commentaries to Mahayana Buddhist texts, there would appear to be links between the ideas expressed in ‘Being and Time’ and Zen Buddhism (through the Kyoto School), which itself evolved from Mahayana Buddhism. This relationship is helpful in that dependent-arising (Table 6, below) provides a useful recognition of implicate order in forming a coherent ‘whole’ with clear application within the methodological framework of symbolic interactionism.

Table 6. Dependent Arising for Physiotherapy Education (Adapted from Gyatso, 1996)

<b>Classification</b>	<b>Descriptor</b>
Dependent upon causes	Learning takes place due to impermanence, dependent on the causes and conditions under which it takes place; the people involved, how and when they interact, what they interact with and where.
Dependent upon name	All things exist dependent upon their name, their label, whether it is a physiotherapist, physiotherapy or any other education, tables, chairs, computers and so on.
Dependent upon parts	Everything has parts, whether it is our own body, or the parts or areas of the physiotherapy profession, and the educational curriculum that supports the learning associated with this, along with the objects and resources involved.
Dependent upon imputation	This relates to the collective view and whether something is a suitable basis to impute the term chair, table, physiotherapist, physiotherapy knowledge, skills and so on.
Dependent on mere imputation by conception.	If something is dependent on a basis for a collective imputation then there must also be dependence upon a conscious mind, individuals being aware, reflecting and expressing.

Within Mahayana, notions of ‘being’ or ‘reality’ are expressed within the two truths - ultimate truth or emptiness, and conventional truth which can be expressed through dependent-arising (Napper, 2003; Buescher 2005). Emptiness supports a view of a lack of inherent existence or independent being, not as a nihilistic view but as a non-affirming negative, which is balanced functionally through the conventions of dependent arising (Napper, 2003), much like two sides of a coin. This view is adapted above (Table 6) from commentary to the ‘Perfection of Wisdom Sutra’, (Gyatso, 1996) and summarised within the context of physiotherapy education, represented by five main ways in which ‘things’ exist as dependent related.

Furthermore, Mahayana philosophy identifies objects (things to be known) and also ‘object-possessors’, ie functioning things that cognise objects (Gyatso, 2002) which creates a helpful relationship with the three premises of symbolic interactionism discussed earlier (Blumer, 1969) and an application within EBL. Object-possessors can be explained through the relationship between expressive sounds (letters, names and phrases), people whose function is to perform activities (and experience their results), and cognition or thinking. In terms of communication through words and phrases within a framework of dependent-arising it is important to appreciate that these are ‘mere’ words, that is nothing other than imputation of agreed label(s), that can be considered as metaphors, terms to support a resemblance. Words and language continuously change in terms of their applied meaning and function (Foucault, 2005), a feature of communication that has witnessed acceleration with the advent of social media for example in the use of acronyms (e.g. lol, omg) and symbols (e.g. emoji’s and memes). Thus there is no independently existing language and the majority if not all can be considered as metaphorical, as symbols that are continuously interpreted (ascertaining meaning), and defined between individuals, groups and cultures to inform action through dialogue (Blumer, 1969). As highlighted by Foucault in relation to language and words “*It is in them that what we imagine becomes what we know, and, on the other hand, what we know becomes what we represent to ourselves everyday*” (Foucault, 2005, p97).

Metaphor:

1. a figure of speech in which a term or phrase is applied to something to which it is not literally applicable in order to suggest a resemblance, as in “A mighty fortress is our God.”
2. something used, or regarded as being used, to represent something else; emblem; symbol.

Dictionary.com (<http://www.dictionary.com/browse/metaphor>)

The use of metaphor explicitly formed the basis of Paper 1 ('It's a funny old game'. Football as a metaphor within induction to practice-based interprofessional learning). Indeed metaphor has been a feature within the titles for three of the other five articles as a means to convey representation of content that is consistent with the methodology but also may be viewed as aesthetically pleasing, even humorous. Paper 3 ('*Appearing the team*'....) recognises the lack of an inherently existent 'team' and the projection of 'team' by the participants through the media of space for reflection and meaningful dialogue. Paper 5 (*A Participatory learning model and person-centred healthcare: moving away from 'one hand clapping'*), promotes participation in recognising the interdependent nature of person-centred care and the education that supports this. How participation is developed, maintained and evaluated is encapsulated within the metaphor of 'moving away from one hand clapping' in highlighting the necessity for participation to create 'sound', i.e. it requires a minimum of two hands, a suitable medium / media for sound to travel, and recipients to receive, interpret, and impute 'hand-clap'. Paper 6 (*Lost but making good time ...*) places the central tenets of this thesis within a social and cultural context; 'lost but making good time' highlighting the context of time and space with the processes of learning and identity. As stated above, the application of metaphors and language is consistent with the tenets of symbolic interactionism (Blumer, 1969) and that of cited Buddhist philosophy. The alignment of Western and Eastern thought reflects a personal stance and a position that cuts across cultures away from single patterns of thought and the limitation of a single horizon (Foucault, 2011) that would fail to represent contemporary society.

In attempting to reconcile social and interpersonal sharing of the 'meanings of things' (page 20) with that of a more individualistic perspective, Harber (2009) frames discussion of symbolic interactionism to argue the value of 'disclosure' to oneself as well as with others, ie symbolic interactionism supporting an emergent self. 'Self and others' must relate to society and the legal and moral systems that drive that society, so

that as identified by Bruner (1991) self-narrative (and identity) is seen to be influenced by a social and cultural context. Thus, there is no absolute individual free will (Harris, 2012) but will that is strongly influenced by power and surveillance (Foucault, 2005).

### *3.2.3 Symbolic Interactionism; Foucault, power, surveillance and identity*

In considering a social perspective of education and the dominance of competency-based, product-driven curricula the work of Michel Foucault (1926-1984) offers a valuable perspective in the analysis of power and surveillance. The critical theories of Foucault range across a historical interpretation of thought largely concerned with ideas of power, knowledge and discourse, influencing a considerable area of postmodern theory (Mills, 2005). Although seemingly diametrically opposite in terms of their background and values, there are similarities between the ideas of Heidegger and Foucault. Furthermore, Foucault reported Heidegger as determining his whole philosophical development (Rayner, 2001). In promoting coherence of the arguments offered, the influence of Buddhist thinking on the work of Foucault, particularly in relation to identity and language has also been recognised (Schaub, 1989).

Within *Discipline and Punish*, Foucault (1991) addresses the structures in place within 19th Century prisons and armies where people were forced to obey sets of commands and behaviours to such an extent that they became part of individual personality, part of their identity. Within contemporary, global, consumerist society, Bauman (2010) argues the impact of society in objectifying individuals to perform particular roles - structured enculturation (Paper 6). Arguably, this has resulted in a controlling 'top-down' approach to professional education based on structure rather than agency, unrepresentative of the complexities of a 'disruptive' contemporary society (Bevan, 2017). The continuing plethora of policies, regulations, standards and protocols within healthcare is understandable from a perspective of public safety, yet has diminished professional autonomy through a reductionist approach that is questionable in its ability to meet individual needs. It is interesting to note that linguistically within physiotherapy there has been movement over the past decade away from the use of the term 'capability' to a lower (but 'safer' and more economic) expectation of 'competence' and a movement towards competency based education that situates learning towards 'stasis' (Kleiman, 2011). The *Dialogical Curriculum Framework* seeks to move away from this position in supporting a more balanced, 'bottom-up' as well as 'top-down' approach to education.

Goffman's interpersonal stance and Foucault's societal view (Hacking, 2004) reflect the dynamics of human nature and the use of dialogue in the promotion of authenticity. Whilst accepting the influence of rules and hierarchy that shape dialogue through power and surveillance (Foucault, 2005), the purpose of space for reflection and dialogue within the curriculum is to approach meaning at a particular time and context, and therefore being and identity (Goffman, 1990).

The methodological framework of symbolic interactionism and concomitant theories presented here are contextualised further within the process of *open dialogue* proposed by David Bohm within the next sub-section (Section 3.3). Section 3.4 concludes the chapter to provide a summary in relation to the methodology, learning and professional identity, and curriculum design, to set a backdrop for discussion of the *Dialogical Curriculum Framework* at Chapter 4.

### **3.3 Bohm; open dialogue, space for reflection and participation for a coherent whole**

David Bohm (1917-1992) was an American physicist who contributed ideas to quantum theory, neuropsychology and the philosophy of mind (Peat, 1997). *On Dialogue* (Bohm, 2004) was written to promote equal status and free space as the most important prerequisites of communication and the appreciation of differing personal beliefs. An essential aspect of this form of dialogue is that participants suspend immediate action or judgment to give themselves and others the opportunity to become aware of the thought process itself, ie space for reflection (Paper 1) in order to move to a new position of understanding and development. This should not be confused with negotiation, a process that leads to compromise, an outcome that nobody really wants, and the risk of fragmentation of ideas and the unwitting promotion of intolerance (Bohm, 2007).

There is a need for physiotherapists to be effective in an interdependent, complex world that although full of technological advances, paradoxically reflects an increasing level of intolerance. In promoting space and time for dialogue (a focal point of all papers within the sample) is to accept that there is no unique truth nor any predetermined inherent professional identity underpinned by reductionist competencies. The purpose of space

for reflection is to support a ‘bottom up’ dialogue rather than acquiesce to ‘top down’ authority, an attempt to move away from a reactive model of learning, towards a model of learning that is always aware of ‘the whole’ to promote action that serves ‘the whole’ (Kahneman, 2012; Senge et al, 2010), (Figure 4, below). Reactive learning reflects a ‘top down’, teacher and competency driven approach to learning that is merely concerned with technical knowledge and skills, limited in depth, contextual awareness and understanding of professional identity, rooted in stasis.

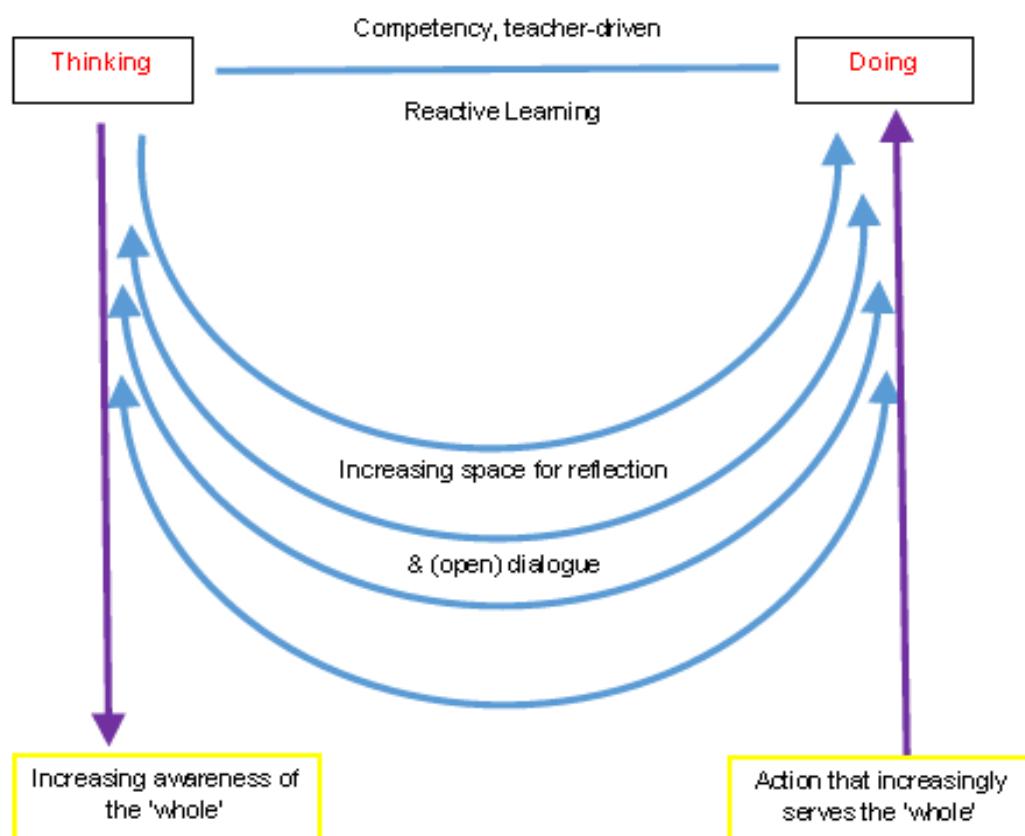


Figure 4. Thinking, doing; the 'whole' picture (adapted from Stephens & Rickard 2016; Senge et al, 2010)

Participation (CPAC, Paper 3, page 13) is a prerequisite for open dialogue, promoting opening up of judgements and assumptions to create coherence of parts within a whole (Senge et al, 2010). The promotion of coherence of parts within a whole can be considered the overall purpose of the sample of papers, explicitly articulated within the participatory learning model (Papers 2 and 5), and the proposed *Dialogical Curriculum Framework*.

Kahneman (2012) highlights the tendency of humans to make decisions based on feelings rather than thinking, according to whether an object is liked or disliked thereby limiting opportunities to understand and learn. The process of thinking and feeling is proposed as a paradox rather than a problem (Bohm, 2004) being rooted in a human tendency towards dualistic perception (Gyatso, 1996) of subject and object as separate rather than interdependent entities (Heidegger, 2008; Bohm, 2004). Things are not always so (Suzuki, 2002), i.e. they do not exist as they seem to appear. To make a 'world' takes more than one person and therefore the collective representation is key in understanding how individuals present to others and how others present to them (Heidegger, 2008; Bohm, 2004; Goffman, 1990) within societies that create rules and morals (Heidegger, 2008; Foucault, 2005). At Paper 3, within the CPAC schema, 'participation' is taken as the willingness to be involved with confidence and without fear of not being accepted, within a professional and social context. Thus the intention is not to create separation of object and subject but to create a sense of being together (Bohm, 2004) where boundaries are not really separations but are just there for descriptive purposes at any given point, in gaining understanding (Blumer, 1969).

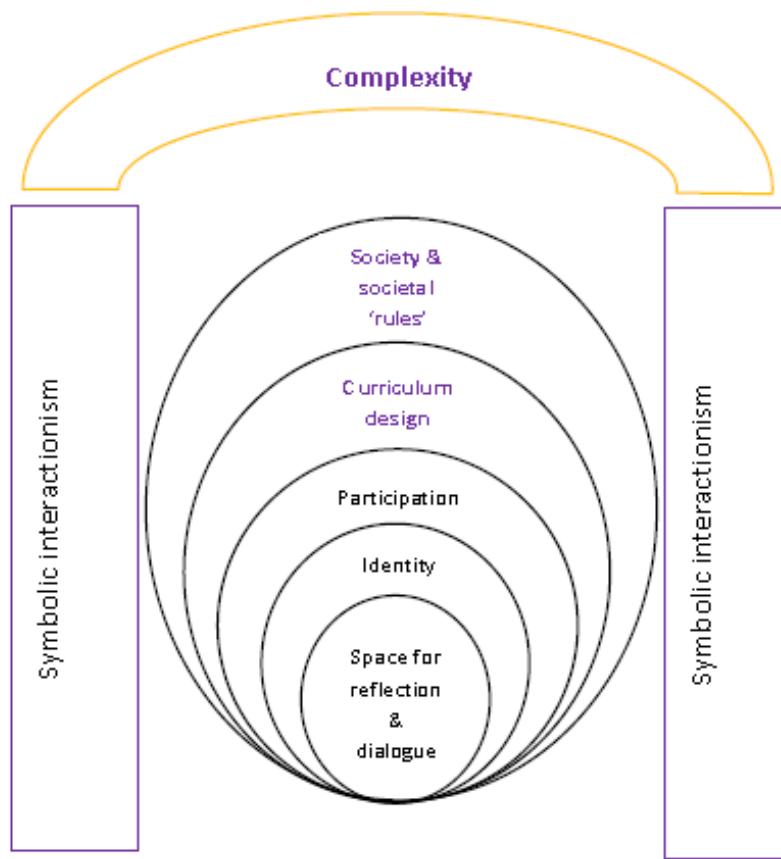
Participation (Paper 3; Bohm 2004) is a process framed by society and its rules, in shaping identity within the context of space for reflection and dialogue. Figure 4 reflects learning based on open dialogue in promoting a combined 'bottom up' (ie all participants) and 'top down' approach to learning. The purpose in promoting space for reflection and open dialogue is to create time and space for insight of being and identity through the ability to tap into complexity. Thus the *Dialogical Curriculum Framework* shapes learning through enquiry based methods that reflects activity within a complex, contemporary society, ie brings order to fragmentation to form a coherent whole (Figure 4, page 27).

### **3.4 Symbolic interactionism, identity, and curriculum design**

To summarise; in framing the argument for a *Dialogical Curriculum Framework*, symbolic interactionism is proposed as a reality based on impermanence, to be understood as an interdependent, social interaction with others. Learning and professional identity is shaped through individuals' social definitions - people respond not to a physical reality but to the social understanding of reality; an individual/collective appearing of reality as an interdependent whole and not fragmented parts.

Bauman (2010) uses the analogy of a jigsaw when representing identity. One usually starts from a position of possessing the final image beforehand, with all pieces being present, a goal-orientated activity (product). Within professional identity, the labour is means-orientated (process). One starts from a number of pieces already obtained or that seem worthy of having, with only a vague concept of the final ‘picture’. Pieces are continually ordered and re-ordered in the attempt to generate some pleasing pictures; “*you are experimenting with what you have and also adding to this*” (Bauman, 2010, page 49). In professional education although there are standards to guide, there is much more to education, learning and identity than ‘ticking the boxes’ of the standards. Due to the complex nature of contemporary society, the final picture, the product, is always changing. This is the context for the discussion of the *Dialogical Curriculum Framework* within the following Chapter.

#### 4. The case for a dialogical curriculum framework



*Hasten slowly, you will soon arrive,* is adapted from a quote attributed to Milarepa, an 11th Century Tibetan Buddhist scholar (Evans-Wentz, 2000). Within the original meaning these lines present an encouragement to apply patience and 'steadfast' effort to practice and not to waste the opportunities

presented in life. This chapter discusses the *Dialogical Curriculum Framework* and its application with reference to the development of MSc Physiotherapy (pre-registration), Northumbria University.

*"..... As I needed to shoot the videos a few times , it was a good opportunity to refine some of my skills. Another benefit was ..... the group effort was required .... bouncing ideas of what was necessary"*

Student quote, Paper 4, p339

As a product, the general aim of pre-registration physiotherapy education is in the education of safe and effective autonomous practitioners to meet the requirements of professional and educational regulatory bodies (HCPC, 2013; CSP 2013; Skills for Health, 2017; NHS Employers, 2017a). As argued by Bauman (2010) and Foucault (2005), within notions of autonomy there exists 'buy in' to a knowledge and power relationship by all involved, though not as sinister social conditioning of individuals and

groups; things ‘just are’ (Suzuki, 2003; Katagiri, 1988). The *dialogical curriculum* is an attempt to distribute knowledge and power more evenly in pursuit of tolerance and coherence in the support of learning. Doing things (professional education in this case) ‘with’ rather than ‘to’ people. As Bauman (2010) asserts, everyone wants to be autonomous. Autonomy is the fabric of 21st Century life, the paradox being the illusion of free-will (Harris, 2012; Foucault, 1991) and the impossible challenge in education to produce predictable outcomes that commission the future (Edwards, 2008).

Notions of professional autonomy are not specific to physiotherapy or healthcare. As discussed at the previous chapter the paradoxes surrounding knowledge, power, regulation, and surveillance are reflective of society as an interdependent whole. Understanding and ‘doing’ interdependence genuinely concerns resilience in holding a belief that healthcare and healthcare professional education is by people for people. Qualities of tolerance, respect, and coherence through open dialogue (Bohm, 2004) make us individually and collectively resilient (Bauman, 2005). This has been a feature of papers 1 to 5, in seeking to understand (inter)professional identity (Papers 1 and 3), relationships with service users or People with Experience (Papers 2 and 5) and a commitment to clinical skill development (and therefore continuing professional development) through deliberate practice (Paper 4).

Underpinning these activities are the processes of cognition and decision-making based on System 1 and System 2 thinking (Kahneman, 2012; Crosskerry, 2009; Stanovich, 2009). A detailed analysis of System 1 and System 2 (or ,Type 1 and Type 2) thinking is beyond the scope of this work. However, a brief overview is provided at Table 7 (page 32), to provide context.

The two systems are interdependent. Most of what is thought and done originates from System 1, with System 2 taking over when more specific processing is required or desired. System 2 is also credited with monitoring of behaviour, making an individual self-aware, and of possible errors about to be made through System 1. System 1 continuously generates suggestions for System 2 (impressions, feelings, intentions). If System 2 endorses these through analytical thought, then these become beliefs and actions. Thus, there is ‘toggling’ across Systems through mindful reflection (Kabat-Zinn, 1994).

Table 7. System 1 and System 2 Thinking (Kahneman, 2012)

System	Descriptor
System 1	Intuitive mode, that operates automatically, with little to no effort and no sense of voluntary control e.g. an immediate impression of liking or disliking something
System 2;	A more critical thinking mode, that allocates attention to more effort requiring mental activities that demand it for example working out the mathematical challenge of $17 \times 23$ , and are often associated with the more subjective experiences of choice and concentration.

Hence, the central processes driving thinking for enquiry and the *Dialogical Curriculum Framework* are in creating space for reflection and dialogue (to engage System 2) and participation, framed by symbolic interactionism. Making meaning of experiences to learn and shape identity is as a result of an approach that is based on an emphasis on processes that engage human interaction in pursuit of (notional) outcomes through ‘emancipatory ignorance’ (Biesta, 1998; Edwards, 2008). Learning based on an understanding of the whole (Figure 4 page 27) rather than reacting to the parts.

The parameters and dynamics of the *Dialogical Curriculum Framework* are articulated through four personal and professional attributes, four professional learning themes and ten professional learning constructs. The processes of space for reflection, open dialogue, participation and symbolic interactionism drive learning and professional identity, immersed within the context of UK policy and society. For contextual clarity a definition of physiotherapy (CSP, 2013) is provided at page 33.

#### 4.1 A Dialogical Curriculum Framework

A *Dialogical Curriculum Framework* for physiotherapy education is illustrated in Figure 5 (page 35). The framework reflects a process to meet the requirements of healthcare professional education within contemporary society through a balance of structure and agency. An egalitarian attempt to promote ‘bottom-up’ as well as ‘top-down’ participation through open dialogue and the provision of space for reflection, the framework seeks to

address the tensions between knowledge, power and (healthcare) professional education

Physiotherapy is a healthcare profession that works with people to identify & maximise their ability to move & function. Functional movement is a key part of what it means to be healthy. This means that physiotherapy plays an important role in enabling people to improve their health, wellbeing & quality of life.

Physiotherapists use their professional knowledge & practical skills, together with thinking skills & skills for interaction in their day-to-day practice. This combination of knowledge & skills means that practitioners can work in partnership with the individual & other people involved with that person.

Physiotherapists recognise that physical, psychological, social & environmental factors can limit movement & function. They use their knowledge & skills to identify what is limiting an individual's movement & function, & to help individuals decide how to address their needs.

Physiotherapy's values means that practice is person-centred, ethical & effective. The evidence-base underpinning physiotherapy is constantly evolving as practitioners develop new knowledge & understanding through critical reflection, evaluation & research. This evolving evidence base supports the use & development of physiotherapy's scope of practice. The Royal Charter gives physiotherapy a broad scope of practice that includes manual therapy, exercise & movement, electrotherapy & other physical approaches.

Physiotherapy is an autonomous profession. This means that physiotherapists can accept referrals for assessment from a range of sources: from an individual themselves (self-referral) or from other people involved with that individual.

Physiotherapy can offer a range of interventions, services & advice to improve individuals' health & wellbeing.

Physiotherapy works to maximise an individual's movement capability at three different levels. It can help maintain & improve the body's movement & function by offering treatment when someone is acutely ill in hospital. It can also improve someone's function & independence (at home, at work) by offering rehabilitation & advice. It can also enhance their performance & participation (in their community & wider society) by offering advice & by challenging the environmental or social barriers that limit participation.

Physiotherapy's strong clinical leadership & adaptable workforce means that it can deliver high quality innovative services that are accessible, effective & efficient. Physiotherapy maintains strong links between clinical & academic settings. This means that the profession responds to developments in practice, education or research, & actively ensures its workforce continues to be fit for purpose.

Definition of Physiotherapy (CSP, 2013, page 4)

As argued within Chapter 3, there is no inherent existence or truth and therefore no absolute identity (for a physiotherapist). Identity is shaped within a curriculum by the participants, i.e. largely by the students, with support from educators rather than by a curriculum delivered by educators that merely teach and assess students in accordance with professional standards. The proposed curriculum framework seeks to understand power-knowledge and focus on the discursive processes that brings the subject (a physiotherapist) into being.

At Figure 5, the blue background represents society, 'British culture' in terms of the political, social, economic, and educational landscape. The professional Standards of Proficiency for Physiotherapy (HCPC, 2013), and Standards of Education and Training (HCPC, 2017) along with associated frameworks (for example NHS Employers, 2017a; CSP, 2013) although not entirely prescriptive in terms of subject content, identify standards to be met through programme and module learning outcomes. This has been achieved within the MSc Physiotherapy (pre-registration) Professional Framework Northumbria Awards (PFNA) validation and HCPC/CSP approval through cross-mapping exercises (see Appendix 8. Section 4. Masters Degree Programme Learning Outcomes, Appendix 9. HCPC Standards of Proficiency Cross Mapping); processes indicative of *power-knowledge* (Foucault, 1991), arguably benevolent in support of public safety yet also hierarchical in terms of surveillance.

*It is not the activity of the subject of knowledge that produces a corpus of knowledge, useful or resistant to power, but power-knowledge, the processes and struggles that traverse it and which it is made up, that determines the forms and possible domains of knowledge,*

Foucault (1991, p28)

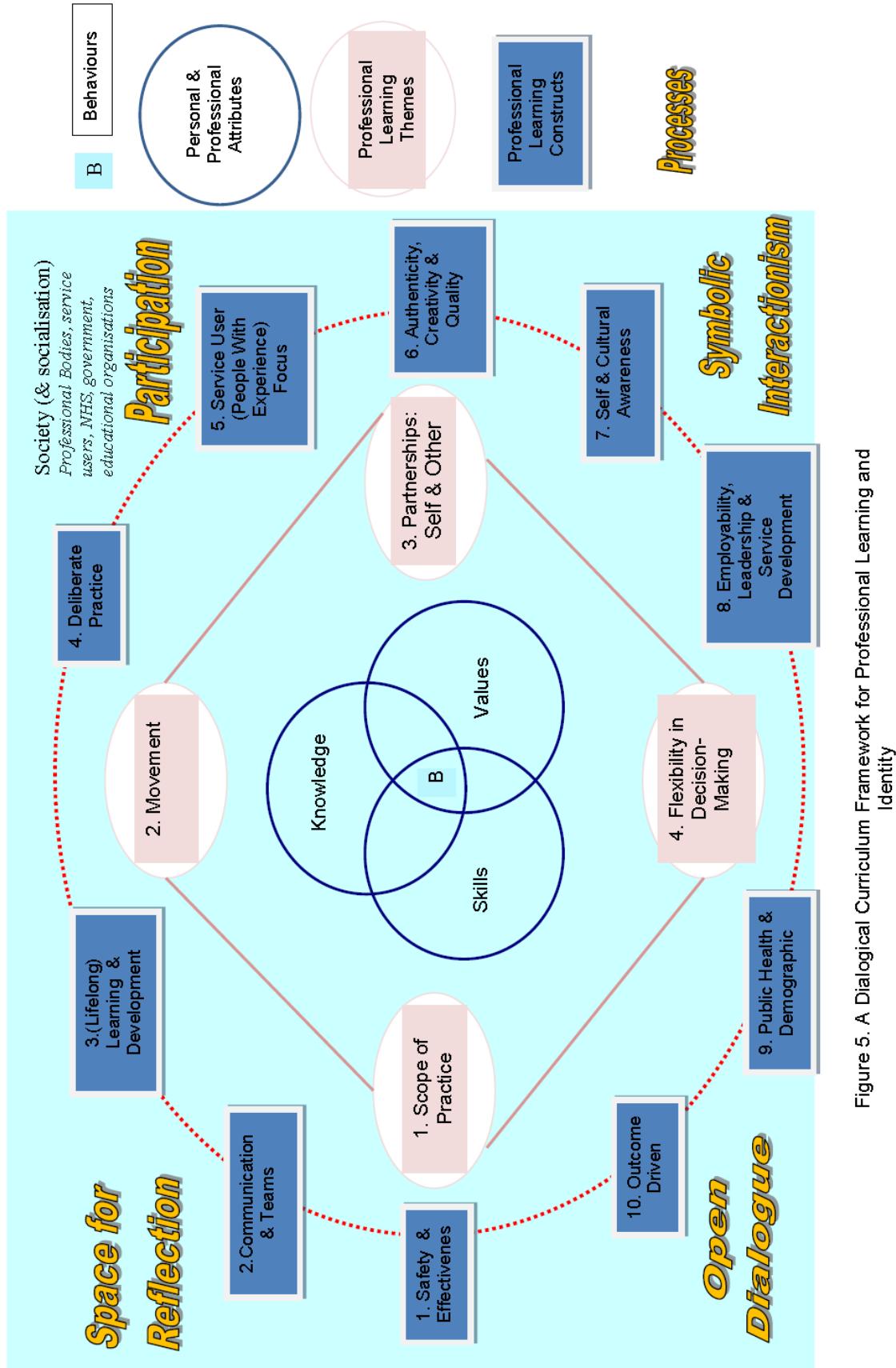


Figure 5. A Dialogical Curriculum Framework for Professional Learning and Identity

*Personal and professional attributes* are drawn from the CSP Physiotherapy Framework (CSP, 2013), a framework designed to promote and develop physiotherapy practice across all countries in the UK. It serves to describe and define behaviours (and associated values), knowledge, and skills required for contemporary practice, across all levels from support workers, to senior staff level, and a range of settings and roles. The *attributes* not only represent a point for ‘emergence’ (Byrne, 2005) in a complex process articulated within professional body standards, but also a point of arrival for students, in recognising that they ‘come into’ the profession with a set of behaviours, skills, knowledge, and values. The *professional learning constructs* indicate key thematic areas for contemporary practice (largely policy and profession driven) that shape the curriculum, which in turn influence and are influenced by the *professional learning themes*, systems (Davis and Sumara, 2008) that integrate characteristics of the profession and the educational approach (enquiry-based learning). The *professional learning themes* function to link *core attributes* and *professional learning constructs* in a dynamic and constantly changing process in the emergence of learning and identity through open dialogue, space for reflection, participation, through a process of symbolic interactionism.

The 10 *professional learning constructs* are therefore elements of the programme that shape the curriculum outcomes and content through their articulation with the *professional learning themes*. It is argued that these constructs could be representative of any professionally regulated education programme. The four *professional learning themes* are broader thematic aggregates to link the *constructs* and the *attributes* within the context of Physiotherapy. Table 8, defines *professional learning themes* within a professional and a learning context (supported by relevant evidence and the 6 Papers inform the commentary), and Table 9 defines *professional learning constructs* within the context of professional learning supported by relevant subject area evidence and the 6 papers that inform the commentary.

Table 8. A Dialogical Curriculum Framework; *professional learning themes*

<b>Professional Learning Theme</b>	<b>Professional characteristics</b>	<b>Learning characteristics</b>
1.Scope of Practice	<p>Maximising individuals' movement potential within a scope of physiotherapy practice interventions that include:</p> <ul style="list-style-type: none"> <li>● manual therapy</li> <li>● exercise &amp; movement</li> <li>● electrophysical modalities</li> <li>● kindred physical approaches</li> </ul> <p>(CSP 2013, HCPC 2013)</p>	<p>Promotes a wide range of abilities including knowledge / skills creation, team-working, information literacy, creativity (Kahn &amp; O'Rourke, 2005).</p> <p>Papers 1-6</p>
2.Movement	<p>Conceptualise and promote movement as a continuum, within a microscopic (molecular) to macroscopic (person in society) context (Cott, &amp; Finch, 2007)</p>	<p>Open-ended activities, enquiry as a process of seeking and 'travel' as a learner that is unceasing, (Hutchings, 2007).</p> <p>Papers 1-6</p>
3.Partnerships: Self & Other	<p>To facilitate the sharing of information, advice &amp; ideas with a range of people, using a variety of media (including spoken, non-verbal, written &amp; e-based)</p> <p>(CSP, 2013)</p>	<p>Zone of Proximal Development Vygotsky (1978), the value of relationships between persons, environment and tools.</p> <p>Communities of Practice (Lave &amp; Wenger, 1991)</p> <p>Papers 1-6</p>
4.Flexibility in Decision-Making	<p>Key attribute as an autonomous professional. To take responsibility for actions, behaving ethically in achieving excellence in the delivery of an effective service (CSP, 2013)</p>	<p>To identify and develop a broad range of abilities, including managing complex enquiries and the ability to synthesise learning as a lifelong learner (Kahn &amp; O'Rourke, 2005)</p> <p>Papers 1-6</p>

Table 9. A Dialogical Curriculum Framework; *professional learning constructs*

<b>Professional Learning Construct</b>	<b>Characteristics</b>
1.Safety & Effectiveness	A foundation of competence, the ability to benefit and not harm self or others (Papers 3 & 4; NHS, 2017)
2.Communication and Teams	The development of intelligence in team working and communication with others across a broad range of levels via a broad range of media (Papers 1 & 3; Trede, 2012,)
3.(Lifelong) Learning & Development	A commitment to participation in learning, recognising the continually changing contexts for clinical practice and a journey towards 'expertise' (Paper 6; CSP, 2013)
4.Deliberate Practice	Strongly associated with 'expert' practice, that places value on repetition and reflection in the development of skills (Paper 4; Ericsson, 2004)
5.Service User (People with Experience [PWE]) Focus	A commitment to person-centred physiotherapy / healthcare (Papers 2 & 5; CSP, 2013 )
6.Authenticity, Creativity & Quality	Evidence-based practice that draws on formal and informal knowledge to inform complex, person-centred decision-making which lies at the heart of sound physiotherapy / healthcare practice (Papers 2, 4, & 5; CSP 2013; Trede 2012).
7.Self & Cultural Awareness	The ongoing development of self-identity as a physiotherapist, which is always related to others (Papers 1, 3, 4, 5, & 6; CSP, 2013)
8.Employability, Leadership & Service Development	A commitment to influencing the activities of individuals or an organised group in its efforts towards goal setting and goal achievement in continuous improvement (Papers 1, 4 & 6; Hartley & Benington, 2010).
9.Public Health & Demographic	The broad context for professional practice, in understanding public, professional and political expectation and range influences on this, for example ageing population, technological advances, national and global politics and economy (Papers 2, 3 & 5; DH, 2012).
10.Outcome Driven	Purposeful physiotherapy that is person-focused and driven by mutual goals (Papers 2 & 5; DH, 2012)

With the apparent strong influence of professional body standards, the *Dialogical Curriculum Framework* may be perceived as just another ‘top-down’ policy dictated framework, subject to heavy surveillance. However, the processes driving the curriculum seek to provide a diversified way of learning, targeted at contemporary and future employment and employability, recognising the inevitability of surveillance.

*although surveillance rests on individuals, its functioning is that of a network of relations from top to bottom, but also to a certain extent from bottom to top and laterally: this network ‘holds’ the whole together and traverses in its entirety with effects of power that derive from another: supervisors, perpetually supervised*

(Foucault, 1991, p176-177)

At a simplistic level, the proposed curriculum framework rests on what is thought and said (and how) rather than by who across a broad range of enquiry that is largely task driven (for example Papers 3, 4) or scenario driven (for example Papers 1, 2, 3, 5). A genuine attempt to address some coherence in power relationships is made for example, through the paucity of formal lectures promoting staff as ‘the guide on the side’, a collaborator and participant rather than ‘sage on the stage’ (Fox, 2005). The dialogical processes within created space for reflection shapes learning and professional identity through symbolic interactionism.

The transformation or movement towards ‘qualified professional’ within a two-year period (accelerated MSc programme) requires the establishment of social cohesion within an inclusive group of students and staff. The dynamic, complex nature of relationships across the programme enables ‘reflexively organised activity’ (Giddens, 1997), that connects learning to form a coherent whole. This is achieved through understanding the influences of more global phenomena such as the law, British culture, educational and professional regulation and more proximal classroom-based events through dialogue and narratives (Lawler, 2008) to provide a trajectory (Giddens, 1997) and transformation of self, ie. ordering and re-ordering of ‘jigsaw pieces’. The framework represents a shift in centre of gravity away from a structured ‘scaffold’ of product dominated curricula towards a more collaborative student-centred approach that acknowledges the potential for co-production of learning. Thus, it is rooted within a reflective paradigm for education (Lipman, 2003) and the concepts of zones of proximal development (Vygotsky, 1978) and communities of practice (Lave and Wenger, 1991); education on the edge of chaos, (Kleiman, 2011). Within the example

of the accelerated MSc Physiotherapy (pre-registration) programme introduced at Chapter 2 (Section 2.1, p 11) this is highlighted through workshop delivery in the academic setting and negotiation of clinical practice learning outcomes that culminates at the final programme module through the negotiation of module learning outcomes, (Appendix 10. PT0709; Innovation and change for contemporary physiotherapy).

The following section provides a brief summary of the development of MSc Physiotherapy (pre-registration), Northumbria University since its inception in 2003 that reflects the ongoing development and application of the *Dialogical Curriculum Framework*. Appendix 11 (How to hasten slowly...) provides a 'quick guide' to the development and implementation of the framework for anyone wishing to pursue this approach in educating the practitioners of the future.

**4.2 MSc Physiotherapy (pre-registration) and the dialogical curriculum framework** MSc Physiotherapy (pre-registration), Northumbria University was originally validated and approved in 2003. Ongoing review and development of the programme has been supported by an iterative development of the curriculum design. Two subsequent re-validations and a reframing of the programme within the Professional Framework for Northumbria Awards (PFNA, Northumbria University 2015) during Spring 2017 has integrated learning derived from University and practice-based settings and, in partnership with practice-based stakeholders, embedded approximately one third of study within the practice environment. This amounts to a minimum 1000 hours of learning as required by the Chartered Society of Physiotherapy (CSP, 2015). The purpose of the programme is to develop the knowledge, skills, values and behaviours required to become a physiotherapist eligible for professional registration. The curriculum is also required to comply with Masters Level 7 of the Framework for Higher Education Qualifications (FHEQ) (QAA, 2014) in providing opportunities to develop abilities in dealing with complex issues, demonstrating self-direction and originality, whilst continuing to advance knowledge and understanding.

The Professional Framework for Northumbria Awards (PFNA) (Northumbria University, 2015) sets out a framework for curriculum design to ensure that programmes align with and contribute to, the outcomes of the Northumbria Corporate Strategy 2013-18

(Northumbria University, 2013), and Vision 2025 (Northumbria University, 2013). The framework outcomes are built around the concept of the Northumbria Graduate with an emphasis placed on four pillars of Research Rich Learning, Employment and Employability, Technology Enhanced Learning, and Assessment for Learning. As well as existing within the national frameworks governing Higher Education, PFNA also seeks to maintain and develop strong relationships through accreditation with Professional, Statutory and Regulatory Bodies (PSRBs), in this case the HCPC and CSP. The proposed *Dialogical Curriculum Framework* was employed in the development of the successful PFNA validation, (Appendix 8 MSc Physiotherapy (pre-registration) Programme Specification) in March 2017 and subsequent re-accreditation with the HCPC and CSP in May and June respectively. There were no conditions applied for any of these events with eight commendations (a favourable outcome is four) cited at the CSP event.

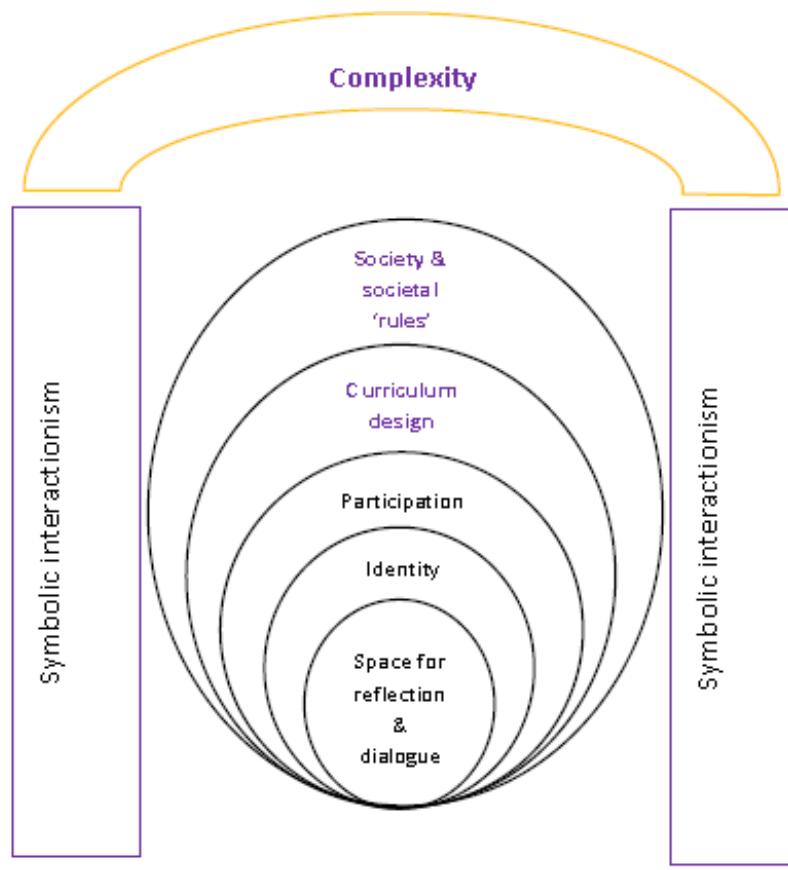
#### **4.3 Academic award, PSRB registration and complexity**

Within physiotherapy, as with any pre-registration health and social care professional education programme concerns lie with gaining the award and learners being eligible for PSRB registration and re-registration. This requires a commitment to lifelong learning and a vehicle through which to record development. Although discussion is beyond the scope of this work an attempt to capture student learning shaped by the *Dialogical Curriculum Framework* and the emergent themes of the papers informing this thesis has been made through the development of the ‘webfolio’ (Appendix 12). The framework offered by the ‘webfolio’ is not prescriptive, with the content and platform for its development very much left to individual preference. Although anecdotal feedback from students is largely positive, as was that from conference dissemination (Stephens, Parr & Clarkson 2014) more formal research concerning development and use of the ‘webfolio’ is indicated.

The process of reflection and education being concerned with human interaction is not isolated to physiotherapy. Generally, learning is mediated and co-constructed with others (Mulcahy, 2012) being interdependently rather than independently constructed. As Mulcahy (2012) states, learning is ‘*distributed across persons, tools and environments*’ (p 124). Education is complex (Fenwick, Nerland & Jensen 2012; Kleiman, 2011; Haggis, 2008) and as such requires the participation of a broad range

of stakeholders (Paper 6). If viable in enhancing the available curriculum design ‘menu’, the potential to adapt the *Dialogical Curriculum Framework* for other professions and levels of award (ie not just MSc) needs to be considered. The final chapter of the commentary seeks to address this through further consideration of contemporary pre-registration healthcare education, and potential for adaptation of the attributes, themes and constructs as a framework for learning within other healthcare professions and levels of award.

## 5. ‘Hasten slowly’ for a broader impact?



Time is space, is being. Individuals are not independent but connected with others. To become a healthcare professional requires the power of individual and collaborative effort to master the necessary knowledge, skills and values that manifest professional behaviour and identity. The

*Dialogical Curriculum Framework* is proposed as a way of achieving this within a rapidly changing pre-registration health professional education landscape. The final chapter of this thesis seeks to explore potential application to other healthcare professions across varying levels of education.

As of September 2017, undergraduate pre-registration healthcare programmes moved away from public funding to self-funding (UK Government, 2016), although the two year accelerated pre-registration MSc programmes were assured public funding for 2017-18. In addition a plethora of pre-registration routes has been proposed by the UK Government including apprenticeships, two year BSc(Hons), integrated Masters, and Doctorate level education (UK Government, 2016; Council of Deans 2017). This at a time when the role of Physiotherapists, Nurses, and Allied Health Professionals is rapidly changing with demand growing.

The UK Government has argued the NHS, independent care and social care sector, students, universities and wider public sector will all benefit from introducing the same reforms in health education that have taken place across the rest of higher education (UK Government, 2016). This is predicted to provide a greater number of healthcare professionals, reduce costs and reliance on agency staff, and enable a greater number of students to realise an ambition to enter the profession of their choice. A broader range of pathways to gain professional registration claims to provide benefits to students, healthcare organisations and HEIs, e.g. programmes of shorter duration, quicker to gain employment or being in employment for the duration of study (apprenticeships). All of this arrives at a time when consumer demand and choice is predominant in what is offered by service providers, universities and other education providers.

The initial NHS Employers (2017b) physiotherapy degree apprenticeship standard consultations, were circulated across the autumn of 2017, with standards for other professions either having been established (for example, Nursing) or being open for consultation (for example, Occupational Therapy, Podiatry). Whilst appreciating the iterative approach taken, the first two consultations regarding the proposed physiotherapy standard did little to allay fears of possible regression towards competency-based education. Table 10 (page 45) summarises a number of personal observations from the consultation across Autumn 2017.

Across the physiotherapy standards consultation, initially there appeared to be substantial omissions allied to the ten professional learning constructs of the *Dialogical Curriculum Framework*, and an absence of any real emphasis on the professional learning themes of *partnerships, and flexibility in decision-making*. Limitations in what is acknowledged as a consultation exercise does at least raise possibilities for opportunities provided by curricula that are more process orientated to shape education. By January 2018 the CSP received confirmation that the Institute for Apprenticeships had approved the standard for the physiotherapy degree apprenticeship (CSP, 2018). This had been pre-empted by the CSP in clearly framing expectations for pre-registration education across taught doctorate, integrated masters, and compressed BSc(Hons) degrees (CSP, 2017).

Table 10. Limitations observed at physiotherapy apprenticeship standard consultation  
Autumn 2017

Questions regarding uptake by Trusts providing specialist services and therefore not being able to offer a rounded education
Not all service users recover; the role of physiotherapy in palliative care and mental health settings was absent
Service user (PWE, Papers 2, 5) perspectives held quite a low profile, so that the profile of person-centred care was questionable
Questions raised over the educational requirements for entry to programmes
The absence of a pre-registration Masters level apprenticeship
Little reference to a biopsychosocial model of health
Greater emphasis being required with regard to professional autonomy, critical thinking, clinical reasoning, the role of physiotherapy in health promotion / public health
Insufficient mention of team working
No real reference to service improvement and leadership

Aligned with these professional education standards, a consultation paper released at a similar time by the Department of Health (2017) recognised the need for professional regulation to change, to be “*faster, simpler, better and less costly*” (DoH, 2017 p4).

Anecdotally, the challenges of fitting ‘everything’ into pre-registration education has been a point for discussion across a number of years, highlighting the importance and challenges offered by the null curriculum (Eisner, 1985), ie what is selected to be omitted from a curriculum. In 2005 following development of the initial iteration of (pre-registration) MSc Physiotherapy, I explored the potential for transferability of enquiry-based learning approaches within physiotherapy (MSc and BSc(Hons)) across pre-registration education (Stephens & Dawson, 2005) from the perspective of academic staff experiences. The six emergent themes from this work (expressed in pairs below)

provide some useful guidance in terms of ‘points to consider’ in the application of the *Dialogical Curriculum Framework*:

- Quality relationships and quality knowledge; that is dependent on the rich dialogue within the student group and between the students and staff (Papers 1 - 5).
- Coherence within and between programmes, and personal and professional development; opportunities emerge from the ‘discomfort’ of uncertainty with coherence in teaching and learning viewed as a key requirement for success. More than an element of being ‘lost but making good time’ (Paper 6).
- Resources and contradictions; being ‘lost but making good time’ can be stressful for both students and staff, but at the same time lead to success and is fun. Access to rooms and other resources and changing ways in which they are used (Paper 4) may not always fit within any current administrative bureaucracy.

Adapted from Stephens & Dawson, (2005)

The following points should be recognised before moving on to represent the potential adaptability of the *Dialogical Curriculum Framework*:

- Any change will be emotive and require sensitive, and pragmatic handling.
- Change can bring added value to staff development, despite any apprehension and anxiety.
- Is dependent upon developing and maintaining dialogue and relationships, so that the building of coherence is ongoing, and seen as everyone’s concern, everyone’s responsibility.

Stephens & Dawson, (2005)

### **5.1 A dialogical curriculum framework for others. Time for change?**

As identified within Chapter 2, present day students are naturally creative learners, curious and active problem solvers with a range of activities outside university that hold a great potential in transferable skills (Lingo & Tepper, 2010). In promoting a more process driven curriculum it is necessary to avoid the dangers of reactive learning that focuses on technical competence within a context limited, protocol dependent curriculum (ie product dominated). Disruption to stimulate disequilibrium and feedback

(Kleiman, 2011) is required to promote authentic learning. However, the use of creativity and imagination requires courage.

*It takes courage to let foreign places and ideas be represented in a playful dance. Judgement on the other hand, requires a sense of responsibility. It ensures that the imagination is actively and practically anchored by directing it towards the common good.*

Romer (2013) citing John Dewey

As observed previously, there are ‘rules’, so that a completely open curriculum ie one devoid of learning outcomes (products) is highly unlikely to be successful at validation and professional accreditation events. It is necessary to reflect PSRB standards of proficiency within programme (and module) learning outcomes. However, although a form of ‘order’ is required within curriculum design, it should be understood that whilst attachment to order can satisfy a need for security this becomes problematic if resulting in fixed programmes of thought that prevent creative activities necessary to meet the needs of both present and future healthcare profession education needs. Opportunity presents within the *Dialogical Curriculum Framework* through deconstruction of the ‘rules’ to form curricular themes and constructs around which to base enquiry driven by dialogue within space for reflection involving a community of learners (Lave & Wenger 1991).

Figure 6 (page 48) offers an adapted format for the *Dialogical Curriculum Framework*. The only differences from that represented at Chapter 4 (Figure 5, page 35) arise at the first and second *professional learning themes* in terms of ‘Scope of Practice’ and ‘Movement’. Whilst the learning characteristics for each of these themes remain similar, the professional characteristics would require amendment (Table 8, page 37) to reflect scope of practice and defining professional characteristic respectively for a selected profession. For example, the latter could be represented by ‘compassionate care’ for Nursing (RCN, 2008; NMC, 2015), or ‘meaningful occupation’ for Occupational Therapy (HCPC, 2013b), or ‘perioperative care’ for Operating Department Practitioners (HCPC, 2014).

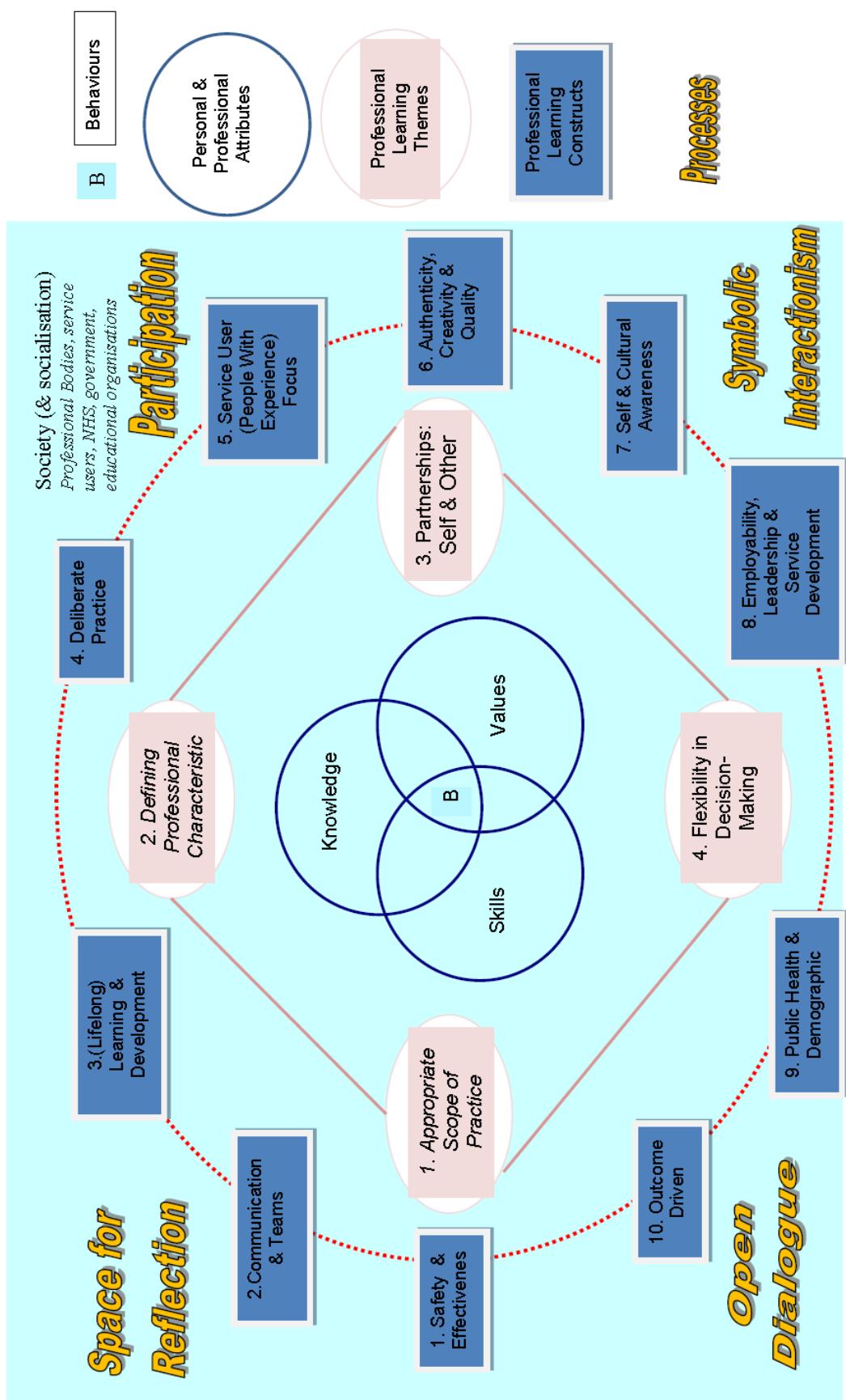


Figure 6. A Dialogical Curriculum Framework for Professional Learning and Identity for Others?

It is proposed that all healthcare professional students, irrespective of background and level of pre-registration study enter their profession with a range of knowledge, skills, values and behaviours, a basis on which to shape professional identity. Shaping of identity is based on an understanding of 'I am like this,' as part of being aware of the 'whole' and resultant action (behaviour) based on the 'whole' (Figure 4, page 27). As previously argued this is achieved through open dialogue, within space for reflection to enable participation framed by the ten *professional learning constructs*, and a methodology of symbolic interactionism across both academic and clinical settings, and address the challenge of "*I came into nursing because I care. You taught me how to care and now I don't care anymore*" (Chapter 2, page 10).

Professional education that is participatory in nature (Papers 2, 3, 5) and that involves co-production of learning (Edwards, 2015) through largely workshop based methods including opportunities for actively recorded learning (Paper 4; Appendix 9. Webfolio) holds potential for personal and professional development at the edge of chaos (Kleiman, 2011). The *Dialogical Curriculum Framework* functions to shape learning driven by a process of enquiry, with opportunities to

- Engage with tasks, problems and contexts
- Self-organise and self-direct
- Work collaboratively, to be creative in sharing perceptions, questions, and assumptions
- Critically explore thoughts, feelings and practice
- Allocate and accept responsibility, formulate plans
- Create knowledge and skills, influenced by values to inform behaviours
- Reflect on why, how and what

Within the framework tutors are recognised as fallible participants (Lipman, 2003), with access to a broad range of innovative, valid, appropriate resources. A 'quick guide' for those wishing to adopt the principles of the *Dialogical Curriculum Framework* for pre-registration programmes is provided at Appendix 11. The Framework is not designed to provide a short-term quick fix, but does require an authentic commitment to open dialogue that promotes space for reflection and learning through enquiry.

## **5.2 Conclusions through iteration**

The proposed *Dialogical Curriculum Framework* cannot be considered a finished article but represents iteration of a process driven curriculum that will continue to evolve through further exploration, study and development. However, the example of the accelerated MSc Physiotherapy (pre-registration) discussed at Chapters 2, 3 and 4 provides evidence and encouragement for success of an iterative approach to curriculum design that is process-driven, in meeting the requirements of healthcare professionals of the present and the future. As argued by Syed (2016), society has moved away from organisation dominated by ‘engineers’ providing a finished structure to be implemented, towards organisation that owes much to the approach of ‘biologists’ in providing continual development through change.

Contemporary healthcare professional education must produce safe and effective practitioners as a minimum requirement but not practitioners with a preponderance to drift back to stasis (Kleiman, 2011) through attachment to ‘tick-box’ competency. The processes supporting the *professional learning constructs* in particular, facilitate qualities to drive continuing development; education and learning for capable practitioners delivering healthcare that is people-centred, context-relevant, authentic, and wise (Higgs et al 2008; Higgs & Titchen 2001).

Conclusions presented here are impermanent, open to review and further development. Some apology is made in offering conclusions that raise more questions than answers, but it would be incoherent and extremely short-sighted to offer a solid rather than liquid end to the commentary. The *Dialogical Curriculum Framework* seeks to promote professional education driven by creative, purposeful learning embedded in a societal experience so that all participants hold the sense of reasons for learning at the heart of the process. Tutors and students, as participants have the opportunity to engage in co-production and continuing evaluation of learning experiences rather than following product dominated procedures in meeting the requirements for healthcare that is safe, effective, and innovative in not merely reacting or responding to change but also in ‘being’ change.

The five initial questions listed below are very much to be viewed as strengths and opportunities presented by the framework:

1. Would there be a chance that a process driven curriculum would promote learning capability rather than mere competence, and enhance the learning experience for all participants?
2. Would governance of learning (quality assurance and enhancement) and associated surveillance reflect the potential for horizontal and bottom-up accountability rather than top-down vertical accountability?
3. What might be done to create even more creative, disruptive learning opportunities, in a complex society - at the edge of chaos?
4. Would the curriculum framework concepts be transferrable and how?
5. What might further iterations of the curriculum framework look like?

The concepts surrounding the *Dialogical Curriculum Framework* may appear idealistic in a consumer driven society seemingly orientated towards products and institutions of lifelong consumer education (Bauman, 2010). However, at the heart of the argument in support of the framework is one of people as social processes that are purposive and creative. Reality is based on dynamic, continuous social interaction with others - symbolic interactionism (Mead, 1992; Blumer, 1969). Physical reality, identity, and function is achieved through individuals and groups' social definitions so that people respond not to physical reality but to the social understanding of reality. It is in understanding healthcare professional education as a continuous, coherent whole rather than a series of fragments that somehow join up to produce a healthcare professional, that the *Dialogical Curriculum Framework* is based.

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## Glossary

Being	A general concept encompassing notions of reality and existence.
Chaos	A property of complex systems whose behaviour is unpredictable owing to great sensitivity to small changes in conditions.
Chartered Society of Physiotherapy	The chartered professional body and union for physiotherapy.
Community of practice	A group of people who share an interest or passion for something they do, and learn as they interact regularly.
Complexity	The behaviour of systems / society whose components interact in multiple ways and follow local rules, meaning there is no reasonable higher instruction to define the various possible interactions.
Contemporary society	The circumstances and ideas of the present age, characterised by technological innovation and increasing human interconnection and globalisation.
Culture	The ideas, customs, and social behaviour of a particular people or society.
Curriculum	Broadly speaking, the totality of student experiences that occur in an educational process.
Dialogue	Written, spoken or other conversational exchange between two or more people.
Dialogical Curriculum Framework	A predominantly process-driven curriculum, a feature of which is the role of space for reflection and open dialogue, and participation. Presented as an overview or 'skeleton' of interlinked items and serves as a guide that can be modified as required by adding or deleting.
Emergence	A phenomenon whereby larger entities arise through interactions among smaller or simpler entities. The relationship between 'parts' and 'whole', whereby the whole exhibits properties that the parts in themselves do not.
Enculturation	The process by which individuals / groups learn the culture that they are surrounded by. It enables

	them to function as members of that society. It involves things, moral values, behaviors, expectations, rituals and language.
Enquiry-based learning	A process of learning that is driven by enquiry, largely owned by learners with an emphasis on collaboration and information resources.
Explicate order (unfolded order)	Ordinary notions of space, time and existence that are derived from a deeper (implicate) order.
Health and Care Professions Council	An independent, UK-wide regulatory body responsible for setting and maintaining standards of professional training, performance and conduct of the 16 healthcare professions that it regulates.
Identity	The qualities, beliefs, personality, looks and/or expressions that make a person / group.
Implicate order (enfolded order)	An ontological concept, coined by David Bohm that is seen as a deeper and more fundamental order of reality. Originally developed to explain the 'chaotic' behaviour of subatomic particles.
Iteration	The act of repeating a process, to generate a sequence of outcomes, with the aim of approaching a desired goal, target or result.
Kyoto School	A group of 20 <sup>th</sup> century Japanese thinkers who developed original philosophies by creatively drawing on the intellectual and spiritual traditions of East Asia, those of Zen Buddhism / Mahāyāna Buddhism in particular, as well as on the methods and content of Western philosophy.
Mahayana Buddhism	One of the main existing branches of Buddhism. The Sanskrit word " Mahayana " means great vehicle.
Nursing and Midwifery Council	The professional regulatory body for nursing and midwifery in the UK.
Participation	The willingness to be involved with confidence and without fear not being accepted.
Pedagogy	The method and practice of teaching, especially as an academic subject or theoretical concept.
Postmodernism	Postmodernism is the philosophical proposal that reality and knowledge are socially constructed, that truth-claims are political power plays, so that reality

	is what individuals or social groups make it to be.
Reflection	Higher order intellectual and affective activities to engage, critically analyse and evaluate experiences in order to lead to new understandings and appreciation of thinking and doing.
Reflexively organised activity	Referring to the ‘project’ of self that consists of sustaining coherent but continuously changing biographical narratives
Royal College of Nursing	The professional body and union for Nursing.
Self	The set of an individual's characteristics, such as personality and ability, including the perceptions of abilities, flaws, status, and worth.
Society	A community of people living in a particular country or area, having shared customs, laws, and organisations.
Socio-material framework	Relating to the relationships between technology, work and organisation, that attempts to understand complexity of the social and material in everyday life.
Symbolic interactionism	The acceptance of symbols as culturally derived social objects having shared meanings and thereby the means to construct a reality.
Zen Buddhism	A Japanese school of Mahayana Buddhism that emphasises the value of meditation and intuition rather than study of scripture.
Zone of optimal operation	The point at which a system is poised just before it moves into an actual chaotic state, ‘on the edge of chaos.
Zone of proximal development	The difference between what a learner can do without help and what they can do with help.



Accompanying Material

Appendices

A1: **Stephens J.**, Abbott-Brailey H., & Pearson P. (2007) It's a Funny Old Game.  
Football as a Metaphor in Interprofessional learning *Journal of Interprofessional Care*  
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Paper 1

## **“It’s a funny old game”. Football as an educational metaphor within induction to practice-based interprofessional learning**

JOHN STEPHENS<sup>1</sup>, HILARY ABBOTT-BRAILEY<sup>1</sup>, &  
PAULINE PEARSON<sup>2</sup>

<sup>1</sup>*Northumbria University, and <sup>2</sup>School of Medical Education Development,  
Newcastle University, UK*

### **Abstract**

The Common Learning Programme in the North East of England (CLPNE) sought to introduce interprofessional education into the practice setting for pre-registration health and social care students. Students, clinical educators/mentors, and facilitators met within groups over a period of 3–6 weeks to explore interprofessional working and learning together. This paper evaluates the use of a game, the Football Stadium, to stimulate participants’ exploration of practice-based interprofessional working and learning at CLPNE induction sessions. Data consisting of verbal and written feedback from students and clinical educators/mentors, and field notes from facilitators covering 22 CLPNE pilot sites (February 2003–July 2005) was supplemented by researcher observation at 12 sites. Two themes emerged from the data: the use of the Football Stadium as an “ice-breaker” at team induction and, the use of the Football Stadium as a vehicle to facilitate reflective learning. Key issues included personal identity and role within a novice – expert continuum, creating and developing the team environment and, enhancing and developing learning communities. Although recognized as requiring careful, sensitive facilitation, the Football Stadium is a simple means to present learning opportunities for interprofessional education within a non-threatening learning environment that facilitates active participation.

**Keywords:** *Interprofessional education, induction, gaming, football*

### **Introduction**

The use of gaming as a learning strategy has been recognized as providing a flexible and non-threatening environment on which to base positive interactions between individuals from differing backgrounds (Gary et al., 1998). This paper evaluates the use of a particular game – the Football Stadium – as a vehicle to stimulate pre-registration health and social care students’ exploration of practice-based interprofessional team working and learning. Within the context of this evaluation, interprofessional learning is defined as an interactive process where members of different professional groups learn with, about, and from each other (Barr, 2002).

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Correspondence: John Stephens, MEd PGDipd GradDipPhys MCSP, Senior Lecturer, HCES, Northumbria University, Coach Lane Campus, Newcastle upon Tyne NE7 7XA, UK. Tel: +44 (0)191 2156647. Fax : +44 (0)191 2156303.  
E-mail: john.stephens@unn.ac.uk

The Common Learning Programme (Department of Health [DoH], 2002; Pearson et al., 2006) in the North East of England (CLPNE) constitutes collaboration between Newcastle University, Northumbria University, Teesside University and Strategic Health Authorities (SHAs) within the region. While interprofessional education (the process) and interprofessional learning (the desired product) can take place through different student groups learning the same thing in the same place, e.g., joint lectures, or through being taught by different professional groups, the clinical placement remains a key opportunity for interprofessional education to take place (Barr, 2002). The aim of the CLPNE is to develop, implement and embed innovative interprofessional, work-based clinical placements that promote collaborative undergraduate learning and working in health and social care for the North East of England (Pearson et al., 2006). Students from different professional groups are presented with the opportunity to engage with, and reflect on the process of team working through the exploration of real patient care issues from an interprofessional perspective, i.e., to learn how to do interprofessional working.

A critical aspect of bringing students from differing professions to work together is in the process of induction. Teambuilding is an activity that should not be viewed as a product, but as a process (Rushmer, 1997; Gilbert et al., 2000; Kennedy, 2001) for which induction marks the start in a “process of becoming”. Butterfield and Pendegraft (1996) identified the group formulation process as being ripe for investigation raising the question of whether the method to form the group influences its subsequent failure or success. The influence of games within human development is acknowledged by Corbeil (1999) arguing that adult games and children’s games form part of a continuum progressing irrespective of whether they are considered as learning or play.

A game can be defined as “an activity carried out by cooperating or competing decision-making individuals seeking to achieve, within the rules, their objectives” (Wolf & Duffy, 1979 cited in Bays & Hermann, 1997). The evaluated game – the Football Stadium – has no element of competition, the focus of the game being one of cooperation. Aside from games being identified as presenting learning opportunities appropriate to group learning (Gary et al., 1998), gaming activities have been valued in the potential to stimulate adult learning through diverse and innovative means (Henry, 1997).

Gary et al. (1998) suggest that games are well suited to group learning situations and particularly useful for learners in heterogeneous groups. The Football Stadium is particularly suitable for interprofessional educational settings as it develops an attitude of collaboration and professional responsibility. The opportunity for immediate feedback and encouragement of motivation is augmented by the creation of a non-threatening learning environment that facilitates active participation, and is fun (Gary et al., 1998) to enhance teambuilding skills such as interpersonal communication, negotiation, consensus building, facilitation and trust, and thus engender a willingness to work together (Gilbert et al., 2000).

Prior to commencing CLPNE, students allocated to particular clinical practice areas are invited to participate in a common learning group and receive an information package about the Programme. The first practice-based session is facilitated by an (academic) educationalist and a clinical educator/mentor. The participating students may never have met before and are from a range of different professional groups (such as physiotherapy, nursing, social work, medicine, speech and language therapy, radiography). In addition they may be at different stages in their educational preparation, with some groups comprising a varied mix of students, from those on their very first clinical placement to students undertaking their final clinical placement prior to graduation. Hence an activity to address these issues was incorporated into the induction session and was presented as the Football Stadium game.

## The Football Stadium

The Football Stadium (Figure 1) represents the Health and Social Care setting. The game itself constitutes a large piece of green card marked out in white with the lines of a football pitch with an imaginary surrounding stadium. It is emphasized that the process of the activity is important, not a detailed knowledge of football. Facilitators (academic and clinical mentors) also participate as members of the group, their involvement contributing to the ethos of collaborative learning and mutual support.

Everyone is provided with a piece of paper and asked to consider the person at a football game who they are *currently most like in the health and social care setting*. The person selected can be anyone, e.g., a player, a referee, a fan, board member, manager, coach, programme seller and so forth. Individuals then draw their character, cut them out and place within the Football Stadium according to perceived “position” (Figure 2). On completion of the task, each individual explains the choices they have made.

Each person is then asked to consider who they *would like to be in a health and social care setting when they qualify (further on career path for facilitators)*. Again this can be anyone within the Football Stadium. A similar process is followed, whereby each individual shares and explains the choices they have made.

The ensuing discussion functions to facilitate student reflection and further consideration of perceived key points relating to teamwork, teambuilding, and themselves as “team players” based around four questions:

- What is a group or team?
- Why do we organize work in groups?
- What are the problems of working in groups?
- How can effectiveness in teamwork be improved?

The final question serves as a link question, a probe for students to consider guidelines for their own team/group behaviours, and in effect create a mandate for their team and themselves as team members.

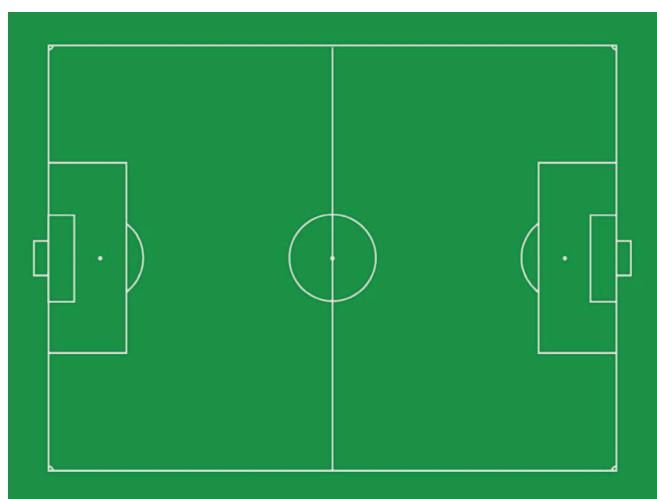


Figure 1. The Football Stadium.



Figure 2. Football Stadium in action.

Thus use of the game provides a vehicle for exploration of common experience or generic perception of teams and teambuilding. The Football Stadium itself serves as a metaphor for health and social care practice.

### Data collection, management and analysis

Data sources included verbal and written student feedback along with facilitators' structured field notes from 22 CLPNE pilot studies, supplemented by researcher observation at 12 sites, from February 2003 to July 2005. Practice areas constituted critical, acute, and continuing care settings located across hospital-based services, intermediate care, and community-based services.

Three members of the evaluation team individually and then collectively analysed feedback through a process of content analysis to identify key issues and emergent themes (Silverman, 2005).

### Findings and discussion

The initial intention of the Football Stadium was as a vehicle to function as an "ice-breaker", within the Induction Session. The perception was that it would serve as a non-threatening method to assist group bonding and initiate thinking about health and social care teams, roles and role-relationships within teams. However, from data collected, the influence and value of the game reached far beyond this initial intention.

I feel that although I am on the pitch, the floodlights just hit me and were blinding. I can't really see what's going on at times and don't know what to do. (Student)

The concept of health and social care explored within the metaphor of the Football Stadium, allowed those involved to think about their own (and others') roles as

professional, learner, and qualified practitioner in many ways. Two main themes emerged:

- (1) The use of the Football Stadium as a vehicle for team induction;
- (2) The use of the Football Stadium as a vehicle for reflective learning.

*(1) The use of the Football Stadium as a vehicle for team induction*

Butterfield and Pendegraft (1996) discuss the use of “warm-up” or introduction games to help to “break the ice” between participants. Rushmer (1997) identifies this process of “speaking to” and “getting to know” (p. 319) as key aspects of teambuilding as it enables relationships between team members to develop. It is acknowledged that although generally human relationships develop over time, in certain circumstances this process needs to be accelerated. The interprofessional common learning groups were examples of such circumstances due to their relatively short duration (3–6 weeks).

Gaming has also been identified with other benefits such as flexibility of approach, creativity and fun. Within a group setting games can help to facilitate effective communication through helping people to relax and reduce barriers. Brandes and Phillips (1989), advocate the use of games to promote the flow of communication between complete strangers, in particular shy people who may need added encouragement to actively participate.

Within the North East of England there is a “football culture”, often with friendly rivalry between the local teams. Indeed at a National level a number of authors (Whannel, 2002; Williams, 2005; Parker & Lyle, 2005; Williams, 2006) highlight the repositioning of football over the past 20 years from that of a male dominated culture to that of a “global celebrity culture”, that transcends divisions of gender, race and class. Thus football as the focus of the game seemed an appropriate choice to stimulate interest and perhaps provide something the participants could relate to in a concrete way. Initial concerns regarding a perception of gender bias associated with football by “players” were unfounded.

Although some individuals did hold some initial misgivings about their perceived knowledge of football, all participants engaged with the process and seemed to enjoy the experience as an ice-breaker. The game seemed to dissolve potential professional “tribal” barriers (Soothill et al., 1995) and allow participants to engage at a more personal level. There appeared to be a flattening of any perceived hierarchy, facilitating open dialogue between participants and raise awareness of team members’ skills and experiences in an open, non-threatening manner.

... I wasn't 100% sure of all the different positions in the football field ... I thought it was like a really unusual way to start out because at first I thought, a football field what has that got to do with all this you know, but . . . it did get us into having a bit of a discussion . . . it was interesting. (Student)

... it was good . . . it just broke the ice and let you start discussing your ideas and everyone had to do it, so you sort of just couldn't just sit and not speak, and then after you had done that everyone was willing to put their ideas in. (Student)

By the end of the session they were communicating much more freely and it all felt more comfortable. Think the football game was instrumental in this process – it allowed

students to share in a safe and non-threatening way and is great for lubricating group processes. (Facilitator)

Besides breaking down barriers the metaphor of football facilitated consideration and articulation of individuals' perceptions of teams. This naturally led to an open exploration of the nature and function of interprofessional team working based on participants' experience. The Football Stadium game not only served as a vehicle for induction but also a catalyst to explore the concept of teams and team working.

It is postulated that the naïve format of the game, with its green card pitch and the requirement to "cut and paste" the figures contributed to the success of the game. The almost child-like quality perhaps created an environment to let down the "professional guard" and "play the game" in a creative and enjoyable way. The Football Stadium is an inexpensive, flexible, low-tech resource that is not reliant on specialist teaching and learning facilities.

The students engage with it in a deeper way without really realising, mainly I think because of the fun element. It's a game and it's a novel way of doing things. (Facilitator)

## *(2) The use of the Football Stadium as a vehicle for reflective learning*

Lipman (2003) identifies two broad (and contrasting) paradigms of education – the standard paradigm of normal practice, and the reflective paradigm of critical practice. The stated aim of the CLPNE in providing students from different professional groups with the opportunity to engage with, and reflect on the process of team working is firmly rooted within the latter.

The value of the Football Stadium as a catalyst within this process had not been anticipated. The original, intended function of the game was merely to act as an ice-breaker at induction. However, what evolved over the initial round of CLPNE pilot studies was the recognition of an activity that stimulated reflection without some of the "baggage" of introspection, and self-consciousness often associated with this process (Clouder, 2000). Perhaps the novelty of the Football Stadium assists in circumnavigation of potential barriers and in turn "seems to energise and enthuse those taking part" (Facilitator). Again, although perhaps a little over-poetic it could be argued that this effect is attributable to the continuing development of a trend towards "post-modern consumption" (Williams, 2005) of football in recent years.

Three key categories relating to reflective learning emerged from the evaluation data:

- (1) Personal context for interprofessional learning & working;
- (2) Collaborative context for interprofessional learning & working;
- (3) Enhancing & developing learning communities.

## *(1) Personal context for interprofessional learning & working*

The Football Stadium game provides an environment in which to develop insight into personal identity and role within health and social care. Participants used opportunities to verbalize their role through their "position" in the stadium.

Students tended to see themselves either in a passive position in the stadium (e.g., spectator, substitute) or as struggling to cope within a more active position (e.g., midfield player, striker, goal keeper). This somewhat naïve view of students may be due to their limited exposure to more political and cultural aspects of health and social care in the

practice setting. The characteristics and attributes in either case appeared to conform to notions of novice practice (Benner, 1984).

I am a substitute, aware of the game. I know what's happening but you wouldn't pick me first. (Student)

I see myself as a midfield player. I want to be involved in the game but I just can't get a kick. The game seems to be passing me by. (Student)

Clinical mentors' views emerged as more flexible, and dependent upon the requirements of the ongoing game. They demonstrated a much broader and more subtle view of their role and the complexities of the health and social care game. They demonstrated an awareness and alertness of the dynamic relationships within the minutiae of clinical practice whilst still retaining "the bigger picture".

Well, it depends. I might be right back, I might be goal scorer. It might depend on patient problems, the requirement of the service and so on. (Clinical Mentor)

There appeared to be a number of benefits to the public disclosure of participants' perceptions of their position in the stadium in that it:

- (a) clearly helped share common fears and anxieties and legitimized this for students;
- (b) provided appreciation for mentors of current perceptions of students and their possible learning needs;
- (c) provided the opportunity to be exposed to the expert's view of "play";
- (d) highlighted a clear context for practice and learning;
- (e) facilitated appreciation of each individual's journey in progressing from novice to expert, i.e., continuing professional development.

These five elements highlight the potential to contextualize novice and expert practice within a framework of continuing professional development related to patient-centred care.

## *(2) Collaborative context for interprofessional learning & working*

Individuals' articulation and subsequent group discussion of perceived position and role within the Football Stadium naturally progressed to exploration of possible benefits and limitations of teamworking. Students were able to debate the issues that teams could face and moved beyond the notion of interprofessional teamworking merely being "a good thing" to a more informed and balanced view. Based on this shift students then considered how they intended to perform as members of a team within both the context of the CLPNE group and within their clinical setting, i.e., generation of a team mandate to translate the theory into the reality of practice.

During subsequent CLPNE meetings students were able to use the mandate as a focus for reflection on individual and team working, review of patient-centred team goals and also to inform future patient contact. It was observed that often students used the "language" of the Football Stadium to articulate their reflections on progress of themselves as individuals, the team itself and work with patients/clients from both an individual and team perspective.

It was quite, well, everyone had a different perspective, I thought it was quite good... because... from one session to the next... where I did see myself had changed... (Student)

A week later when we came back to it I had a lot better idea and I was able to actually say, well yeah, I now think that I have changed from just being a spectator to sort of being more involved with everything that is going on... (Student)

### (3) Enhancing & developing learning communities

Following initial induction, as part of the CLPNE process, weekly facilitated meetings were held with student teams. During each meeting students reviewed team activity and function over the preceding week, and on the basis of these discussions set goals for the following week.

I really noticed a difference. The (physiotherapy and nursing) students talked and worked together on the ward in ways that they hadn't done before. (Clinical Mentor)

It appeared that the impetus provided by the Football Stadium at induction provided a positive contribution to the process of student team planning and review both within and outside of these scheduled meetings. It seemed that increased student collaboration within practice had been enhanced by the catalyst of the Football Stadium.

Students articulated value in the scheduled meetings to provide space for reflection, away from the intensity of clinical practice. This space provided an optimal environment for individual and collective reflection, often using Football Stadium language to actively engage in a peer coaching process (see Figure 3). As a result of this "players" felt more able to "keep up with play" on rejoining "the game", and in turn positively influence patient care.

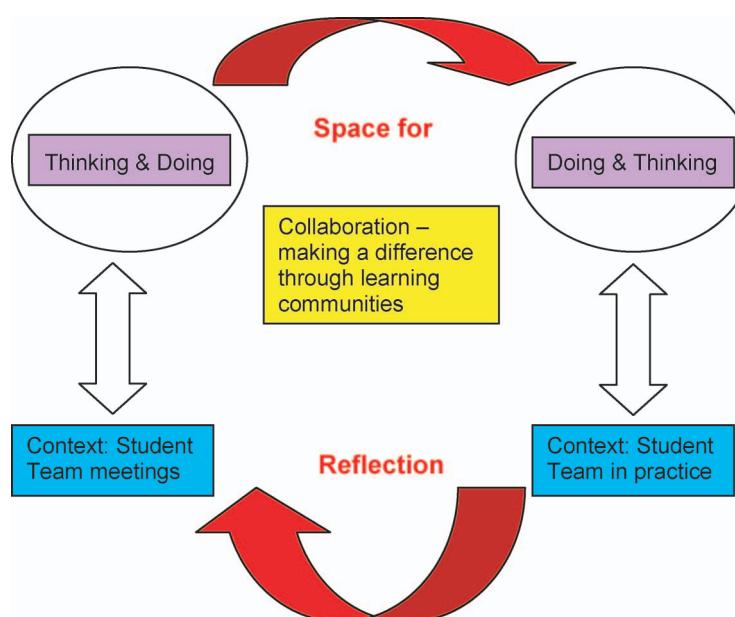


Figure 3. Playing the game.

### *The Football Stadium – the beautiful game?*

The evidence presented suggests the Football Stadium as a valuable catalyst within the critical process of induction, and also as a metaphor for Health and Social Care practice. However, there are issues that should be considered in terms of the game as a vehicle to stimulate reflection, and also the data collection processes for the evaluation.

Whilst the vast majority of participants engaged enthusiastically with the metaphor, a small number found this a challenging concept. One individual did struggle to relate to the game and was not comfortable with the concept.

As soon as the card came out, I thought . . . . oh my god! Not this! I just couldn't see it.  
(Student)

The data collection process for this evaluation was very much a developmental process, the potential added value of the Football Stadium aside from the intended function as an icebreaker becoming apparent following the first round of CLPNE pilot studies during February 2003. Apart from one session, the Football Stadium game was not video/audio-taped, being reliant on field notes, the reflections and memory of each facilitator, recorded immediately on completion of each meeting. This was reflected in the learning experience of the facilitators, who articulated some initial ambiguity in terms of the "goals" of the exercise at the first round of pilots.

I do wonder whether it could have been better facilitated by myself if I'd had a little more understanding of the different roles and had thought through where they might see themselves. (Facilitator)

Thus in some respects, the facilitators could be recognized as novices within the implementation and development of the game. They (facilitators) were not necessarily specialists in the particular practice area, specialist knowledge of this falling within the remit of the clinical mentors. It is recognized that the facilitation of interprofessional learning within the CLPNE pilot studies required movement outside the comfort zone of an individual's own profession/practice area, to appreciate and stimulate exploration of the broader, interprofessional, perspective as an "educational coach".

This position appears to be valued by students, who perceived the facilitator as being "agenda-free" in terms of the practice area context – the facilitators never met any of the patients, or observed student-patient contact. Although this has advantages perhaps, in terms of creating an open, accepting relationship between the students, clinical mentor(s) and the facilitator, there is obviously a need for a sensitive approach to facilitation.

### **Conclusion. Towards making a difference**

The stated aim of the CLPNE is to develop, implement and embed innovative interprofessional, work-based clinical placements which promote collaborative undergraduate learning and working in health and social care for the North East of England (Pearson et al., 2006) . . . and also to *make a difference*. Induction of students into this process is viewed as crucial in stimulating learning opportunities towards raised awareness and participation in interprofessional education and working.

The Football Stadium is a simple means to present learning opportunities for interprofessional education. The opportunity is facilitated by the creation of a non-threatening

learning environment that stimulates active participation, and is fun, but that also requires careful, sensitive facilitation. Its use and evolution has been a learning experience particularly for the facilitators and also the clinical mentors involved.

Those wishing to use the Football Stadium as part of an interprofessional education induction strategy may find it valuable to consider the following points:

- (1) Keep it simple. The use of the green card creates a focus for discussion;
- (2) Keep it practical. The physical activity of cutting out figures provides thinking time and may help with engagement;
- (3) Keep it involved. Make sure everyone gets heard and is involved – facilitation to build trust;
- (4) Keep it fun. Let the interprofessional education and learning emerge. The Football Stadium is just the vehicle for the process, not the objective.

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<http://nrl.northumbria.ac.uk/1648/>

Paper 2

# Service user and carer involvement in physiotherapy practice, education and research: getting involved for a change

Diana Jones, PhD<sup>1</sup>  
 John Stephens, MEd<sup>1</sup>  
 Wendy Innes, MPhil<sup>1</sup>  
 Lynn Rochester, PhD<sup>2</sup>  
 Ann Ashburn, PhD<sup>3</sup>  
 Emma Stack, PhD<sup>3</sup>

1. School of Health, Community and Education Studies, Northumbria University, Newcastle upon Tyne, UK
2. Clinical Ageing Research Unit, Newcastle University
3. School of Health Professions and Rehabilitation Sciences, University of Southampton

## ABSTRACT

Although not new, the concept of patient, carer and public involvement has been increasingly embedded in health and social care policy, and in recent decades strengthened through statutory requirements. Physiotherapists need to respond to the evolving involvement culture by finding appropriate ways to translate policy into practice in clinical settings, education and research contexts. It is argued that for involvement to be meaningful it should happen at every stage from policy making, through service development, to education and training, and research, creating a circle of involvement. This invited clinical commentary will set out one physiotherapy programme's attempt to create a circle of involvement in its work within a UK university. It will share examples of involvement activities and their outcomes, and reflect on the challenges and opportunities for the future. **Jones D, Stephens J, Innes W, Rochester L, Ashburn A, Stack E (2009): Service user and carer involvement in physiotherapy practice, education and research: getting involved for a change. New Zealand Journal of Physiotherapy 37(1): 29-35.**

## BACKGROUND

User involvement has become a dominant discourse in health and social care. Users are patients, carers or clients who are current or recent recipients of a service, or members of the public with an interest in the health of their communities. This distinction underlines the increasing concern of governments to involve citizens both in decisions about their individual care, and in collective decisions about the overall shape of services. Involvement is perceived to widen the views and experience informing decision-making; increase the acceptability of decisions made; and lead to more individual and community responsibility for health (WHO 2006). Physiotherapy forms part of the fabric of health provision and the profession needs to be aware of the drivers for involvement, and to be competent at involvement in all facets of its work.

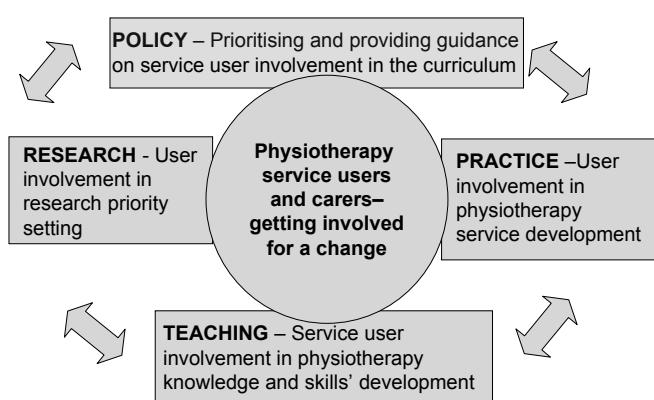
Despite a raft of UK policy over the past 20 years in relation to involvement of the public in developments in service provision, more recently with matched performance indicators, the UK government's own analysis is that there is little evidence that involvement is "stitched into" all aspects of the work of National Health Service (NHS) organisations (Department of Health 2008). UK performance has also evaluated poorly at the level of patients' involvement in their own care. A recent report based on two population surveys undertaken in six countries – Australia, Canada, Germany, New

Zealand, UK and USA – in 2004 and 2005, focusing on six indicators of how much patients were engaged in their own care, found the UK performed worse on nearly all indicators (Coulter 2006). The report concludes that poor performance points to failures in professional education, low expectations of professional bodies and regulators, and a failure of the system to encourage partnerships between clinicians and patients. New knowledge and skills are required to embed involvement activities. Work has been undertaken to map competencies for individual and collective involvement at different levels of practice in the healthcare workforce (Sutcliffe 2007).

For user involvement to be meaningful it is important that it occurs at every stage of the cycle from government policy making, through shaping services in line with policy, to commissioning workforce education and training (Hawley et al 2005). Involvement is also important in the research that will underpin policy, practice and education. This notion of a coherent circle of involvement has informed the work of the School of Health, Community and Education Studies (SHCES) at Northumbria University.

The policy-practice-teaching-research involvement circle is illustrated in Figure 1. The aim of academic, clinical and research staff involved in the circle is to model service user involvement in order to sensitise training physiotherapists to the

**Figure 1: Physiotherapy service users and carers in a policy-practice-teaching-research circle of involvement (based on Hawley et al 2005, with permission)**



agenda and prepare them to address it in a variety of contexts. Examples of involvement activities and outcomes for each of the elements in Figure 1 will be presented, followed by a reflection on future challenges and opportunities. The term 'user' in this account refers to a patient, carer, client or member of the public.

### **Policy - prioritising involvement activity in higher education**

The ability to involve patients and the public appropriately in decision-making about their own healthcare, and the health of their communities, is a key factor in employability in the healthcare economy. The Health Professions Council (HPC) registers healthcare professionals, and assesses and approves education and training programmes for thirteen professions, including physiotherapy, in the UK. The inclusion in the HPC's latest consultation of an explicit request for comments on how the standards and guidance for education and training could better support service user involvement (HPC 2008) directly addresses the criticism of the low expectations of professional regulators in terms of involvement (Coulter 2006).

Northumbria University made service user and carer involvement in the curriculum a strategic priority in 2004 following a joint request from social work, nursing and allied health academics for a whole-systems approach to involvement. A committee involving staff and service users with reporting lines to senior management was constituted. Local research-based guidance on involvement was developed from academic, administrative, user and carer experience (Walsh & Cook 2008). Northumbria University is part of a Centre for Excellence in Healthcare Professional Education (CETL4HealthNE 2008) which aims to foster curriculum development for employability in the modernised healthcare service. The Centre provides resources for teaching fellows to provide leadership in its areas of focus. One of the Centre's foci is user involvement in the curriculum, and the People with Experience work group develops and shares good practice, innovative teaching

approaches and resources to support this agenda. An archive of local health and social care narratives, and a DVD, developed in partnership with people with sensory disabilities, to raise awareness of their specific needs when interacting with the health system, have been developed (CETL4HealthNE 2008).

### **Practice - user involvement in physiotherapy service development**

Examples from the clinical work of physiotherapy lecturer-practitioners can make clear links between policy and practice for students in the classroom. A Northumbria University physiotherapy lecturer-practitioner is a specialist physiotherapist in the management of ankylosing spondylitis (AS) with a commitment to involving service users in individual decision-making and service development (Innes & Moss 2006; Innes 2007). The process of user involvement in physiotherapy service development for AS, set out in this section, is presented to students. Service users involved in the AS service development subsequently became involved with physiotherapy curricular development in the University context (Stephens & Jones 2007) (see Figure 1).

In 2003 all AS patients registered in one physiotherapy department were invited to a meeting to give their views on the AS service; 25% attended. Self-referral and regular monitoring were appreciated, and education and supervised exercise were identified as areas for development. Patient views shaped the resultant patient education and exercise programme, which was monitored via feedback questionnaire, with the results fed back to a focus group of service users in 2005. The group agreed that the positive feedback represented their views, however the therapist pointed to poor attendance as an issue. The service user group consensus was that attendance should be compulsory to access further treatment; this however would have contradicted government policy on patient choice (NHS Choices 2008). Annual follow up programmes were requested to support self-management. The invitation for carers to attend was appreciated and it was felt this should be encouraged. In 2006 a questionnaire was distributed to previous programme attendees asking if they would like a refresher course and what its content should be. The first refresher course was completed in 2007, with feedback sought before and after the course to inform ongoing development.

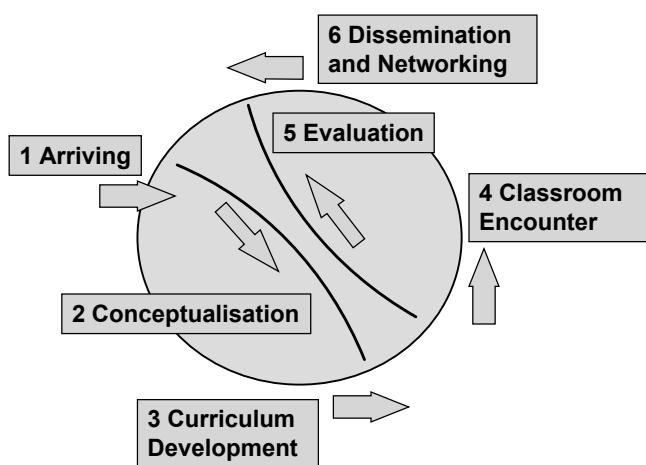
This example of user involvement to inform practice is illustrative of patient-centred specialist support for self-management of long term conditions, a key government policy objective (Department of Health 2006). By working in partnership with AS patients the lecturer-practitioner addressed their health status and co-produced an appropriate service. However, in addition, the 'social capital' (National Institute for Health and Clinical Excellence 2008) of those involved in service development,

their active community connections, was enhanced by linking them to physiotherapy educational development activities (Stephens & Jones 2007).

## **Education - user involvement in physiotherapy knowledge and skills' development**

The physiotherapy programme team aim to make the policy and practice of user involvement come alive in the curriculum (Figure 1). One example of this approach is the embedding of the physiotherapy service user perspective within a developmental approach to the teaching of clinical reasoning skills throughout the three years of the programme. In Year 1 the focus is on assessment for practice (decision-making as a key skill); Year 2, management of practice (person-centred care); and Year 3, integrated reasoning (linking theory and practice to meet individual need). The physiotherapy team employ a participatory model, based on Rowan's (1981) research cycle model (Figure 2). This model represents level five working on Tew et al's (2004) five level ladder of involvement. Level one sees the curriculum planned, delivered and managed with no consultation or involvement of service users, whilst level five sees service users and teaching staff working together systematically and strategically across all areas, with their work underpinned by a statement of values. Service users involved in the AS physiotherapy service development form part of the curriculum development team.

**Figure 2: Participatory model of physiotherapy curriculum development (based on Rowan, 1981)**



The six stages of the participatory model, with associated activity, are:

### **1 Arriving:**

This stage is characterised by an awareness by academics of the national involvement policy context and its link to patient-centred physiotherapy education; knowledge of the SHCES and CETL4HealthNE service user involvement initiatives; and the potential to share the patient

partnerships nurtured by lecturer-practitioners and senior clinician colleagues for educational purposes.

### **2 Conceptualisation:**

An appreciative inquiry approach (Hammond, 1998) is used to facilitate dialogue between physiotherapy service users, students and lecturers. Appreciative inquiry focuses on 'when things worked well', encouraging a solution-focused discussion about how individuals can do more of what works rather than less of what does not. A framework of 'communicative ethics' (Scrambler 2001) is explicitly articulated in a contract signed at the start of the session. The framework encourages all participants to express their ideas freely, to introduce or question topics, and to respect confidentiality following the session.

### **3 Curriculum Development:**

Development activities are undertaken in partnership with physiotherapy service users, including: identification of the focus for sessions (e.g. seeing people in the context of their families; employment issues); construction of session plans; development of a contract outlining a code of conduct; logistics (suitable rooms, travel, parking, payment); articulation of a person specification for physiotherapy service users, to include characteristics such as having an interest in the education of physiotherapists; clarification of roles and responsibilities for all participants before, during and after sessions; and format for the evaluation of sessions.

### **4 Classroom Encounter:**

Lecturer facilitators meet, support and introduce physiotherapy service users to the student group and review the aims and structure of the session. The contract is introduced and signed. Students are encouraged to set personal learning outcomes at the start of the session which are evaluated with the formal learning outcomes at the end. Facilitated classroom interaction gives the students the opportunity to spend time considering 'how things should work' and 'how things do work' with physiotherapy service users.

### **5 Evaluation:**

On completion of the teaching session data from student written and verbal feedback and learning outcomes are available. Debriefing interviews take place with physiotherapy service users and lecturer facilitators. Key themes to emerge from evaluation are the need to build trust and be genuine in relationships with patients; an awareness of the value of physiotherapy; and the need for coherence between organisational systems and the lives of individuals coping with long term conditions. Students value the time they have with the service users to explore issues in depth.

## **6 Dissemination and Networking:**

This participatory model of physiotherapy curricular development was presented at a Northumbria University learning and teaching conference (Stephens & Jones 2007). A database of service users interested in involvement is being developed under the auspices of CETL4HealthNE which will enable a search for and communication with individuals interested in participating in future modules.

Key elements of this curricular development involve the following: articulation of a theoretical and pedagogical framework; collaboration to identify service user partners; innovation in curricular design and delivery; and evaluation. Addressing sustainability involves identifying staff and service user development needs; maintaining clarity of purpose; evolution of involvement across levels of learning; and continued nurturing of relationships.

## **User involvement in research**

In common with active partnerships in the curriculum, involvement in research means that "people who use services are active partners in the research process rather than 'subjects' of research" (Hanley et al 2004). Partnering can take place at different levels e.g. consultation or collaboration, and at one or all stages of the research process, from identifying topics to dissemination. Like other research funders and research ethics committees, the Chartered Society of Physiotherapy (CSP) (2008a) Charitable Trust, which allocates research funding through the Physiotherapy Research Foundation, assesses proposals for user involvement and has service users on its scientific panel.

One example of involvement in research concerns links between service users with Parkinson's disease (PD) and their carers, and a rehabilitation research group (North-South Parkinson's Rehabilitation Collaboration - NSPRC), in relation to setting research agendas (Figure 1). Eighteen people took part in a two hour research topic generating and prioritising exercise (Jones et al 2007), followed by a later feedback session. All were Parkinson's Disease Society (PDS) volunteers. Seventeen were involved in running branches of the Society and one was a member of the PDS Research Advisory Panel; ten had PD, six were carers or former carers, and two had no personal experience of the condition but both had been volunteering with the PDS for over ten years.

A range of simple participatory methods were employed to develop agreement on research priorities (Dynamix Ltd 2002). An ideas avalanche technique was used to generate a list of topics that participants thought should be researched. This is a quick way to gather ideas from a group. It is suitable for 3-30 people; takes approximately 10 minutes; and requires a flip chart and pen. Ideas are recorded as people call them out. Dot voting was

used to prioritise the ideas. This method is suitable for 10-100+ people, takes approximately 10 minutes and requires adhesive dots (3 for each participant). The results of the ideas avalanche are tidied up into a list of ideas (>10) on a flip chart, leaving space next to each idea. Participants place their dots next to the ideas they think are most important.

Diamond ranking was employed to finalise the priority ranking. This activity helps to set priorities. It is suitable for a number of groups of 4-8 people and takes approximately 20 minutes. It requires post-it notes and a diamond drawn on flip chart paper. The top nine ideas from dot voting are identified and each idea is written on a post-it note. Members of each group discuss where they are going to place each of the nine ideas. The research idea that the group thinks is the most important is placed at the top of the diamond shape. The two next most important research ideas are placed in the second row. Three ideas are placed across the centre of the diamond, leaving two further places in the fourth row and one place at the base of the diamond. Results of more than one group are collated by giving ideas a score of 5 points for first place at the top of the diamond, 4 points for second row places, 3 points for third row places, 2 points for fourth row places, and 1 point for ideas placed at the base of the diamond. Table 1 shows how research ideas developed and were prioritised using these techniques.

The PDS is committed to ensuring that their research agenda reflects both the views of people with PD and the research community. The treatment of non-motor symptoms and the role of, and support for, carers were two of the six priority areas identified for the period 2005-2009 (PDS Research Team 2007). These reflect the highest placed topics in the local priority setting exercise and the theme PDS members felt intersected with all others, that of carers' issues (Table 1). NSPRC members' current research portfolio focuses on investigating gait, balance, falls and communication with the aim of promoting independence and self-efficacy (Miller et al 2006, Nieuwboer et al 2007, Ashburn et al 2008). The interaction of motor and non-motor problems has been explored in the portfolio, for example in relation to gait-related activity and fatigue (Rochester et al 2006) and dual tasking and cognitive and affective factors (Rochester et al 2008). The Rescue project, which investigated rhythmic cueing to improve gait and gait related mobility in PD, acknowledged the importance of informing carers about the approach by including a downloadable information sheet for carers on its website (Rescue Consortium 2008). However working with people with PD from the topic priority stage of the research process will help researchers to focus research questions on what really matters to individuals living with the condition, an aspect which is becoming of central importance for funders.

**Table 1: Generating and prioritising PD rehabilitation research topics**

Ideas avalanche	Suggested research topics
	Fatigue restrictions Communication in PD – including writing, effect on self-esteem, facial expression Stress – effect on movement, tremor, speech; components (emotion, motivation, depression, frustration) Exploring the loss of independence, including driving Living with PD and other conditions/carers' conditions Facilitating movement through medication fluctuations House design – threshold freezing, doors/carpets Importance of being adaptable Carer stress, permanently 'on duty' Doing several things at the same time
Dot voting	<b>Topics as prioritised by dot voting</b> Effect of stress/emotional impact Communication issues Fatigue restrictions Loss of independence Movement fluctuation strategies Living with PD and other conditions Being adaptable Carer stress, permanently 'on duty' Threshold freezing and design
Diamond ranking	<b>Final priority ranking of topics</b> The perspective of carers was seen to be an important component of all of the prioritised topics. It was identified as an important cross-cutting theme.

1. Effect of stress/emotional impact. Loss of independence
2. Communication issues
3. Fatigue restrictions
4. Movement fluctuation strategies
5. Threshold freezing and design
6. Living with PD and other conditions
7. Being adaptable

## Reflection on future challenges and opportunities

An ageing population, lifestyle consequences such as obesity, changes in family structure, advances in medical technology, and demands from healthcare consumers for a personalised health service will all contribute to the increasing need for shared responsibility in decision-making at individual and collective levels in healthcare systems around the world (WHO 2005). The CSP (2008b) initiated a debate with its members on the future contribution of physiotherapy in relation to changing contextual factors, particularly the move from a health service focused on illness to one focusing on health and well-being. Service users and service user groups, as well as CSP members and other professionals, were key stakeholders in the consultation.

A common criticism of involvement activity relates to the perceived lack of representativeness of the service user voice. A theoretical understanding of the level of the voice – personal, group or overarching user or carer experience – is important when considering whom to consult (Williamson 2007). Individual service users can contribute their personal view of how a physiotherapy service was experienced and whether their needs were met. A condition specific service user organisation with established procedures to consult with their members can input knowledge about their group's experience of physiotherapy services. A coalition of service user groups may put forward a representative to advocate on behalf of their alliance. The role of patient, carer and public involvement leads in health organisations, or champions for involvement in academic or research contexts includes keeping

up to date with involvement theory and practice. Support for these posts from senior management helps ensure that the involvement agenda is central in organisational developments.

A key question to be addressed, however, relates to what difference, if any, involvement makes to service development, research and education. Whilst NHS organisations have a statutory duty to involve service-users, formal evaluations are rarely undertaken, leading to a paucity of reliable evidence about the effectiveness of public involvement (Coulter & Ellins 2006). A dearth of evaluative studies was similarly identified in a review of consumer involvement in research and development priority setting in the NHS (Oliver et al 2004). A literature review on involvement in healthcare education attempted to assess the impact of involvement in the curriculum on students' knowledge and skills, and the quality of care delivered (Morgan & Jones 2008). Four of the thirty studies included in the review addressed impact; research designs included one randomised controlled trial, two quasi-experimental designs and a qualitative comparison. Only limited evidence of impact was identified in a set of studies with methodological weaknesses. These included lack of information about reliability and validity of attitude scales, non-standard treatment of groups, and comparison of groups experiencing involvement at different stages in their training. The cause and effect, or 'external', view of change generated by social interventions is deemed inappropriate by Pawson & Tilley (1997) who propose an alternative realistic, or 'internal', evaluation framework. A focus on the context, the mechanisms and the outcomes of an intervention can provide an understanding of what works, for whom, in what circumstances

and why. The exploration of these relationships in relation to user involvement in physiotherapy practice, education and research would provide an opportunity for all stakeholders in an initiative to collectively explore context-mechanism-outcome patterns to inform future developments.

Whilst the examples used in this invited clinical commentary have been UK based, the issues being tackled are universal and the practical approaches largely transferrable if considered in the light of local cultural issues. Many of the conceptual discussions about the nature, levels and approaches to involvement can be found set within the New Zealand Primary Health Organisation context in Neuwelt's (2007) Community Participation Toolkit. Saunders et al (2007) provide a model framework for participation between Australian government research grant awarding bodies and the voluntary sector on funding decisions. While the debate is ongoing about whether user involvement is being driven by democratic and emancipatory or managerial and regulatory purposes (Cowden & Singh 2007), practitioners, educators and researchers need to operationalise involvement on the ground. Key steps include identifying policy drivers and involvement models against which to assess what is already happening; developing a strategic approach based on an explicit set of values; mapping and linking with stakeholders to build a community of practice for development and sustainability; and building evaluation into any involvement initiative undertaken.

#### Key Points

- Identify government policy driving involvement and engagement of service users in their own healthcare and the shape of service provision
- Identify models of involvement against which to map the performance of your area of physiotherapy practice, education or research
- Ensure a strategic, whole-systems approach to involvement is supported by senior management and based on a set of shared values
- Build strong and sustainable partnerships with appropriate groups, and commit to a culture of evaluation for learning

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## ADDRESS FOR CORRESPONDENCE

Diana Jones. E-mail anna.jones@northumbria.ac.uk

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A3: **Stephens J.**, Abbott-Brailey H., & Platt A. (2011) Appearing the team: from practice to simulation. *International Journal of Therapy and Rehabilitation* Vol 18(12) p672-682

Paper 3

# 'Appearing the team': from practice to simulation

John Stephens, Hilary Abbott-Brailey, Alan Platt

**Background:** The growing trend in the development of high fidelity simulation within undergraduate health care education has produced a range of frameworks and guidelines to structure learning opportunities offered through simulation. An attempt to articulate the process of learning through simulation based on clinical practice experience would appear to be a useful step in the development of simulation-practice links in the provision of further options to facilitate students' learning and continuing professional development.

**Content:** The experience of team identity and integration for undergraduate health care students ( $n=16$ , adult nursing, physiotherapy, radiography) undertaking their first critical care practice placement is explored and used to underpin a reflective model to inform learning opportunities offered through high fidelity simulation. The analysis of human interaction offered by Erving Goffman through the use of dramaturgical metaphor is applied to frame the key emergent themes of the critical care experience—'observation', 'fitting in', and 'making a difference'—and shape the developing reflective model.

**Conclusions:** Within the proposed model, the importance of 'space for reflection' and 'meaningful dialogue' within the context, participation, accessibility, and credibility (CPAC) schema are critical aspects that facilitate the integration and development of confidence in task/technical and interpersonal competencies supporting effective clinical outcome.

Key words: ■ high fidelity simulation ■ pre-registration interprofessional education ■ team working and integration ■ reflective practice

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John Stephens is Senior Lecturer, School of Health, Community and Education Studies, Northumbria University, UK and Hilary Abbott-Brailey is Senior Lecturer, School of Health, Community and Education Studies, Northumbria University, UK and Alan Platt is Senior Lecturer, School of Health, Community and Education Studies, Northumbria University, UK

Correspondence to:  
John Stephens  
E-mail: john.stephens@northumbria.ac.uk

This paper seeks to explore undergraduate nursing, physiotherapy, and radiography students' experience of team identity and integration during their first critical care practice placement; to inform the development of a reflective model intended to frame learning opportunities offered through high fidelity simulation in an academic setting. The contribution of 'positive clinical exposure' (Blackstock and Jull, 2007) to learning and the development of professional knowledge and skills is an obvious but complex process. The use of high fidelity simulation within an academic setting is recognized as a valuable addition to the pre-registration 'learning and development menu' (da Silva Bezerra Fitipaldi and Azeredo, 2005; Blackstock and Jull, 2007; Jones and Sheppard, 2008).

Frameworks that articulate the structural components for a successful simulation-based education activity have been produced (Blackstock and Jull, 2007; Riley, 2008) i.e. 'what to do' in terms of planning, briefing, performance,

debrief, feedback and feed-forward. Indeed, an attempt to frame the process of learning through simulation, based on a practice-based experience, would appear to be a logical and useful step in the further development of authentic learning (Aubrey and McMorrow, 2010) through simulation.

The proposed framework originated from two of the authors' (JS and HA-B) experience as members of the Operational Group, Common Learning Programme in the North East of England (CLPNE) (Pearson et al, 2006), one of the four Department of Health funded Common Learning Project sites 2002–2006. During practice placements students from different professional groups were presented with the opportunity to engage with, and reflect on, the process of team working through the exploration of real patient care issues from an interprofessional perspective.

The main focus for CLPNE practice-based interprofessional learning, involves 'teams' of 4 to 8 undergraduate students from different pro-

fessional groups working together during one practice placement over a specified period, usually 4–6 weeks. After a week of general induction activity, the students worked with one or more patients of the professional team in which they were placed, meeting regularly with a facilitator to plan case management and evaluate team working (*Figure 1*).

The value of pre-registration critical care learning experience for undergraduate students has been recognized not just in terms of benefits to the learning of essential skills for students but also benefits for the qualified staff providing support along with enhanced recruitment to the practice area (Cochrane et al, 2008). The highly technical environment has been identified in contributing to students' understanding of the importance of team working within critical care units and the particular challenges offered by the setting (Hough, 2001; da Silva Bezerra Fitipaldi and Azeredo, 2005; Laporta et al, 2005; Pryor and Prasad, 2008). In citing the work of Biley (1989) and Gosbee (1998), Hough (2001) highlights the importance of interpersonal and communication skills in contributing to effective teamwork, and in particular mutual respect, and mutual teaching and learning.

In terms of a theoretical underpinning in making sense of students' experience, the work of Erving Goffman (Goffman, 1990; 1972), based around the metaphor of acting, is used to frame discussion surrounding key emergent themes. As stated by Burns (1992) the concept that 'all the world's a stage' predates Shakespeare to at least the time of Plato. Although arguably 'of its time' we would view the work of Goffman as particularly pertinent to inform approaches to learning through simulation and consider re-visiting within the context of collaborative working and learning.

## METHODS

A case study approach, using mixed methods was employed gathering data from a convenience sample of two undergraduate student groups. Students placed within a local critical care unit for their clinical practice placement were invited to participate in CLPNE. Each of the two groups consisted of nursing, physiotherapy, and radiography (total  $n=16$ ) students across various levels of their pre-registration education. This was the first experience within a critical care unit for all students. Students undertook their usual clinical practice placement (of varying duration for each profession) and over a four week period within this time

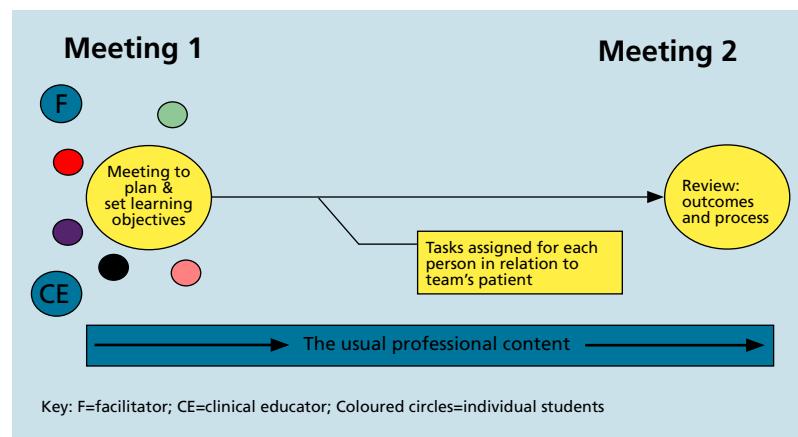
engaged in weekly meetings as an interprofessional team to explore patient care issues (*Figure 1*). Weekly meetings were observed and field notes taken by a researcher linked to CLPNE (AS), with written and verbal feedback gained from participating students (individual and group interviews, reflective logs), clinical educators (clinicians supervising each student during placement) and group facilitators (JS, HA-B) through the completion of diary sheets to capture details of the sessions and reflections on how they had gone (Pearson et al, 2006) as part of the evaluation of CLPNE.

As with the all settings for CLPNE, realistic evaluation (Pawson and Tilley, 1997) formed the framework for evaluation, 'Outcomes are explained by the action of particular mechanisms in particular contexts' (Pawson and Tilley, 1997). Thus causal powers and explanations lie within the social relations and organizational structures they form. Pearson et al (2006) argue that relationships between causal mechanisms (CLP teams and sessions) and their effects (learning experiences intended and unintended) are not fixed or permanent but dependent on the context (practice setting and culture, group make up, facilitation, and so forth). The evaluation aim in the case of the critical care practice placement setting was to evaluate the setting (context), key features and activities (mechanisms), and outcomes of practice-based pre-registration IPE sessions developed and piloted as part of CLPNE.

Specific objectives for CLPNE were:

1. To describe and develop an understanding of the structure, organization, and running of sessions (the mechanisms)
2. To describe the contexts within which the sessions take place
3. To identify, describe, and discuss a range of

*Figure 1. Common Learning Programme North East (Pearson et al, 2006)*



outcomes of the initiatives

4. To explore the perceptions of those involved including: students, facilitators, and clinical educators.

(Pearson et al, 2006)

The context for this particular piece of work has been linked to outcome 4, in relation to team identity and integration during critical care practice placement.

Data was analyzed in several stages linked to the overall evaluation of CLPNE and then specifically linked to the context of team identity and integration through the process of framework analysis (Ritchie and Spencer, 1994) as this was believed to provide a versatile approach to the analysis of the qualitative data collected, allowing the mass of data to be organized in a structured manner. Key themes were identified through triangulation of sources of data, and investigators (AS, JS, HA-B), (Strauss and Corbin, 1998; May, 2001; Gomm, 2004) and in turn the relationships between them were interpreted and mapped (*Figure 3*). Synthesis of the findings supported by theory offered by Goffman in relation to high fidelity simulation was developed by JS. Review and discussion through a series of collaborative conversations with fellow authors (HA-B, AP [School Lead for Simulation Education]), and initial discussions with JS and AS resulted in

further development to articulate the proposed simulation framework.

Ethical approval for CLPNE was granted by the Northern and Yorkshire MREC.

*Figure 2* summarises the evaluation and development process within the overall context of this paper, in proposing a framework for simulation.

## FINDINGS AND DISCUSSION

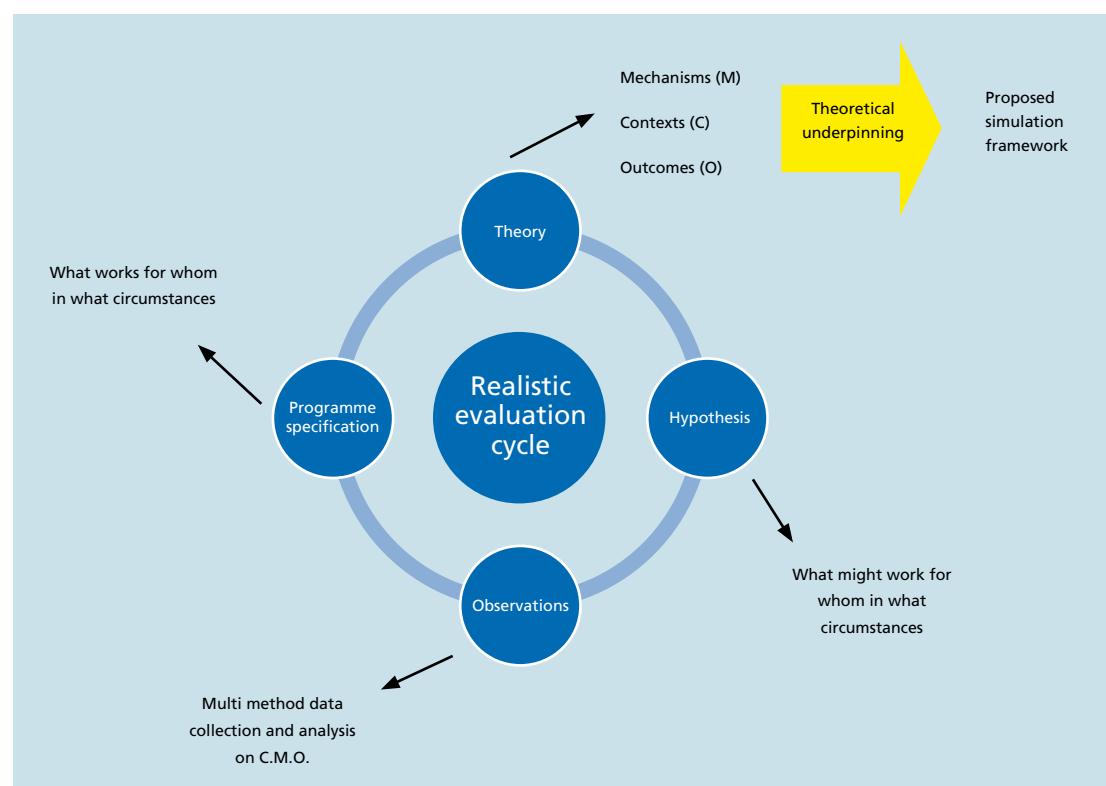
This section discusses the findings, integrating mechanisms, contexts, and outcomes, in relation to students' experience of team identity and integration during their first critical care practice placement. The work of Goffman is used to provide theoretical underpinning and inform the development of a proposed framework to support learning opportunities within high fidelity simulation.

Despite an induction to the unit, the highly technical, 'closed' environment of ICU and the dynamic nature of the team,

**"a lot of different people coming and going" (Student Nurse, during CLPNE session)**

created anxiety for students in relation to role ambiguity and a perceived inability to 'fit in

**Figure 2. Realistic evaluation cycle informing simulation framework (adapted from Pawson and Tilley, 1997)**



and feel useful'. Experience of previous clinical practice placements on open ward or departmental settings had normally enabled role clarification and integration within the ward/departmental team through being able to undertake simple tasks, and talk to patients, which wasn't the case in the ICU:

**"A team is a small number of people with complimentary skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable."**

Katzenbach JR and Smith D (1998, p14)

Students felt unable to even begin to fulfill a role in contributing to the simplest definition of 'a team', the initial challenge being in physically identifying 'the team' and its members. Access to appearance, behaviours, and 'props' (Goffman, 1990) that usually help to identify the various performers, for example clothing, posture, speech, facial expression, were denied to the students through ICU staff being dressed in the same clothing ('scrubs', mask etc) with identity badges often difficult or impossible to read due to positioning e.g. sideways on a hem of clothing:

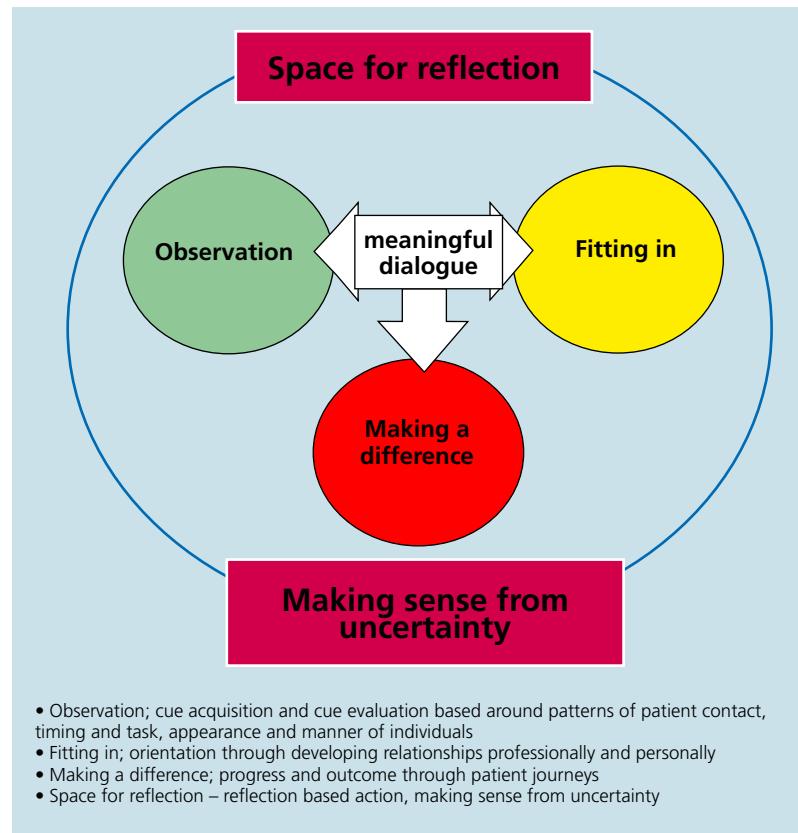
**"Everyone just looked the same. I just felt awkward ...[COCKING HEAD TO ONE SIDE] ... you know trying to read name badges clipped sideways on the 'blues'."**  
(Physiotherapy student, during CLPNE session)

This denied ability to access appropriate cues underpinned the loss of confidence and role ambiguity which aligned with high expectations of themselves (wanting 'to do well' and 'not let anyone down') provided for some feelings of 'impostership' as described by Brookfield (2008). The desire for credibility as a developing professional became a source of frustration and doubt over their ability in the new setting.

Over the first two weeks of clinical practice in each student group four key interdependent processes for enabling strategies emerged, represented in the model (*Figure 3*) and summarized below.

### **Observation; cue acquisition, and cue evaluation**

A foundation strategy for all students was observation, picking up on patterns of patient contact and the timing and manner of tasks undertaken by individuals. Initially, this was a



**Figure 3. Processes in appearing the team**

slow and frustrating process as previous clinical practice experience failed to form a basis for confident application on the critical care unit. As participant observers, (Gomm, 2004) students within the CLPNE meetings, pieced together evidence gathered from their experience relating to time/timing, location, people, and their role. The process of observation, identification, and orientation to the team was rooted within a hypothetico-deductive framework (Higgs et al, 2008) characterized by novice (Benner, 1984) reasoning—cue acquisition, hypothesis generation, testing and evaluation—in the attempt to make informed deductions.

An important factor in facilitating the process of identification and orientation within the team was contact and conversation, particularly the more social, 'less pressured' interaction with students from other professions within the CLPNE meetings (*Box 1*). The conversation quoted refers to the 'usual' experience of the radiography student coming onto the unit to use the portable X-Ray machine, and everyone immediately diving for cover!

A framework of professional contact with the patient evolved (simplified example, *Figure 4*) that served to contextualize action and to enable a process of 'appearing' the team. What became apparent to the students as this process unfolded

"Well, whenever I come on to the unit, everyone just runs away." Radiography student  
 "What do you want?" Nursing student  
 "Just to say 'hello' and not disappear would be great." Radiography student

**Box 1. Student conversation during CLPNE session**

was the ever changing, impermanent nature of 'the team'. It didn't exist in a fixed, independent manner, but was dependent upon tasks and context of those tasks to meet individual patient need.

### Fitting in

Goffman (1990) uses the term 'front' to identify 'that part of the individual's performance which regularly functions in a general and fixed fashion to define the situation for those who observe the performance', performance in this case being the activity of an individual within the environment (critical care) in completing meaningful tasks. The environment includes not just equipment and furniture but also the 'props' used by the performers, such as uniform, and personal pieces of equipment.

Through a process of 'trying and testing out', learning by doing within the reality of practice, students were able to orientate themselves within the teams. The plural is purposefully used here to reflect the situation of an emergent team for each student, dependent upon their position within that team. Teams are not independent enti-

ties but are interdependent, and depend upon the position, experience, and ability of each team member (including the patient), and the situation and influences at hand for any particular decision and/or task. Hence 'appearing the team', whereby teams and team working are recognized as dependent-related phenomena, constructed by each and all of the 'actors' involved.

Students' identity of variations in team structure, role, and purpose of the 'actors' evolved as being dependent on the individualized patient problem(s) (the situation at any given time) and in doing so identified the necessity of different teams for different patients at different times. From this understanding developed the notion of what the students termed 'core' and 'peripheral' teams. A core team was defined as comprising players physically present within the critical care environment and whose function is to actively contribute to decision-making and performance of particular patient-related tasks that involves direct contact with the patient. The peripheral team consists of individuals who may or may not actually meet the patient or come into direct contact with other team members. The function of the peripheral team is in the provision of support within three broad areas:

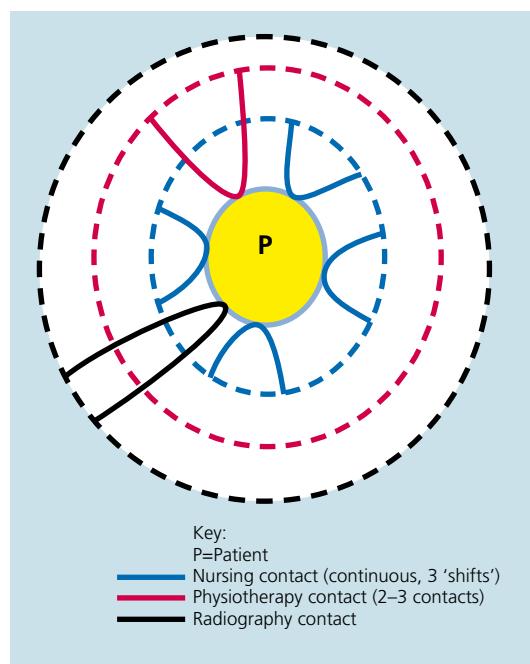
1. Provision of information (e.g. lab results, X-ray results)
2. Undertaking interpretive tasks i.e. tasks or provision of equipment that provides patient/team support but may not appear through direct contact with the patient e.g. ward clerk, dieticians, cleaners etc.)
3. Undertaking definitive tasks i.e. tasks involving direct patient contact e.g. porters, radiographers (taking X-ray), pain team.

The replication of peripheral team definitive tasks and the general role of the core team acknowledges students' growing appreciation of what we would term as the 'situationality' of teams, the movement of personnel between core and peripheral, dependent on the situation. Although beyond the scope of this article, it is argued that an understanding of this process is crucial to effective and efficient individualized patient care.

### Making a difference

Patterns of contact and 'front stage' (Goffman, 1990) behaviours within the closed environment of the intensive care served to 'appear the team' for students and thus enable integration to make a perceivable difference to individual patient care. It was interesting that the patterns of contact enhanced the appreciation of making a difference to patient care through events such

**Figure 4. Typical patterns of patient contact over a working day**



as weaning from ventilation, changes in nutritional status, promotion of active movement, pressure area care, and also through feedback of the patient journey once transferred from the unit. Physiotherapy students followed continuing patient care once discharged from the unit to an open ward and were able to report back on continued progress during CLPNE meetings.

Thus it was recognized that the interfaces between identified core and peripheral teams are transient in nature depending on the current or anticipated patient problem (situationality). The 'actors' continually change the effective working of the team to deliver effective and efficient patient care, in essence being one that concerns gathering, sifting and analytical processes relating to information, co-ordination of patient support and also environmental support (*Figure 5*). The binding feature of this being effective and timely communication:

**"Students from the different professions spoke to each other more. I'd say that they were more confident and it seemed easier for the radiographer coming into the environment." (ICU Practitioner, interview)**

### Space for reflection

The student team meetings provided physical and cognitive space for reflection, free from the 'hurly-burly' of the unit and the opportunity to (re)contextualize and plan for a range of possible situations before returning to the busy environment of clinical practice. The dramatological context of 'front stage' and 'back stage' is particularly apt here. Particular value of team meetings ('back stage') was based around social contact that facilitated discussion of clinical and technical competency, at an appropriate pace, and provided opportunities for peer support further promoting the benefit of working and learning together.

The opportunity for further exploration, analysis, and learning based on experiences of 'observation', 'fitting in', and 'making a difference' was based around a structured and meaningful dialogue. As Boud et al (2006) have identified, the main influence on any learning and development is individual/group experience of the world and how individuals construct or 'appear' it. Reflection is a critical process in understanding experience and drawing lessons from it, i.e. a developmental, generative process. Thus, within CLPNE, although all students on practice placement worked towards set, profession-specific learning outcomes and competencies, the facility to develop additional outcomes was generated through a process

of dialogical reflection (Donaghy and Morss, 2000) i.e. a process that leads to, rather than merely concluding action and learning (reflection-based action).

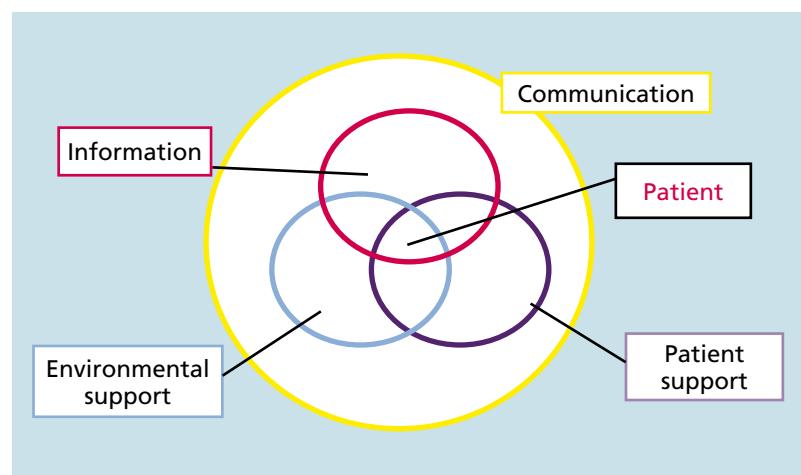
### And so to simulation

The selection of students' first critical care learning experience to inform the framework was made in recognition of a relatively close approximation in terms of environment to that usually offered by high fidelity simulation, critical/acute care within a predominating biomedical model. Social interaction, relationships, and space for reflection in making sense of experience whether 'real' or 'simulated' are viewed as critical for successful learning. In reviewing the work of Erving Goffman, Manning (1992) represents Goffman's work of identifying and exploring broad assumptions people use in their everyday life, through what he refers to as the SIAC schema (see *Table 1*).

In adapting this schema based on the findings of this practice-based study the authors developed the CPAC schema for simulation in an attempt to 'shape' reflection and dialogue between (all) involved 'actors' (students, staff and simulator, as appropriate) across an identified structure for simulation—e.g. planning, briefing, performance, debrief, feedback, and feed-forward (Blackstock and Jull, 2007; Riley, 2008). *Figure 6*, expresses the processes in appearing the team (see *Figure 3*) within the context of simulation.

The process of 'observation' within practice translates to the activities of 'seeing, thinking, and doing', based around the planning, briefing and interpretation of the given case scenario or task. Cues acquired from this interpretation require formulating to generate hypotheses for 'doing' based around the evolving plan of

**Figure 5. Core and peripheral team interface**



**Table 1. Cross-pollination SIAC and CPAC**

SIAC (Manning, 1992)	CPAC – schema for simulation education
S 'situational propriety'—meaning of actions is linked to the context in which they arise. It is not possible to understand behaviour without knowledge of the situation in which it occurs.	C 'context'—full appreciation of the tasks/case scenario and situation, learning environment, other 'actors' involved, core, and extended team.
I 'involvement'—the capacity to give (or withhold from giving), attention to the activity at hand. People are generally under pressure not to be merely involved, but appropriately involved.	P 'participation'—the willingness to be involved with confidence and without fear of not being accepted. Being aware of both professional and social role within the context.
A 'accessibility'—concerned with participant ratification. The expectation of and duty to give social courtesy to others, to be sociable.	A 'accessibility'—participant ratification. The expectation of and duty to co-operate with others in identification of the role of self and others.
C 'civil inattention'—also concerned with participant ratification. Willing to be seen as non-aggressive but also deferential to others, particularly to strangers through e.g. limited/lack of eye contact. It is the respect owed to and expected from strangers.	C 'credibility'—having confidence in the respect, professionally and socially, for self and others. Being comfortable with the educational situation (believing it to be purposeful), and individual/team role.

action which will also include necessary equipment, patterns of contact (particularly for inter-professional simulation exercises), and timing of tasks. To support the context of practice in simulation wearing clinical uniform can have a profound impact on decisions and actions of the 'actors' involved (Finn et al, 2010).

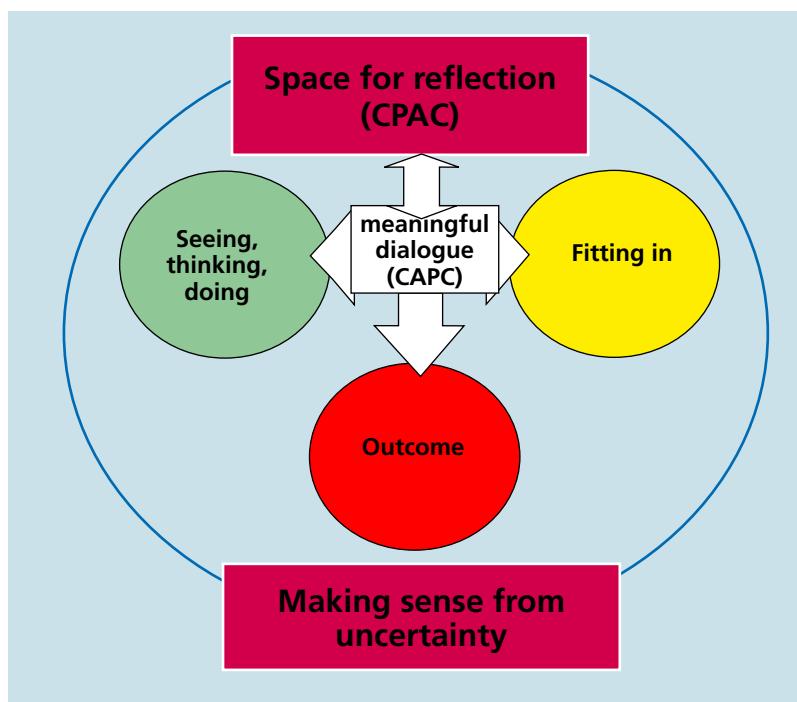
'Fitting in' is critical to the process. Orientation to the scenario/task through developing relationships professionally and personally is required to encourage and motivate participation with the simulation tasks/situations. Failure to facilitate this effectively will impact on 'outcome', the relative success or

failure of tasks undertaken and the teamwork processes involved. Throughout the processes of 'seeing, thinking and doing', attention to cue acquisition and evaluation to inform technical competencies in order to potentially 'make a difference' is integrated with the more adaptive competencies of communication and interpersonal skills to facilitate rounded development of competence and confidence (Leonard et al, 2004; Flin et al 2009) within a non-threatening environment.

'Space for reflection' is literal, both in terms of time and place. At a general, colloquial level everyone experiences reflection. It is a natural human activity (Katagiri, 2007). However, as a high level cognitive and affective skill (Donaghy and Morss, 2000) time, space, and practice are required to develop reflective skills to a level that 'fuels' effective clinical decision-making skills as well directing learning and development.

The use of 'time-outs', i.e. the build-in of time for students to take stock of the ongoing simulation activity employing the key themes and CPAC schema to guide reflection and inform dialogue, is critical to the process making sense, and learning. This requires a certain amount of flexibility in the nature and use of reflective space in terms of the nature and context of the task, set learning outcomes, and the professional groups involved. Hence a process of dialogical reflection (Donaghy and Morss, 2000) is used to fuel a values-based enquiry-based learning approach (Aubrey and McMorrow, 2010). As identified by Wakerhausen (2007), reflection is a multidimensional activity which in order to facilitate meaningful insight and learning should involve the

**Figure 6. Processes for simulation**



following perspectives:

- Reflecting on—themes, tasks, activities, topics
- Reflecting with—a range of beliefs and concepts
- Reflecting from—a particular perspective, point of interest
- Reflecting in—a particular context(s) i.e. surroundings, environment  
in order to enhance learning and development, through ‘making sense from uncertainty’.

## CONCLUSIONS AND TAKE HOME MESSAGES

The setting up and facilitation of practice-based interprofessional education within the critical care setting was a challenging task, particularly for students. The highly technical environment was initially perceived as quite stressful, particularly in terms of students’ expectation of their own performance. Interestingly, this high expectation was not shared by clinicians working with the students. The learning process within the CLPNE study highlighted the importance of development of the ‘softer’ skills within health-care and how crucial it is to strike a balance between technical and adaptive competencies (Kumar, 2000) to make a difference in terms of effective patient care.

The authors are aware that the practice-based evaluation included just three professions, which is obviously a limitation in terms of transferrability. Certainly no claim is being made for generalization across undergraduate health care education. However, related themes did emerge in other settings for CLPNE that involved up to six different professions (Pearson et al, 2006). The shared technical environment (broadly speaking) of critical care and high fidelity simulation, acknowledging the differences in terms of consequences of action, does provide for links between the two in terms of (enquiry-based) learning opportunities that are credible and in many ways authentic (Aubrey and McMorrow, 2010).

Simulation is accepted and actively promoted as an effective learning tool (Alinier, 2007; Chief Medical Officer (CMO), 2009), and it is important that the focus is not placed entirely on technical tasks. A critical aspect in developing learning opportunities through simulation is in creating space for reflection and dialogue—to provide the time, and optimal conditions for the novice practitioner to ‘appear the team’, and be part of that team, so that reflection is necessarily contextualized within the simulation experience. Developing human relationships can be

## KEY POINTS

- High Fidelity simulation is recognized as a credible and authentic learning activity.
- It is important that the emphasis for learning maintains the balance between technical and adaptive competencies in order to reflect the practice environment.
- The inclusion and promotion of ‘space for reflection’ and ‘meaningful dialogue’ is integral to the learning process for the novice practitioner.
- Processes for Simulation supported by the CPAC schema are offered as a model to promote learning in a non-threatening and authentic manner.

complex within any environment, at any level. Thus ‘Processes for Simulation’ along with the CPAC schema is offered as a framework, tools to support learning in a non-threatening and authentic manner. **UTR**

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## COMMENTARIES

Today's management of health care problems need interprofessional teamwork. Cooperation between professionals from different areas of health care is a prerequisite for successful everyday clinical work, whether in primary health care centres or in specialized hospital settings. Knowledge about the respective skills, competences, and roles of other professionals enables the optimal use of individual expertise, and the team as a whole.

In order to achieve complex health care education, there is a need for different simulation options.

In medicine and health care there are simulations used for training, for example surgical simulator systems for education and training of difficult technical skills.

### This study

In this paper the authors present a set up with undergraduate students from nursing,

**“Knowledge about the respective skills, competences, and roles of other professionals enables the optimal use of individual expertise, and the team as a whole”**

physiotherapy and radiography. The simulation system focus on teamwork, integration between professions during the students' first clinical placement within a critical care unit.

Instead of focusing on technical issues, the aim of this investigation was to study the teamwork of an interprofessional group of undergraduate students. The focus was on perception of the involved students, facilitators, and clinical educators.

The analysis of the participants experiences are well performed and interesting. The results will be important for further

planning of similar settings of simulation in health care education.

### Professor Ola Wahlström

Linköping University  
Department of Clinical and Experimental Medicine  
Orthopaedics  
Sweden  
ola.wahlstrom@liu.se

Simulation alone may not transfer skills to the clinical settings but the dialogue process may help in increasing this skill (Finan et al, 2011). Indeed, retention of the skills learnt may depend on medical knowledge, clinical skills, non-medical skills, contextual crisis management skills, along with consistent process of dialogue, reflection, observation, and practice. Since patients may become wary about

**“... as simulation becomes increasingly prevalent in medical schools and resident education, more studies are needed to see if simulation training improves patient outcomes”**

medical students experimenting to practice on them, the 'bedside learning' poses many challenges. Furthermore, patient safety and

health care quality, mount pressure on consultants to be cautious about using 'bedside teaching' rigorously. However, few clinicians

attempt to address the challenges of clinical settings by adopting the fidelity simulations to procedural performance. There are varied results from studies regarding the improvement in residents' performance following training via simulation, such as being comfortable to perform procedures and theoretical medical knowledge (Okuda et al, 2009). Indeed, the worth of simulation based learning is further supported by a systematic review by Issenberg et al (2005) which ascertains that high fidelity simulations are an improvement in medical education. But their effectiveness depends on quality, rigor and communication, and high fidelity (Issenberg et al, 2005). Finally, as simulation becomes increasingly prevalent in medical schools and resident education, more studies are needed to see if simulation training improves patient outcomes.

### This study

This study shows simulations are a reliable tool for strengthening learners and for teaching topics through observing, dialogue process, teamwork, and contexts which are likely to support better learning. The study discusses that the reflective practice helps to increase acceptance and confidence from the uncertainty and complexity of professional learning. Better learning is further possible using the team formation, helping to develop non-technical skills such as personal values, critical awareness, prejudice, assumptions, and analysis of hesitations; which all contribute to build constructive learning awareness and collegial relationships. This study shows direct improvements in clinical outcomes from the use of simulation for training. Further, the study depicts the effectiveness of simulation in the teaching of clinical knowledge,

procedural skills through teamwork, observation and communication.

### Conclusion

The practice to simulation to practice is an ideal model clearly emerging out of the paper. However, as mentioned in this paper, the initial cognitive and physical struggle to 'appear the team' can be a slow and steady

**“The limitations of time experienced by health care students may be because of intense workload and time pressures which could perhaps be eased by exploring alternative means of learning ”**

process. It usually takes time for the team to emerge, but once present, one hopes it will automatically unfold into a common objective of learning, reflecting with experiential guidance, and an exchange of information between peers. Furthermore, the learning process in medical education is distinctive compared to other disciplines in a number of respects, such as; a) knowledge intensiveness: knowledge constitutes both the main input and output of medical learning; b) human resource intensive: compared to other disciplines, there is high dependency on expertise and experience of the workforce working in clinical settings, and at the

same time a high level of perishability, and high level cultural sensitivity; c) intangible: the activities are mostly processes rather than products, therefore medical learning/services cannot be stored, touched or transported but are unique in terms of density of experiential learning. However, these limitations may be addressed provided there is adequate consultants' time for young professionals. The limitations of time experienced by health care students may be because of intense workload and time pressures which could perhaps be eased by exploring alternative means of learning. Therefore, there is a need for senior clinicians to have to test, re-test and promote the practice of simulations, reflections through meaningful dialogue process with seniors/peers as an important means of learning.

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### Dr TN Sathyanarayana

Indian Institute of Public Health  
India

drsathya1@gmail.com

The use of technical equipment is involved in both high fidelity simulation and critical care environments. But in simulation, although it is accepted as an effective learning tool, there is an ever present danger of focusing on technical tasks. Developing learning frameworks appropriate for simulation from within critical care, where real patients are being cared for, would seem to offer authentic context for facilitating the 'softer' skills of communication, social and interpersonal relations.

**“...in simulation, although it is accepted as an effective learning tool, there is an ever present danger of focusing on technical tasks”**

### This study

This paper aims to provide a reflective model for framing simulated learning opportunities, based on the experience of mixed teams of undergraduate health care students as they identify with and integrate within the critical care environment. In addition to the usual critical care placement students were invited to weekly interprofessional meetings about patient care.

Data from observation field-notes, interviews and logs were collected from stu-

dents, clinical educators and group facilitators and organized under Pawson and Tilley's (1997) realistic evaluation: mechanisms, context and outcomes. Ritchie and Spencer's (1994) framework analysis led to findings that enabled a schema to be developed for guiding reflection and informing dialogue across the usual simulation stages.

## Conclusions

Although the findings were interesting they were not wholly unexpected. Human factors have featured as part of aviation train-

ing since WW2 and have more recently become part of medical education, especially in simulation exercises. It would be useful to acknowledge this body of knowledge. However, this paper usefully suggests that high fidelity simulated learning should encourage reflection, development of relationships and interprofessional participation and offers a framework for simulation education.

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**Lynda D'Avray**

Senior Lecturer

St. George's

University of London

*ldavray@sgul.ac.uk*

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A4: **Stephens J.**, & Parr. (2013) The development of media-driven clinical skills through using the 'e-skills portfolio'. *International Journal of Therapy and Rehabilitation*. Vol 20(7) p336-342

Paper 4

# The development of media-driven clinical skills through using the 'e-skills portfolio'

John Stephens, Mike Parr

**Background:** The 'e-skills portfolio' has been developed to give students the opportunity to engage in a creative approach to learning the distinctive core skills of: electrotherapy, manual therapy and therapeutic exercise. This paper aims to review the development and implementation of this e-skills portfolio within a pre-registration MSc physiotherapy programme.

**Content:** Students work in small groups, and capture (through film or images) practice of clinical skills through simulation in the university setting. The analysis of the e-skills portfolio involved a pluralistic approach to: analysing data collected from two student discussion groups ( $n=21$ ); reviewing submitted portfolio content; and teaching team reflections. Findings were then coded, and the emergent themes identified. Emergent themes from the data included assessment of skills and feedback, reflective practice, employment, continuing professional development through peer and self-coaching, and resource access.

**Conclusions:** Engagement in compiling the e-skills portfolio appears to promote students' continuing professional development through a critical process of peer- and self-coaching and deliberate practice. This practice of using the e-skills portfolio is based within an adapted action research model, and appropriate learning support, particularly in IT, is a crucial element in this process.

Key words: ■ E-skills portfolio ■ Deliberate practice ■ Continuing professional development

Submitted 25 September 2012, sent back for revisions 16 May 2013; accepted for publication following double-blind peer review 17 June 2013

This paper aims to review the development and implementation of an electronic skills (e-skills) portfolio within an enquiry-based learning approach. This approach frames learning, teaching and assessment for the MSc Physiotherapy (pre-registration) programme at Northumbria University.

The challenge of developing the core clinical skills of physiotherapy (Chartered Society of Physiotherapy, 2011; Health and Care Professions Council (HCPC), 2012a) within a 2-year, full-time, accelerated, pre-registration MSc physiotherapy programme, and staff dissatisfaction with more formal academic practical skill assessment approaches led to the development of the 'e-skills portfolio'. The portfolio provides an opportunity for students to develop, record, and reflect on the instruction, acquisition, practice and evaluation of clinical physiotherapy skills within a simulated non-clinical student role-play context.

The rationale for developing the e-skills portfolio also recognises academic stresses and, in particular, examination stresses having profound effects upon students' wellbeing and performance (Shamsdin et al, 2010). It is our belief that demonstration of competencies can be assessed using a more formative and developmental learn-

ing experience, in which learning and associated assessment is valued as a social process (Ladyshewsky, 2010). Therefore, the e-skills portfolio was developed with a view to it being a viable alternative to the more traditional skills-based examination.

## Context

In common with all UK pre-registration physiotherapy programmes, the course at Northumbria University is designed to provide graduates with the educational and clinical experience to work in a range of health and social care settings. The programme is designed to address the HCPC's validation requirements: *Standards of education and training for physiotherapists* (HCPC, 2012b) to produce skilled graduates who are eligible to practise as registered physiotherapists in the UK.

The programme seeks to develop physiotherapists who are able to respond effectively to changes within clinical practice, through developing cognitive skills and practice competencies in the context of research, critical awareness and reflection. The MSc Physiotherapy programme at Northumbria University adopted and developed an enquiry-based learning (EBL) approach.

The accelerated format and small cohort numbers (10-12 students) present an opportunity to

John Stephens  
is a Senior Lecturer and  
Programme Leader of the  
MSc Physiotherapy (pre-  
registration) programme  
at Northumbria  
University, UK;

Mike Parr is a Senior  
Lecturer for the MSc  
Physiotherapy (pre-  
registration) programme  
at Northumbria  
University, UK.

Correspondence to:  
John Stephens  
E-mail: john.stephens@  
northumbria.ac.uk

engage in a learning process that is recognised as different to more traditional modes of education. This form of learning requires a period of adjustment if learners have no familiarity with it, to promote a collaborative process of learning that is valuable but demanding (Deignan, 2009). Although it is beyond the scope of this article to debate the merits and challenges of EBL, we value the ability of this approach to encourage diverse teaching and learning methods. Arguably, more diverse teaching and learning methods may promote increased flexibility and adaptability, particularly for developing the registered entry-level physiotherapists' decision-making skills.

### The e-skills portfolio

For each of the six taught modules within the Northumbria MSc Physiotherapy programme, students compile an electronic portfolio record of simulated clinical skills framed by an EBL approach. The module staff provide an introduction to each skill within formal practical workshops, with the opportunity for students to 'replicate' and practise each skill. Each module includes a minimum of seven clinical skills drawn across core areas of therapeutic exercise, electrotherapy, and manual therapy. At each stage, the portfolio is compiled in 'hard' format, with background information to supplement filmed footage and images captured onto a portable media format. This information and footage is accompanied by student reflections on the efficacy of applying, learning and identifying areas for development for each selected individual skill, and also the portfolio 'experience' as a whole (see *Appendix 1*, for an example).

A formal teaching session provides guidance regarding the portfolio's format and content to introduce the concept to students and outline the necessary resources required to complete it. Technical support within the campus Clinical Skills Centre is available in the form of lending cameras and laptop computers, and access to IT staff for technical advice regarding film footage editing. In recent years, with the rapid development of mobile technologies, access to IT staff for advice has become largely unnecessary.

Although the accelerated MSc Physiotherapy programme recruits student graduates with honours degrees in related subjects and therefore successful higher education experience, positive academic experiences during the first year of study are crucial for student engagement, satisfaction, retention and course completion (van der Meer and Scott, 2010). Peer coaching and peer-assisted learning are well-established methods for promoting student learning within academia (Potter,

1997); these methods are complementary to formal teaching without attempting to replace it. Joyce and Showers (1995) comment that a combination of: theory, demonstration, deliberate practice and collaborative evaluation, combined with coaching, lead to significant gains in performance.

The theoretical framework underlying this form of learning is that of constructivism: students assemble and (re)align their own knowledge through a process of cognitive growth, in which they share discussions surrounding theory and practical skills. Topping (2005) comments that establishing trust between peers is a major factor in this form of learning as students acquire skills through active support, and through a shared commitment to learn and create goals. The formative nature of the e-skills portfolio was given great consideration. A summative examination could arguably introduce an element of competition between students in the compilation of the portfolio.

Indeed, Ladyshevsky (2006) makes an interesting observation about reward structures that are influenced by learning outcomes. Ladyshevsky (2006) described how cooperative, competitive or individualistic structures may feature when assigning learners reward structures and these structures are applied to clinical practice. However, these structures may also be applied to the e-skills portfolio's formative structure as it is argued that the cooperative nature of media-driven skills competencies fosters peer feedback in a non-competitive and non-individualistic manner. Summative assessment for the portfolio had been considered but, following discussion with students, the notion of imposing strict guidelines was felt to be a barrier to creativity; hence the formative nature of assessment was retained. Therefore, staff provide students with written feedback on safety, efficacy and further development for each submitted skills set.

We evaluated the e-skills portfolio, particularly the student experience of compiling it and how they perceived its value and purpose, using a pluralistic approach (Smith and Cantley, 1985; Hall, 2004; Petersen and Kwan, 2004). This consisted of: a formal module evaluation (a university requirement concluding each taught module); a review of portfolio content by the authors during marking; informal student discussion groups with four student cohorts; and module teaching team discussions.

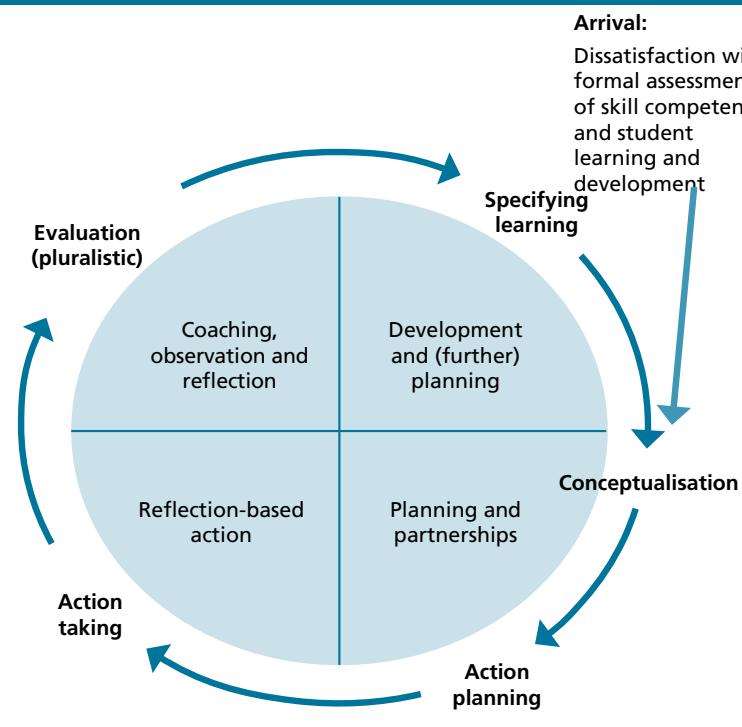
This article is not intended to provide a formal report of 'data analysis' and evaluation findings. As a review and analysis of the e-skills portfolio's development, the following integrates discussion of key emergent themes and issues.

## DISCUSSION

From an EBL perspective, the process of compiling the portfolio aims to maximise learning opportunities through social constructionism (Steffe and Gale, 1995). This is a process of dialogue between participants rather than a tutor-driven agenda and sits within a framework of 'assessment for learning' (McDowell, 2007; Wake and Watson, 2007). However, the adaptation of the approach within the context of meeting professional statutory regulatory body (PSRB) and public safety requirements is recognised, i.e. a degree of professional 'surveillance' (Wackerhausen, 2009) is necessary. Arguably, as a formatively assessed piece of work, completion and submission may not be viewed as mandatory; however, student cooperation in compiling the portfolio has yet to prove an issue. A commitment towards competence and continuing professional development (HCPC, 2012a; 2012b) is instilled in and accepted by students. Skills practised for portfolio inclusion are invariably assessed summatively (at a pass/fail level) within clinical practice placement periods, and often provide a context for summative module assessments.

*Figure 1* presents an analysis of the development of the e-skills portfolio within an adapted action research model (adapted from Susman, 1983), driven by the core processes of developing partnerships, reflection, and coaching.

**Figure 1. Development of the e-skills portfolio (adapted from Susman, 1983)**



Collaborative partnerships between students and academic/technical staff are key to the e-skills portfolio's success. The collaboration between students is particularly important in promoting competence, learning and continuing professional development through peer and self-coaching within an enquiry-based framework. Initial perceptions of the portfolio as merely an assessment tool were quickly dispelled through engagement with the process.

**'Completing this e-skills portfolio was a productive task...'** (Student 1 comment.)

**'The visual feedback...allowed for me to critique myself and see where I think I need to improve and develop.'** (Student 2—written comment from portfolio conclusion.)

Critical to the success of the portfolio is students' willingness to engage in 'deliberate practice' (Ericsson et al, 1993), along with pragmatics of access to resources (rooms, equipment, software, IT expertise). The role and characteristics of deliberate practice are well documented by Ericsson (et al, 1993; 2004; 2006; et al, 2007a; et al, 2007b), and Starkes and Ericsson (2003), who identified that motivation to practise and improve a task is the most frequently-cited concern regarding skill acquisition and development. Therefore, students' pre-existing knowledge should be considered and they should be given feedback regarding technique after a period of instruction. Repeated execution of these techniques follows where students perform the same or similar tasks (Ericsson et al, 1993; Krampe and Ericsson, 1996). In constructing and meeting these conditions, practice leads to improvement in both students' performance and their speed of task execution.

However, it should be noted that skill acquisition using deliberate practice is neither simple nor brief in terms of commitment and time. Ericsson et al, (1993) suggest that this practice extends over a period of at least 10 years, which is equivalent to 10 000 hours. The differentiation of 'deliberate' practice as opposed to merely practice is that deliberate practice is highly structured, with the explicit goal of performance enhancement. The inclusion, therefore, of a specific clinical case study example for each skill has been recommended within the CD/DVD section of the portfolio to focus application of the skills to a specific context. This case study is also cross-referenced to the written section of the portfolio, which considers the theoretic-

cal application of the skills, such as indications, dangers, physiological and therapeutic effects, along with a brief description of the presenting features of the patient case study. Experience from evaluation of the portfolio is that students are usually unwilling to commit to recording any footage of skills demonstration until they have received peer feedback of a sufficient level of encouragement to build confidence. Students also expressed elements of uncertainty about their preparedness to practise:

**'I think that it would have been great to have a more practical grounding... before doing the e-skills. This way I think it would have allowed me to be more creative in what I put in the portfolio... ...As I needed to shoot the videos a few times, it was a good opportunity to refine some of my skills. Another benefit was ... the group effort was required... bouncing ideas of what was necessary'**  
**(Student 3 comment.)**

Figure 2 summarises the process of deliberate practice within the e-skills portfolio context. This can be considered to be integrated within the adapted action research model (see Figure 1).

This programme's EBL philosophy has evidently influenced student engagement with the integrated approach to skill acquisition and development. As previously stated, the point of 'arrival' (Figure 1) was in our dissatisfaction with formal practical skills assessment and development in the academic setting. It is important to reflect not just on 'what' the topic is and on professional interest but also on the environmental and collaborative perspective (Wackerhausen, 2009). It is the formation and development of partnerships, not just between students but also between members of staff and students, that is critical to the portfolio's potential success or failure.

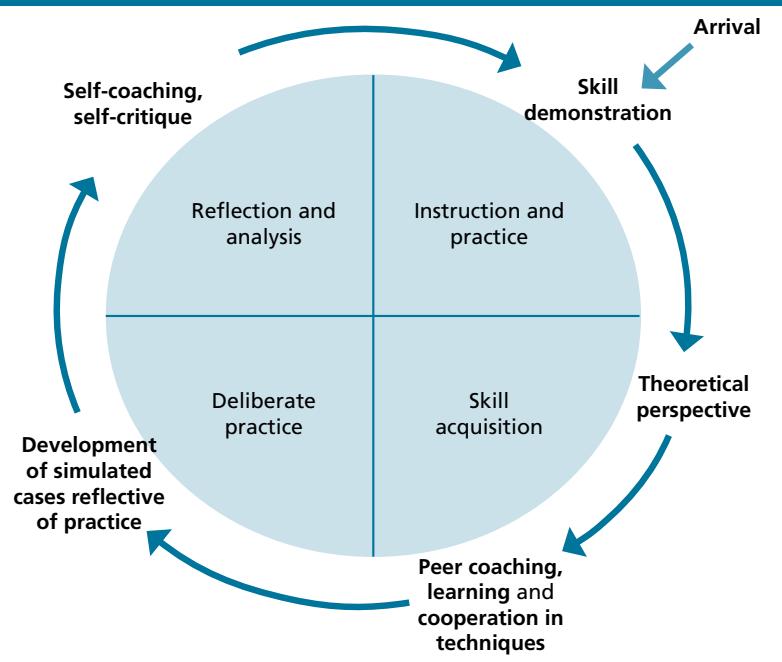
An initial literature search found little, particularly within physiotherapy education, about tackling our problem/dissatisfaction. 'Conceptualisation' allowed for refinement of our thinking through discussion, initially, between the authors to clarify the links we were seeking to construct between teaching, learning, assessment and continuing development. As an aside, it is interesting (and rewarding) that informal conversations with students towards completion of the programme indicate that they view the e-skills portfolio as an important resource to make available at job interviews. There are also reports of continued use and development

as part of 'in-service' education and development after qualification for some students. A supporting infrastructure of access and booking for equipment and rooms was obviously critical to students' success or failure in compiling their e-skills portfolios.

'Action planning' (see Figure 1) within the cycle incorporated the development of a three-way arrangement between students, technical, and academic staff that facilitated student learning within the portfolio guidelines and the skills portfolio menu (see Table 1). It was at this stage during the first run of the portfolio that students requested access to a formal 'marking grid' and were keen to have the work awarded a mark, as identified and discussed earlier. Many students did not fully appreciate the notion that even at the start of their career, as 'peer novices', they are able to support and learn from each other. However, when the benefits of support, confidence building and self-efficacy were explained, and the problems it may produce regarding competition (Ladyshevsky, 2006a), the students readily accepted the formative assessment style.

Once students started to engage with the process of putting the portfolio together ('action taking'), a 'threshold level' (our term) of preparation and deliberate practice (Ericsson et al, 1993) was identified at which they were prepared to commit skills to film (see Table 1, for example). Discussion with student groups revealed that they perceived an acceptable level of competency was based on the initial demonstration of a particular practical skill. This is unsurprising

**Figure 2. Developing deliberate practice**



considering the relatively novice level of learning and therefore the reliance on a process attempting to replicate the demonstrated skill, i.e. 'reflection-based action'. However, what is of interest was the level of peer coaching and dialogical reflection (Moon, 2006) to create a context for recording the skill (in the form of a case study) and thus the wish to formulate rather than seeking to merely copy the demonstrated skill. Therefore, the use of space for reflection (Stephens et al, 2007) would seem an important factor for learning while compiling the skills portfolio. Students appreciate the space to make mistakes while honing foundation physiotherapy skills—some had even included a set of 'outtakes' on the CD/DVD.

Following completion of filming each skill, students valued the accompanying written narrative and, in particular, the reflective element regarding the final performance and process in order to evaluate and identify areas of learning and development. Therefore, the process of portfolio compilation and reflection on this seeks to develop a 'growth mind-set' (Syed, 2010) with a focus on continuing development rather than with any particular view of excellence beyond safe and effective practice. Although focused on the tasks in hand, the process of 'action taking' also required students to network and negotiate with support staff to access rooms and equipment, which facilitated what were identified as valuable management skills to operationalise the necessary tasks for completing each section of the portfolio.

As stated earlier, a pluralistic approach has been undertaken in the ongoing evaluation and development of the portfolio and its use ('evaluating' and 'specifying learning'). Continuing evaluation has been triangulated from data collected from: formal module evaluation/review (feedback from stu-

dents, module team, external examiners) required by the University to evaluate all taught modules; informal conversations between staff and students; written comments made within e-skills portfolios; conversations between technical staff and module staff; a focus group with one student cohort; and opportunistic conversations with ex-students.

A key element to successful engagement with the e-skills portfolio identified by all involved (particularly students) is time management—time for planning, time for practice, time for filming, and time for reflection. Indeed, the most common recommendation from successive student groups under the banner 'key messages to next year's students' is to start portfolio preparation early in a module. This possibly indicates procrastination is (still) alive and well among contemporary student groups.

However, the value of the e-skills portfolio is clear from a short-term and long-term perspective:

**'... Valuable resource for practice for many years. It will allow for evidence of development and could be used in conjunction with continuing professional development courses and resources'.  
(Student 4 comment from portfolio conclusion.)**

To successfully complete the portfolio, collaborative, interdependent planning, working and reflection are involved and can be termed 'plan, do, review, plan again'. Continuing learning is a central but complex (Byrne, 1998) process that is similar but distinct for all involved. Students learn and develop from a more reliant position (of replicating demonstrated, context-free skills, on reflective engagement through formulating and innovating simulated skills and engagement with the evidence base) towards something that is much more contextually aware. For example, students develop their own case scenarios to demonstrate their own skills. This does occasionally produce some interesting incongruence, for example an exercise programme designed for an 'elderly faller' simulated by a 20-something individual.

The e-skills portfolio's long-term value and impact has been evident through employment, employability and continuing professional development. Examples of skills taken from e-skills portfolios have been taken to job interviews by students, and have anecdotally created considerable interest from interviewers. This is a functional aspect of the portfolio that we had not considered but it seems a logical extension of its purpose of evidencing students' ability. Furthermore, conversation with ex-students now in employment has

**Table 1. Module e-skills portfolio menu (example)**

Skill	Format	Mandatory/ optional
Assessment techniques in both musculoskeletal and cardiorespiratory patient	Film	Mandatory
Manual techniques in cardiorespiratory patients		Mandatory
Manual techniques in cardiorespiratory patient		Mandatory
Active and passive stretching techniques	Film/digital images	Optional: Choose any four from the seven options
Endurance-based exercise programmes		
Endurance-based exercise programmes		
Proprioceptive neuromuscular facilitation techniques		
Relaxation techniques		
Manual hyperinflation		
Manual hyperinflation		

revealed ongoing use of the e-skills portfolio in CPD activity such as in-service training sessions.

Reflection on the continuing development of the e-skills portfolio raises some valuable points that are mainly positive in nature, along with a small number that require consideration to promote learning at a comfortable, enjoyable, less stressful level. The portfolio functions to introduce learners to the concepts of deliberate practice, and fosters the ethos of practice as a visual aid to view and review both short-term and long-term progression. Through building learner engagement and confidence, the e-skills portfolio facilitates space for reflection on the identification of skills competency and areas for development. Therefore, the e-skills portfolio can be viewed as a process and a resource that fosters both self-development and self-reflection—through establishing learning partnerships to encourage constructive, meaningful coaching dialogue, i.e. critical reflective practice (Ghaye and Ghaye, 1998), for skills development. However, it is well worth highlighting that the e-skills portfolio is time-consuming, e.g. setting up and the recognised ‘tedium’ (Ericsson 1993, Syed 2010) of skills practice, and requires appropriate resourcing.

Finally, it is particularly pertinent that the rapidly-changing nature of multimedia advancement is happening not just in general society but also in education. This means that the e-skills portfolio is constantly evolving. The evolution of information technology over recent years towards small units of mobile technology such as ‘tablets’ and iPhones with the ability to synchronise and store larger amounts of data in a variety of ways (e.g. ‘cloud technology’) necessitates a continually-changing process of portfolio construction. Despite these changes, the portfolio should maintain, in theory at least, a fairly standard but flexible format. From its original inception, the e-skills portfolio has evolved from a VHS cassette, to a CD/DVD phase, into more widely-accessible methods such as individual websites, and ‘personal space’ facilities, e.g. ‘PebblePad’.

The rise of this generation of technologies offers new possibilities for both portfolio compilation and submission. Students now have options for file sharing and exchange in a range of formats along with opportunities to collaborate in real time from different locations using technology such as ‘Skype’ and ‘FaceTime’. Although this may not offer a great difference in structure or format of the portfolio, advancing technology will undoubtedly contribute further to the peer coaching, constructivist, and collaborative enquiry-based

principles that underpin the e-skills portfolio’s philosophy. Many of these possibilities are dependent on the availability of internet connections but Deloitte (2011) predicted that the proliferation of wi-fi hotspots suggests that wi-fi will become the default network for video applications.

## CONCLUSIONS

Engagement with deliberate practice within a reflective framework offered by the e-skills portfolio appears to promote student engagement with continuing professional development through a process of peer and self-coaching within an adapted action research model (Susman, 1983). Despite the emphasis and undoubtedly reliance on a rapidly-changing technological culture, the importance of establishing and cultivating meaningful, collaborative partnerships is essential for successful outcomes. After all, physiotherapy and physiotherapy education (as arguably is the case with any public service profession) are delivered for humans by humans. It is the manner in which options for this inter-dependent interaction can be made available and exploited that is the case in point.

Encouraging the use of mobile technologies within a flexible format for learning seems to promote student ownership of their learning and development. However, it does carry the caveat of emphasis on a tutor role that is concerned with facilitating discrimination of information rather than mere information-giving followed by assessment at a later date. As Mason and Rennie (2008) identified, today’s students, as with the wider population, operate within a fast-moving, rapidly-changing multimedia culture and are generally extremely ‘techno-savvy’. The e-skills portfolio is a vehicle that can be used to facilitate, record and evaluate learning and development of practical skills both within the short and long term, in a relatively simple, focused and robust format. It is this relatively simple format, aligned with choice and a purposeful yet enjoyable process for staff and students, which provides potential transfer of the e-skills portfolio concept and experience across a broad range of professions.

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## APPENDIX 1:

### E-skills portfolio format

Cameras can be borrowed from the technical support staff in the Clinical Skills Centre or module tutors. Skills that are captured should contain a minimum of 20 seconds of footage and include (as appropriate) spoken narrative providing a commentary to the skill being undertaken. Room availability and booking should be arranged through the module teaching staff.

### Portfolio format and content

The portfolio will be in hard format, i.e. a file/box file and should include:

- Contents section
- Introduction: provides a brief overview of the content, your rationale for inclusion and available evidence base for skills included in the portfolio (one side of A4)
- Skills sections (minimum of seven skills). These should include a cross-reference to film footage contained on the CD (enclosed as an appendix within the portfolio), along with a brief written commentary to the technique performed, and brief notes regarding indications/contraindications/precautions, safety issues, and key points for effective application of the technique. For skills that are recorded in digital image format, cross reference to CD may be included, but a selection of images should be printed (3 to a page) and include a brief written commentary to the technique at each image as appropriate. Brief notes regarding indications/contraindications/precautions, safety issues, and key points for effective application should also be provided
- Conclusion/summary: provides brief detail relating to the development of clinical skills, possible value of portfolio to developing skills in practice, and your experience of compiling the portfolio (one side of A4).

## KEY POINTS

- This paper reviews the development and implementation of an electronic skills portfolio within an enquiry-based learning approach.
- The portfolio provides an opportunity for students to develop, record, and reflect on the instruction, acquisition, (deliberate) practice and evaluation of physiotherapy clinical skills within a simulated non-clinical student role-play based context.
- Engagement in the compilation of the 'e-skills portfolio' appears to promote student learning and continuing professional development through a critical process of peer- and self-coaching within an adapted action research model.
- The portfolio serves as a vehicle to facilitate, record and evaluate learning and development of practical skills both in the short and long term, in a relatively simple, focused and robust format.

A5: **Stephens J.** (2015a) A participatory learning model and person-centred healthcare: moving away from 'one hand clapping'. *European Journal for Person Centred Healthcare*. Vol 3. Issue 3. 279-287.

<http://nrl.northumbria.ac.uk/24193/>

Paper 5

## BRIEF COMMUNICATION

# A participatory learning model and person-centered healthcare: moving away from 'one hand clapping'

John Stephens MA (Ed Res) MEd PGDipEd Grad Dip Phys MCSP DipSP

Senior Lecturer, Faculty of Health and Life Sciences, Northumbria University, Newcastle upon Tyne, UK

### Abstract

**Background:** This article reports on the development of a series of facilitated workshops within two pre-registration physiotherapy programmes framed by an adapted participatory learning model in an attempt gain some understanding of the facilitation of learning that is person-centred and collaborative in nature.

**Methods:** Data collected during the 'Evaluation' phase within the adapted participatory learning model is pluralistic in nature, with feedback gained from students, People with Experience (PWE) and workshop facilitators.

**Findings and Discussion:** Students and PWE valued the workshops, with a desire to 'do their best' for others being a key motivator. Key themes associated with emergent learning includes the importance of building trust and being genuine in practice and the coherence between organisational systems and the lives of individuals when 'things' work well. The provision of 'space for reflection' is a critical factor in the success of the workshops.

**Conclusion:** The participatory learning model offers a structure to organise a learning process in a manner that is not only conceptually appealing but also of practical use. The model would seem to have the potential for transfer to broader areas of professional education. In embracing participation '*don't be afraid to start*' and '*learn from doing*' are key messages of encouragement.

### Keywords

Complexity, participatory learning models, person-centered healthcare, physiotherapy, pre-registration professional education, teaching and learning

### Correspondence Address

Mr. John Stephens, Senior Lecturer, Room H011, Faculty of Health and Life Sciences, Northumbria University, Coach Lane Campus, Newcastle upon Tyne, NE7 7XA, UK. E-mail: john.stephens@northumbria.ac.uk

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## Introduction

The volume, range and pace of change within modern healthcare systems is being largely driven by government policies that increasingly seek to involve patients, service-users, carers and the public in service development and clinical decision-making (cf. People with Experience (PWE) [1]), in order to inform the provision of individualised care [2-6]. The level of complexity within professionals' practice makes close collaboration with PWE a necessity in the education of pre-registration healthcare professionals to promote the development of optimal clinical decision-making skills in the delivery of safe, effective and efficient person-centred care.

This article reports on the development of a series of facilitated workshops within two pre-registration physiotherapy programmes framed by a participatory learning model (adapted from [7]) and underpinned by the concepts of complexity science [8-9], in an attempt to gain some understanding of the facilitation of learning that is

person-centred and collaborative in nature. Particular emphasis is placed on two key features of complexity: interdependence and emergence. The participatory learning model offers a structure to organise a learning process in a manner that is not only conceptually appealing, but also of practical use. Although this article is specific to physiotherapy the model is generic, with many facets of the workshops being easily transferable across professions.

Professional healthcare education programmes within the Faculty of Health and Life Sciences, Northumbria University, UK committed to patient and carer involvement in the curriculum in 2004 and the Faculty continues to be active in the continuing development of this *agendum* within programmes at pre-registration and post-registration level with regional links via the People with Experience work stream of the CETL4HealthNE [10]. The Physiotherapy Programmes team of the Faculty has drawn on local and regional networks to embed the patient perspective in the teaching and learning of clinical reasoning across both the BSc (Hons) and MSc pre-registration Physiotherapy programmes.

## Broad Context: complexity and collaboration

In discussing the contribution of complexity science to understanding collaborative professional learning, Fenwick [8], McMurry [11], Haggis [12] and Byrne [13] identify a number of key principles pertinent to professional education, with the concepts ‘interdependence’ and ‘emergence’ being central to this process. People, materials, organisations and phenomena are seen as diverse yet interdependent elements that interact and emerge together in dynamic structures, with a focus on effects rather than causality. Interactions are multiple and multiply connected [12] and it is this multiplicity of interactions through time which produces effects. Thus, knowledge and learning can be viewed as an “assemblage” [14], representing processes that are not viewed as individualistic, but rather sociomaterial in nature, dependent on social groups and their practice knowledge.

The complexities of professional knowledge and practice have far reaching implications for education [15], with continuing debates regarding teaching ‘excellence’ recognising sociomaterial influences in terms of the responsiveness of higher education to policy drives towards employability and enterprise within a culture of measurement and control [16]. In considering claims by Torbert in relation to collaborative inquiry as long ago as 1988 [7], the more empirical approaches to educational research (and arguably curriculum development) and their characteristic methods of measurement can often fail to address the situationality of practice and thus ‘person-centredness’, through reductionism. With direct reference to patient involvement in education, Tew, Gell and Foster [17] describe five levels of involvement related to curriculum design. Level 1 sees the curriculum planned, delivered and managed with no consultation or involvement of patients, while Level 5 sees all stakeholders working together strategically and systematically across all areas, with the work underpinned by a clear statement of values (i.e., moving away from ‘one hand clapping’).

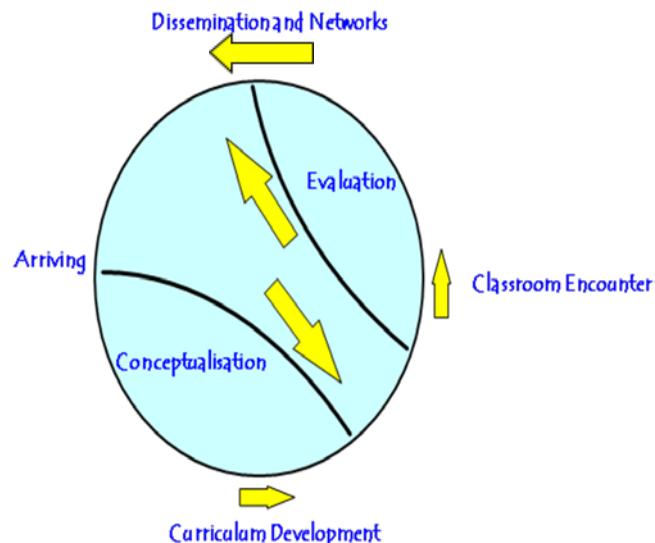
## Specific Context; PWE workshops and participatory learning

Connections between individuals, environments and experiences are non-linear and uncertain. Within the context of person-centred healthcare the development of PWE involvement within the curriculum for physiotherapy has involved collaborations in identifying PWE, workshop design, student engagement, workshop delivery, evaluation, dissemination and networks. To facilitate learning there is a need to stimulate perturbation within a system, a system believed to be best represented through a Participatory Learning Model (Figure 1 [18]) based on a collaborative approach that provides a theoretical framework in the development of the PWE workshops, presenting a process that is cyclical and continuous in

nature. The six represented phases are dynamic in terms of movement between ‘inward’ (Conceptualisation and Evaluation) and ‘outward’ (Arriving, Curriculum Development, Classroom Encounter and Dissemination and Networks) movements of reflection, thinking and action, that are personal (inward) and collaborative (outward) in nature. Thus, the participatory process represents a conscious and genuine movement away from a more basic, empirical model (Figure 2) that would involve PWE at the point of classroom encounter only.

Within the physiotherapy programmes, modules with a focus on clinical decision-making [19] provide opportunities for students to reflect and develop knowledge and learning in relation to their experience of physiotherapy practice. Service provision is examined and the student is guided towards exploring the broader needs of the individual and their family including carers, spouses and parents.

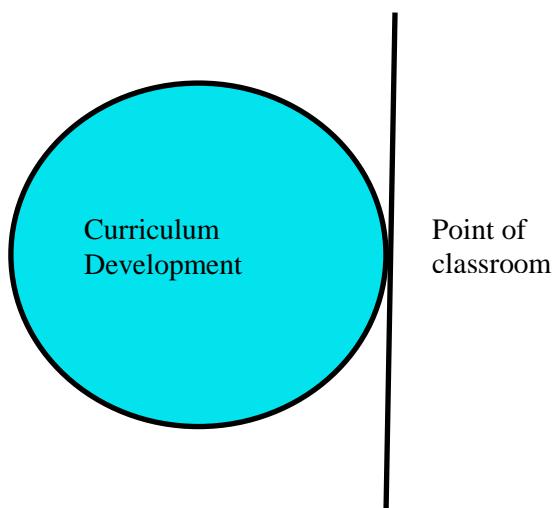
Figure 1 The Participatory Learning Model [18]



A key feature in facilitating an integrated approach to person-centred physiotherapy/healthcare is the contribution to the learning process of ‘People with Experience’ (PWE) to provide service user perspectives for professional development. An appreciative inquiry approach [20] is employed across the workshops (which vary in duration from 2-3 hours), where the emphasis is placed on ‘when things worked well’.

In recognising that interactions of this nature have the potential to become highly emotive, it is helpful to negotiate ground rules in order to make explicit the roles and expectations for participants (Students, People with Experience and Facilitators (academic staff) and to negotiate a clear context for the management, structure, organisation, delivery, monitoring and evaluation of the workshops.

Figure 2 The 'empirical' curriculum (adapted from Reason and Rowan [7])



## Six phases of the Participatory Learning Model

### Arriving

Personal desire for a genuine collaborative inquiry in an attempt to address the reality of individualised physiotherapy practice in education, led to the consideration of a more participatory approach ('Arriving', Figure 1). The creation and development of partnerships has been critical in the choice to move away from 'one hand clapping', that is, away from a one-sided, empirical approach to curriculum design towards a systematic and genuine attempt at participation.

It is necessary for the continuing development of healthcare services and education within the United Kingdom (UK) to accommodate public and political expectations [2-4] in striving towards the provision of person-centred care, this necessitating person-centred education by and for healthcare professionals. The current drive towards the involvement of patients and communities in the development, delivery and evaluation of health and social care is reflected in the inclusion of 'People with Experience' as one of the six identified work streams within the CETL4HealthNE initiative [10].

Initial contact with PWE was developed through partnerships with senior lecturer-practitioners and other senior clinical colleagues. The rationale for selection of these staff groups is based upon their unique position in terms of knowledge and understanding of both the higher education and clinical environments, to facilitate recruitment of suitable PWE. Discussion between the author (JS) supported by a University Reader with a specific interest in PWE involvement in education and aforementioned grades of colleagues, resulted in the

development of a person specification for PWE (Box 1, below), to enable an agreed and explicit set of criteria in the identification of potential PWE.

### Box 1 Person specifications for PWE

People with Experience should have:

1. A shared commitment to improving physiotherapy practice and in interest on contributing to and participating in the education of physiotherapists
2. Experience of physiotherapy either directly or as a carer of someone who has received physiotherapy
3. Acceptance and agreement to work within boundaries of confidentiality
4. Acceptance of and agree to work within the agreed Contract outlining a code of conduct
5. Willingness to work with the module team to ensure issues which might affect ability to engage are addressed, e.g., access and timing needs
6. There will be no age limits or discrimination on the basis of gender or culture
7. The freedom to withdraw at any point without feeling obliged to justify this decision. All participants within the process are volunteers
8. Ownership and therefore copyright to any teaching materials produced from their own resources

### Conceptualisation

Accepting that human beings are generally social and relational in their nature and that members of Society relate to each other within certain norms and conventions, made it necessary to give open consideration to the development of the person specification and also to the development of a Framework of Roles and Responsibilities (Table 1) at the inward movement of 'conceptualisation'. Although at first consideration this may appear to be a move in pursuit of establishing, as it were, a 'power-base', the motivation underpinning the development of this framework documentation was quite the reverse, that is, to risk manage in recognition of sensitive areas of discussion that could emerge within workshops and also in recognition of the professional and political drivers in pre-registration education highlighted earlier.

The aim of the workshops was to draw on the personal experiences of individuals who have either cared directly or cared for someone who has received physiotherapy through a process of constructive dialogue, of 'communicative ethics' as postulated by Habermas [cf. 21]. The focus of the dialogue accepts the importance of the individuals' phenomenological world. An appreciative

Table 1 Working with People With Experience. A Framework of Roles and Responsibilities

	<b>Pre-session</b>	<b>During session</b>	<b>Debrief</b>
Facilitators	Identification & preparation of participants Establish contract for interaction Establish specific aims for session Identify appropriate room space, timing & pacing for session	Confirm the contract Revisit session aims Session facilitation that ensures optimal & equitable dialogue Provision of appropriate session closure	Allow exploration of feelings evoked by the session (students & people with experience) Confirm learning and contribution to continuing development (students) Understanding the experience of involvement in the session and the potential for future engagement (PWE)
Students	Negotiate an acceptable session contract Undertake appropriate preparatory activity	Adhere to session contract Engagement with dialogue to pursue session aims Appreciate the learning that has taken place and recognise the point of closure	Exploration of feelings evoked by the session Confirm learning and contribution to continuing development
People with Experience	Negotiate an acceptable session contract Negotiation of needs e.g., transport, timing, pacing, support during session, diet/pharmacology	Adhere to session contract Engagement with dialogue to pursue session aims Recognition of and contribution to the point of closure	Exploration of feelings evoked by the session Understanding the experience of involvement in the session and the potential for future engagement

inquiry approach [20], to focus on ‘when things worked well’, was used to facilitate discussion that is motivated towards solutions, of how individuals can collaborate in decision-making and achieve resultant successful action.

In recognising potential conflicts of interest (individual, moral and professional) for PWE, students, and facilitators, the need for an explicit code of conduct, a ‘contract’, designed to promote an environment where participants feel welcomed and understood, was critically important. Physiotherapy/healthcare decision-making is not to be value free and cannot be dominated by a sole individual. Negotiation and the development of ongoing dialogue are key features of the process described here. Hence the contract was designed for negotiation around the three core values of the communicative ethics process. Each individual should be allowed, in a constructive manner to: (1) participate in discourses, expressing their attitudes, wishes and needs; (2) introduce any topic into the discourse or call into question any topic & (3) not participate if they so choose [21].

### Curriculum Development

The outward movement to ‘Curriculum Development’ commenced through telephone contact with prospective PWE in order to provide a background to the workshop(s), provisional agreement to participate and to arrange a meeting with the author (JS) at a mutually suitable time and place. Development activities took place within this

meeting and included identification of the focus for the session(s) (e.g., physiotherapy assessment, management, seeing people in the context of their families, employment); construction of a ‘Lesson Plan’; development of the contract; logistics (travel, suitable room booking, parking, payment) and discussion of the person specification for PWE and the format for the evaluation of sessions were all undertaken prior to an agreement to participate. Furthermore, information regarding the preparation (including travel arrangements), participation and evaluation of teaching and learning sessions and the payment available is provided, together with an opportunity to discuss any possible impact payment may hold for those individuals in receipt of benefits and/or allowances. Any necessary documentation to be completed by the individual in meeting University requirements is worked through in detail with help offered to complete the documentation if necessary. Suitable rooms and timing of sessions are negotiated, as far as practicable, in a manner that is PWE-led or at least sensitive to individual need. In addition, opportunities are provided for ongoing support and guidance for PWE prior to, during and following the session by the module staff/module tutor. Debriefing is mandatory and included a reflective, evaluative element. Participating PWE are also offered the opportunity to be matched with a buddy for the session. Details relating to provision of necessary cover if unable to attend are provided.

The resultant planned sessions ranged from two to three hours in duration working with groups between 10

(MSc programme) and 24 (BSc (Hons)) students in number. The general focus for sessions within Year 1 BSc (Hons) Physiotherapy workshop has been clinical assessment, management of practice (person-centred care) in Year 2 and an integrated approach to clinical decision-making (linking theory and practice) in meeting individual need in Year 3. The MSc Physiotherapy programme (a 2-year accelerated programme) PWE workshop generally reflects the BSc (Hons) Year 3 approach. Within each programme these sessions are supported by materials accessed 'on-line' in other areas of each programme. The workshops provide an opportunity to engage with PWE, face-to-face, for a period of time well in excess of that usually enjoyed within clinical practice. This provides 'space for reflection' [22] and the opportunity for 'meaningful dialogue' [23] in the continued construction of students' identity as physiotherapists with a focus on individualised, person-centred care.

### **Classroom Encounter**

The 'Classroom Encounter', the actual running of the workshop, is the responsibility of the workshop facilitator (a member of academic staff from the respective module team). Facilitators meet, support and introduce PWE to the student group. 'The Contract' and the workshop format is explained to students and everyone is issued with a workshop evaluation sheet.

A minimalist definition of learning can be considered as 'growth in knowledge' [24] that is located within the individual and based on their previous experience. In the facilitation of learning it is important to appreciate this growth in knowledge to have social and contextual elements [14]. Issues described at 'Conceptualisation' and 'Curriculum Development' provide clear opportunities for this growth in terms of time and space for reflection within the social group participating in the workshop. The assembled social group draws on individuals' lived experience (all participants are potentially 'people with experience' of physiotherapy and healthcare), to explore clinical practice through appreciative inquiry. In seeking to embrace an approach to learning that recognises students of the 2000's ('millennials') as generally having a preference for experiential activities that are entertaining, exciting and structured [25], a more 'colloquial' social context for the workshops is created through reference to popular culture.

The general format of PWE workshops is based on the popular television programme 'Baddiel and Skinner unplanned' [26]. A television audience interact with the two comedians (David Baddiel and Frank Skinner) in free-form dialogue. 'Secretaries' (usually 2 in number) are recruited from the audience to record perceived key points on a whiteboard for future reference and review and to inform discussion in moving towards a conclusion.

Following personal introductions, led by the workshop facilitator, the aims and structure of the session are discussed at the 'Classroom Encounter' and the contract introduced and signed. Students consider and record personal learning outcomes which are evaluated with the formal workshop learning outcomes at the end of the

session. Two 'secretaries' are recruited from the group to summarise, note and illustrate items of interest for review on sets of flipchart paper at various points in the session.

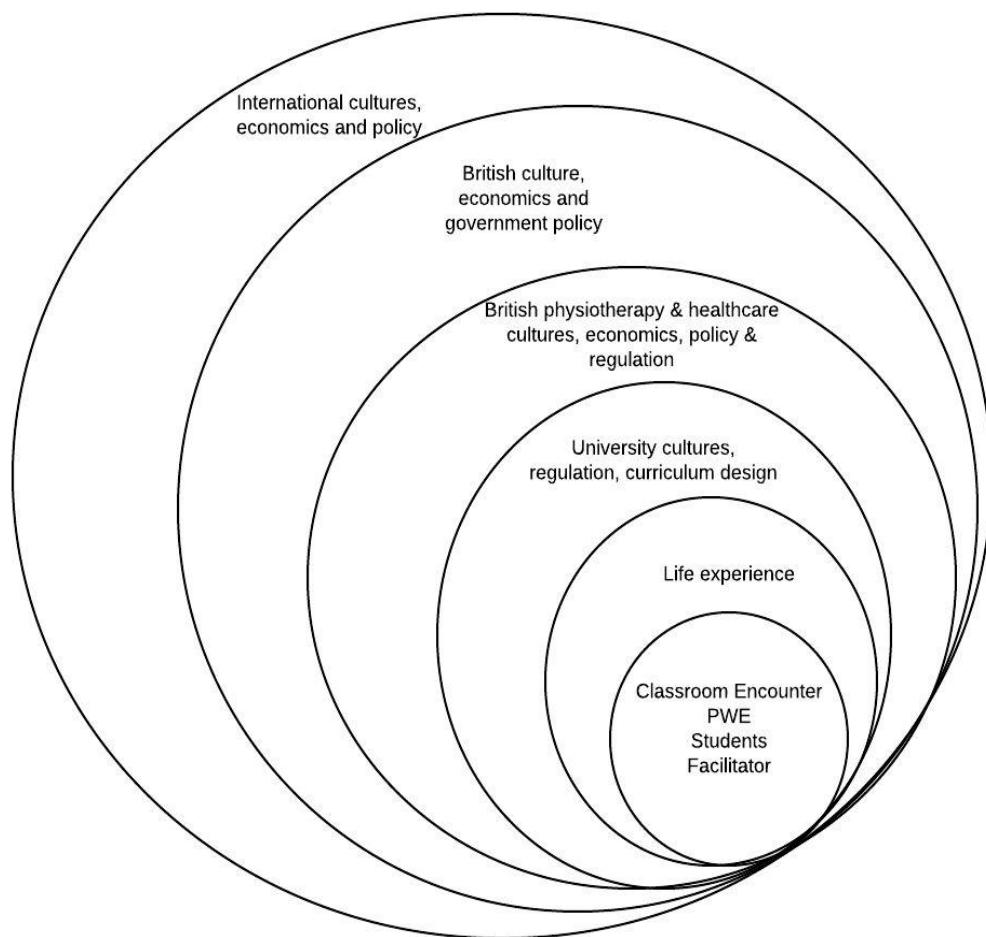
In holding one of the premises of complexity that nothing has 'reality' outside those involved, each workshop, although similar in format, is quite distinct in terms of focus of dialogue and reflection. Interactions between different PWEs, student groups and facilitators brings a unique flavour to each workshop, particularly in recognising that things are 'not always so' [27] in terms of assumptions that are made in relation to person-centred physiotherapy. Hence, any emergence of learning is within the context of the interdependent relationship between those present and their lived experience and influencing factors both within and outside the environment (see Figure 3). However, workshops generally fall into two broad phases in terms of format.

The PWE is invited to bring along an artefact or 'prop' that is representative of them and their life [28] in order to stimulate initial discussion. Examples of props have ranged from photographs of family, or those representing employment/an interest or hobby (a framed photograph of a Harley-Davidson motorcycle), to poetry written about an experience linked to their condition and a young baby brought in by its mother. The person involved initially provides a very brief overview of who they are and a life event (using the prop) that illustrates their 'experience' and then engages in dialogue with the student group (with appropriate support from the facilitator) with a focus on trying to see things from the PWE perspective that is, what might be important to them, what are their concerns, what may be their expectations. Thus, there is a deliberate attempt to 'look at things' from the other persons perspective to consider issues such as sensitive information (for who, when and how), influences and perceptions of verbal and non-verbal communication, active listening, social rituals linked to opening and closing of interactions, possible power positions within interactions and vulnerability.

Although events can be highly emotive it is not a primary intention for them to be so, but more to explore and challenge perceptions. However, healthcare is recognised as an emotional labour [29]. If professionals are to deal with the emotions of others they not only need to try to see things from the perspective of others, but also to be familiar with their own emotional states [30].

Based on this foundation the second phase of the workshop then explores a key decision(s) that the PWE and their physiotherapist made - what and how decisions were made, how things happened, how they turned out and how things happened in what way. The framework for this reflective dialogue is one of detailed description, clarification, explanation, analysis of PWE story and to reflect on what has been learned and how this might impact on students' professional practice and continuing professional development. Thus, facilitated interaction provides the time and space across the workshop for students to consider 'how things should work' and 'how things do work' for people with experience of physiotherapy services, that seeks to integrate self-awareness, reflection and critical/rational thinking [31,32].

Figure 3 Organised Complexity and the Classroom Encounter



## Evaluation

At the end of the workshop students complete evaluation forms and also provide informal verbal feedback through constructive conversation involving the whole group that includes recommendations for future workshops. The evaluation forms, which are distributed at the start of the workshop, comprise two set learning outcomes and space to set (individual) additional learning outcomes, which can be 'graded' on a 4-point scale in relation to achievement. In addition, students are asked to identify 3 points of learning from the workshop, the usefulness of the session, suggestions for future workshops and any further comments. In addition, informal debriefing interviews are undertaken with the PWE and workshop facilitators.

Thus, there is an inward movement to 'Evaluation' (of the 'Classroom Encounter') that is pluralistic in nature in that feedback is sought from students, PWE and the session facilitators. This movement is aligned with 'Conceptualisation' (Figure 1) in seeking to gain insights of meaning and understanding for all participants. While appreciating the impossibility of an objective understanding, there is a distinct possibility of developing

understanding through personal involvement and acknowledging the implications of that involvement [33]. The movement to 'Evaluation' recognises the 'Classroom Encounter' as complex in that it is dynamic, interdependent, non-linear and ambiguously bounded [12].

Although it is not the purpose of this article to present a formal evaluation, selected emergent issues of interest will be briefly discussed in support of the participatory learning model. Generally, students and PWE value and enjoy the workshops, with a desire to 'do their best' for others in each case being a key motivator. The impact of participation for a number of students has been a standout feature of learning as demonstrated by three of the student comments presented below from written feedback over the past six years:

"This has totally changed the way I think about clinical practice"

".... how what we consider to be important differs from what the patient considers to be important"

"Patient didn't feel any different when treated by a student"

Key themes associated with emergent learning are outlined in Box 2.

#### Box 2 Key themes associated with emergent learning

- The importance of building trust and being genuine in physiotherapy practice
- The value of physiotherapy - physiotherapy does work and is valued!
- The limitations of health service provision. This was quite a surprise to a number of students in terms of the bureaucratic 'maze' that some people had to negotiate to access services and the level of isolation experienced at times
- The coherence between organisational systems and the lives of individuals, when 'things' did work well

The value and enjoyment of the workshops appears to be attributable to the level of participation afforded to participants and also to the space afforded for reflection [22]. The workshops provide time and space for students and PWE that is not readily available in clinical practice, to explore experiences that they have participated in shaping and where, for example, both parties have contributed to the outcomes, format and structure of the workshops and are not merely following a strictly prescribed agenda or lesson plan, in keeping with Level 5 for service user involvement in education described by Tew, Gell and Foster [17]. In addition, the adoption of a non-healthcare general format (linked to popular culture in this instance) - 'Baddiel and Skinner Unplanned' [26] is also thought to put participants at ease and enhance the level of interaction underpinned by the ethos of appreciative inquiry [20] and communicative ethics [21].

#### Dissemination and Networks

The outward movement to 'Dissemination and Networks' represents an overt attempt to provide feedback into the world outside direct participants (PWE, students, university staff), before continuing to a new point of 'Arriving'. Within the application described here, formal and informal networks have developed across the PWE and clinician population within the physiotherapy profession and also outside of this linking to Faculty and University Learning and Teaching groups and CETL4HealthNE. Wider dissemination of the participatory model has occurred at learning and teaching conferences nationally and internationally and also within a published article related to service user and carer involvement in physiotherapy practice, education and research [1].

With each cycle of the Participatory Learning Model described here, there are potentially a large number of emergent inter-related variables that can influence and frame the process as 'organised complexity'. Figure 3 provides a simplistic mapping of this process, from the

'microscopic' (activity within *Classroom Encounter*) to the 'macroscopic' (national and international cultures, economics and policy). Here, we see overlapping open, dynamic and ever changing organised systems (represented by the concentric rings), interactions within and across systems influence and their impact on each and every phase of the participatory learning model described, in an interdependent, non-linear fashion [12]. The implications for these concepts lie in the potential for transfer of the learning model and also the workshop style across professions.

#### Discussion, conclusion and developments

Well-defined conclusions in relation to participatory learning may appear to be something of a misnomer in terms of the underpinning concepts of complexity science. However, in reporting the development of the workshops within a participatory model there are a range of useful observations and recommendations to be made in terms of evolution across levels of learning.

The participatory model provides a valuable framework to facilitate active engagement between PWE, staff and students, in order to create dynamic and credible learning experiences for all those involved. The space for reflection and purposeful dialogue within workshops that contain an element of popular culture 'distortion' built into the design provides a genuine attempt to move away from so called 'one hand clapping'. Participant feedback on the experience is essential to learning and development for all and the links between PWE and academic staff have led to other opportunities for curriculum development (e.g., involvement in validation as well as other teaching and learning sessions/learning resource development).

As the physiotherapy curriculum has changed, so different learning activities have evolved across levels, for example, the use of poetry and written narrative within teaching and learning activity for a Year 1 module related to Neurology. The articulation of the participatory model as a pedagogical framework within complexity theory is valuable in gaining understanding through which to inform developments of the continuing emergence of this approach in the curriculum. Collaboration in identifying partners, developing materials and sessions, negotiation of learning outcomes and activities and evaluation, has allowed for a certain element of creativity and also personalisation in participation.

The participatory model would seem to have the potential for transfer to broader areas of professional education. In embracing participation and complexity, key messages of encouragement are '*don't be afraid to start*' and '*learn from doing*'. However, it is important to think about any training needs across organisations and individuals, to find and nurture relationships, to be creative and also to have clarity of purpose.

In conclusion, then, the Participatory Learning Model described here, is advanced as an important contribution to the person-centred healthcare literature.

## Acknowledgements and Conflicts of Interest

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## Paper 6

# We're lost but making good time: Enquiry-based learning and professional identity



**John Stephens**  
Senior lecturer,  
Department of  
Sport Exercise and  
Rehabilitation,  
Northumbria  
University, UK.

In the UK, physiotherapy is recognised as an autonomous health profession that is subject to the regulation of standards for both practice and education by the Health and Care Professions Council. In addition, the Chartered Society of Physiotherapy, as the professional body for physiotherapists in the UK, has set out a clear vision of the values, knowledge, skills and behaviours associated with proficient physiotherapy practice. In adding political context to professional regulation, contemporary health care policy recognises the growing levels of complexity and uncertainty in practice that have significant implications for pre-registration education and the curricula that supports this.

Pre-registration undergraduate and postgraduate physiotherapy degree courses are offered by 35 universities across the UK. Undergraduate degree programmes are 3 years in duration in England, Wales and Northern Ireland and 4 years in Scotland, while pre-registration master's degrees are spread over 2 extended academic years. In common with undergraduate Physiotherapy BSc(Hons) courses, MSc programmes are regulated by the Health and Care Professions Council and Quality Assurance Agency for Higher Education.

Programmes are therefore required not only to direct learning to meet academic requirements, but also to 'shape' enculturation of learners to meet the requirements of Professional

Statutory Regulatory Bodies. Although programme outcomes are prescriptive, the means of achieving them are much less so (Bithell, 2007). With a reduced amount of time available and the level of academic study required, this would suggest a different approach to learning being not only necessary but also as an opportunity to engage in a creative approach to learning and development.

Cultural 'shaping' is achieved through the curriculum and pedagogy that support it (Osberg and Biesta, 2008). The promotion of a structured enculturation in health professional education would appear to be endemic among policymakers in particular, often irrespective of the complexity and demands of contemporary health care delivery. This, combined with high public expectations of quality care, raises challenges, particularly across 2-year accelerated MSc programmes. Unstructured enculturation (i.e. letting learners do as they wish) has serious implications for public safety, yet in shaping learning to reflect the 'messiness' of contemporary health care, structured enculturation would seem to be undesirable.

## A case for enquiry-based learning

Collaborative and cooperative learning has been revitalised and refashioned over the past 20 years or so through the advent of the internet and burgeoning of multimedia resources and simulation in health professional education. Learning characteristics of the 'Millennials' (individuals born since 1982) include qualities such as the ability to multitask, with preferences for networked and collaborative activities that focus on learning from film, images and sound rather than text.

However, these qualities also bring disadvantages of questionable quality

control with regard to resources, and limited reflection. In addition to changes in learners, the movement of tutor roles away from the 'sage on the stage' to 'guide on the side' (Fox, 2005) suggests a much more open and flexible role. Complex educational material, when appropriately structured, can be understood by novice learners in a particular discipline. The concepts of the spiral curriculum and scaffolding prevalent across all levels of education are arguably easier to structure across 3 years' undergraduate study than 2 years of accelerated master's level study.

An enquiry-based learning approach holds the potential to drive curricula through the establishment of activities that are scenario-, task- or skill-driven, drawing on students' previous learning and life experiences along with their developing professional experience. The characteristics of enquiry-based learning, such as the engagement of students as partners in the learning process and collaborative work that promotes social interaction and cohesion in the learning group (Hutchings, 2007), provide focus in achieving learning outcomes.

Attaining a professional qualification within a 2-year period requires the establishment of social cohesion within groups, including staff, to form a functioning system of support. Such dynamic relationships enable 'reflexively organised activity' (Giddens, 1997) that connects learning across more expansive influences, such as educational and professional regulation, with more personal events through dialogue and narratives (Lawler, 2008) to provide a trajectory of self and transformation.

Adapting to an enquiry-based learning approach, a very open-ended approach to learning, is challenging for the majority of students and can initially

be quite frustrating (invoking a sensation of being ‘lost’) as learners begin to create their ‘path’ for learning and identity. The notion of space for reflection, and ‘being time’, of recognising time as something more than a commodity is essential for success in engaging with these processes. Hence, the evoked imagery of being ‘lost but making good time’ can be an apt metaphor for the early experience of enquiry-based learning.

### **Emergent professional identity**

Trede (2012) places professional identity in the context of professionalism, which in turn informs decision making fuelled by reflection—the process that drives enquiry-based learning. It is recognised that professionalism and professional capability are influenced by factors such as family background and social conditions, but importantly also through university learning.

‘Identity’ in itself is a challenging concept (Lawler, 2008), and hinges on what may appear a contradictory combination of sameness and difference. Individual people are unique, hence the notion of person-centred health care, yet we share common identities such as ‘men’, ‘women’, ‘British’, and so on. This latter position may appear to support the learning of a rigid framework of professional standards, i.e. how to behave as a physiotherapist. In the interests of safe and effective practice, this would seem sensible but at the same time quite limited when the complexities surrounding contemporary person-centred health care are considered.

Globalisation and the breakdown of the social certainties of ‘solid modernity’ are being replaced by ‘liquid modernity’ (Bauman, 2004)—although offering a political and, perhaps, nostalgic longing for rigid order requires a balance between structured and unstructured enculturation for identity (Osberg and Biesta, 2008). Thus, professional identities should be recognised as emergent phenomena, constructed by the individual in the context of social groups (Bauman,

*‘An enquiry-based learning approach holds the potential to drive curricula through activities that are scenario-, task- or skill-driven, drawing on students’ learning and life experiences along with their developing professional experience.’*

2004; Lawler, 2008). Identities are dynamic, being continuously interpreted and reinterpreted through narratives—complex processes by which ‘we’ identify with ‘other’ (Lawler, 2008).

Life is lived forwards but understood backwards. Students create narratives through time that present balance between opportunity and risk, of letting go of the past and realising the potential ways of being and acting (Giddens, 1997). In essence, time is being (Heidegger, 2010). Within narrative, arguably, the notion of ‘being time’ arises through space for reflection (Stephens et al, 2007). Thus, enquiry-based learning can promote professional self-identity as an emergent enculturation that is based on a narrative based on dialogue, which is in turn based on space for reflection.

### **CONCLUSIONS**

Experience of the social world, in this case professional education, can be ‘storied’. Enquiry-based learning can help to shape sets of learning episodes to make an ongoing story that makes it possible to say ‘I am like this’. Self-actualisation as a professional implies control of time, through holding a dialogue with time. The journey to professional identity is seen as a series of passages in development for

the self that is internally referential in making sense of oneself. The journey of master’s level pre-registration education is one of challenges, of peaks and troughs in meeting the requirements of a broad range of stakeholders, whereby support of students is critical in creating learning opportunities that are authentic and context-relevant.

IJTR

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A7: Outputs linked to the sample of Papers

## Paper 1.

Stephens J., Abbot-Brailey H., & Pearson P. (2007) It's a Funny Old Game. Football as a Metaphor in Interprofessional learning *Journal of Interprofessional Care* Aug.21(4):375-85 [http://jr3tv3gd5w.search.serialssolutions.com/?ctx\\_ver=Z39.88-2004&ctx\\_enc=info%3Aofi%2Fenc%3AUTF-8&rfr\\_id=info:sid/summon.serialssolutions.com&rft\\_val\\_fmt=info:ofi/fmt:kev:mtx:journal&rft.genre=article&rft.atitle=%22It%27s+a+funny+old+game%22.+Football+as+an+educational+metaphor+within+induction+to+practice-based+interprofessional+learning&rft.jtitle=Journal+of+Interprofessional+Care&rft.au=Stephens%2C+John&rft.au=Abbott-Brailey%2C+Hilary&rft.au=Pearson%2C+Pauline&rft.date=2007&rft.pub=Informa+UK+Ltd&rft.issn=1356-1820&rft.eissn=1469-9567&rft.volume=21&rft.issue=4&rft.spage=375&rft.epage=385&rft.id=info:doi/10.1080%2F13561820701401247&rft.externalDocID=10\\_1080\\_13561820701401247&paramdict=en-US](http://jr3tv3gd5w.search.serialssolutions.com/?ctx_ver=Z39.88-2004&ctx_enc=info%3Aofi%2Fenc%3AUTF-8&rfr_id=info:sid/summon.serialssolutions.com&rft_val_fmt=info:ofi/fmt:kev:mtx:journal&rft.genre=article&rft.atitle=%22It%27s+a+funny+old+game%22.+Football+as+an+educational+metaphor+within+induction+to+practice-based+interprofessional+learning&rft.jtitle=Journal+of+Interprofessional+Care&rft.au=Stephens%2C+John&rft.au=Abbott-Brailey%2C+Hilary&rft.au=Pearson%2C+Pauline&rft.date=2007&rft.pub=Informa+UK+Ltd&rft.issn=1356-1820&rft.eissn=1469-9567&rft.volume=21&rft.issue=4&rft.spage=375&rft.epage=385&rft.id=info:doi/10.1080%2F13561820701401247&rft.externalDocID=10_1080_13561820701401247&paramdict=en-US)

## Supporting and associated outputs

- Stephens J., Gilthorpe J., & Daly J. (2014) Simulation in Physiotherapy Education: creating space for learning and 'being' through practice and rehearsal. Poster presentation. Physiotherapy UK, October 2014, Birmingham
- Stephens J. (2013) Reflections for identity through space, time and participation. Table-top workshop. Pedagogic Study Day, Northumbria University, Newcastle upon Tyne.
- Gilthorpe J. & Stephens J. (2013) Developing competency and confidence through assessment for learning. Poster Presentation, HEA Assessment Conference, June 2013, Birmingham
- Gilthorpe J. & Stephens J. (2012) Developing competency and confidence through assessment for learning. Poster Presentation, Physiotherapy UK Conference, October 2012, Liverpool
- Parr M. & Stephens J. (2012) 'Media-driven clinical skills competencies. Poster presentation, Physiotherapy UK Conference, Liverpool, October 2012
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- Parr M. & Stephens J. (2008) 'Lights, camera, action' – media-driven clinical skills competencies. HEA Festival of Learning, Carlisle, March 2008
- Stephens J., Abbott-Brailey (2007) Healthcare students' strategies to aid team identification and integration within a critical care setting, EIPEN 1<sup>st</sup> International Conference, Krakow, September 2007
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- Steven A., Stephens J., & Pearson P. (2005) 'The Football Stadium', Workshop, 1st Regional Primary Care Education Conference Celebrating Education in Primary Care, Barnsley, June '05.
- Stephens J., Dickinson C. & Pearson P. (2005)'Undergraduate students' perceptions of common learning in practice' Interprofessional Learning Conference, Bradford, June '05.

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Stephens J., Dawson P., & Pearson P. (2003) 'Work in Progress - the common learning programme' CSP Annual Congress, ICC, Birmingham, Oct '03

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Stephens J., & Pearson P. (2002) 'The Common Learning Project' Northern England Workforce Development Confederation, 2nd Annual Confederation Forum, Newcastle upon Tyne, Nov '02

#### Common Learning Programme North East

This publication was linked to a two year research project for which I was a member of the Operational Group. The Common Learning Programme North East (CLPNE) was one of four Department of Health funded programmes that examined the issues and opportunities for pre-registration health professionals.

Paper 2.

Jones D., Stephens J., Innes W., Rochester L., Ashburn A., & Stack E. (2009) Service user and carer involvement in physiotherapy practice education and research: getting involved for a change. *NZ Journal of Physiotherapy*, Vol 37, pp 26 – 32.

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Supporting and associated outputs

Stephens J. (2015) A participatory learning model and person-centred healthcare: moving away from 'one hand clapping' Poster presentation, Physiotherapy UK 2015, ECC, Liverpool, October 2015

Gilthorpe J., Connell T., & Stephens J. (2015) 'Let the platform see the learning': eLP and participatory learning. Poster presentation, 3 Rivers Conference, Sunderland University, March 2015.

Stephens J. & Jones A. (2008) Partnerships in education – moving away from one hand clapping. Poster presentation 4<sup>th</sup> Academic Practice and CETL Study Day and Conference, Northumbria University, June 2009

Stephens J. & Jones A. (2007) Partnerships in education – moving away from one hand clapping. Northumbria Conference, September 2007

Stephens J. & Dawson P. (2005) 'Changing Contexts towards meeting the challenge; pre-registration MSC Physiotherapy, enquiry-based learning, and staff development' CSP Annual Congress, ICC, Birmingham, Oct '05.

Stephens J., Gregg A., Crozier S., & Slowie D. (2005)'Black Leather Seats and Big Bose Sound. Using drama to facilitate interprofessional learning' Interprofessional Learning Conference, Bradford, June '05.

Crozier S., Gregg A., Slowie D., & Stephens J. (2004) 'Black Leather Seats and Big Bose Sound' Northumbria Conference, Newcastle upon Tyne, June '04.

Centre for Excellence in Teaching and Learning (CETL).

The work carried out for this publication contributed to the 'Service user and carer involvement' (People with Experience) workstream for CETL4Health. CETL4Health NE is a consortium of North East England Universities and NHS partner organisations. The purpose of CETL4Health NE is to design and deliver innovative learning and teaching programmes and share best practice in healthcare education.

Paper 3.

Stephens J., Abbott-Brailey H., & Platt A. (2011) Appearing the team: from practice to simulation. *International Journal of Therapy and Rehabilitation* Vol 18(12) p672-682  
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Supporting and associated outputs

- Stapleton C., & Stephens J. (2014) Technology and Professional Identity. Oral presentation, Physiotherapy UK, October 2014, Birmingham
- Stephens J., Gilthorpe J., & Daly J. (2014) Simulation in Physiotherapy Education: creating space for learning and 'being' through practice and rehearsal. Poster presentation. Physiotherapy UK, October 2014, Birmingham
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- Stephens J. & Dawson P. (2005) Changing Contexts towards meeting the challenge; pre-registration MSc Physiotherapy, enquiry-based learning, and staff development. CSP Annual Congress, ICC, Birmingham, Oct '05
- Steven A., Stephens J., & Coghill E. (2005) Undergraduate Interprofessional Education in the Critical Care Setting. Critical Care Conference, Freeman Road Hospital, Newcastle upon Tyne, May '05.
- Stephens J., Dawson P., & Johnson P. (2003) The development of clinical reasoning in undergraduate physiotherapy education. CSP Annual Congress, ICC, Birmingham, Oct '03.
- Stephens J., & Smith A. (2001) Learning in clinical practice - a multidisciplinary approach. Qualitative Evidence-Based Practice Conference, Coventry University, May '01.

Common Learning Programme North East

This publication was linked to a two year research project for which I was a member of the Operational Group. The Common Learning Programme North East (CLPNE) was one of four Department of Health funded programmes that examined the issues and opportunities for pre-registration health professionals.

#### Paper 4

Stephens J., & Parr. (2013) The development of media-driven clinical skills through using the 'e-skills portfolio'. *International Journal of Therapy and Rehabilitation*. Vol 20(7) p336-342

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#### Supporting and associated outputs

Stephens J., & Dunbar M. (2014) Developing autonomous learning through the use of information technology. Oral presentation, Physiotherapy UK, October 2014, Birmingham

Stapleton C., & Stephens J. (2014) Technology and Professional Identity. Oral presentation, Physiotherapy UK, October 2014, Birmingham

Stephens J., Parr M., & Clarkson C. (2014) Personal and Professional Webfolio. Poster presentation, Physiotherapy UK, October 2014, Birmingham

Stephens J., Gilthorpe J., & Daly J. (2014) Simulation in Physiotherapy Education: creating space for learning and 'being' through practice and rehearsal. Poster presentation. Physiotherapy UK, October 2014, Birmingham

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Parr M. & Stephens J. (2012) 'Media-driven clinical skills competencies. Poster presentation, Physiotherapy UK Conference, Liverpool, October 2012

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Gilthorpe J. & Stephens J. (2010) Developing competency and confidence through assessment for learning. Poster Presentation, Northumbria University, March 2010

Gilthorpe J. & Stephens J. (2010) Developing competency and confidence through assessment for learning. Poster Presentation, 3 Rivers Consortium Conference, Sunderland University, March 2010

- Parr M. & Stephens J. (2008) 'Lights, camera, action' – media-driven clinical skills competencies. Poster presentation 4<sup>th</sup> Academic Practice and CETL Study Day and Conference, Northumbria University, June 2009
- Parr M. & Stephens J. (2008) 'Lights, camera, action' – media-driven clinical skills competencies. Northumbria Conference September 2008
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- Stephens J. & Dawson P. (2005) 'Changing Contexts towards meeting the challenge; pre-registration MSC Physiotherapy, enquiry-based learning, and staff development' CSP Annual Congress, ICC, Birmingham, Oct '05.
- Stephens J., Dawson P., & Johnson P. (2003) 'The development of clinical reasoning in undergraduate physiotherapy education' CSP Annual Congress, ICC, Birmingham, Oct '03.

## Paper 5

Stephens J. (2015a) A participatory learning model and person-centred healthcare: moving away from 'one hand clapping'. *European Journal for Person Centred Healthcare*. Vol 3. Issue 3. 279-287.

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## Supporting and associated outputs

Stephens J. (2015) A participatory learning model and person-centred healthcare: moving away from 'one hand clapping' Poster presentation, Physiotherapy UK 2015, ECC, Liverpool, October 2015

Gilthorpe J., Connell T., & Stephens J. (2015) 'Let the platform see the learning': eLP and participatory learning. Poster presentation, 3 Rivers Conference, Sunderland University, March 2015.

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Gilthorpe J. & Stephens J. (2010) Developing competency and confidence through assessment for learning. Poster Presentation, 3 Rivers Consortium Conference, Sunderland University, March 2010

Stephens J. & Jones A. (2008) Partnerships in education – moving away from one hand clapping. Poster presentation 4<sup>th</sup> Academic Practice and CETL Study Day and Conference, Northumbria University, June 2009

Stephens J. & Jones A. (2007) Partnerships in education – moving away from one hand clapping. Northumbria Conference, September 2007

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Stephens J., Dawson P., & Johnson P. (2003) 'The development of clinical reasoning in undergraduate physiotherapy education' CSP Annual Congress, ICC, Birmingham, Oct '03.

Centre for Excellence in Teaching and Learning (CETL).

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is a consortium of North East England Universities and NHS partner organisations. The purpose of CETL4Health NE is to design and deliver innovative learning and teaching programmes and share best practice in healthcare education.

## Paper 6

Stephens J. (2015b) We're lost but making good time: enquiry-based learning and professional identity. *International Journal of Therapy and Rehabilitation*. Vol 22. No 10. 406-407

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## Supporting and associated outputs

Stephens J., & Dunbar M. (2014) Developing autonomous learning through the use of information technology. Oral presentation, Physiotherapy UK, October 2014, Birmingham

Stapleton C., & Stephens J. (2014) Technology and Professional Identity. Oral presentation, Physiotherapy UK, October 2014, Birmingham

Stephens J., Parr M., & Clarkson C. (2014) Personal and Professional Webfolio. Poster presentation, Physiotherapy UK, October 2014, Birmingham

Stephens J., Gilthorpe J., & Daly J. (2014) Simulation in Physiotherapy Education: creating space for learning and 'being' through practice and rehearsal. Poster presentation. Physiotherapy UK, October 2014, Birmingham

Stephens J. (2013) Reflections for identity through space, time and participation. Table-top workshop. Pedagogic Study Day, Northumbria University, Newcastle upon Tyne.

Stephens J. & Dawson P. (2005) 'Changing Contexts towards meeting the challenge; pre-registration MSC Physiotherapy, enquiry-based learning, and staff development' CSP Annual Congress, ICC, Birmingham, Oct '05.

Steven A., Stephens J., & Coghill E. (2005) 'Undergraduate Interprofessional Education in the Critical Care Setting' critical Care Conference, Freeman Road Hospital, Newcastle upon Tyne, May '05.

## A8: MSc Physiotherapy (pre-registration) Programme Specification

## Programme Framework for Northumbria Awards: Postgraduate Programme Specification (Masters, PG Dip)

QAA Expectation: A2.2: *Degree-awarding bodies maintain a definitive record of each programme and qualification that they approve (and subsequent changes to it) which constitutes the reference point for delivery and assessment of the programme, its monitoring and review, and for the provision of records of study to students and alumni.*

*The programme specification is the primary source of information relating to the programme. The programme specification forms a central document for students, employers and staff. It should be written from the perspective of the student.*

Programme Title	MSc Physiotherapy (pre-registration)	Programme Code	
Home Faculty	Health and Life Sciences	Department	Sport, Exercise and Rehabilitation
Other Contributing Faculty	Choose an item.	Department	

### **SECTION 1: Programme Aims**

**In addition to the Northumbria Graduate Characteristics, a Northumbria Postgraduate will:**

**For PG Cert / Diploma:**

- Critically reflect on their own work and that of others
- Present and justify their work, in the context of wider theories and practice, to their peers
- Display and critically apply expert knowledge within areas of their discipline and /or its practice

**For Masters degree:**

- Conceptualise, theorise and undertake research which addresses complex issues and which advances understanding within the discipline or practice
- Contribute to the creation of new knowledge and /or applications to practice within their discipline through a critical understanding of the processes through which knowledge is created.
- Formulate balanced judgements when considering incomplete or ambiguous data and can communicate these judgements clearly to both specialist and non-specialist audiences

**The overall aims of this particular MSc programme are:**

1. To explore the key issues relating to Physiotherapy within context of contemporary healthcare delivery in a creative, innovative manner
2. To meet the standards of knowledge, skills, values and behaviours in meeting the requirements of relevant professional (regulatory) bodies
3. To stimulate a collaborative, enquiry based approach to the complex nature of physiotherapy, healthcare and societal needs
4. To research, sift, critically appraise, apply and generate knowledge relevant to physiotherapy practice

5. To develop critical, analytical and reflective skills as clinical practitioners who are confident to explore, influence and lead the complexities and boundaries of effective physiotherapy and to thrive in responsibility for your progress as professional learners
6. To develop a philosophy of person-centred health promotion, rehabilitation, and palliative care underpinned by reflective practice based on your own professional practice; which is genuine, creative, inclusive and sensitive to the health needs of society

**How does the programme aim to engender / enable the development of the Northumbria Graduate qualities within the specific subject discipline? (max 250 words per section)**

The MSc Physiotherapy degree is underpinned by a philosophy of the right of every individual in society have the opportunity to access and experience the best physiotherapy care. To realise this goal, you, as a physiotherapist, must be creative, motivated, resilient, and sensitive to the needs and wishes of each individual you work with. It is vital therefore that you understand your own thinking, learning and creativity as an authentic autonomous practitioner.

You will need both a strong philosophy of values-based physiotherapy along with flexible learning and development strategies to enable you to contribute to the rapidly changing, complex healthcare system within a technology-driven age.

You are expected to adhere to the professional standards of practice, values and behaviours as set out by the Health and Care Professions Council (HCPC) and the Chartered Society of Physiotherapy (CSP). We will encourage and expect that you will pursue and develop broad areas of competence, capability and interest through your learning experiences. This will occur within the University through analysis of research and the evidence-base for physiotherapy, within your clinical practice placement experience and ultimately the opportunity to reflect on your development as a safe and effective professional.

The degree is a two-year full time pre-registration physiotherapy programme designed to integrate your learning experiences in the University and across a broad range of clinical practice settings. These experiences will enable you to develop the necessary knowledge, skills, values and behaviours required to be eligible for professional registration.

**SECTION 2: Programme Overview: (Max 250 words per section)**

*This section is aimed at providing a prospective or current student with a brief overview of the programme in answer to the specific questions and will form an element of the programme handbook. It is not intended to capture the detail of the programme design.*

2.1	<b>Why should I study this programme at Northumbria?</b> This section should contain reference to the specific advantages or strengths of undertaking the programme at Northumbria. Reference should be made to any unique selling points in terms of students' satisfaction, elements of the programme not typically included elsewhere, employment opportunities etc.
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With a motivation to become a registered physiotherapist, you should enter your physiotherapy career via the MSc Physiotherapy programme, at Northumbria because you understand the success our graduates have in achieving HCPC registration and gaining employment on completion of the programme.

The MSc Physiotherapy programme aims to enhance the clinical, critical and reflective abilities that will underpin your professional understanding and early career development. Our consistently impressive employability rates across a broad range of career options and the quality of our graduates are just two indications of the value that potential employers place on the education you will receive. The knowledge, skills, values and behaviours that MSc Physiotherapy provides and enhances will give you confidence as you engage with a career designed to challenge your thinking and develop your effectiveness as a physiotherapist whether clinically, in research or further study such as PhD. You will be supported by a team of motivated, specialist tutors that have extensive experience in clinical practice and academic areas of expertise and who work collaboratively with staff and students from other professions / disciplines, and who share your passion for physiotherapy. Student satisfaction rates are exceptionally high for this programme.

2.2	<b>How will I learn on this programme?</b> This section should contain an overview of the learning and teaching philosophy of any approaches used, including the use of Technology to Enable Learning within, the programme. It should outline which research informed learning approaches will be used, and how the approaches may differ by level.(Reference: Northumbria Research Rich Learning Policy)
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You will learn through a combination of university-based and clinical practice-based opportunities that seek to underpin professional learning with academic knowledge and critical understanding. The programme is framed within an enquiry-based learning approach that is largely workshop-driven, along with tutorials and integrating technologically enhanced learning opportunities both within your own student group and with others. This will provide you with opportunities to critically reflect on your clinical practice-based experience and develop an appreciation of the importance of integrating physiotherapy theory and practice. Thus your learning will be situated in 'zones of proximal development' where experiential, collaborative and individualised strategies will enable you to develop the personal, professional and transferable skills associated with proficient, innovative newly qualified physiotherapists.

Essentially, this is a rigorous intellectual and practical approach giving you the opportunity to develop and demonstrate safe and effective physiotherapy practice, a systematic application of knowledge and skills to become an autonomous professional. The learning strategy,

enhanced by technology, will enable you to not only make full use of Northumbria University resources but also inspire the application of technology in clinical practice as part of contemporary health care services. Clinical practice placements will also provide you with opportunities to develop professional networks that will be important to your own career development.

2.3	<p><b>How will I be assessed on the programme?</b> This section should contain the programme philosophy, the purpose (and hence nature) of assessment tasks at each level, and how these will complement the learning and teaching philosophy in enabling the achievement of learning outcomes. It will also identify how formative assessment will occur, and how students will be supported in fully understanding the requirements and expectations of an assessment task, and how feedback will be given to enhance learning. (Reference: Northumbria Assessment and Feedback Policy.)</p>
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The programme learning outcomes together with the Northumbria University Assessment and Feedback principles underpin the rationale for assessment on the MSc Physiotherapy programme. Assessment is concerned with the development and demonstration of your knowledge, understanding and of your professional competence as a physiotherapist, together with your academic development as a student in the University. The assessment processes are both formative and summative as we believe they should not only measure and judge your learning but also facilitate and shape your intellectual and professional development. Assessments are designed to motivate you and stimulate your interest, to challenge you to develop your skills, and to enable you to reflect on feedback on your progress.

Module assessments reflect a variety of strategies that have been carefully selected to suit your needs as a student on this programme and as a safe and effective physiotherapist. These include written assignments, presentations, reflective professional portfolios and clinical practice expectations related to professional conduct and the assessment, planning and delivery of person-centred physiotherapy. Self – assessment, peer feedback and collaborative approaches are central features of our assessment philosophy. Module tutors will directly support you in fully understanding the requirements and expectations of each assessment task and the detailed feedback you receive will further enhance your learning and contribute to your ongoing performance. The assessment opportunities on this programme will enable you to demonstrate that you meet the requirements to be awarded a MSc Physiotherapy and eligibility for registration with the HCPC / CSP.

2.4	<b>What option modules are available within the programme (how and when do I choose my options)?</b> This section will include information on how students will be informed of options available, and how they be supported in making option choices.
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To meet Professional Statutory Regulatory Body (PRSB) requirements all modules within MSc Physiotherapy (pre-registration) are compulsory.

However, there are two areas of the curriculum where 'options' will be made available to you:

1. There will be three options available for the 60 credit research project in meeting the MSc award. You will be informed of these options at the induction programme for the course. Details and process surrounding the options will be covered in a robust and rigorous manner at the Year 1 module *Research in Health and Social Care*, where you will be supported by module staff in the development of your research proposal. Furthermore, during the *Pre-reg MSc Occupational Therapy & MSc Physiotherapy Project* module across Year 2, you will be additionally supported by a research project supervisor, alongside module staff to guide you through processes including research ethics, data collection & analysis, and write up as appropriate.
2. The final clinical practice placement within the programme will be an 'elective' placement in a clinical area and location of your own choosing. This can include international placement to experience physiotherapy within differing cultures. The main provisos for the placement are a) the location is safe b) you will have a named, qualified clinical educator c) indemnity insurance as required d) you can provide a source of funding. You will be supported in your choice and confirmation of placement area by academic and placement administration staff, and guided towards possible sources to assist organisation and funding (including competitive bursaries available within and outside the University).

2.5	<b>How will I be supported pastorally on the programme?</b> This section should contain information on what pastoral support is available for students on the programme, and how students may access the support.
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During induction, you will be introduced to the programme administrative procedures and support services available within the University. In addition to your Programme Leader, you will be allocated a Guidance Tutor. All Guidance Tutors from the programme are qualified physiotherapists with an established background in clinical practice and fully understand the challenges you will face as you commence your professional career. Guidance tutorials are a core aspect of your education and provide you with opportunities to engage in discussion and reflect on your own learning.

Your Programme Leader, and Guidance Tutor can be contacted by email or telephone and are available to help you with queries and specific issues concerning the programme such as; requests for leave of absence, issues concerning personal extenuating circumstances and illness. Furthermore, 'Student Central' located in the Library, is an excellent point of contact for many types of support such as; disability issues, faith issues, counselling and mental health support, finance, welfare issues and international student support. Student services have a drop-in facility for emergencies and enquiries, and also a more formal booking system for longer and more frequent visits.

The student representatives chosen by your cohort, and the support staff within the Student Union, are also a point of call if you have queries related to your programme. The programme also enjoys close links with the CSP through a student-cohort elected CSP representative, and promote networking across pre-registration programmes in the UK and possibly beyond, through working with our Professional Body.

2.6	<p><b>How will I be supported academically on the programme?</b> This section should contain information on what academic support is available to students on the programme. It should include details of how support at module level may be accessed outside formal scheduled teaching; how students will be guided in relation to their academic progress; and how faculty and university learning support may be accessed.</p>
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Successful academic achievement requires a robustly organised support and guidance processes to help you focus on your learning and development. In addition to the pastoral support you will receive, the programme leader together with module and subject tutors will provide guidance and academic counselling to ensure that you are able to confidently engage with the academic rigour of the programme. The enquiry-based learning approach across modules also engenders strong peer support in establishing a community of learning. Inclusive, open dialogue and narrative within scheduled learning contact (workshops, seminars, tutorials) is a feature of support both face to face and virtually. In addition, during the development of your research project you will receive the support of a research project supervisor who will advise you through the process of project development, ethics submission, project operation and write-up.

You will spend a significant amount of time in clinical practice, where you will be supported by experienced clinicians. Clinical practice placements will also be supported by visiting academic tutors to further facilitate your learning experience.

Extensive support is also accessible online as part of the University's commitment to technology enhanced learning. This includes the use of the e-learning portal (Blackboard including Pebble+) and social networking and collaborative tools.

A central feature of the academic support available to you is the service provided by the University Library. This 24/7 service caters for all your

learning needs, has extensive access to electronic texts and tutorials that will directly support the development of academic skills aimed at improving your critical thinking and analytical writing.

<b>2.7</b>	<b>How will I be involved in the programme?</b> This section should contain information on how students' views on their experiences will be collected during the programme, and how feedback on the views collected will be given. It should also contain general information on the types of roles available to students related to programme involvement. (Reference Student Engagement Policy)
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Your programme is supported by open student involvement facilitated through the enquiry-based learning process and also through your student representative. These representatives are chosen by the students for each year group and their role (supported by the Student Union and their Programme Leader) is to collect student opinion and feedback their cohorts experience of the programme. These students then report to the Student Staff Programme Committee meeting. The outcome of these meetings is shared by the Programme Leader in open dialogue with the group, your programme site on the eLP, and student representatives also share the discussions with their cohort. Traditionally there are also strong links with our professional body, the Chartered Society of Physiotherapy (CSP) through a group selected CSP group representative that provides the opportunity for dialogue at a national level.

At a modular level, you will be actively engaged in the development of individual modules by being asked to provide informal and formal feedback to Module Leaders, of your experience with modules. Part of this process is the completion of a Module Review, but tutors appreciate feedback at any time.

The relationship between the academic team and the student cohort is viewed as integral to the success of the programme so that a more informal approach to contact is encouraged, so as far as possible we can be responsive to the ongoing needs of the cohort and are able to tailor subject knowledge delivery as part of dialogue and ongoing narrative that shapes your professional identity.

<b>2.8</b>	<b>How will I be prepared for employment / further study on the programme?</b> This section should contain information on the opportunities available to students to enhance their employment / future study prospects, e.g. placement, study abroad, live projects, work based learning / assessment. (Reference: Northumbria Employability, Enterprise & Entrepreneurship Plan)
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By enrolling on this Health and Care Professions Council approved, pre-registration programme, also with Chartered Society of Physiotherapy approval, you will have already demonstrated motivation to practice physiotherapy. Successful completion of the programme makes you eligible to register with the HCPC and also upgrade student membership of the CSP to that of a registered professional. During your time studying on the MSc programme you will be subject to professional regulation by virtue of HCPC approval.

This programme will fully support you as you gain the required experience and demonstrate capability that will lead to the award of MSc Physiotherapy (pre-registration). Completion of all modules within the programme are mandatory as is the successful completion of a minimum of 1000 clinical practice placement experience in order to meet eligibility for professional registration.

The focus on employment runs as a core element throughout the programme and you will be encouraged to develop and maintain your Personal and Professional Development File or 'webfolio' to inform and support employment opportunities on completion of the programme, and provide a foundation for future successful continuing professional development necessary for HCPC re-registration and career progression.

As a graduate of this programme you can expect to be highly successful in gaining employment as a registered physiotherapist. Well over 90% of students are successful in finding employment either within the NHS, private, charity sector or progress to further study (eg PhD) within 6 months of successful programme completion.

### **SECTION 3: Programme Structure**

On completion, your award will depend on the level of achievement as indicated here. Successful completion of the MSc level award is necessary for eligibility to register with the Health and Care Professions Council (HCPC):

	<b>Award</b>	<b>Components</b>	<b>Eligibility for HCPC Registration</b>
1.	MSc Physiotherapy	20 credits, taught modules @ Level 6 100 credits, taught modules @Level 7 60 credits, research project	Yes
2.	PG Diploma in Health Studies	20 credits, taught modules @ Level 6 100 credits, taught modules @Level 7	No
3.	PG Cert in Health Studies	20 credits, taught modules @ Level 6 40 credits, taught modules @Level 7	No

**The Figure at the following page provides an overview of the programme structure**

**Note that the MSc programme is January start. Semesters are labelled as for the programme, e.g. Sept – Jan is Semester 2**

Induction	(Programme) Semester 1	(Programme) Semester 2
<b>Year 1 (&amp; pre-course)</b> <ul style="list-style-type: none"><li>• Anatomy workbook</li><li>• Critical appraisal tools</li><li>• Professionalism &amp; professional conduct</li><li>• Mandatory skills</li></ul>	<p><i>PT0606 Physiotherapy professional practice studies 1</i> (Level 6; 20 credits; YL) Summative assessment: Practical viva</p>	<p><i>PT0705 Assessment &amp; rehabilitation for movement &amp; function</i> (Level 7; 20 credits; YL) Summative assessment: written assignment</p>
	<p><i>PT0706 Research in Health &amp; Social Care</i> (Level 7; 20 credits; Sem 1) Summative assessment: Research project proposal</p>	<p><i>PT0707 Movement for function &amp; participation</i> (Level 7; 20 credits; Yr 1 Sem 2 &amp; Yr 2 Sem 1) Summative assessment: Presentation (poster) viva</p>
		<p><i>PT0710 Pre-reg MSc Occupational Therapy &amp; MSc Physiotherapy Project</i> (Level 7; 60 credits) Summative assessment: project write-up for publication; plus reflective account of the research process</p>
<b>Year 2</b> <ul style="list-style-type: none"><li>• Mandatory skills</li></ul>	<p><i>PT0708 Physiotherapy professional practice studies 2</i> (Level 7; 20 credits; YL) Summative assessment: written assignment</p>	<p><i>PT0707 Movement for function &amp; participation</i> (Level 7; 20 credits; Yr 1 Sem 2 &amp; Yr 2 Sem 1) Summative assessment: Presentation (poster) viva</p>
	<p><i>PT0710 Pre-reg MSc Occupational Therapy &amp; MSc Physiotherapy project</i> (Level 7; 60 credits) Summative assessment: project write-up for publication; plus reflective account of the research process</p>	<p><i>PT0709 Innovation &amp; change for contemporary physiotherapy</i> (Level 7; 20 credits) Summative assessment: Presentation viva</p>

Yellow: YL    Blue: Single Semester    Purple: YL across Yr 1 and 2

## **SECTION 4: Programme Learning Outcomes**

QAA Expectation: A3.2

*Degree-awarding bodies ensure that credit and qualification are awarded only where:*

- *The achievement of the relevant learning outcomes has been demonstrated through assessment.*
- *Both UK threshold standards and their own academic standards have been satisfied.*

**Students undertaking this programme are expected to achieve the following learning and educational outcomes on completion of each stage (level) of the programme prior to progression to the next stage.**

(Programme learning outcomes should be specific to area/s of study and should reflect national subject benchmarks and qualification framework level descriptors)

*Please note PLOs are cumulative across the award/s and should not be repeated in each section.*

### **Postgraduate Diploma Programme Learning Outcomes (120 Credits)**

#### **Knowledge & Understanding (K&U):**

1. demonstrate a critical awareness of current issues and developments in physiotherapy practice
2. demonstrate an in-depth and systematic knowledge and understanding of the role, purpose, and scope of practice that informs safe and effective physiotherapy.
3. demonstrate a comprehensive understanding in the delivery of evidence-based, person-centred physiotherapy practice
4. understand the complex relationships between theory and practice in physiotherapy and health and social care
5. understand the complex relationships between safe and effective person-centred care and the continuous development of health and social care services that support this

#### **Intellectual / Professional Skills & Abilities (IPSA):**

1. deal with complex issues within professional practice systematically and creatively
2. demonstrate awareness of and commitment to meeting the professional requirements of the role of the physiotherapist including professional values, professional duties, and the statutory framework relating to physiotherapists responsibilities
3. undertake systematic critical self-reflection, within the development of professional skills and attributes
4. forge positive, effective working relationships with others
5. use initiative and take responsibility in order to successfully assess, plan, deliver and evaluate person-centred physiotherapy practice
6. demonstrate the ability to effectively communicate and record practice across a broad range of levels and media
7. adopt a critical appreciation of how technology can be used to enhance their academic performance and professional capacity for person-centred care and service delivery.

#### **Personal Values Attributes (Global / Cultural Awareness, Ethics, Curiosity) (PVA):**

1. be able to make decisions in complex and unpredictable situations
2. demonstrate the ability to plan and deliver safe, effective and efficient physiotherapy beyond the demands of professional standards, including

global citizenship;

3. demonstrate understanding of physiotherapy, health and wellbeing within a global context, at both a national and international level.
4. show self-awareness in their own beliefs, commitments and prejudices to demonstrate a non-judgemental, compassionate attitude towards others

### Postgraduate Diploma Level 7 Learning and Teaching Matrix

Module Code	Credits	Core Option	Module title	Research Rich Learning Nexus: indicate main strategy applied for each module				Assessment Method	ESAF Submission		PLOs assessed
				Led	Orientated	Based	Tutored		Yes	No	
PT0606	20	C	<i>Physiotherapy professional practice studies 1</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Practical Viva	<input type="checkbox"/>	<input checked="" type="checkbox"/>	KU: 1 IPSA 1-5 PVA: 4
PT0705	20	C	<i>Assessment &amp; rehabilitation for movement &amp; function</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Written assignment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	KU: 1, 2, 3 IPSA: 2, 3, 6 PVA: 2,3
PT0706	20	C	<i>Research in Health &amp; Social Care</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Written research proposal	<input type="checkbox"/>	<input type="checkbox"/>	KU: 4, 5 IPSA: 1, 3. PVA: 3, 4.
PT0707	20	C	<i>Movement for function &amp; participation</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Presentation (poster) viva	<input type="checkbox"/>	<input checked="" type="checkbox"/>	KU: 1, 2, 3, 4 IPSA: 1, 2, 3, 4, 5 PVA: 1, 2, 3
PT0708	20	C	<i>Physiotherapy professional practice studies 2</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Written assignment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	KU: 1, 3 IPSA 1, 3, 4 PVA: 1, 4
PT0709	20	C	<i>Innovation &amp; change for contemporary</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Presentation viva	<input type="checkbox"/>	<input checked="" type="checkbox"/>	KU: 1, 2, 3, 4, 5*

			<i>physiotherapy</i>									IPSA: 1, 2, 3, 4, 5, 6* PVA: 1, 2, 3, 4*
												*Dependent on IPSA 1

**Lower Level Award (60 Credits Level 7)**

Postgraduate Certificate	YES	<input checked="" type="checkbox"/>	If yes, indicate award title:	PG Cert Health Studies	NO	<input type="checkbox"/>
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**Lower Level Award (120 Credits Level 7 Completion)**

Postgraduate Diploma	YES	<input checked="" type="checkbox"/>	If yes, indicate award title:	PG Dip Health Studies	NO	<input type="checkbox"/>
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**Masters Degree Programme Learning Outcomes (180 Credits)**
**Knowledge & Understanding (K&U):**

1. demonstrate an in-depth and systematic knowledge and understanding of the role, purpose, scope of practice that informs safe and effective physiotherapy practice in the achievement of HCPC Standards of Proficiency.[\[all Professional Learning Themes \(PLTs\)\]](#)
2. demonstrate a comprehensive understanding in the delivery of evidence-based, person-centred physiotherapy practice [\[PLT2, 3; Professional Learning Constructs \(PLCs\) 5, 6, 9\]](#)
3. understand the complex relationship between theory and practice in physiotherapy and health and social care demonstrating a practical understanding of how established techniques of research and enquiry are used to create and interpret knowledge in the profession [\[PLT 1, 4; PLC 1, 6, 10\]](#)
4. understand the complex relationships between safe and effective person-centred care and the continuous development of health and social care services that support this. [\[PLT 1, 3; PLC 1, 2, 5, 8\]](#)
5. plan, develop, manage and appraise an original piece of research relevant to physiotherapy practice [\[PLT 1, 3 PLC 3, 5, 6, 8, 10\]](#)

**Intellectual / Professional Skills & Abilities (IPSA):**

1. demonstrate awareness of and commitment to meeting the professional requirements of the role of the physiotherapist including

professional values, professional duties, and the statutory framework relating to physiotherapists' responsibilities [PLT 1, 2,3; PLC 3, 5, 6, 8, 10]

2. undertake systematic critical self-reflection, within the development of research skills, alongside professional skills and attributes [PLT 2, 3, 4; PLC 3, 4, 6, 7]

3. forge positive, effective working relationships with others [PLT 3; PLC 1, 2, 5, 7]

4. use initiative and take responsibility in order to successfully assess, plan, deliver and evaluate person-centred physiotherapy practice [PLT 1 – 4; PLC 1, 4, 5, 6, 7, 9 10]

5. demonstrate the ability to effectively communicate and record practice across a broad range of levels and media [PLT 3; PLC 2, 6, 7, 10]

6. adopt a critical appreciation of how technology can be used to enhance your academic performance, learning, and professional capacity to facilitate person-centred care and service delivery. [PLT 1, 4; PLC 3, 4, 5, 6, 7, 8]

**Personal Values Attributes (Global / Cultural Awareness, Ethics, Curiosity) (PVA):**

1. be able to make decisions in complex and unpredictable situations [PLT 4; PLC 6, 7, 8, 10]

2. demonstrate the ability to plan and deliver safe, effective and efficient physiotherapy beyond the demands of professional standards, including global citizenship [PLT 1, 2, 4; PLC 1, 2, 4, 6, 7, 10]

3. demonstrate understanding of physiotherapy, health and wellbeing within a global context, at both a national and international level. [PLT 1, 2, 3; PLC 1, 6, 7, 9, 10]

4. show self-awareness in their own beliefs, commitments and prejudices in keeping with a non-judgemental, compassionate attitude towards others [PLT 3, 4; PLC 1, 7, 8]

### Masters Degree Learning and Teaching Matrix

Module Code	Credits	Core Option	Module title	Research Rich Learning Nexus: indicate main strategy applied for each module				Assessment Method	ESAF Submission		PLOs assessed
				Led	Orientated	Based	Tutored		Yes	No	
PT0710	60	C	Pre-reg MSc Occupational Therapy & MSc Physiotherapy Project	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Written research as for publication and written reflective account of the research process	<input type="checkbox"/>	<input checked="" type="checkbox"/>	KU: 2, 4 IPSA: 5, 9 PVA: 12,13,16
		Choose an item.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

## SECTION 5: Opportunities for placement / study abroad

Please tick as appropriate					Yes	No
<b>a) Will the programme be offered as a two year full time programme with a yearlong study abroad?</b>					<input type="checkbox"/>	<input checked="" type="checkbox"/>
<i>If yes, please provide brief details of how this has been designed into the programme and how the learning opportunities will be assessed.</i>						
Module Code	Credits	Core/option	Module Title	Which programme learning outcomes is the module designed to contribute to?		
		Choose an item.				
<b>b) Will the programme be offered as a two year full time programme with a yearlong Work Placement?</b>					<input type="checkbox"/>	<input checked="" type="checkbox"/>
<i>If yes, please provide brief details of how this has been designed into the programme and how the learning opportunities will be assessed.</i>						
Module Code	Credits	Core/option	Module Title	Which programme learning outcomes is the module designed to contribute to?		
		Choose an item.				
<b>c) Will semester based study abroad be offered as an option within the programme?</b>					<input type="checkbox"/>	<input checked="" type="checkbox"/>
<i>If yes, please provide brief details of how this has been designed into the programme and how the learning opportunities will be assessed.</i>						
Module Code	Credits	Core/option	Module Title	Which programme learning outcomes is the module designed to contribute to?		
		Choose an item.				
<b>d) Will semester based work placements be offered as an option within the programme?</b>					<input type="checkbox"/>	<input checked="" type="checkbox"/>

If yes, please provide brief details of how this has been designed into the programme and how the learning opportunities will be assessed.

Module Code	Credits	Core/option	Module Title	Which programme learning outcomes is the module designed to contribute to?
		Choose an item.		
<b>e) Other</b>				<b>Yes</b> <b>No</b>
Are work placements integrated into module outcomes as required by PSRBs				<input checked="" type="checkbox"/> <input type="checkbox"/>
Are optional summer / vocational learning opportunities available?				<input checked="" type="checkbox"/> <input type="checkbox"/>
Will field trips / study tours be incorporated into the programme?				<input checked="" type="checkbox"/> <input type="checkbox"/>
Are workplace visits available to students?				<input checked="" type="checkbox"/> <input type="checkbox"/>

**If you answered yes to any of the above four questions, please provide brief details of how these have been designed into the programme and how the learning opportunities will be assessed.**

*Example: details of any additional costs to the student for field trips etc. should also be identified.*

**Details re modules at e)**

Clinical Practice Placement (CPP) periods are integrated within 2, year-long modules that run across the MSc programme. These modules are *Physiotherapy Professional Practice Studies 1* (Year 1) and *Physiotherapy Professional Practice Studies 2* (Year 2). Three periods of CPP will be integrated within each of these modules, which are seen as central 'planks' to each year of the MSc, to which the remaining modules hold a very close relationship.

CPP enables students to meet HCPC and CSP requirements in terms of scope and total hours of practice placement experience.

The University enjoys a very close relationship with local (and wider) physiotherapy services. Students are 'supervised' by Clinical Educators (registered physiotherapists) who have undertaken the relevant Clinical Educators course, run by the University. Clinical Educators are also responsible for assessment of students in practice (supported by Visiting Academic Tutors, Clinical Practice Placement Tutor, the Clinical Practice Placements Administration Team, as well as other related staff. The Clinical Practice Assessment Booklet provides further detail of placements and their assessment. (PFNA Supplementary Information document, Appendix 4).

<b>Module Code</b>	<b>Credits</b>	<b>Core/option</b>	<b>Module Title</b>	<b>Which programme learning outcomes is the module designed to contribute to?</b>
PT0606	20	Core	<i>Physiotherapy Professional Practice Studies 1</i>	<ul style="list-style-type: none"> <li>• <b>KU:</b> 1</li> <li>• <b>IPSA:</b> 1-5</li> <li>• <b>PVA:</b> 4</li> </ul>
PT0708	20	Core	<i>Physiotherapy Professional Practice Studies 2</i>	<ul style="list-style-type: none"> <li>• <b>KU:</b> 1, 3</li> <li>• <b>IPSA:</b> 1, 3, 4</li> <li>• <b>PVA:</b> 1, 4</li> </ul>
<b>If you answered no to all the above, please provide a brief explanation.</b>				

## SECTION 6: Programme Design

Programme Design Pillars (as applied to programme design)	How and where have these incorporated into the design of programme? (Max 200 words per section)
<p><b>Northumbria University Research Rich Learning, with specific reference to how the programme will:</b></p> <ul style="list-style-type: none"> <li>• Embed student engagement in critical scholarship across the programme.</li> <li>• Use research to benefit learning and teaching from the first year of undergraduate study onwards. Specifically at:           <ul style="list-style-type: none"> <li>➢ <u>Level 4</u>: Year 1 students should be introduced to the academic literacies required to perform successfully in higher education. In this formative year, it is expected that Research Rich Learning will be chiefly concerned with introductions to research methodologies and knowledge construction, gaining confidence of approaches to research and critical thinking and with sufficient guidance for students to enable them to engage in well-structured and bounded enquiry based learning.</li> <li>➢ <u>Level 5</u>: Year 2 students should be provided with bounded, but flexible, negotiated opportunities for greater critical enquiry; during this year students should be given more opportunities to operate as participants in research projects. Students should be encouraged to develop their critical thinking, and in taking responsibility for their own study, such as by defining their own research projects and literature based reviews</li> <li>➢ <u>Level 6</u>: Year 3 students will capitalise on the academic experiences of the previous years, synthesizing their learning and experience through a summative 'capstone' assignment which demonstrates autonomous learning, academic rigour, self-directed purpose, and intellectual ambition.</li> <li>➢ <u>Level 7</u>: Masters level students will systematically demonstrate and apply understanding and knowledge at the forefront of their discipline or professional practice. Mastery will entail the development of depth and specialism in their selected area of interest, which will generally be assessed via an independently conducted, innovative project which demonstrates and utilises appropriate techniques of inquiry, critical evaluation and synthesis. Students will demonstrate the attributes of taking responsibility of their own learning, dealing with complexity, acting with initiative, learning independently, and communicating and defending their work effectively to a wide range of audiences</li> </ul> </li> </ul>	<p>On the programme you will be asked from the outset to engage in rich research-based learning and scholarship focused upon enabling you to research, access and apply knowledge of the subjects in the physiotherapy curriculum to the opportunities you provide for people in receipt of physiotherapy services. These approaches are embedded within the enquiry-based learning approach across the programme.</p> <p><i>Physiotherapy professional practice studies 1</i> will introduce you to the central movement theories and concepts that form the foundations of your understanding, upon which to build your knowledge of physiotherapy practice. <i>Research in Health and Social Care</i> will build on this re-orientation of your skills towards research within physiotherapy and healthcare, and provide you with the opportunity to plan, develop, manage and appraise an original piece of research relevant to physiotherapy</p> <p>Across the programme you will engage in greater self-reflection, analysis and critical enquiry of research-based practice, that are central to the development of your knowledge and understanding and the development of clinical reasoning skills that characterise autonomous professional practice. You will be encouraged to take greater responsibility for the development of your own critical thinking through defining your specific learning outcomes related to clinical practice placements.</p>

The full RRL plan can be accessed at:

<https://intranet.northumbria.ac.uk/cs/pdf/ar/rrl>

## **Technology Enhanced Learning, with specific reference how the TEL environment of the programme will:**

- Be driven by the pedagogy and learning opportunities that it offers.
- Ensure that all students will benefit from an approach to TEL which is both specific to their needs and benefits from a One University approach to delivery, provision and standards.
- Be one in which staff and students can be innovative, take risks and explore current and emerging technologies
- Ensure students have a clear understanding of the purpose and nature of TEL as part of the programme philosophy and pedagogy and their broader learning and teaching experience.

The full TEL principles can be accessed at:

<http://nudev.northumbria.ac.uk/tel/what-is-tel.html>

The student experience on this programme will be enhanced through the use of technology to support the engagement with module content, collaborative and individual learning, driven by an enquiry-based learning approach.

Learning will be supported through the effective use of eLP, Pebble+, Social Media applications and Electronic Reading Lists across all modules on the programme. This is a key aspect in the support of both university and clinical practice based learning.

A particular feature of the programme will be in developing an 'e-skills' portfolio to showcase your professional skills within a simulated context to promote professional identity and employability. You will have the opportunity integrate the 'e-skills' portfolio within your personal and professional portfolio ('webfolio'), a resource that you will shape to support your own learning needs in readiness for employment as an autonomous professional.

You will also develop a clear understanding of how technology and innovation has the potential to enhance person-centred physiotherapy practice in consideration of interventions such as 'gaming' and service development tools such as remote therapy.

The programme adopts the University's driver to improve your student experience by enabling electronic submission, assessment and feedback of all written assignments across the programme.

## **Northumbria Employability, Enterprise and Entrepreneurship, with specific reference to how the programme will:**

- Embed employability in learning and teaching strategies through engagement with the employability framework
- Enable all students to have the opportunity for career development learning
- Enable all students to have the opportunity for a work related learning experience
- Provide opportunities for students to have access to enterprise and entrepreneurial learning

The full EE&E plan can be accessed at:

<https://intranet.northumbria.ac.uk/cs/pdf/ar/EmployabilityEnterpriseEntrepreneurshipPlanFinal>

Successful completion of the MSc programme secures your eligibility to apply for HCPC registration, and thereby practice as a physiotherapist in the UK. Your academic and practice based learning across the programme is designed not just to meet academic award requirements but also HCPC Standards of Proficiency for Physiotherapists.

The research rich, enquiry-based learning approach will support your critical understanding of contemporary physiotherapy practice and research to directly inform your own practice. Through the completion of your personal and professional development file ('webfolio'), you will be able demonstrate a proactive approach to your own learning and subsequent professional development in readiness for employment.

**Northumbria Assessment Principles, with specific reference to how assessment and feedback strategies across the programme will:**

- Help students to clarify goals, criteria and standards before, during and after assessment
- Encourage authentic learning
- Provide high quality feedback to enable students “to improve”
- Use summative assessment as a learning tool
- Provide formative assessment opportunities
- Develop self-assessment and reflection
- Promote dialogue around assessment
- Use/adopt inclusive approaches to assessment that support learning and achievement across a diverse and increasingly internationalised student body

The full Northumbria Assessment & Feedback Policy can be accessed at:

<https://intranet.northumbria.ac.uk/cs/word/ar/AFLPolicydoc>

Programme, and module handbooks provide the necessary information regarding the assessment completion, submission, feedback and return process. These documents provide support and guidance upon best practice approaches to each assessment, whilst demonstrating how each module develops sequentially throughout the range of inclusive assessment processes adopted, and explicit modular specific assessment criteria.

As you progress through the programme you will be able to engage with increasing flexibility and choice in focus for your own pathway to achieving the programme learning outcomes.

In addition to this, access to tutorial support both pre- and post-assessment will help you to clarify each assessment task and utilise the feedback from formative and summative outcomes and inform practice for future students. This is moderated in accordance with Northumbria Assessment and Feedback Policy requirements and is designed to directly support and positively impact on your opportunities for individualised; goal setting, self-assessment and reflective practice that supports your personal and professional learning and development.

As physiotherapy students you are tasked with becoming capable practitioners to fulfil the role and purpose of a physiotherapist in benefiting those that you work with along with determining your own development through your ability to act purposefully and professionally on feedback received.

**EXTERNAL DESIGN CONSIDERATIONS / PSRB requirements**

If applicable, please append any mapping exercise as required by the PSRB.

HCPC SETs appended.

## SECTION 7: Programme Overview / Summary

<b>Programme Title and Award</b>	MSc Physiotherapy (pre-registration)									
<b>UCAS or other Admissions Code</b>										
<b>Northumbria Programme Code</b> ie SITS route code										
<b>Mode(s) of Delivery</b> please indicate the main mode of delivery in bold	Classroom-based	<input type="checkbox"/>	Distance Learning	<input type="checkbox"/>	Blended	<input type="checkbox"/>				
<b>Mode(s) of Attendance</b> please indicate the main delivery	Full-time	<input checked="" type="checkbox"/>	Sandwich	<input type="checkbox"/>	Part-time	<input type="checkbox"/>				
	Other please specify									
<b>Location of Delivery</b> (at Northumbria)	City Campus <input type="checkbox"/>		Coach Lane Campus <input checked="" type="checkbox"/>		London Campus <input type="checkbox"/>					
<b>Location(s) of Delivery</b> (if other than Northumbria)										
<b>Education Provision with Others / Transnational Education</b> if applicable	Northumbria Programme Delivered:			<input type="checkbox"/>	Dual Award	<input type="checkbox"/>	Joint Award	<input type="checkbox"/>	Partner Programme leading to a Northumbria award	<input type="checkbox"/>
	By the partner			<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		
	With the partner			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	At the partner			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	Partner Institution(s)									
	<b>Date(s) of Approval / Review</b>	Click here to enter a date.								
<b>QAA Subject Benchmark Group</b>										
<b>PSRB accreditation</b> if applicable										

**Admission Requirements** including approved arrangements for admission with advanced standing, where appropriate.

The academic entry requirement for the MSc programme is a 2:1 honours degree award in a subject related area of study, or equivalents.

At your personal statement within the application form you should include details of your rationale for choice of career, evidence of investigation of the role and purpose of physiotherapy, transferrable knowledge, skills, values and behaviours relevant to a career in physiotherapy, and detail of your engagement with research.

**Application Procedure**

At present applications are direct to the University. Your application will be screened for evidence of meeting / potential to meet the academic entry requirement, your rationale for choice of career, evidence of investigation of the role and purpose of physiotherapy, transferrable knowledge, skills, values and behaviours relevant to a career in physiotherapy, and detail of your engagement with research (personal statement), supported by at least one reference from (preferably) an academic referee. Applications are evaluated and moderated against set criteria to short-list for interview.

Interview events are held at Northumbria University where you will have the opportunity to meet staff and have a tour of the facilities. Your interview will be facilitated by two members of staff, usually a combination of academic and clinical staff. A current pre-registration student may also be present. Interviews are graded against established criteria and offers made accordingly.

In the event of your unavailability to attend an interview event, a 'skype' interview can be negotiated.

**Variation from Assessment Regulations or the Modular Framework** Provide details of any approved variations from the Assessment Regulations for Northumbria Awards (ARNA)

## **SECTION 8: Log of Changes**

*Any changes made to an approved Programme Specification (other than typographical corrections) should be logged below. Where it is not practicable to change an existing Programme Specification, a new version is required.*

	<b>Brief summary of change to Programme Specification</b> (including section number)	<b>Programme code(s) affected by change</b>	<b>Programme title(s)</b>	<b>Date of approval / amendment</b>	<b>Admin change Y/N</b>	<b>Change takes effect</b>	
						<b>Stage / year of programme eg Year 3</b>	<b>Semester / academic year eg S2;05/06</b>
1.					Choose an item.		
2.					Choose an item.		
3.					Choose an item.		
4.					Choose an item.		

## A9: HCPC Standards of Proficiency Cross Mapping

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## Standards of proficiency (SOP) mapping – physiotherapist

MSc Physiotherapy (pre-registration)

### **Key**

#### Modules

PT0606: Physiotherapy Professional Practice Studies 1

PT0705: Assessment & Rehabilitation for Movement & Function

PT0706: Research in Health & Social Care

PT0707: Movement for Function & Participation

PT0708: Physiotherapy Professional Practice Studies 2

PT0709: Innovation and change for physiotherapy

PT0710: Pre-reg MSc Occupational Therapy and MSc Physiotherapy Project

Programme and Module Learning Outcomes (PLOs & MLOs) are grouped around 3 themes; Knowledge & Understanding (KU); Intellectual / Professional skills and abilities (IPSA); Personal Values Attributes (PVA)

### **For additional guidance**

1. At the Programme Specification, Section 4, Masters degree learning and teaching matrices, each module assessment is mapped against Programme Learning Outcomes (PLOs) assessed.
2. At each Module Specification, MLOs are mapped against the module assessment and relevant PLOs.

<b>Standard of proficiency</b>	<b>Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)</b>
<b>Registrant physiotherapists must:</b>	
<b>1</b> be able to practise safely and effectively within their scope of practice	Programme Specification All programme aims and programme learning outcomes (PLOs)
<b>1.1</b> know the limits of their practice and when to seek advice or refer to another professional	Module specifications PT0606: Module Learning Outcomes (MLOs) IPSA 1; PVA 1 PT0705: MLOs KU 1, 2 PT0707: KU 2 PT0708: KU 1, 2; IPSA 2
<b>1.2</b> recognise the need to manage their own workload and resources effectively and be able to practise accordingly	Module specifications PT0606: KU 2; IPSA 2 PT0705: KU 2; IPSA 1, 2 PT0707: IPSA 1, 2 PT0708: IPSA 3 PT0710: IPSA 2
<b>2</b> be able to practise within the legal and ethical boundaries of their profession	Programme Specification Programme Learning Outcomes (PLO) KU: 1, 2, 4 IPSA: 1, 3 PVA: 2, 4

<b>Standard of proficiency</b>	<b>Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)</b>
<p><b>2.1</b> understand the need to act in the best interests of service users at all times</p>	<p>Module specifications  PT0606: KU 2; IPSA 1; PVA 1  PT0705: KU 2; PVA 1  PT0706: PVA 1  PT0707: KU 2; PVA 1  PT0708: KU 1, 2; IPSA 2; PVA 1  PT0710: PVA 2</p>
<p><b>2.2</b> understand what is required of them by the Health and Care Professions Council</p>	<p>Module specifications  PT0606: IPSA 1, 2; PVA 1  PT0705: KU 1, 2; IPSA 1; PVA 1  PT0706: IPSA 1, 2; PVA 1  PT0707: KU 2; IPSA 1, 2; PVA 1  PT0708: IPSA 1, 2, 3 PVA 1  PT0709: KU 1; IPSA 1  PT0710: KU 1; PVA 1, 2</p>
<p><b>2.3</b> understand the need to respect and uphold the rights, dignity, values, and autonomy of service users including their role in the diagnostic and therapeutic process and in maintaining health and wellbeing</p>	<p>Module specifications  PT0606: PVA 1  PT0705: KU 2; PVA 1  PT0706: KU 2; PVA 1  PT0707: KU 2; PVA 1  PT0708: KU 1, 2; IPSA 1, 2; PVA 1  PT0710: IPSA 2; PVA 2</p>

Standard of proficiency	Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)
<b>2.4</b> recognise that relationships with service users should be based on mutual respect and trust, and be able to maintain high standards of care even in situations of personal incompatibility	Module specifications PT0606: PVA 1 PT0705: PVA 1 PT0706: PVA 1 PT0707: KU 2; PVA 1 PT0708: KU 1, 2; IPSA 1; PVA 1 PT0710: PVA 2
<b>2.5</b> know about current legislation applicable to the work of their profession	Module specifications PT0606: KU 2; IPSA 1 PT0705: KU 1; IPSA 1 PT0707: IPSA 1 PT0709: KU 1 PT0710: IPSA 2
<b>2.6</b> understand the importance of and be able to obtain informed consent	Module specifications PT0606: KU 2; PVA 1 PT0705: IPSA 1; PVA 1 PT0706: KU 1, 2; PVA 1 PT0707: KU 2; IPSA 1; PVA 1 PT0708: KU 1, 2; IPSA 1; PVA 1 PT0710: PVA 2

Standard of proficiency	Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)
<b>2.7</b> be able to exercise a professional duty of care	Module specifications PT0606: IPSA 1; PVA 1 PT0705: KU 1, 2; IPSA 1; PVA 1 PT0706: KU 2; PVA 1 PT0707: KU 2; IPSA 1; PVA 1 PT0708: KU 1 IPSA 1, 2, 3; PVA 1
<b>3</b> be able to maintain fitness to practise	Programme specification PLOs; KU 1, 3: IPSA 1, 2, 6: PVA 2, 3, 4
<b>3.1</b> understand the need to maintain high standards of personal and professional conduct	Module specifications PT0606: IPSA 2; PVA 1 PT0705: KU 2; PVA 1 PT0707: KU 2; PVA 1 PT0708: IPSA 1, 2, 3; PVA 1 PT0709: KU 1
<b>3.2</b> understand the importance of maintaining their own health	Module specifications: PT0705: PVA 1 PT0707: PVA 1
<b>3.3</b> understand both the need to keep skills and knowledge up to date and the importance of career-long learning	Module specifications PT0706: IPSA 2 PT0705: IPSA 1 PT0707: IPSA 1 PT0709: IPSA 1
<b>4</b> be able to practise as an autonomous professional, exercising their own professional judgement	Programme specification PLOs; KU 1, 2, 3, 4: IPSA 1, 4, 5: PVA 1, 2, 3, 4

Standard of proficiency	Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)
<b>4.1</b> be able to assess a professional situation, determine the nature and severity of the problem and call upon the required knowledge and experience to deal with the problem	Module specifications PT0606: KU 1, 2 PT0705: KU 1; IPSA 1 PT0707: KU 2; IPSA 1 PT0708: KU 1, 2; IPSA 1, 3
<b>4.2</b> be able to make reasoned decisions to initiate, continue, modify or cease techniques or procedures, and record the decisions and reasoning appropriately	Module specifications PT0705; KU 1, 2; IPSA 1, 2 PT0707: KU 1; IPSA 1, 2 PT0708: KU 1, 2; IPSA 2, 3 PT0710: KU 1
<b>4.3</b> be able to initiate resolution of problems and be able to exercise personal initiative	Module specifications PT0606: KU 1; IPSA 1, 2 PT0705: KU 2; IPSA 1; PVA 1 PT0707: KU 2; IPSA 2; PVA 1 PT0708: KU 1; IPSA 1, 2; PVA 1 PT0709: KU 1 PT0710: KU 1; IPSA 2
<b>4.4</b> recognise that they are personally responsible for and must be able to justify their decisions	Module specifications PT0606: IPSA 1, 2 PT0705: IPSA 1, 2 PT0706: IPSA 1 PT0707: KU 1; IPSA 1 PT0708: IPSA 1, 3

<b>Standard of proficiency</b>	<b>Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)</b>
<b>4.5</b> be able to make and receive appropriate referrals	Module specifications PT0606: IPSA 1 PT0705: KU 2; IPSA 2 PT0707: KU 2; IPSA 2 PT0708: KU 1; IPSA 2, 3
<b>4.6</b> understand the importance of participation in training, supervision and mentoring	Module specifications PT0606: IPSA 2 PT0705: KU 2; IPSA 2 PT0707: KU 1; IPSA 1 PT0708: IPSA 2 PT0709: IPSA 1 PT0710: PVA 1
<b>5</b> be aware of the impact of culture, equality, and diversity on practice	Programme specification KU 1, 2, 3, 4;; IPSA 1, 3, 4, ,5 ,6: PVA 1, 2, 3, 4
<b>5.1</b> understand the requirement to adapt practice to meet the needs of different groups and individuals	Module specifications PT0606: PVA 1 PT0705: KU 2; PVA 1 PT0706: PVA 1 PT0707: KU 2; PVA 1 PT0708: KU 1; IPSA 1, 3; PVA 1

<b>Standard of proficiency</b>	<b>Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)</b>
5.2 be able to recognise the need to identify and take account of the physical, psychological, social and cultural needs of individuals and communities	Module specifications PT0606: PVA 1 PT0705: KU 2; PVA 1 PT0706: PVA 1 PT0707: KU 2; PVA 1 PT0708: KU 1; IPSA 1, 3; PVA 1
6 be able to practise in a non-discriminatory manner	Programme Specification PLOs: KU 1, 2, 4; IPSA 1, 2, 3, 4, 6; PVA 2, 3, 4  Module specifications PT0606: PVA 1 PT0705: PVA 1 PT0706: PVA 1 PT0707: PVA 1 PT0708: KU 1; PVA 1
7 understand the importance of and be able to maintain confidentiality	Programme specification PLOs: KU 1, 3, 4; IPSA 1, 3, 4, 5, 6; PVA 2, 4
7.1 be aware of the limits of the concept of confidentiality	Module specifications PT0606: IPSA 1; PVA 1 PT0705: KU 2; PVA 1 PT0706: PVA 1 PT0707: KU 2; PVA 1 PT0708: KU 1, 2; IPSA 1 PT0710: KU 2; IPSA 2

<b>Standard of proficiency</b>	<b>Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)</b>
7.2 understand the principles of information governance and be aware of the safe and effective use of health and social care information	Module specifications PT0606: IPSA 1; PVA 1 PT0705: KU 2; PVA 1 PT0706: PVA 1 PT0707: KU 2; PVA 1 PT0708: KU 1, 2; IPSA 1 PT0710: KU 2; IPSA 2
7.3 be able to recognise and respond appropriately to situations where it is necessary to share information to safeguard service users or the wider public	Module specifications PT0606: IPSA 1; PVA 1 PT0705: KU 2; PVA 1 PT0706: PVA 1 PT0707: KU 2; PVA 1 PT0708: KU 1, 2; IPSA 1; PVA 1 PT0710: KU 2; IPSA 2; PVA 1
8 be able to communicate effectively	Programme specification PLOs: KU 1, 2; IPSA 1, 3, 5, 6; PVA 2, 4
8.1 be able to demonstrate effective and appropriate verbal and non-verbal skills in communicating information, advice, instruction and professional opinion to service users, colleagues, and others	Module specifications PT0606: IPSA 1 PT0705: KU 2; IPSA 1 PT0706: KU 2 PT0707: KU 2 PT0708: IPSA 1, 2

Standard of proficiency	Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)
<b>8.2</b> be able to communicate in English to the standard equivalent to level 7 of the International English Language Testing System, with no element below 6.5	Programme specification: Admission Requirements PFNA Supplementary Information document: page 4, Admissions  (also note Northumbria University English Language Requirement; <a href="https://www.northumbria.ac.uk/international/international-admissions/english-language-requirements/">https://www.northumbria.ac.uk/international/international-admissions/english-language-requirements/</a> )
<b>8.3</b> understand how communication skills affect assessment and engagement of service users and how the means of communication should be modified to address and take account of factors such as age, capacity, learning ability and physical ability	Module specifications PT0606: IPSA 1; PVA1 PT0705: KU 2; IPSA 1; PVA 1 PT0706: KU 2; PVA 1 PT0707: KU 2; PVA 1 PT0708: KU 1; IPSA 1, 2; PVA 1
<b>8.4</b> be able to select, move between and use appropriate forms of verbal and non-verbal communication with service users and others	Module specifications PT0606: IPSA 1; PVA1 PT0705: KU 2; IPSA 1; PVA 1 PT0706: KU 2; PVA 1 PT0707: KU 2; PVA 1 PT0708: KU 1; IPSA 1, 2; PVA 1
<b>8.5</b> be aware of the characteristics and consequences of verbal and non-verbal communication and how this can be affected by factors such as age, culture, ethnicity, gender, socio-economic status and spiritual or religious beliefs	Module specifications PT0606: IPSA 1; PVA1 PT0705: KU 2; IPSA 1; PVA 1 PT0706: KU 2; PVA 1 PT0707: KU 2; PVA 1 PT0708: KU 1; IPSA 1, 2; PVA 1

<b>Standard of proficiency</b>	<b>Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)</b>
<b>8.6</b> understand the need to provide service users or people acting on their behalf with the information necessary to enable them to make informed decisions	Module specifications PT0606: IPSA 1; PVA1 PT0705: KU 2; PVA 1 PT0706: KU 2; PVA 1 PT0707: KU 2; PVA 1 PT0708: KU 1; IPSA 1, 2; PVA 1
<b>8.7</b> understand the need to assist the communication needs of service users such as through the use of an appropriate interpreter, wherever possible	Module specifications PT0606: IPSA 1; PVA1 PT0705: KU 2; PVA 1 PT0706: KU 2; PVA 1 PT0707: KU 2; PVA 1 PT0708: KU 1; IPSA 1, 2; PVA 1
<b>8.8</b> recognise the need to use interpersonal skills to encourage the active participation of service users	Module specifications PT0606: IPSA 1; PVA1 PT0705: KU 2; PVA 1 PT0706: KU 2; PVA 1 PT0707: KU 2; PVA 1 PT0708: KU 1; IPSA 1, 2; PVA 1
<b>9</b> be able to work appropriately with others	Programme specification PLOs: KU 1, 2, 4; IPSA 1, 2, 3, 4, 5, 6; PVA 2, 4

<b>Standard of proficiency</b>	<b>Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)</b>
<b>9.1</b> be able to work, where appropriate, in partnership with service users, other professionals, support staff and others	Modules specifications PT0606: IPSA 1; PVA 1 PT0705: KU 2; PVA 1 PT0706 : KU 2 ; PVA 1 PT0707 : KU 2 ; PVA 1 PT0708 : KU 1 ; IPSA 1, 2 ; PVA 1
<b>9.2</b> understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team	Modules specifications PT0606: IPSA 1; PVA 1 PT0705: KU 2; PVA 1 PT0706 : KU 2 ; PVA 1 PT0707 : KU 2 ; PVA 1 PT0708 : KU 1 ; IPSA 1, 2 ; PVA 1
<b>9.3</b> understand the need to engage service users and carers in planning and evaluating diagnostics, and therapeutic interventions to meet their needs and goals	Modules specifications PT0606: IPSA 1; PVA 1 PT0705: KU 2; PVA 1 PT0706 : KU 2 ; PVA 1 PT0707 : KU 2 ; PVA 1 PT0708 : KU 1 ; IPSA 1, 2 ; PVA 1 PT0710 : PVA 2
<b>9.4</b> be able to contribute effectively to work undertaken as part of a multi-disciplinary team	Modules specifications PT0606: IPSA 1; PVA 1 PT0708 : KU 1 ; IPSA 1, 2 ; PVA 1

Standard of proficiency	Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)
<b>9.5</b> understand the need to agree the goals, priorities and methods of physiotherapy intervention in partnership with the service user	Modules specifications PT0606: IPSA 1; PVA 1 PT0705: KU 2; PVA 1 PT0706 : KU 2 ; PVA 1 PT0707 : KU 2 ; PVA 1 PT0708 : KU 1 ; IPSA 1, 2 ; PVA 1 PT0710 : PVA 2
<b>10</b> be able to maintain records appropriately	Programme specification PLOs: KU 1, 2; IPSA 1, 5, 6; PVA 1, 4
<b>10.1</b> be able to keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols and guidelines	Module specifications PT0606: IPSA 1 PT0705: KU 1; IPSA 1 PT0708: IPSA 2 PT0709: IPSA 1
<b>10.2</b> recognise the need to manage records and all other information in accordance with applicable legislation, protocols, and guidelines	Module specifications PT0606: IPSA 1 PT0705: KU 1; IPSA PT0708: IPSA 2 PT0709: IPSA 1 PT0710: IPSA 1, 2
<b>11</b> be able to reflect on and review practice	Programme specification PLOs: KU 1, 3, 4, 5; IPSA 1, 2, 3, 5, 6; PVA: 2, 4

Standard of proficiency	Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)
<b>11.1</b> understand the value of reflection on practice and the need to record the outcome of such reflection	Module specifications PT0606: IPSA 2 PT0705: IPSA 2 PT0707: KU 1; IPSA 1 PT0708: IPSA 2 PT0709: IPSA 1 PT0710: PVA 2
<b>11.2</b> recognise the value of case conferences and other methods of review	Module specifications PT0606: IPSA 1 PT0705: IPSA 2 PT0706: KU 2 PT0707: KU 2; IPSA 1 PT0708: IPSA 2, 3 PT0709: IPSA 1
<b>12</b> be able to assure the quality of their practice	Programme specification PLOs: KU 1, 2, 3; IPSA 1, 4, 5, 6; PVA 2, 3
<b>12.1</b> be able to engage in evidence-based practice, evaluate practice systematically, and participate in audit procedures	Module specifications PT0606: IPSA 1 PT0705: IPSA 2 PT0707: KU 1 PT0708: IPSA 1, 2 PT0709: KU 1 PT0710: KU 1

Standard of proficiency	Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)
<b>12.2</b> be able to gather information, including qualitative and quantitative data, that helps to evaluate the responses of service users to their care	<p>Module specifications</p> <p>PT0705: KU 2</p> <p>PT0706: KU 1; IPSA 2; PVA 1</p> <p>PT0707: KU 2</p> <p>PT0708: IPSA 1, 3</p> <p>PT0709: KU 1</p> <p>PT0710: KU 1, 2 IPSA 1</p>
<b>12.3</b> be aware of the role of audit and review in quality management, including quality control, quality assurance, and the use of appropriate outcome measures	<p>Module specifications</p> <p>PT0705: KU 1, 2; IPSA 1, 2</p> <p>PT0706: KU 2; PVA 1</p> <p>PT0707: KU 2</p> <p>PT0708: KU 2; IPSA 1, 2</p> <p>PT0709: KU 1</p> <p>PT0710: KU 1, 2 IPSA 1</p>
<b>12.4</b> be able to maintain an effective audit trail and work towards continual improvement	<p>Module specifications</p> <p>PT0705: KU 1, 2; IPSA 1, 2</p> <p>PT0706: KU 2; PVA 1</p> <p>PT0707: KU 2</p> <p>PT0708: KU 2; IPSA 1, 2</p> <p>PT0709: KU 1</p> <p>PT0710: KU 1, 2 IPSA 1</p>

<b>Standard of proficiency</b>	<b>Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)</b>
<b>12.5</b> be aware of, and be able to participate in quality assurance programmes, where appropriate	<p>Module specifications</p> <p>PT0705: KU 1, 2; IPSA 1, 2</p> <p>PT0706: KU 2; PVA 1</p> <p>PT0707: KU 2</p> <p>PT0708: KU 2; IPSA 1, 2</p> <p>PT0709: KU 1</p> <p>PT0710: KU 1, 2 IPSA 1</p>
<b>12.6</b> be able to evaluate intervention plans using recognised outcome measures and revise the plans as necessary in conjunction with the service user	<p>Module specifications</p> <p>PT0705: KU 1, 2; IPSA 1, 2</p> <p>PT0706: KU 2; PVA 1</p> <p>PT0707: KU 2; PVA 1</p> <p>PT0708: KU 2; IPSA 1, 2; PVA 1</p> <p>PT0709: KU 1</p> <p>PT0710: KU 1, 2 IPSA 1; PVA 2</p>
<b>12.7</b> recognise the need to monitor and evaluate the quality of practice and the value of contributing to the generation of data for quality assurance and improvement programmes	<p>Module specifications</p> <p>PT0705: KU 1, 2; IPSA 1, 2</p> <p>PT0706: KU 2; PVA 1</p> <p>PT0707: KU 2; IPSA 1, 2</p> <p>PT0708: KU 2; IPSA 1, 2; PVA 1</p> <p>PT0709: KU 1; IPSA 2</p> <p>PT0710: KU 1; IPSA 1</p>

Standard of proficiency	Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)
<b>12.8</b> be able to evaluate intervention plans to ensure that they meet the physiotherapy needs of service users, informed by changes in circumstances and health status	Module specifications PT0606: KU 1 PT0705: KU 1, 2 PT0706: IPSA 2 PT0707: KU 1, 2 PT0708: IPSA 1, 2, 3
<b>13</b> understand the key concepts of the knowledge base relevant to their profession	Programme specification PLOs: KU 1, 2, 3, 5; IPSA 1, 2, 4, 6; PVA 1, 2, 3
<b>13.1</b> recognise the role of other professions in health and social care	Module specifications PT0606: IPSA 1 PT0705: KU 2 PT0707: KU 2 PT0708: IPSA 1, 2
<b>13.2</b> be aware of the principles and applications of scientific enquiry, including the evaluation of the efficacy of interventions and the research process	Module specifications PT0705: IPSA 2 PT0706: KU 1, 2; IPSA 1, 2; PVA 1 PT0707: IPSA 1 PT0708 : IPSA 1, 2 PT0710 : KU 1, 2 ; IPSA 1, 2, 3

<b>Standard of proficiency</b>	<b>Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)</b>
<b>13.3</b> understand the concept of leadership and its application to practice	Module specifications PT0606; IPSA 1 PT0705; KU 2 PT0707: KU 2 PT0708: IPSA 2 PT0709: KU 1 PT0710: IPSA 2
<b>13.4</b> understand the structure and function of the human body, together with knowledge of health, disease, disorder and dysfunction, relevant to their profession	Module specifications PT0606: KU 1 PT0705: KU 2; IPSA 2 PT0707: KU 2 PT0708: KU 1
<b>13.5</b> understand the theoretical basis of, and the variety of approaches to, assessment and intervention	Module specifications PT0606: KU 1, 2; IPSA 1 PT0705: KU 2; IPSA 1 PT0707: KU 2; IPSA 1 PT0708: KU 1; IPSA 1, 2

Standard of proficiency	Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)
<p><b>13.6</b> understand the following aspects of biological science:</p> <ul style="list-style-type: none"> <li>– normal human anatomy and physiology, including the dynamic relationships of human structure and function as related to the neuromuscular, musculoskeletal, cardio-vascular and respiratory systems</li> <li>– patterns of human growth and development across the lifespan</li> <li>– factors influencing individual variations in human ability and health status</li> <li>– how the application of physiotherapy can cause physiological and structural change</li> </ul>	Module specifications PT0606: KU 1, 2; IPSA 1 PT0705: KU 2; IPSA 1 PT0707: KU 2; IPSA 1 PT0708: KU 1; IPSA 1, 2
<p><b>13.7</b> understand the following aspects of physical science:</p> <ul style="list-style-type: none"> <li>– the principles and theories from physics, biomechanics, applied exercise science and ergonomics that can be applied to physiotherapy</li> <li>– the means by which the physical sciences can inform the understanding and analysis of movement and function</li> <li>– the principles and application of measurement techniques based on biomechanics or electrophysiology</li> <li>– the application of anthropometric and ergonomic principles</li> </ul>	Module specifications PT0606: KU 1, 2; IPSA 1 PT0705: KU 1, 2; IPSA 1 PT0706: KU 1 PT0707: KU 1, 2; IPSA 1 PT0708: KU 1; IPSA 1, 2 PT0710: KU 1

Standard of proficiency	Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)
<p><b>13.8</b> understand the following aspects of clinical science:</p> <ul style="list-style-type: none"> <li>– pathological changes and related clinical features commonly encountered in physiotherapy practice</li> <li>– physiological, structural, behavioural and functional changes that can result from physiotherapy intervention and disease progression</li> <li>– the specific contribution that physiotherapy can potentially make to enhancing individuals' functional ability, together with the evidence base for this</li> <li>– the different concepts and approaches that inform the development of physiotherapy intervention</li> </ul>	Module specifications PT0606: KU 1, 2; IPSA 1 PT0705: KU 1, 2; IPSA 1 PT0706: KU 1, 2; IPSA 1, 2 PT0707: KU 1, 2; IPSA 1, 2 PT0708: KU 1; IPSA 1, 2, 3 PT0710: KU 1
<p><b>13.9</b> understand the following aspects of behavioural science:</p> <ul style="list-style-type: none"> <li>– psychological, social and cultural factors that influence an individual in health and illness, including their responses to the management of their health status and related physiotherapy interventions</li> <li>– how psychology, sociology and cultural diversity inform an understanding of health, illness and health care in the context of physiotherapy and the incorporation of this knowledge into physiotherapy practice</li> <li>– theories of communication relevant to effective interaction with service users, carers, colleagues, managers and other health and social care professionals</li> <li>– theories of team working</li> </ul>	Module specifications PT0606: IPSA 1; PVA 1 PT0705: KU 1, 2; IPSA 1; PVA 1 PT0706: KU 1, 2; IPSA 1, 2 PT0707: KU 1, 2; IPSA 1, 2; PVA 1 PT0708: KU 1, 2; IPSA 1, 2, 3 PT0709: KU 1 PT0710: IPSA 1
<p><b>14</b> be able to draw on appropriate knowledge and skills to inform practice</p>	Programme specification PLOs: KU 1, 2, 3, 4; IPSA 1, 2, 4, 6; PVA 1, 2, 4

<b>Standard of proficiency</b>	<b>Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)</b>
<b>14.1</b> understand the structure and function of health and social care services in the UK	Module specifications PT0705: KU 2 PT0707: KU 1 PT0708: IPSA 1 PT0709: KU 1
<b>14.2</b> be able to deliver and evaluate physiotherapy programmes	Module specifications PT0606: IPSA 1 PT0705: KU 1, 2; IPSA 1 PT0706: IPSA 2 PT0707: KU 2; IPSA 1 PT0708: IPSA 1, 2 PT0709: KU 1
<b>14.3</b> be able to gather appropriate information	Module specifications PT0606: IPSA 1 PT0705: KU 1, 2; IPSA 1 PT0706: IPSA 2 PT0707: KU 2; IPSA 1 PT0708: IPSA 1, 2 PT0710: KU 1

Standard of proficiency	Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)
<b>14.4</b> be able to select and use appropriate assessment techniques	Module specifications PT0606: IPSA 1 PT0705: KU 1, 2; IPSA 1 PT0706: IPSA 2 PT0707: KU 2; IPSA 1 PT0708: IPSA 1, 2
<b>14.5</b> be able to undertake and record a thorough, sensitive and detailed assessment, using appropriate techniques and equipment	Module specifications PT0606: KU 1; IPSA 1 PT0705: KU 1, 2; IPSA 1 PT0707: KU 2; IPSA 1 PT0708: KU 1, 2; IPSA 1, 2
<b>14.6</b> be able to undertake or arrange investigations as appropriate	Module specifications PT0606: KU 1; IPSA 1 PT0705: KU 1, 2; IPSA 1 PT0707: KU 2; IPSA 1 PT0708: KU 1, 2; IPSA 1, 2
<b>14.7</b> be able to analyse and critically evaluate the information collected	Module specifications PT0606: KU 1; IPSA 1 PT0705: KU 1, 2; IPSA 1, 2 PT0707: KU 1, 2; IPSA 1, 2 PT0708: KU 1, 2; IPSA 1, 2

<b>Standard of proficiency</b>	<b>Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)</b>
<b>14.8</b> be able to form a diagnosis on the basis of physiotherapy assessment	Module specifications PT0606: KU 1; IPSA 1 PT0705: KU 1, 2; IPSA 1, 2 PT0707: KU 1, 2; IPSA 1, 2 PT0708: KU 1, 2; IPSA 1, 2, 3
<b>14.9</b> be able to demonstrate a logical and systematic approach to problem solving	Module specifications PT0606: KU 1; IPSA 1 PT0705: KU 1, 2; IPSA 1, 2 PT0706: KU 1; IPSA 1 PT0707: KU 1, 2; IPSA 1, 2 PT0708: KU 1, 2; IPSA 1, 2, 3
<b>14.10</b> be able to use research, reasoning and problem solving skills to determine appropriate actions	Module specifications PT0606: KU 1; IPSA 1 PT0705: KU 1, 2; IPSA 1, 2 PT0706: KU 1; IPSA 1 PT0707: KU 1, 2; IPSA 1, 2 PT0708: KU 1, 2; IPSA 1, 2, 3
<b>14.11</b> be able to formulate specific and appropriate management plans including the setting of timescales	Module specifications PT0606: KU 1; IPSA 1 PT0705: KU 1, 2; IPSA 1 PT0707: KU 1, 2; IPSA 1, 2 PT0708: KU 1, 2; IPSA 1, 2, 3

<b>Standard of proficiency</b>	<b>Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)</b>
<b>14.12</b> be able to apply problem solving and clinical reasoning to assessment findings to plan and prioritise appropriate physiotherapy	Module specifications PT0606: KU 1; IPSA 1 PT0705: KU 1, 2; IPSA 1 PT0707: KU 1, 2; IPSA 1, 2 PT0708: KU 1, 2; IPSA 1, 2, 3
<b>14.13</b> recognise the need to discuss, and be able to explain the rationale for, the use of physiotherapy interventions	Module specifications PT0606: KU 1; IPSA 1 PT0705: KU 1, 2; IPSA 1, 2 PT0706: IPSA 1 PT0707: KU 1, 2; IPSA 1, 2 PT0708: KU 1, 2; IPSA 1, 2, 3
<b>14.14</b> be able to set goals and construct specific individual and group physiotherapy programmes	Module specifications PT0606: KU 1; IPSA 1 PT0705: KU 1, 2; IPSA 1, 2 PT0706: IPSA 1 PT0707: KU 1, 2; IPSA 1, 2 PT0708: KU 1, 2; IPSA 1, 2, 3
<b>14.15</b> be able to conduct appropriate diagnostic or monitoring procedures, interventions, therapy, or other actions safely and effectively	Module specifications PT0606: KU 1; IPSA 1 PT0705: KU 1, 2; IPSA 1, PT0707: KU 1, 2; IPSA 1, 2 PT0708: KU 1, 2; IPSA 1, 2, 3

<b>Standard of proficiency</b>	<b>Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)</b>
<b>14.16</b> be able to select, plan, implement and manage physiotherapy interventions aimed at the facilitation and restoration of movement and function	Module specifications PT0606: KU 1; IPSA 1 PT0705: KU 1, 2; IPSA 1, PT0707: KU 1, 2; IPSA 1, 2 PT0708: KU 1, 2; IPSA 1, 2, 3
<b>14.17</b> know how to position or immobilise service users for safe and effective interventions	Module specifications PT0606: KU 1, 2; IPSA 1; PVA 1 PT0705: KU 1, 2; IPSA 1; PVA 1 PT0707: KU 1, 2; IPSA 1, 2; PVA 1 PT0708: KU 1, 2; IPSA 1, 2, 3; PVA 1
<b>14.18</b> be able to select and apply safe and effective physiotherapy-specific practice skills including manual therapy, exercise and movement, electrotherapeutic modalities and kindred approaches	Module specifications PT0606: KU 1, 2; IPSA 1; PVA 1 PT0705: KU 1, 2; IPSA 1; PVA 1 PT0707: KU 1, 2; IPSA 1, 2; PVA 1 PT0708: KU 1, 2; IPSA 1, 2, 3; PVA 1
<b>14.19</b> be able to change their practice as needed to take account of new developments or changing contexts	Module specifications PT0606: IPSA 1 PT0705: KU 2; IPSA 2 PT0706 : KU 1, 2 ; IPSA 1, 2 PT0707: KU 1, 2; IPSA 1, 2 PT0708: KU 1, 2; IPSA 1, 2, 3 PT0709 : KU 1 PT0710 : IPSA 1

<b>Standard of proficiency</b>	<b>Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)</b>
<b>14.20</b> recognise the value of research to the critical evaluation of practice	Module specifications PT0606: IPSA 1 PT0705: KU 2; IPSA 2 PT0706 : KU 1, 2 ; IPSA 1, 2 PT0707: KU 1, 2; IPSA 1, 2 PT0708: IPSA 1, 2, 3 PT0709 : KU 1 PT0710 : KU 1 ; IPSA 1
<b>14.21</b> be aware of a range of research methodologies	Module specifications PT0705; IPSA 2 PT0706 : KU 1, 2 ; IPSA 1, 2 PT0707: KU 1 PT0708: IPSA 1, 2 PT0709 : KU 1 PT0710 : KU 1, 2 ; IPSA 1, 2, 3
<b>14.22</b> be able to evaluate research and other evidence to inform their own practice	Module specifications PT0705; IPSA 2 PT0706 : KU 1, 2 ; IPSA 1, 2 PT0707: KU 1 PT0708: IPSA 1, 2 PT0709 : KU 1 PT0710 : KU 1, 2 ; IPSA 1, 2, 3

<b>Standard of proficiency</b>	<b>Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)</b>
14.23 be able to use information and communication technologies appropriate to their practice	Module specifications PT0606: IPSA 2 PT0705; KU 2; IPSA 2 PT0706 : KU 1, 2 ; IPSA 1, 2 PT0707: KU 1, 2; IPSA 2 PT0708: IPSA 1, 2 PT0709 : KU 1 PT0710 : KU 1, 2 ; IPSA 1, 2, 3
14.24 know and be able to apply the key concepts which are relevant to safe and effective practice as a supplementary prescriber in order to have their name annotated on the Register (this standard applies only to registrants who are eligible to have their names annotated on the Register)	N/A
15 be able to establish and maintain a safe practice environment	Programme specification PLOs: KU 1, 2, 4; IPSA 1, 4, 6; PVA 1, 2, 3
15.1 understand the need to maintain the safety of both service users and those involved in their care	Module specifications PT0606: KU 1, 2; IPSA 1 PT0705: KU 1; IPSA 1 PT0707: KU 2; IPSA 1 PT0708: KU 1, 2; IPSA 1, 2
15.2 know and be able to apply appropriate moving and handling techniques	Module specifications PT0606: KU 1, 2; IPSA 1 PT0705: KU 1; IPSA 1 PT0707: KU 2; IPSA 1 PT0708: KU 1, 2; IPSA 1, 2

Standard of proficiency	Where can evidence relating to the delivery and assessment of each standard be found in the accompanying documentation? (eg Module descriptor AB1234, Learning outcome XXXX)
<b>15.3</b> be aware of applicable health and safety legislation, and any relevant safety policies and procedures in force at the workplace, such as incident reporting, and be able to act in accordance with these	Module specifications PT0606: KU 1, 2; IPSA 1 PT0705: KU 1; IPSA 1 PT0707: KU 2; IPSA 1 PT0708: KU 1, 2; IPSA 1, 2
<b>15.4</b> be able to work safely, including being able to select appropriate hazard control and risk management, reduction or elimination techniques in a safe manner and in accordance with health and safety legislation	Module specifications PT0606: KU 1, 2; IPSA 1 PT0705: KU 1; IPSA 1 PT0707: KU 2; IPSA 1 PT0708: KU 1, 2; IPSA 1, 2
<b>15.5</b> be able to select appropriate personal protective equipment and use it correctly	Module specifications PT0606: KU 1, 2; IPSA 1 PT0705: KU 1; IPSA 1 PT0707: KU 2; IPSA 1 PT0708: KU 1, 2; IPSA 1, 2
<b>15.6</b> be able to establish safe environments for practice, which minimise risks to service users, those treating them and others, including the use of hazard control and particularly infection control	Module specifications PT0606: KU 1, 2; IPSA 1 PT0705: KU 1; IPSA 1 PT0707: KU 2; IPSA 1 PT0708: KU 1, 2; IPSA 1, 2

A10: PT0709; Innovation and change for contemporary physiotherapy

## Northumbria University Programme Framework for Northumbria Awards - Module Specification

<b>Faculty</b>	Health and Life Sciences	<b>Department</b>	DSER	<b>Subject</b>	Physiotherapy	<b>Module Tutor</b>	John Stephens			
<b>Module Title</b>	Innovation and change for physiotherapy				<b>Module Code</b>	PT0709				
<b>Module Type*</b> (see key below)	CORE									
<b>Module size credits</b>	<b>Level 3:</b>		<b>Level 4:</b>		<b>Level 5:</b>		<b>Level 6:</b>		<b>Level 7:</b>	20
<b>Home programme/s for which the module is designed</b>			MSc Physiotherapy (pre-registration)				<b>Code/s</b>			
<b>Additional Programme/s other than that/those for which the module is specifically designed</b>							<b>Code/s</b>			
<b>Delivery Pattern (Please tick)</b>		<b>Semester based (please specify)</b>	Sem 1 <input type="checkbox"/>	Year Long	<input type="checkbox"/>	<b>Full-time Part-time Distance Learning</b>		<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
<b>Location(s) of delivery:</b> If delivered at EPWO partners please give partner name and location										

**\*KEY:**

APL Accreditation for prior learning  
 CORE PNVQ core skills module  
 DISS Dissertation  
 FLDW Fieldwork  
 INDS Independent study  
 MAFOUN MA foundation modules - ASS

P/F Pass/fail module  
 P/F\_DS Pass/fail dissertation module  
 P/F\_PJ Pass/fail project module  
 P/F\_PL Pass/fail placement module  
 PLAY Placement – academic study abroad FT  
 PLCL Placement – Clinical

PLIN Placement - Industrial  
 PRAC Practical  
 PROJ Project  
 STAN Standard module  
 WKBS Work base study  
 WORK Workshop

**Module Overview (Max 250 words per section)** (This section is aimed at providing a prospective or current student with a brief overview of the module in answer to the specific questions and will form an element of the module handbook)

**What will I learn on this module? (SRS 0001)** Please give a brief indication of the content of the module including the main topic / subject areas studied

Within this module you will have the opportunity to complete your pre-registration learning and development in understanding your unique qualities that will contribute towards your successful registration, employment, continuing professional development (CPD), and your role as a leader and change agent for service development. Through your understanding of contemporary physiotherapy, health and social care and your current position as a potential registrant, you will identify and negotiate module learning outcomes that reflect and critically review your decision-making, communication, and CPD skills developed across the programme and apply them in the development of key themes:

- Autonomous practice, learning and development
- Employment and employability
- Contemporary and emerging areas of physiotherapy practice and delivery
- Leadership and management of change
- Contemporary health and social care policy
- Business and entrepreneurialism

Interactive workshops with module staff and external experts will provide a dynamic format to critically explore your professional identity and maximise your employability and future development as a registered physiotherapist. The clinical areas of Learning Disability, Mental Health, Elderly Care, Paediatrics, and Palliative Care amongst others can be negotiated, as you are provided with the exciting opportunity to shape your learning.

In summary, you will examine service provision and development in the context of individuals in receipt of physiotherapy (and health and social care), families, cultures and contemporary society in general with an emphasis on (new) partnerships that hold potential in offering diverse solutions to challenges and opportunities provided for individuals having greater control over their own care and experience of physiotherapy.

**How will I learn on this module? (SRS 0002)** Please provide a brief overview the learning and teaching approaches the student can expect to experience.

You will have the opportunity to participate in an enquiry-based learning approach that will promote peer and self coaching to meet negotiated module learning outcomes through exploration of contemporary issues within an open workshop format. Technology enhanced learning will play a key role in your learning with the opportunity to engage in *Physiopedia* ([http://www.physio-pedia.com/Main\\_Page](http://www.physio-pedia.com/Main_Page)) projects within small collaborative groups. This will be supplemented by further opportunities to reflect and consolidate practical and decision-making skills through simulation workshops.

External contributors will also be involved in facilitation of your learning in relation to key themes identified at 'What will I learn on this module?'

In developing a ‘community of learning’ within a professional framework, you will be expected to attend teaching sessions, be dressed appropriately for practicals, behave in a professional manner, and engage and contribute to the learning of yourself and others.

**How will I be supported academically on this module? (SRS 0003)** Please provide a brief overview of the academic support available to students, including any support that may be accessed outside formal scheduled teaching.

Successful academic achievement requires a system of robust support and guidance to help you focus on your learning needs. In addition to the pastoral support you will receive, the tutors involved in delivering this module will provide guidance and academic counselling to ensure that you are able to confidently engage with the academic and practical rigour of this module. This dialogue will be face to face in workshops with tutorial support available, and is an essential aspect of the programme’s assessment for learning strategy. Extensive support is also accessible online as part of the University’s commitment to technology enhanced learning. This employs the use of the e-learning portal (Blackboard including Pebble+) and social networking and collaborative tools.

A central feature the academic support available to you is the service provided by the University Library. This 24/7 service caters for all your learning needs, has extensive access to electronic texts and tutorials that will directly support the development of academic skills aimed at improving your critical thinking and communication skills.

**What will I be expected to read on this module? (SRS 0004)** All modules at Northumbria include a range of reading materials that students are expected to engage with. The reading list for this module can be found at: <http://readinglists.northumbria.ac.uk>

(Reading List service online guide for academic staff, this contains contact details for the Reading List team – <http://library.northumbria.ac.uk/readinglists>)

<b>Northumbria University Library Reading List Service (please confirm the following)</b>	<b>Please give date added</b>
A draft reading list has been created and on the university Library Reading List Service	<a href="#">Click here to enter a date.</a>
Reading material has been acquired and digitised (following approval)	<a href="#">Click here to enter a date.</a>
Reading list has been published to students (for module delivery)	<a href="#">Click here to enter a date.</a>

**NB – for PFNA alignment process only, module authors should complete either the University Library e-Reading List, or Appendix 1.**

**Module Learning Outcomes (MLOs)** (*Max of five in total\**, for standard 20-credit modules)  
*\*this can increase to a maximum of 10, for modules with more than 20 credits*

<b><u>What will I be expected to achieve?</u></b>  (SRS 0005) <b>By the end of this module you will be able to:</b>  <b>Knowledge &amp; Understanding:</b> 1. Evidence a critical and innovative understanding of continuing professional development, service delivery and development, and leadership 2. <i>To be completed by the student cohort</i>	<b><u>How will I be assessed?</u></b> (SRS 0006)  Please give details of all formative and summative assessment process indicating which MLOs will be addressed and how feedback will be provided.  Formative assessment will be in the review (by students and staff) of your completed small group 'Physiopedia' projects.  This will inform your summative assessment, a 40 minute (30minutes presentation, 10minutes discussion) oral presentation / viva supported by electronic slides or posters, that critically reviews the completed projects to inform a related service development, and identify personal learning and implications for future personal and professional development.  KU: 1, 2  IPSA: 1, 2  PVA: 1	<b><u>Programme (Level) Learning Outcomes that this module contributes to:</u></b>  [Please insert PLO number as listed on the programme specification]  <b>Knowledge &amp; Understanding:</b> <ul style="list-style-type: none"><li>• KU: 1, 2, 3, 4, 5*</li></ul> <b>Intellectual / Professional skills &amp; abilities:</b> <ul style="list-style-type: none"><li>• IPSA: 1, 2, 3, 4, 5, 6*</li></ul> <b>Personal Values Attributes</b> (Global / Cultural awareness, Ethics, Curiosity) (PVA): <ul style="list-style-type: none"><li>• PVA: 1, 2, 3, 4*</li></ul> <b>*Dependent on IPSA 1</b>
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<b>Pre-requisite(s)</b> (SRS 0007)  Any module which must already have been taken, or any stipulated level of prior knowledge required in order to study this module, (co-requisite core models need not be listed)	
<b>Co-requisite(s)</b> (SRS 0008)  Modules at this level which must be taken with this module	

**Module abstract** (SRS 0009)

**Please provide a brief abstract of the module (150 words max).** This section acts as the 'shop window' for the module, therefore it needs to engage and inspire the student. This is the first thing that the student will read about this module, so it must immediately grab their attention. The main aim is to encourage the student to read on, however the summary should be written in such a way that if the student reads nothing else this section will convey all key messages and benefits that the module will offer. Start by explaining the module title where necessary. Then highlight any selling points relating to the four pillars: Research-Rich Learning; Technology Enhanced Learning; Assessment and Feedback; Employability and Entrepreneurship. Examples may include student satisfaction rates, learning environment, state-of-the-art facilities etc. Finally indicate benefits of the module such as the key skills that the students will gain for future employment and career paths that are open to them.

You will have the opportunity to reflect on the decision-making, communication, and CPD skills across the MSc programme in considering contemporary health and social care and potential future innovations pertinent to the broader needs of the individual across the lifespan. Leadership, service provision and development will be examined.

Negotiated learning outcomes, subject areas / drivers (for example Learning Disability, Mental Health, Elderly Care, Paediatrics, and Palliative Care) will provide you with the exciting opportunity to shape your learning for this module activity through development of an online resource (at Physiopedia ([http://www.physio-pedia.com/Main\\_Page](http://www.physio-pedia.com/Main_Page)) that will not only enhance the learning of your group but also a wider community of learning who will have access to this resource.

The module summative assessment will provide you with the opportunity demonstrate your value to employers through a presentation/viva that evidences your research-rich, enquiry-based learning and creative thinking relevant to contemporary, innovative physiotherapy services.

### **Programme Framework for Northumbria Awards Research Rich Learning Design Pillar (SRS 0090)**

**Embedding Research Rich Learning into the curriculum:** Indicate how students will be actively engaged in research rich learning in this module through: research/enquiry based learning, research tutored learning, research led learning and/or research oriented learning, providing a brief overview of how this / these will feature within the delivery of the module (250 words max)

**Note:**

- **Research/enquiry Based:** L&T\_Based on student-centred enquiry and research activities (conducting research).
- **Research Tutored:** L&T Emphasises learning focused on students actively discussing research, and critically engaging with research outputs
- **Research Led:** T&L structured around subject content and that content is based on the research (learning about research)
- **Research Orientated:** T&L Emphasises understanding of the knowledge production process, and methods of enquiry in the subject (learning how to research)

Research in its broadest sense underpins your learning throughout this module as a group negotiated, enquiry-based learning experience that will conclude your learning at pre-registration level. The negotiation of module learning outcomes and learning activities that integrates an innovative approach to learning within the context of contemporary physiotherapy practice provides you with the opportunity to develop *Physiopedia* projects and expose your ideas and engage with a broader 'audience' of learners. This will provide you with an ideal environment to further advance your knowledge of contemporary physiotherapy practice and service development, and potentially enhance your employability.

The formative and summative assessment tasks in this module provide further opportunity for you to reflect on your understanding of research influenced evidence-based practice and issues and take an enquiry based approach as you seek to develop towards a critical and analytical perspective of service provision and your own continuing professional development. This perspective will allow you to develop your appreciation of theory-practice links and the potential for impact on your learning and development towards autonomous practice and successful employment and future career development.

## Notional Student Workload (NSW) for each mode of delivery

Complete for each delivery mode where the distribution of NSW				Part Time Mode of Delivery			
Full Time Mode of Delivery							
Activity type	Hours	KIS category	KIS category hours		Hours	KIS category	KIS category hours
Lecture	1.0	Scheduled		Lecture		Scheduled	
Seminar				Seminar			
Tutorial	1.0			Tutorial			
Project Supervision				Project Supervision			
Demonstration				Demonstration			
Practical classes and workshops	48			Practical classes and workshops			
Supervised time in studio/ workshop				Supervised time in studio/ workshop			
Fieldwork				Fieldwork			
External visits				External visits			
Tutor guided independent learning	50	Independent		Tutor guided independent learning		Independent	
Student independent learning	100			Student independent learning			
Placement		Placement		Placement		Placement	
Study abroad				Study abroad			
Work based learning				Work based learning			
<b>Total workload</b> <i>200 hours for 20 credit module</i>	200			<b>Total workload</b>			

## Summative Assessment

Sequence 001, 002 etc.	Activity type indicate <b>ONE</b> of the following types:	Brief description of assessment ( <b>max.120 characters</b> ) <i>e.g. type/ length of exam, type/ word limit of coursework</i>	Weighting % or Pass/Fail (for grade only components) <i>Note: % weightings should add up to 100% for module overall</i>	Final assessment		Anonymous submission	ESAF submission
				Yes	No	Yes	No
001	PRE (Presentation)	40 min presentation viva	100%	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
002	Choose an item.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
003	Choose an item.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
004	Choose an item.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
005	Choose an item.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
006	Choose an item.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
007	Choose an item.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
008	Choose an item.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
009	Choose an item.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
010	Choose an item.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
011	Choose an item.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
012	Choose an item.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Reassessment (specify either synoptic or non-synoptic)

<b>Synoptic reassessment</b> One form of reassessment that tests all module learning outcomes	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
<b>Non-synoptic reassessment</b> Where module referred overall, individual failed components of assessment are reassessed	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>

**FOR OFFICE USE ONLY**

**Date of FPARSC Approval**

Click here to enter a date.

<b>Date of entry onto SITS</b>	Click here to enter a date.
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**LOG OF CHANGES POST-APPROVAL**

Please indicate any changes to the approved module descriptor from 2012/13 onwards

<b>Section No.</b>	<b>Brief description of change</b>	<b>Date of Approval</b>	<b>Semester and year of first implementation</b>
		Click here to enter a date.	
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		Click here to enter a date.	

## Appendix 1

### **Indicative Reading for PFNA alignment approval only (to be completed only if e-reading list unavailable at point of alignment approval)**

N.B. This outline indicative reading list will be utilised for approval purposes only, and **a full e-reading list must be produced and available by the June of the academic year prior to the first delivery date of the module** (at which point the section of p.2 referring to University Library Reading Lists should be completed).

Please list below essential key text underpinning the module content and ultimately the learning outcomes:

- Bauman Z. (2010) *Identity* Cambridge, Polity
- Boud D., Cressey P., & Docherty P. (2006) *Productive Reflection at Work* London, Routledge
- Brown G., Esdaile S. A. (2004) *Becoming an Advanced Healthcare Practitioner* London, Butterworth-Heinemann
- Cameron C. (2014) *Disability Studies: a student guide* London:Sage
- Croskerry P. (2009) Clinical cognition and diagnostic error: applications of a dual process model of reasoning. *Advances in Health Science Education* 14: 27-35. DOI: 10.1007/s10459-009-9182-2
- Del Mar C., Doust J. & Glasziou P. (2006) *Clinical thinking evidence, communication, and decision-making*. Blackwell Publishing, BMJ Books
- Gunderman R. (2009) *Leadership in Healthcare* London:Springer
- HCPC (2014) Standards of Continuing Professional Development <http://www.hcpc-uk.org.uk/aboutregistration/standards/cpd/index.asp>
- Higgs, J., Jones M.A; Loftus, S & Christensen, N (eds) (2008) *Clinical Reasoning in the health professions* London, Butterworth-Heinemann
- Hong C.S. and Harrison D. (2012) *Tools for Continuing Professional Development* London: Quay
- Kassirer J.P., Wong J.B., & Kopelman R.I. (2010) *Learning clinical reasoning* Philadelphia; Lippincott Williams & Wilkins Health
- Klein G. (1998) Sources of Power. *How People make decisions*. Massachusetts; MIT Press
- Peck E. (2007) *Organisational Development in Healthcare: approaches, innovations, achievements* Abingdon: Radcliffe medical
- Senge P, Scharmer CO, Jaworski J, & Flowers BS (2010) *Presence. Exploring profound change in people, organizations and society* London, Nicholas Brealey Publishing
- Swain J, French S, Cameron C (2003) *Controversial Issues in a Disabling Society*. Buckingham, Open University Press

## A11: How to Hasten Slowly

How to ‘hasten slowly’; a quick guide to development and delivery of programmes

## **Introduction**

The purpose of this quick guide is to provide a flexible framework in the form of listed items across four phases, for those wishing to adopt the principles of the *Dialogical Curriculum Framework* (DCF) for pre-registration healthcare professional programmes. It will be valuable to be familiar with the rationale and context for DCF offered within the commentary, along with the supporting sample of evidence available at appendices 1-6. Indeed, it is assumed that those wishing to explore the opportunities offered by the *Framework* will at least be inquisitive as to the possibilities of process-driven curricula and an appreciation of the limitations of product-driven curricula in meeting the needs of contemporary healthcare and healthcare professional education.

*“I came into nursing because I care. You taught me how to care and now I don’t care anymore”* (Chapter 2, page)

For those wishing to gain a broad view of curriculum design pertinent to DCF, I can recommend the following two references cited within the commentary:

O’Neil G. (2015) *Curriculum Design in Higher Education: Theory to Practice*. E-book:  
<http://www.ucd.ie/t4cms/UCDTLP0068.pdf>

Fung D. (2017) *A Connected Curriculum for Higher Education*. London: UCL Press  
Downloadable pdf: <https://www.ucl.ac.uk/ucl-press/browse-books/a-connected-curriculum-for-higher-education>

Further context related to fragmentation and the ‘whole’ can be gained from the following sources:

Blumer H. (1969) *Symbolic Interactionism. Perspective and Method* New Jersey:  
Prentice Hall

Bohm D. (2004) *On Dialogue*. London: Routledge

Bohm D and Peat F.D. (2000) *Science, Order and Creativity* London: Routledge

The guide comprises four phases:

1. Curriculum planning
2. Implementation
3. Evaluation for iteration
4. Staff & Student Support

Across each and all phases you should be mindful of the key processes that drive the curriculum (space for reflection, open dialogue, participation, symbolic interactionism) and their combination (enfoldment) to provide a coherent whole to inform an enquiry-based approach to learning.

## **1.Curriculum planning**

As a team:

1. Understand the purpose of your programme based on societal need and regulatory body requirements
2. Review and evaluate resources that will be necessary to deliver the programme
3. Understand feedback gained from consultation with relevant stakeholders e.g previous students, service users, clinical partners, external examiners, professional body advisers
4. Gather information required for successful completion of validation / approval documentation. Understand mapping between agreed programme aims / outcomes, module aims / outcomes to form a coherent whole that integrates employability, research / evidence-based practice, creative use of technology, assessment for learning, and co-production. Ensure that documentation accurately reflects your approach - understand the implications of the Competition and Markets Authority (CMA)
5. Agree on your educational philosophy with respect to the *Dialogical Curriculum Framework* and how module content and process of learning will be integrated within and across academic levels and practice

6. The programme must promote lifelong learning, continuing development of self and others (including an organisational, societal level), ie understand impermanence and interdependence - change is changing all the time!
7. Using the *Framework* as a ‘road map’, highlight elements of the *professional learning constructs* that will form the focus for the delivery of each module across and between levels. For example; an early-stage clinical skills-based module may focus on *safety & effectiveness*; *deliberate practice*; *authenticity, creativity & quality*, should also signpost the seven remaining constructs and their articulation at other modules. Always be mindful of the relationship with the *professional learning themes*, and the essential perspective of the *personal & professional attributes* of the student group to promote *open dialogue* and the role of staff as the ‘guide on the side’.
8. Agree on how elements of creativity and disruption will be integrated into your process and create meaningful learning ‘on the edge of ‘chaos’
9. Develop your approach for induction to the *Framework* processes, and learning through enquiry appropriate to academic / clinical level across your programme
10. Agree on how feedback for continuing development of the programme will be gathered, taking into consideration institutional / professional requirements at modular and programme level i.e. Annual Programme Monitoring
11. Develop notional student workload for learning that is weighted towards seminar / workshop and directed/independent collaborative activity and is progressive across and between levels in terms of student participation moving towards co-production

## **2. Implementation**

### Induction

1. Induction to the programme commences at marketing, recruitment, and admissions. Be creative in employing open dialogue within interview events involving current students, clinicians, and service users where possible
2. At induction to the programme and at level be explicit about the curriculum design and the approach to learning:
  - a. The use of the DCF figure is useful to orientate students (and staff) to relationships between the themes and constructs within the context of the personal and professional learning attributes. This can help facilitate reflection

- and dialogue from the perspective of individuals / group perceived knowledge, skills, values and behaviours
- b. Enable active participation within induction through simple ice-breaking activities for example
- i. The football stadium activity (Paper 1)
  - ii. Small group activity where an individual in each group teaches the rest of their group a simple skill they are familiar with eg an exercise, dance move, trick. Reflect and engage in dialogue as to the process of the activity - the nature of the skill, how it was taught, how it felt and generally how things went - and any implications for professional learning and their role
  - iii. Simple word puzzles or games (eg how many words of 4 letters or more from the word 'comprehension') undertaken individually and then in small teams (obviously using a different but similarly structured word) and reflect on how each activity 'felt', levels of success, skills of different individuals and implications for working with 'self and others'
  - iv. As students get deeper into the curriculum activities can be linked to professional roles to reflect the development of personal and professional attributes eg Service User involvement (Papers 2, 5)

### Learning Activity

1. Promote the use of multimedia, reading materials that are easy to access and consume prior to or at the start of workshops so that the learning community (students and staff) have a basis for dialogue from the start. This may be based on more generic contemporary issues at an early stage and progress to more specific context relevant issues across the programme. A pointed example to illustrate this and that I have employed myself, at a Year 2 BSc(Hons) Physiotherapy module introduction based on various elements of professional practice has been to play a short multimedia clip of the singer-songwriter Ed Sheeran performing live. His use of live recorded musical loops provides a useful point of discussion to appreciate 'wholeness' and fragmentation - the margin for error in timing is minimal - and relate to aspects of autonomous practice as a healthcare professional in the provision of person-centred care, and also education and the integration of modular study to form a coherent whole. The clip used (first 2 minutes) can be found at [https://www.youtube.com/watch?v=D9\\_4IAtWPYg](https://www.youtube.com/watch?v=D9_4IAtWPYg) .

Similar examples from the Arts or contemporary news, can be useful to stimulate thought and dialogue, through images / paintings, music, film and so forth. Be creative (and enjoy) activities that promote thinking skills that integrate science / evidence (e.g evidence-based practice), and the arts, and stimulate insight of implicate and explicate order..

2. Consider carefully the levels of creativity (Chapter 2, page 16) within learning activity and apply appropriately to the level of study. There should always be the opportunity to move beyond mere replication of knowledge, skills, values and behaviours and wherever possible (and appropriate) promote plurality ie the understanding that different things will work in different contexts in different ways - there are rarely any singularly correct answers.
3. By considering and applying the levels of creativity and also the participatory learning model (Chapter 2, page 14) adapted as/if necessary, it is a relatively straightforward progression to integrate progressive elements of co-production. The rewards can be considerable in terms of learning by continuously moving from positions of what the student group knows, so that there is an ongoing focus on the learner (eg Paper 5, Appendix 10).
4. Actively promote the development of a personal learning portfolio, that is process-driven and functional in nature, perhaps similar to the 'webfolio, (Appendix 12). I'm sure teams can develop a better resource! Be non-prescriptive with regard to the platform that individual students wish to use to record their development. Individuals are more likely to engage if they can use a preferred resource, whether this is based in Microsoft word, Google docs, pebblepad, building their own (secure) website, as a few examples.
5. The importance of open dialogue and space for reflection as central themes to the process, in order to promote professional identity and therefore employability. Don't be tempted to rush. Provide time and space for interaction to avoid a very product-driven, reactive learning approach (Fig 4, page 27). Open dialogue has the potential to lead to 'new' views of a subject area that may have implications for module / programme development, research opportunities as well as student learning and identity. It is very different to negotiation, which in from a personal perspective is often related to compromise resulting in action that nobody really wants..
6. Be patient and steadfast in approach. Initially at least, this is often quite a different approach to learning (Paper 6) requiring participation (CPAC, Table 3, page 13) and can be very much a case of 'lost but making good time'.

### **3. Evaluation for iteration**

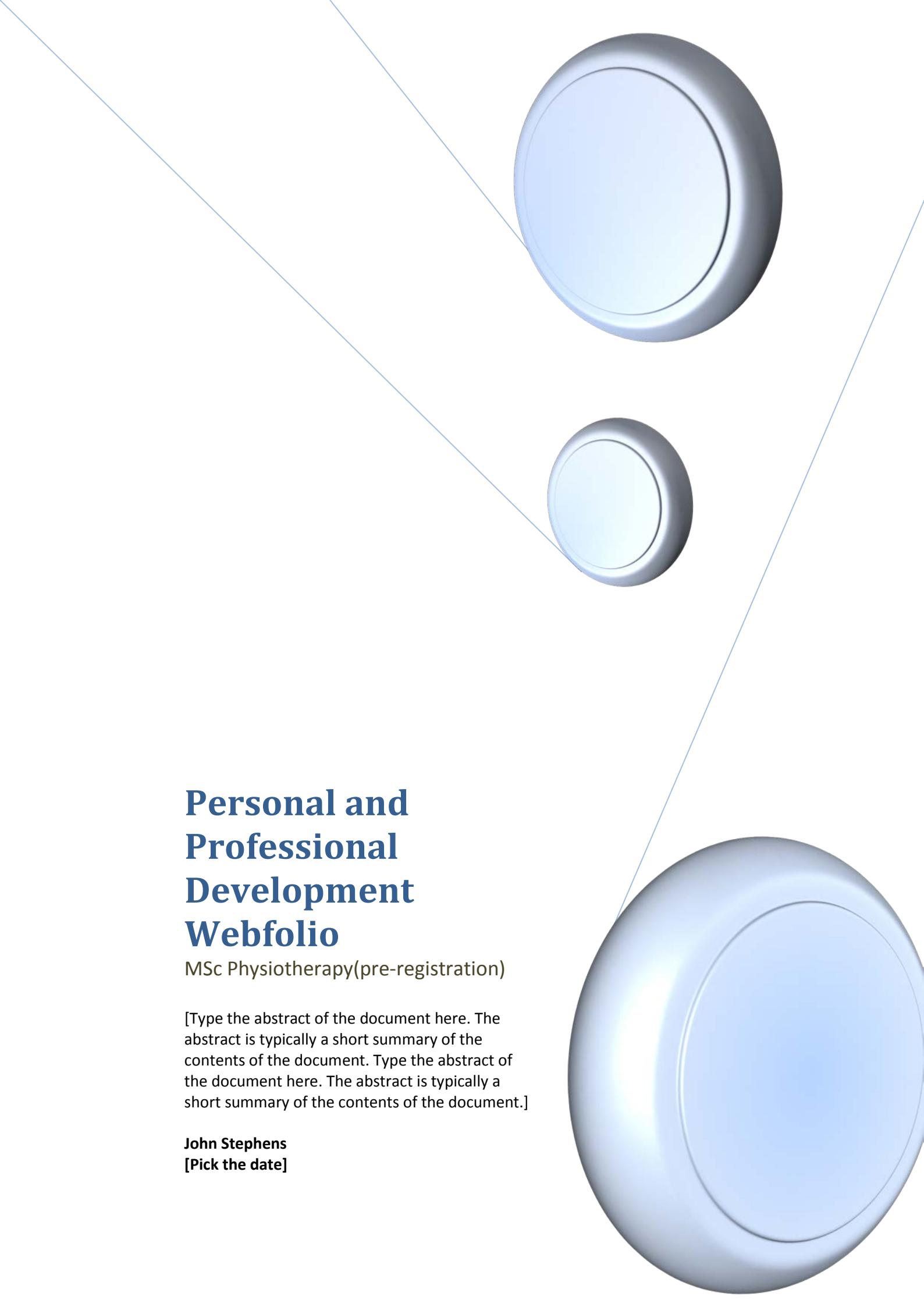
1. Ensure that all staff are familiar with organisational quality assurance and enhancement requirements and processes. Obviously, it is important to comply with institutional annual programme monitoring at module, programme, departmental, faculty and organisational level, focusing on a coherent whole rather than the fragments of your programme and its processes. All stakeholders should contribute to this including students, staff, external examiners / advisers, service users.
2. The process of open dialogue in learning (Fig 4, page 27) holds the potential to promote a very dynamic approach to quality assurance and curriculum development. Staff also have the opportunity to learn more about themselves as 'educators' and promote meaningful development of the programme(s) and themselves so that institutional requirements (noted above) do not become a chore, or a box to tick. As stated above, all stakeholders need to be involved.

### **4. Staff & Student Support**

1. The support of staff and students in the initial and ongoing development and delivery of DCF programmes, as with any programme is paramount to success.
2. As stated at the final point of section 2 regarding implementation there is a need to be patient and steadfast in terms of effort to reap the rewards of this way of working.
3. All members of the learning community need to be aware of the formal support services available at their organisation, whether this relates to academic, technological, or socio-economic support and how to access this.
4. Resources are one of the keys to success and teams need to ensure representation within groups / committees that have a role in resourcing whether relating to material, human, environmental, or social resources within their Department
5. Core to the success of programmes based on the DCF is the continuing open dialogue, in promoting academic, practice-based, and social wellbeing of all involved with the programme. Although formal groups or committees such as staff / student liaison groups are useful in formalising and recording change continual dialogue is encouraged on a social, day-to-day level.

6. An inclusive, coherent approach to support should be a feature of the programme from its inception, to delivery and ongoing development.

## A12: The Webfolio (Outline)



# **Personal and Professional Development Webfolio**

MSc Physiotherapy(pre-registration)

[Type the abstract of the document here. The abstract is typically a short summary of the contents of the document. Type the abstract of the document here. The abstract is typically a short summary of the contents of the document.]

**John Stephens**  
[Pick the date]

[Type text]

## Introduction

This workspace based within 'Pebblepad' (or any format / tool of your choice) will form your Personal and Professional Development Webfolio, a personal space where you can record your development across the MSc Physiotherapy programme. Although you are free to adapt areas and their content to suit individual need and approach to learning you will have the opportunity to develop six integrated areas related to personal and professional development. The process of your development, and a commitment to lifelong learning, is a feature of professional life and is mandatory to your registration and continuing re-registration with the Health and Care Professions Council (HCPC), the professional regulatory body for physiotherapy in the United Kingdom. In considering your progress it may be useful to reflect and map your progress against the HCPC Standards of Proficiency for Physiotherapists ([http://www.hcpc-uk.org.uk/assets/documents/10000DBCStandards\\_of\\_Proficiency\\_Physiotherapists.pdf](http://www.hcpc-uk.org.uk/assets/documents/10000DBCStandards_of_Proficiency_Physiotherapists.pdf)).

The five development areas:

### 1. Recording achievement

This area consists of static documents to keep a record of your academic module assessment marks, clinical practice placement grades, feedback and hours. Please note that it is your responsibility to keep track of your practice placement hours. It is a requirement of the Chartered Society of Physiotherapy (CSP) to record a minimum of 1000 clinical practice hours as part of your pre-registration education.

### 2. Curriculum Vitae and Employment

This area provides the facility to keep an updated c.v. across the programme and that should provide helpful when seeking employment. It may be useful to support your c.v. with supplementary information e.g. related to practice placement experience. Although it is not currently common for prospective employers to request a c.v. as such, maintaining an up to date personal profile will prove valuable in completing personal statements (for example) at job application forms.

### 3. E-Skills Portfolio

This area provides the opportunity for you to demonstrate the development of physiotherapy skills across the programme. Within each module you will be encouraged to practice, record (through film and/or images) and reflect on the development of physiotherapy skills from a menu provided by module staff. Guidance, that you are free to modify, is provided to record written narrative for each skill and you will upload visual media of your skill demonstration to accompany this.

### 4. Evidence-Based Practice and Research Skills

A particular feature of the MSc Physiotherapy programme is the integration of the evidence-base for practice and research skills within each module, along with your active engagement in research and the generation and evaluation of knowledge within your research project. This area will combine some simple documentation linked to the development of a basic research glossary / directory in recognising the transferrable skills that you bring to the programme in this area from previous study and also to record the development of your research proposal and reflect on your engagement with the research process in completing your research project.

### 5. Clinical Practice Placements

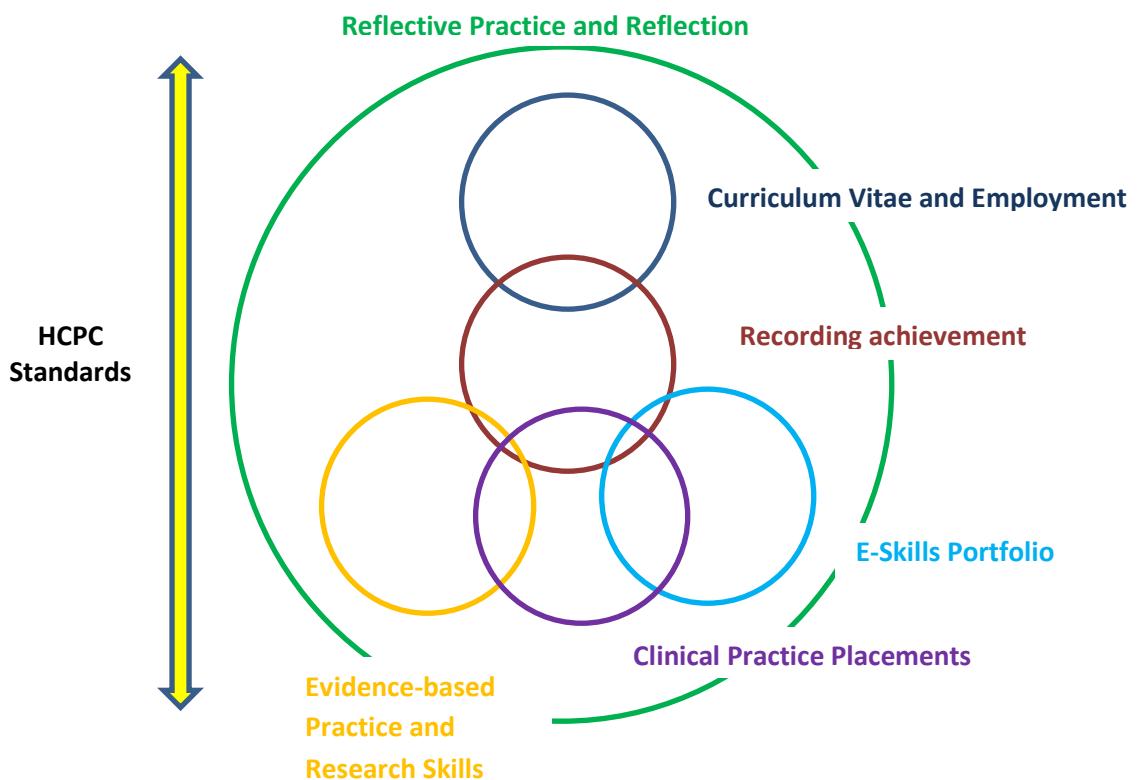
This area contains the necessary documentation that you are required to engage with and complete alongside relevant Clinical Educators and academic staff (e.g. Visiting Tutors) in relation to your six Clinical Practice Placements. Although placements are graded on a pass/fail basis, formative or developmental feedback will include an indication of your performance in relation to that reasonably expected of a newly qualified physiotherapist. It will be useful for you to keep a summary record of placement grades and also cumulative completed placement hours across the programme at 'Recording Achievement'.

### 6. Reflective Practice and Reflection

This area is really the 'engine room' for your participation in the MSc Physiotherapy programme. Explicit links are evident within the 'E-Skills

'Portfolio' and 'Evidence-Based Practice' areas. The process of reflection will be evidenced in your own style and format that can be drawn from a range of options (so that the process is evidence informed) that you are free to adapt to meet your individual and collaborative approach to learning and development. The appreciation of learning as a sociomaterial activity should be very much evident within this area, with the ultimate focus on developing the necessary knowledge, skills, behaviours and values required for contemporary physiotherapy practice.

Development area 6 (Reflective Practice and Reflection) of the webfolio provides a framework of ideas related to reflective practice and its composite themes of self-awareness, reflection and critical thinking. These should be considered in the engagement with other areas. Areas 3, 4, and 5 are interdependent, dynamic learning zones that you are free to explore and adapt, to work individually and in collaboration with other members of the cohort, staff, and also individuals / groups beyond this. These three areas will feed into areas 1 and 2 which will provide evidence of outcome for you within and beyond the duration of the pre-registration programme. Although, as stated at the introduction, you are free to modify areas to suit your needs, schematically at least, articulation of areas may look something like this:



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