  

**Factors Influencing the Development of Advanced Clinical Practice (ACP) Roles in NHS Trusts Providing Acute, Community and Mental Health Services in London: A Synthesis of Key Findings From Three Reports of ACP Roles and Practice Across London With Recommendations.**

Authors: Professor Helen T Allan, Professor Neil Brimblecombe,

Dr Linda Collins, Professor Vari Drennan, Dr Mary Halter, Francesca Taylor

This synthesis is based on three separate studies:

**The Development of Advanced Clinical Practitioners in NHS Organisations Providing Acute, Community and Emergency Services in South London: An Evaluative Interview Study (Appendix 1)**

Professor Vari Drennan, Dr Mary Halter, Francesca Taylor

Centre for Health & Social Care Research, Joint Faculty Kingston University & St. George’s University of London

**A Qualitative Exploration of Factors Influencing The Development of Advanced Clinical Practice Roles in Mental Health and Community Health Services in London NHS Trusts (Appendix 2)**

Professor Neil Brimblecombe Independent Consultant (to the Tavistock and Portman NHS Foundation Trust National Workforce Development Unit)

**A Qualitative Study into Stakeholders’ and Advanced Clinical Practitioners’ (ACPs’) Views and Experiences of Advanced Clinical Practice in Acute and Community NHS Trusts in London (Appendix 3)**

Professor Helen T Allan, Dr Linda Collins, Centre for Critical Research in Nursing & Midwifery, Middlesex University

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*These reports are of independent evaluations commissioned to complement the national audit by Health Education England/Ipsos MORI 2019 National Survey of Advanced Clinical Practice, in order to inform future activities supporting the development of effective and sustainable ACP roles.*

*This report reflects the views of the authors based on study data, and are not necessarily those of the funders Health Education England.*

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# Synthesis: Executive Summary

This executive summary reports on a synthesis of three evaluations undertaken in 2019 in London National Health Services to investigate:

1. The extent of adoption of advanced clinical practice (ACP) roles
2. Factors facilitating or deterring the development of the roles
3. Future plans for the development of new and existing staff in ACP roles across nursing, midwifery, allied health professions and health scientists.

The evaluators were also asked to identify any published or unpublished evaluations of the involvement of ACPs in service provision.

Following the publication of the ‘Multi-professional framework for advanced clinical practice in England’ (Health Education England [HEE] 2018), IPSOS Mori undertook an online national census of ACPs on behalf of HEE in summer/autumn 2019 (due to report early 2020), to provide insights into the development of ACP roles. The national survey will be shared with all NHS Trusts later in 2020.

To complement the national survey two higher education institutions (HEIs) and the National Workforce Development Unit were commissioned by HEE London to conduct a qualitative evaluation of ACP roles in the NHS workforce in London. Interviews were conducted in Autumn 2019 with stakeholders employed in NHS organisations providing community, acute (secondary and tertiary services), mental health and emergency services and other organisations with roles in supporting ACP development. The details of the research are given in the individual reports in appendices.

This executive summary reports the findings common across the three studies. The synthesis suggests that ACP roles are clustered around a small number of services, such as urgent and emergency care, musculoskeletal services, critical care and podiatric surgery, with very limited workforce planning about the future role of ACPs. There was found to be a low level of familiarity with the NHS advanced clinical practice multi-professional framework in trusts and with the concepts of advanced clinical practice more generally. However, all three evaluations identified enthusiasm from a wide range of professionals and senior managers around the potential of these roles to make a significant contribution across services, in terms of enhancing patient care, in line with current national policies, and staff career pathways. Some participants saw ACP posts as a means of addressing staffing shortages, particularly of trainee doctors in the acute sector. However views varied: some participants considered that ACPs were expected to work at an advanced level for their profession, bringing considerable experience to the role and as such ACPs’ practice was viewed as fundamentally different to that of trainee doctorsIdentification of funding sources for ACP posts was seen a major factor in future planning with some opportunities arising through commissioning and business planning processes, but otherwise the absence of ring-fenced finance for ACP posts was an inhibitor. Factors supporting and inhibiting the development of such roles varied to some extent between types of professions, but overall demonstrated an interplay between: the resource environment, the extent of knowledge about ACPs, the receptiveness of the service environment and pro-active change management.

Participants argued that ACP roles might contribute to addressing challenges related to: increasing patient demand for health services and changing patterns of morbidity; poor retention and recruitment into health care professions and challenges of embedding technological innovations into health care service delivery in the future. Uncertainty about the evidence of the value of ACP roles in different types of services was reported to be an inhibiting factor and local evaluations were rare or undertaken in the past and not available. No participants were able to identify any local reports on patient and public views of ACP roles.

Some participants expressed concern that there are currently few staff with appropriate experience and academic ability ready to progress into ACP roles in the near future and that there was a need for long term developmental pathways to allow staff to develop the required skills.

**Recommendations and Actions for key stakeholders**

* HEE, working with local trusts, should promote greater knowledge and adoption of the NHS ‘Multi-professional framework for advanced clinical practice in England’ within health organisations,
* HEE, working with local HEI providers, should promote understanding within other professions and/or interdisciplinary teams about the potential contribution of ACPs at undergraduate and post graduate levels and in continuing professional development,
* HEE should share and promote examples of trust (and services) workforce strategies for ACP posts,
* HEE and trusts should support the publication and dissemination of internal evaluations of ACP posts (including of patient and public perceptions) as well as case studies; and encourage externally funded evaluations,
* Trusts should engage with professional groups and patient/service user representatives to ensure good understanding of the ACP role,
* Trusts should work together in facilitated groups to share learning in terms of their own developments, challenges and best practice.

# Synthesis: I**ntroduction**

## Investigating the Issues Influencing ACP Development in London NHS Organisations

In 2019, HEE commissioned IPSOS MORI to conduct a national census of NHS trusts in England (2019). This followed the publication of the HEE /NHS Improvement professional framework for advanced clinical practice (2018) and sought to provide a snapshot of the spread of advanced clinical practice roles and associated issues, in particular

* the lack of evidence as to progress in developing ACP roles
* what contribution ACPs make to health improvement
* what contribution ACPs could make in England to a workforce for the future.

The Census took place in Autumn 2019 (due to report 2020). To complement this national work, the London HEE team commissioned three qualitative evaluations covering different areas of clinical practice, which focused on factors perceived as influencing the development of ACPs - study 1. Drennan et al., study 2. Brimblecombe, study 3. Allan & Collins (see Appendices 1-3). The evaluation questions addressed were:

1. What has influenced the development of ACP roles?
2. To what extent are NHS acute, community, mental health and emergency services employing and deploying ACPs?
3. What are the factors influencing the success or otherwise in introducing and sustaining ACPs in the workforce?
4. Is there documentary or published evidence of the value, or otherwise, of ACP roles and of patient perceptions of ACP roles?

## Methodology of Interview Phase of ACP Census in London

Initial contact with NHS organisations across London was established by the study investigators with key informants (education leads or directors of nursing in each trust most frequently) to inform them about the qualitative evaluation phase, which consisted of individual and joint semi-structured interviews or focus groups either face-to-face, by phone or video. Interviews were requested by email with staff who may have had a significant role in influencing or delivering the development of ACP within trusts, including directors of nursing, medical directors, directors of human resources/workforce development, operations managers, education leads, leads for allied health professions, chief pharmacists, leads for ACPs and ACPs in acute, mental health, community and ambulance trusts across London. Full details of interview methodology and methods conducted by each study team are given in the individual reports in appendices 1-3.

NRES review was not required for these qualitative evaluation studies. HEI study teams followed their university’s ethics review processes.

In total, across the three studies, fifty-nine participants were formally interviewed either face to face, or by telephone/video, as preferred by the participants. Interviews were individual or joint and one focus group took place, with 10 executive directors of nursing in mental health/community healthcare. With permission, interviews were recorded or contemporaneous notes made, transcribed and since it was hard to give total anonymity because of the uncommon roles of participants, names and explicit identifiers were removed. Analysis was framed by the research questions as well as thematically. Details of the data collection and analysis are given in the study reports in appendices 1-3. There were further informal interviews with stakeholders across NHS trusts by the study investigators (details in Appendices 1-3).

## Synthesis of the Reports’ Findings

A synthesis of the findings from the three studies was carried out by subjecting the data from the three studies to a thematic analysis to identify, interpret and report common themes (Braun & Clarke, 2006) and to identify any notable differences in findings between the studies. The three sets of findings were initially discussed at a meeting, with all authors reading the three separate reports, followed by email and phone commentary on similarities and dissonances. HA then completed an initial thematic analysis from these inputs, which was then reviewed independently by the other authors and then refined through further iterations of the analysis.

Three main themes seen as being important for the successful development of ACP roles emerged from the data:

1. Attitudes towards ACP development and understanding of the role
2. Opportunities for ACP development
3. Challenges to development – financial and organizational.

Ideas about what should change to make the introduction of ACPs successful are discussed in the discussion section.

### Attitudes towards ACP development and understanding of the role.

The full extent of employment of ACPs nationally will be known with the publication of the IPSOS census data later in 2020. In this section we identify the local approach to the introduction of ACP roles as described by staff from participating London NHS Trusts and the reported factors influencing the introduction.

In the qualitative findings from these studies, it was evident that there exists variability both in terms of areas of advanced clinical practice development and the length of time ACPs had been employed in the trust. This slow development was described as organic by the participants in these evaluation interviews.

*“I think what's happened is that posts have evolved over time, led by services or the trust, or the geography and I think, in terms of the ACP, I don't think that has been led specifically across the trust”.* (Director of Nursing 2/ Study 1)

In studies 1 and 3, the authors found that ACP roles were mainly clustered in certain types of services such as urgent and emergency care services, musculoskeletal services, critical care and podiatric surgery. Across the evaluations, participants agreed that ACPs had been introduced in an unplanned way “*not in a strategic manner*” as had happened with other new roles in nursing such as nurse consultants. It was also noted that ACPs had emerged largely on a self-selection basis i.e. the individual ACP had put themselves forward to develop their career. There was a clear narrative around self-development and being focused on how they were training to become ACPs as a way to stay in clinical practice and advance their career. Some participants from AHP and health scientist perspectives reported there wasn’t necessarily agreement within their professional groups that ACP roles were viewed as desirable career choices. There were one or two examples of strategically planned and financed introduction of ACP posts and some trusts with aspirations to expand this approach in their future workforce plans.

The macro or structural and organisational factors influencing the development of advanced clinical practice posts were suggested to be:

* Strategic commitment and direction involving a structured approach to move ACPs from ad hoc developments supported by individuals to an embedded group with a clear purpose in workforce development and planning, such as:
	+ Approaches to workforce shortages, particularly trainee doctors,
	+ Role clarity (identifying what the ACP role was expected to address and achieve),
	+ Reducing attrition of skilled professionals,
	+ The financial commissioning of services with requirements that reflected national NHS England policy in the Long Term Plan(2019) on the workforce for integrated care, for urgent and emergency services (with reimbursement for ACP roles)
	+ Prevention of attrition of the workforce
	+ Integration of services,
* Demonstration projects of services with ACP roles, for example hospital outreach ACP services for frail older adults,.
* Opportunities created by external funding for training cohorts of ACPs,
* Developing career opportunities to retain experienced staff,
* Commissioning an inclusive and flexible university based ACP course as potential ACPs would have different needs in terms of education/training and be from a wide range of disciplines,
* Evidence of value, where this existed, to meeting the priorities of the organisation.

Micro or personal and interpersonal factors which influenced the development of ACP roles included:

* The development of roles by individuals themselves who seemed highly driven,
* Reported mixed views from medical and consultant staff with some reported as very supportive of the creation of ACP roles and others more hesitant or concerned , particularly about the absence of evidence for such changes in many services and of longer term consequences,
* Attitudes of managers across the managerial structures in the employing trusts with some senior managers perceived by ACPs as too engrained in professional worldviews and philosophies of care to want to move to what was perceived as a more generic form of practice.

The last group whose attitudes shape the acceptability of ACP and therefore its introduction and development are patients’. Generally, across the evaluations, there was felt to be positive attitudes to ACPs among patients. The role of the specialist nurse was ubiquitous and it was felt that nurse ACPs and the dietician ACP benefited from patients’ acceptance of specialist practice. However, no local evaluations or reports of patients’ views of ACPs were identified.

### Opportunities for ACP Development

Key factors influencing ACP development were reported as: demonstrable success of ACP roles, financial resources for posts, influential champions and infrastructure to support continuing professional development, sustainability and spread of ACP posts.

Many participants reported that ACP roles had initially been developed to address a problem or improve services:

*We recruited some extra ACPs to take forward a pilot that we ran for one particular neighbourhood in the community. And given the successes that we found from running that pilot our Clinical Commissioning colleagues commissioned the service for the rest of the neighbourhoods.* (Operations manager 2/study 1)

The same impetus of service improvement was described by those reporting initial development as being driven by individuals who wanted to become ACPs and were supported by their managers within small teams. Participants reported that the degree of personal investment should not be underestimated nor the necessity for support and mentoring and finally, incentives and rewards. This was recognised by managers and expressed by ACPs interviewed.

Those roles/posts that demonstrated success (in addressing the problem they were intended to) were then maintained or embedded in a service. Sustainability for ACP posts was described as financialthrough commissioned contracts for the service which included ACP roles or through internally budgeted ACP posts. However, no participants were able to provide written or published evaluation reports of ACP roles in their services.

Financial resources for training staff to achieve ACP level was also reported as an enabler. Some participants reported no difficulty filling advertised ACP posts suggesting there was a ready supply of staff with the pre-requisite education and/or experience level for the role. Others reported investment in training posts and supervisory time from clinicians had been significant factors enabling the development of ACPs. Some participants reported these as pilot projects funded through HEE.

Enabling structural support elements included:

* Having visible organisational commitment to ACP roles which included a long-term view e.g. in workforce strategies,
* Having senior staff champion the ACP role, such as executive directors and clinical directors,
* Having a senior staff member with a remit to support the development of ACP roles and share good practice.

Equally important was how organisational structural support could enable individuals; two good case examples are given of in Box 2 and Box 3 from study 1 and Box 1 and 2 in study 3 (see appendices 1-3). ACPs interviewed in studies 1 and 3 added the presence of robust arrangements for supervision and mentoring to this list of structural enablers. This was viewed as important in retaining and developing ACPs. ACPs interviewed highlighted the importance of peer support from other ACPs and were keen for peer support opportunities including pan-London peer support opportunities. They thought their learning at advanced level was more important than their differences in professional knowledge and experience.

### Challenges to Development – Financial and Organisational

In all organisations, ACPs were a small percentage of the total number of posts and all organisations were addressing multiple workforce issues and innovations, which provided a challenging context. Key factors perceived as inhibiting the development and growth of ACPs were typically the converse side of factors that supported growth. The following issues were commonly reported:

* Lack of identified funding and resources for ACP positions and training. Short term budgeting cycles constrained short and medium term workforce planning. Some participants perceived that that the high cost of ACPs, once trained, outweighed the benefit to the service as a whole, although there was no evidence to support this.
* Confusion and lack of knowledge of ACPs’ potential contribution to patient care from a range of health care professions. There was more familiarity with roles such as nurse consultant and in some instances, confusion between these roles and ACP roles:

“At *the moment finance for any developments is a big issue but then there is a huge level of confusion as to what ACP means amongst managers and staff and confusion over whether* [independent] *prescribing confers ACP level.”* (Senior Manager 2/study 1)

*“[I] hadn’t realised it applies to any professional” (study 2)*

*“..strange that nurse consultants could not be ACPs in some cases, but that is way roles have developed” (Director of Nursing/study 2)*

Some managers showed a lack of understanding of the contribution ACP roles could make and the level of education and training such roles would require, i.e. M level and beyond, although others were commissioning education and planning internal development opportunities against HEE’s NHS ACP multi-professional Framework, others. There was a concern with how to map ACP against competencies.

Other challenges or concerns reported were:

* Anxiety over the correct use of advanced in a post holder’s title now ACPs were being introduced,
* Lack of detailed workforce planning by trusts and by managers at all levels within trusts beyond the immediate short/ medium term. There was a reported lack of structural mapping of ACPs against current and future workforce models,
* Nervousness, resistance and unanswered questions particularly from medical colleagues although study 2 shows some resistance among senior nurses to thinking outside existing new roles such as nurse consultants,
* Lack of education/training for non-nurse ACPs who were required to adapt CPD courses originally designed for nurses e.g. prescribing,
* Risk of losing qualified ACPs from Trusts.

Whilst individual practitioners were seen as taking a risk in developing their career alongside the investment in time and possibly money for training/education if not available from their employer, the trust also took a risk if funding was not available within the trust for employing ACPs on qualifying. ACPs interviewed argued that they were committed to their roles as ACPs and saw this as their career development separate to the workforce needs of any particular NHS trust. Most ACPs were confident that if their trust could not employ them once they were qualified, they would move to find suitable employment. Some other ACPs had developed individual, more specialist roles specific to their own trust. Those interviewed in management positions were aware that not employing ACPS they had supported was a risk for the trust but equally, one that needed to be addressed in workforce planning for the longer term. They were also aware that in supporting ACPs, they were at the same time supporting training (funded from HEE) and addressing a range of workforce transformation issues. Some participants argued that for the smaller professional groups and smaller NHS organisations these risks should be shared across a broader NHS economy.

## Discussion

This synthesis of three evaluations of ACPs’ roles concludes that the numbers of ACP roles were fairly small in of the NHS trusts the evaluation teams approached and were developed in only a small number of services. The general lack of detailed understanding as to requirements for ACPs echo findings from international research, where lack of role clarity has been commonly identified as a major challenge to the development of similar roles (Lowe et al 2012; Jokiniemi et al 2012).

We are able to identify a number of similarities in the context in which ACPs and advanced clinical practice have developed across a number of trusts in London.

Factors perceived as facilitating the future development of ACP posts:

* NHS trusts developing a common strategic vision and clarity around the role,
* Financial commitment from within the trust to developing roles,
* Producing evidence of added value that advanced practice and ACPs contribute to achieving improved patient outcomes.

Factors which were considered to hinder development of ACP posts included:

* A lack of clear role descriptions,
* A lack of support or understanding from other professions and/or interdisciplinary teams,
* Public confusion,
* Financial constraints within trusts which constrained their thinking and development of advanced clinical practice and the funding of ACP posts.

The presence of these inhibiting factors mean that the development of advanced clinical practice and the funding and support of individual ACP posts in many trusts has relied heavily on individual professional’s commitment, tenacity and drive to succeed in a complex workforce environment. Individual participants in two of the studies reported that the experience of trying to introduce new ACP roles had been personally stressful for them. The degree to which personal costs of developing as an ACP shape the job satisfaction and intention to stay in post should be explored in future evaluations.

The factors listed above have interacted at the structural, personal and interpersonal levels to make such development challenging although rewarding.

The reported absence of internal and publicly available evaluations of ACP roles, including public responses to these new roles, suggests there is a significant evidence gap for those looking to develop such roles. The evaluators were unable to identify strong quantitative evidence of effect on outcomes against which to consider the reports of participants given in the three studies. There was marked lack of published or internal evaluation of ACP posts, although there is some international evidence of positive effect on clinical outcomes (for example Newhouse et al 2011) – however, that said, in those services where ACP posts had been sustained for a number of years it was considered that initial internal evaluations or reviews had informed local planning. Managers were happy with the ACPs they supported in post and keen to promote advanced clinical practice further. The participants have offered some suggestions for tangible actions to: support wider dissemination of the evidence regarding the contribution of ACPs; influence the resource environment; provide infrastructure for workforce change management; and address the reported confusions and unanswered questions evident amongst professionals and managers.

The reported lack of familiarity at all levels of NHS organisations with the concept of ACP and the NHS ACP multi-professional framework, will not be a surprise to those leading workforce transformation nationally or in London. Similar confusion and uncertainly has been reported regarding the introduction of new roles and practice in nursing, midwifery, allied health professionals and health scientists. We note the confusion with new roles in the past and more recently such as nurse practitioners, first contact physiotherapists, paramedics, nursing associates, physician associates and with new activities such as prescribing by nurses, pharmacists and others, Similarly lack of knowledge and understanding of strategic frameworks has been reported before in nursing (Lowe et al 2012; Jokiniemi et al 2012; O’Driscoll et al., 2018; Allan, 2019).

We report, in the main, the ad hoc development of ACP posts although it is evident that in some types of services, such as emergency services, there has been more planned development and more wide spread support by key stakeholders (managers, clinicians, practitioners and commissioners) over the longer term.

It was evident that there was greater recognition of the need to move from such organic developments to planned growth with funded ACP positions, allocated budgets and training and support. However, participants reported there wasn’t necessarily agreement amongst all stakeholders at service level that ACP posts were required to address key problems of increasing demands on services, quality in service delivery and patient experience and shortages of staff – particularly trainee doctors in the acute sector. A clear distinction was made by some participants between ACPs’ practising at an advanced level of their profession and thus differently to trainee doctors. While additional funding was reported to promote ACP roles in new models of service, most described inhibiting factors and resistance when funding for ACP and ACP trainee posts could only come from another professional groups’ staff budget.

## Limitations

The three reports provide evidence of views from a range of staff in roles important to the development of ACP roles. However, the qualitative method of enquiry requires some caution when interpreting results. Participants may have been indirectly and unintentionally influenced in their responses due to their own expectations of what the studies were seeking to find out. The sample size was also small, compared to the very large number of healthcare staff employed by the NHS in London and our findings cannot be generalised. Although beyond the scope of these studies, the absence of views from patients/service users is an area requiring further investigation.

## Conclusions

The synthesis suggests that ACP roles are currently clustered around a few types of services, such as urgent and emergency care musculoskeletal services, critical care and podiatric surgery. with very limited workforce planning involving ACPs. There was found to be a low level of familiarity with the NHS advanced clinical practice multi-professional framework in trusts and with the concepts of advanced clinical practice more generally. However, all three studies identified enthusiasm from a wide range of professions and senior managers as to the potential of these roles to make a significant contribution across services, in terms of enhancing patient care in line with current national policies, and staff career pathways as well as addressing staffing shortages, particularly of junior doctors in the acute sector. Finance (for example through commissioning and business planning) for ACP posts was a major supporting factor and conversely the absence of ring-fenced finance for ACP posts was an inhibitor. Factors supporting and inhibiting the development of such roles vary to some extent between types of professions but overall demonstrate an interplay between: the resource environment, the extent of knowledge about ACPs, the receptiveness of the service environment and the extent of features associated with pro-active change management.

The evaluations suggest that ACP roles may contribute to addressing challenges related to: increasing patient demand for health services and changing patterns of morbidity; poor retention and recruitment into health care professions and challenges of embedding technological innovations into health care service delivery in the future. However the uncertainty about the evidence of the value of ACP roles in different types of services was a strong inhibiting factor which calls for future evaluations both local and national.

The findings also suggest that are currently few staff with appropriate experience and academic ability ready to progress into ACP roles in the near future. Long term developmental pathways to allow staff to develop the required skills and to embed these pathways in workforce planning are required in the future..

Finally, the limitations we have noted should be borne in mind when considering these findings and our recommendations. As we state above, strong quantitative evidence of effect on outcomes (as opposed to gathering data on people’s perceptions) in many clinical settings where there are few ACP posts and most will operate within teams is not available to allow us to make robust generalizable conclusions. This raises the need for further quantitative, outcome evaluations of advanced practice by ACPs.

## Recommendations and Actions for all stakeholders

* HEE, working with local trusts, should promote greater knowledge and adoption of the NHS ‘Multi-professional framework for advanced clinical practice in England’ within health organisations,
* HEE, working with local HEI providers, should promote understanding within other professions and/or interdisciplinary teams about the potential contribution of ACPs at undergraduate and post graduate levels and in continuing professional development,
* HEE should share and promote examples of trust (and services) workforce strategies for ACP posts,
* HEE and trusts should support the publication and dissemination of internal evaluations of ACP posts (including of patient and public perceptions) as well as case studies; and encourage externally funded evaluations,
* Trusts should engage with professional groups and patient/service user representatives to ensure good understanding of the ACP role,
* Trusts should work together in facilitated groups to share learning in terms of their own developments, challenges and best practice.

# Appendix 1: The Development of Advanced Clinical Practitioners in NHS Organisations Providing Acute, Community and Emergency Services in South London: An Evaluative Interview Study

Professor Vari Drennan, Dr Mary Halter, Francesca Taylor

Centre for Health & Social Care Research,

Joint Faculty Kingston University & St. George’s University of London

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Contact : v.drennan@sgul.kingston.ac.uk

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**Introduction**

Internationally health care systems are developing advanced clinical practitioners (ACPs), such as nurse practitioners, to address growing health care needs, shortages of doctors and financial constraints. At present in the United Kingdom there is no state regulation for such roles in nursing, midwifery, allied health professionals or health scientists, either for the level of education or clinical competency.

In England, Health Education England (HEE) which is responsible for workforce planning and training is supporting the development of ACP roles in all types of professional groups (nurses, midwives, allied health professionals and health scientists). In a joint statement with NHS Improvement, HEE has defined advanced clinical practice as “*delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master’s level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence*.”

HEE has undertaken a national census of ACPs in summer/autumn 2019 (due to report late 2019/ early 2020), to provide a snapshot of the spread of ACP roles and associated issues. To complement this national work, the London HEE team commissioned an evaluative study concerned with factors influencing the development of ACPs. The evaluation questions addressed were:

1. What has influenced the development of ACP roles?
2. To what extent are NHS acute, community and emergency services employing and deploying ACPs?
3. What are the factors influencing the success or otherwise in introducing and sustaining ACPs in the workforce?
4. Is there documentary or published evidence of the value, or otherwise, of ACP roles and of patient perceptions of ACP roles.

The study was framed by theories of innovation in health care systems and also relationships between professions. The study design was in the interpretative tradition, using semi-structured interviews to gather data. Interviews were requested with Directors of Nursing, Medical Directors, Directors of Human Resources/Workforce Development, operations managers, education leads, leads for allied health professions, chief pharmacists, leads for ACPs and ACPs in acute, community and ambulance trusts across London. Thirty interviews were conducted face to face or by telephone as preferred. With permission, interviews were recorded or notes made, transcribed and anonymised. Analysis was framed by the research questions as well as thematically 5.

### The Extent of Employment of ACPs and Influences on Developing ACP Roles

All the NHS organisations approached had some ACP roles. The ACP roles were mainly clustered in certain types of services such as urgent and emergency care services, musculoskeletal services, critical care and podiatric surgery. Participants reported that some services had a long history of between 10 to 20 years of developing ACP roles (for example in urgent and emergency services) while other types of single ACP posts were relatively recent. Box 1 gives a case example of an established ACP-led service.

BOX 1

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| --- |
| Advanced Physiotherapy Practitioners (APP) at St George's University Hospital NHS Foundation Trust provide several clinics within the hospital and community. These are all musculoskeletal (MSK) focused and provide expert assessment and opinion for patients with various MSK conditions. They are:* Orthopaedic/Neurosurgery/Rheumatology practitioner clinic - An APP working in orthopaedics, neurosurgery and rheumatology assessing and managing complex patients. These clinics are specifically designed to better manage complex MSK patients who may or may not need surgical management or rheumatology work up. This APP role is a traditional triage service (25 years in practice) providing expert MSK opinion that was initially designed to complement the secondary care offer by managing patients more appropriately and ultimately reduce the burden on orthopaedic, neurosurgical and rheumatology consultants.
* Community MSK Interface Clinical Interface Service (MICAS) - An APP working primarily with GP referred complex patients, where the GP is seeking expert assessment and management, and sometimes when they are unsure if the patient needs physiotherapy, further investigations or referral to orthopaedic or rheumatology consultants or pain clinics.

All APP’s act as expert MSK physiotherapists within the main physiotherapy outpatient department. Here, they assess, order investigations and treat complex patients as well as supervising all levels of clinician. Ben Wanless, Consultant MSK PhysiotherapistSt George's University Hospitals NHS Foundation Trust Email: benwanless@nhs.net |

There was variation across the organisations in the extent to which ACP level posts were part of the workforce strategy. While some participants reported that their organisation had a good understanding of the numbers and types of ACP roles, others reported that their organisation was just starting to collect this information. Some organisations had siloed development of ACP roles in one or a small number of services or directorate, others described a more comprehensive strategy at an organisational level. A key issue was reported by many as the challenge for services and organisations to move from the organic development of roles and individuals to a planned development with budgeted and funded ACP positions.

*“I think what's happened is that posts have evolved over time, led by services or the trust, or the geography and I think, in terms of the ACP, I don't think that has been led specifically across the trust”.* Director of Nursing 2

“*The whole thinking behind ACPs, of non-medical staff and particularly for us at* [name of hospital] *we're extremely challenged trying to find doctors to work within* [service]*. It's really important for us that we do optimise skills that are within non-medical workforce as much as we can”* (Operations manager 1)

“*It was very self-directed, I literally had to force it to happen…The protocols were written by myself ....And then I just kind of took it to our governance structures for approval, and then I kind of oversaw it through the end…I didn't have a clinical manager above me to drive it forward, so I had to do it mysel*f.” (ACP 7)

The reported factors influencing the development of ACP posts were found to group into six categories:

* An internal organisation response to workforce shortages (particularly of junior doctors) and meeting increasing patient demand;
* The commissioners of services with requirements that reflected national NHS England policy in the Long Term Plan on the workforce for integrated care, for urgent and emergency services and for general practice (with reimbursement for ACP roles);
* Opportunities created by commissioners providing funding for pilots (or demonstration projects) of services with ACP roles, for example hospital outreach ACP services for frail older adult;
* Opportunities created by external funding for training cohorts of ACPs;
* Developing career opportunities to retain experienced staff; and
* Roles developed by individuals and then integrated into services.

Organisations varied in response to questions as to whether there were planned developments of more ACP roles from: *yes* and it was written into strategic plans; *uncertain* as there is more work to be done in reviewing workforce needs; *possibly but opportunistically* depending on availability of funds for training.

We turn now to consider factors supporting and inhibiting the development of ACP posts; here we found consistency between the views of those in leadership and management roles and those who were ACPs.

**Factors Supporting the Development, Maintenance and Growth of ACP Roles**

Two key factors were reported as enablers – finance and evidence of value of ACP posts.

Finance was considered to be the key enabler – whether through commissioned contracts for the service which included ACP roles or through internally budgeted ACP posts. Many participants reported that ACP roles had initially been developed to address a problem or improve services. Those roles/posts that demonstrated success were then maintained or embedded in a service.

*So the* [type of ACP] *role developed out of conversations with a consultant about three years ago and we tried it out with the* [type of ACP] *in the outpatient clinic, in a room next to the consultant, seeing follow-up patients. We showed the consultants saw more patients, the ACP freed up the consultant time, the waiting time to be seen by a consultant met the targets and more, overtime by doctors reduced and income increased. It was an easy business case to make in other specialities after that.* (Senior service manager 2).

*“We ‘ve been very pleased with how the ACP roles have really helped address junior doctor shortages and other issues in [name of service] and so are now taking that learning to [name of another service] and looking to see where else we can have ACPs”. (*Medical Director 1)

For some services the pilot element was some years previously, while for others these were more recent, for example commissioners funding pilot services, evaluating and then funding the service to expand.

*We recruited some extra ACPs to take forward a pilot that we ran for one particular neighbourhood in the community. And given the successes that we found from running that pilot our CCG colleagues commissioned the service for the rest of the neighbourhoods.* (Operations manager 2)

No participants were able to provide written or published evaluation reports of ACP roles in their services.

Financial resources for training staff to achieve ACP level was also reported as an enabler. Some participants reported no difficulty filling advertised ACP posts suggesting there was a ready supply of staff with the pre-requisite education and/or experience level for the role. Others reported investment in training posts and supervisory time from clinicians had been significant factors enabling the development of ACPs. Some participants reported these as pilot projects funded through HEE.

At the same time as pointing to the ‘hard’ enablers for ACP roles such as finance and evidence of value on measures of importance to their trust, participants also reported other enabling structural support elements. These included:

* Having visible organisational commitment to ACP roles which included a long-term view e.g. in workforce strategies;
* Having senior staff champion the ACP role such as executive directors and clinical directors; and
* Having a senior staff member with a remit to support the development of ACP roles and share good practice.

Two case examples are given of organisational structural support in Box 2 and Box 3.

ACPs added the presence of robust arrangements for supervision and mentoring to this list of structural enablers. This was viewed as important in retaining and developing ACPs.

Box 2

|  |
| --- |
| Lewisham and Greenwich NHS Trust has a history of the developing Advanced Clinical Practice (ACP) roles in Emergency care, these have now expanded in both clinical area and the range of healthcare professionals undertaking such roles. Given the HEE Multi-professional Framework for advanced clinical practice focusses on a level of practice as a trust we have embarked on the task of reviewing the range of roles to identify who are working at this level. The current workforce working at this level of practice includes nurses, paramedics, physiotherapists, midwifes and a range of other allied-healthcare professionals. Due to the scale of this task to review all specialist roles the trust opted to develop a two-year Consultant and Advanced Clinical Practice Strategy focussing on the identification and development of the current workforce working at this level followed by identifying the future workforce needs. The strategy is underpinned by a clear governance framework to support this agenda and encompasses the enhanced and consultant levels of practice; representative of a clear career pathway. This strategy has been agreed by the trust management executive and an advanced clinical practice steering group established reporting to the trust workforce and education committee. To support the further development and support of the ACP workforce, we have developed an “ACP Clinical Educator” post, which is being delivered by two people for half their working week. The other half of their role they work clinically in their advanced practice role. These new posts are aimed to enable clinical working and supervision with the whole range of trainee ACPs across the Trust to support them in developing their clinical skills and critical decision making. In addition to this a range of ACP development workshops are being planned and delivered between the ACP Clinical Educators and the Trust lead ACP. Currently this post is a seconded post, but it is hoped to become a substantive role going forward.If you would like any additional information about the Trust Strategy and or the ACP Clinical Educator post then please feel free to contact: Sarah Davies, Head of Nursing Training and Development, UEC ACP Lead London HEE, Honorary Fellow, London South Bank University, RCEM Credentialed ACP. Email sarah.davies14@nhs.net |

Box 3

|  |
| --- |
| St George’s University Hospitals NHS Trust wanted to further develop and support Advanced Clinical Practitioner roles and services across the trust. As part of the strategy to achieve this, I was recruited as a Consultant Nurse in Advanced Practice. I am part of the Emergency Department (ED) team and I work 50% clinically as an ACP. The other parts of my role as a Consultant Nurse is education, research, development, improvement and innovation and strategic and facilitative leadership. I am responsible for developing and leading the Advanced Clinical Practitioner (ACP) service in ED. I line manage the ACPs and trainee ACPs as well as responsible for their training and development. I am also the lead for advanced clinical practice development at St George’s. I have undertaken a ACP scoping exercise and established a Trust ACP workforce group. We have developed an ACP Trust strategy to create a standard approach for the utilisation of and development of ACP roles within the Trust, to benefit patient care and the workforce. I chair an ACP working group which reports to the trust workforce development committee. I feel that this role has been pivotal in bringing together and developing future Advanced Clinical Practitioners and ACP services throughout the trust.  If you would like more information please contact Lee Patient, Consultant Nurse Advanced Clinical Practice, Emergency Department , Honorary Clinical Lecturer, Kingston University and St George’s, University of London. Email: lee.patient@stgeorges.nhs.uk |

**Factors Inhibiting the Development, Maintenance and Growth of ACP Roles**

In all organisations, ACPs were a small percentage of the total number of posts. All organisations were addressing multiple workforce issues and innovations. This provided the backdrop as to the priority level ACP development received. Inhibiting factors were reported in three main themes:

* Finance and resources for ACP positions and training;
* Confusion and lack of knowledge of ACPs; and
* Nervousness, resistance and unanswered questions.

The three themes were interlinked and differently ordered by participants.

“At *the moment finance for any developments is a big issue but then there is a huge level of confusion as to what ACP means amongst managers and staff and confusion over whether* [independent] *prescribing confers ACP level.”* (Senior Manager 2)

### Financial and Resource Inhibitors

Key issues regarding finance and resources for ACP positions was said to relate to:

1. The lack of workforce planning and resulting absence of business cases for ACP positions,
2. The siloed nature of staffing establishments and budgets by professional groups, resulting in a reluctance to release finance from one type of position for another e.g. long term vacant medical post released to fund an ACP post,
3. Underestimates of supervision and support required from medical staff and others, particularly while in training and in first year.

There were also reported problems in funding education for ACP level practice and in supporting the training supervision and assessment by clinicians. There appeared to be three models of resourcing education and training on a continuum of the extent to which the cost was borne by the organisation or by the individual:

* The creation of training posts by the employer with internal and /or external (HEE) funding and support for supervision, assessment and signoff of clinical skills,
* Funding of education modules by the employer with some study leave, with or without allocated supervision assessment and sign off of clinical skills,
* Self-funded education modules with some study leave, with or without allocated supervision assessment and sign off of clinical skills.

It was striking from the interviews with ACPs, the significant levels of investment of their own time and finance they had invested as individuals, often over years, to achieve their ACP level of practice. There were many individualistic routes in their education and training.

Conversely there were participants in leadership and ACP roles who pointed to the costs for an organisation in supporting the education and training as often there were not the ACP posts to appoint staff to on completion and consequently they obtained jobs elsewhere.

“*So we* [trust] *supported this cohort of three trainee* [name of profession] *ACP posts with funding from HEE and at the end there were no posts for them and they have all got jobs in other trusts and PCNs* [primary care networks]” trust lead for profession. (Senior Manager 5)

### Lack of Knowledge as Inhibitor

Another key inhibitor, given greater priority than finances by some participants, was the lack of knowledge about ACP level practice and its potential value. This lack of knowledge and awareness was reported to be amongst senior clinicians and senior managers but also to be present in the professional groups from which ACPs are expected to develop. Additionally, there was reported to be confusion regarding terminology, job titles and the difference between clinical specialist roles and ACP roles.

For senior clinicians and managers there was reported to be a lack of knowledge about the evidence of effectiveness for ACPs, as far as it existed, and sometimes even a rejection of evidence as applicable to that settings/service. Some participants suggested that managers were focused on the immediate and short term and could not look more broadly and long term at workforce changes.

For the professions, there was reported to be a lack of knowledge about ACP as a career option. Those with remits for AHPs and health scientists pointed out that it was not obviously an attractive career choice in all their professions, and that other pathways could lead to higher levels of pay and more interesting jobs.

### Inhibiting Attitudes – Nervousness, Resistance and Unanswered Questions

While some participants reported outright resistance to ACP posts from mainly some doctors and nurses, others described there to be more a sense of nervousness about the concept, particularly from doctors. In addition to lack of evidence (e.g. on safety and impact), the nervousness was attributed to concerns that converting medical establishment posts to ACP posts would be irreversible even if ACP posts proved not to be of value.

*“Given that we've converted some medical posts into ACP vacancies so that we can recruit, there's a nervousness around changing that medical model; so around accepting that what was traditionally… carried out by medics at quite a junior grade can now be carried out by ACPs.”* (Operations manager 2)

Some participants argued that many professionals were reluctant to consider ACP work through lack of clarity about education routes, career progression, fear of the types of additional responsibilities, and for some whether the salary reflected the responsibility.

*So amongst the* [AHP professional groups named] *there is real hesitancy and in some cases fear of the type of ACP roles taking on some of the work of the junior doctors. They view it as just too big a leap. They have questions like: are they protected, supported, if something goes wrong? Will their pay reflect the responsibility?* (AHP lead 1)

Many participants also pointed to confusion and unanswered questions over governance and quality issues associated with ACP education, training and credentialing as inhibiting factors to further developments.

*“There needs to be some oversight, some, I suppose localised or regional commitment to agreeing to take staff that move elsewhere…I don’t think what’s been banged out really is the supervision and sign-offs. So it’s only going to be as robust as the senior people, the senior clinical specialists who are signing it off. I haven’t really seen hard facts about how that’s going to be moderated really.”* (AHP Lead 4)

### Suggestions for Regional Action to Support ACP Development

Many participants were very appreciative of the work and support from HEE and HEE London regarding ACP development. HEE was seen to be helping create a framework for consistency from previous piecemeal developments Some noted that the HEE ACP census work had given them impetus to consider ACP more broadly across their organisation.

*“We've definitely been very grateful, certainly, for the support that we've had to develop staff through an HEE funded advanced practice pathway, and that's another thing that attracts people to the role because paying for a master's programme is pretty expensive these days*.” (ACP Lead 1)

While funding for education and training supervision was a frequent response as to what else would be of value in ACP development, participants also offered a range of suggestions for HEE London to consider, which are listed below (unprioritsed):

*For the individual professional*

* Create career decision charts applicable to different groups of professionals,
* Awareness promotion of different types of ACP roles for different professionals,
* Re-visit whether there could be more explicit wording as to what an ACP is and is not,
* Pan-London peer support opportunities.

*For the development and maintenance of professionals into ACP roles*

* Develop London wide strategy to address ACP education for small professional groups and small district general hospitals/organisations,
* Consider regional training programmes and commitments,
* Consider funding interdisciplinary education events rather than silo between medical education and education for others,
* Support ACP networks pan-London.

*For organisations supporting the development and maintenance of an ACP workforce*

* Awareness promotion of types and value of ACP roles with more sharing of knowledge/access to national information,
* Support for individuals/services to write up and publish evidence of value and impact for wider dissemination,
* Recommendations on mechanisms and structural supports for taking forward the ACP agenda,
* Guidance on processes of how to match individuals to ACP framework,
* Develop generic templates for business cases and evidence,
* Provide guidance on supervision requirements,
* Co-ordinate a bit more between HEE workstreams and communications to organisations.

**Concluding Comments**

This evaluative study was able to identify that ACP roles were a relatively small group in most organisations and developed in a small number of services. Factors supporting and inhibiting the development of such roles vary to some extent between types of professions but overall demonstrate an interplay between: the resource environment, the extent of knowledge about ACPs, the receptiveness of the service environment and the extent of features associated with pro-active change management. The reported absence of internal and publicly available evaluations of ACP roles, including of public responses to the new roles, suggests there is a significant evidence gap for those looking to develop such roles. The participants have offered some suggestions for tangible actions to: support wider dissemination of the evidence regarding the contribution of ACPs; influence the resource environment; provide infrastructure for workforce change management; and address the reported confusions and unanswered questions evident amongst professionals and managers.

Many of the ACPs we interviewed volunteered to provide case examples of their work and the value it offered their services. These types of exemplars as given in the report might also help address the reported wide spread lack of knowledge. It was evident that the services with the highest density of ACP roles had been developing these posts, with attendant supporting structures, for many years if not over a decade. Sharing such learning with clinicians and managers in services new to the concept could be a positive step in support of the workforce transformation required in NHS policy.

# Appendix 2: A Qualitative Exploration of Factors Influencing The Development of Advanced Clinical Practice Roles in Mental Health and Community Health Services in London NHS Trusts

Author:

Professor Neil Brimblecombe

**Acknowledgements**

The author is grateful for the generous sharing of time and viewpoints by all those interviewed for this study.

**Executive Summary**

This study is a component of a larger evaluation commissioned by Health Education England to explore issues regarding advanced clinical practice (ACP) roles in NHS Trusts in London.

A qualitative investigation comprising

1. A focus group with directors of nursing, which was carried out face to face
2. Semi-structured individual interviews, conducted face to face or by phone with senior staff who could potentially influence the introduction of ACP roles, from two NHS trusts providing mental health service and community health care services
3. Structured interviews with other professionals engaged in specific aspects of ACP development, conducted face to face or by phone

Data were analysed using thematic framework analysis, identifying themes that illustrated common issues raised by participants.

**Results**

The interviews were carried out between August and October 2019 by the author (NB). Twenty individuals participated, of whom 8 were solely in the focus group, 10 were interviewed individually and 2 as a pair. Participants included directors of nursing from 9 (of 10) London mental health trusts and 11 other individuals involved in professional leadership, operational management, organisational development and educational roles.

A thematic analysis of responses suggested 7 themes as being important to ACP development: understanding of the role and the NHS framework for ACP, attitudes, learning from current ACP and other roles, pre-requisites for development, challenges, opportunities and future support.

Despite the participants being generally unfamiliar with the NHS ACP multi-professional framework, there was enthusiasm for the potential of these roles, from a wide range of professions, to make a significant contribution across services, in terms of enhancing, both, patient care and staff career pathways.

No single profession or area of practice was identified as being uniquely suitable for ACP roles. Participants expressed some concern as to a potential shortage of staff with appropriate experience and academic ability to be able to progress into ACP roles in the near future. Participants identified a need for a long term developmental pathway to allow staff to develop the required skills.

Attitudes of the workforce towards these roles were seen as important, particularly those of the medical profession, which were perceived as generally more positive to such new roles than in the past. Any potential concerns that patients/service users might have about ACP roles were seen as being resolvable by provision of clear information about the role and its requirements.

The participants’ experience of developing other advanced roles and skills, such as non- medical consultants and non-medical prescribing, led them to believe that role clarity was vital to success. Several emphasised that selection of candidates for ACP roles should be based on service need, rather than on the availability of volunteers. There was consensus that current workforce planning processes were not sufficiently developed in trusts to provide evidenced and detailed plans for ACP development.

**Implications**

This study provides some insight into factors perceived as important to the development of ACP roles by executive directors and other senior staff in mental health and community healthcare services. The sample of 20, whilst small, is representative to a degree of the range of senior staff, although a more expansive study would be needed on which to base firm recommendations.

The participants were generally enthusiastic as to the potential of ACPs making a major contribution to care provision, but these views were expressed in the context of there currently being very few formally designated ACPs and a lack of detailed plans for creating more such roles in most trusts. The themes derived from interviews echo many of those from recent research undertaken in the UK and other countries. The findings tentatively suggest a number of actions to support the successful introduction of ACP roles, including more engagement with trusts regarding the NHS Framework for ACPs, active engagement within trusts between clinical professions and service user/patient representatives regarding new roles, sharing learning across organisations and developing a standardised approach to evaluate the effectiveness of ACP posts.

Neil Brimblecombe 21/11/2019

**A Brief Qualitative Study of Factors Perceived as Influencing The Development of Advanced Clinical Practice Roles in Mental Health and Community Health Services in London NHS Trusts.**

### Study Context

This study is one of a series commissioned by Health Education England to explore issues regarding the development of advanced clinical practice (ACP) roles in NHS Trusts in London. The study focuses on trusts providing both mental health and community healthcare services. Information from the study is intended to complement that gathered by the Health Education England/Ipsos MORI 2019 National Survey of Advanced Clinical Practice, in order to inform future activities supporting the development of effective and sustainable ACP roles. This report reflects the views of the author, based on study data, and are not necessarily those of Health Education England. This report does not provide a comprehensive summary of ACP related literature.

### Background

Within the NHS in England, Advanced Clinical Practice (ACP) is defined as that which is:

 *‘…delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master’s level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence.*

*Advanced clinical practice embodies the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people’s experience and improve outcomes.….’ (Health Education England 2017)*

### Advanced Clinical Practice in England

In 2017, Health Education England, in collaboration with a range of professional colleges, produced a framework that described parameters for advanced clinical practice in the NHS in England, the ‘Multi-professional framework for advanced clinical practice in England’. This framework built on previous work within the NHS in the UK and international approaches to advanced clinical practice.

### Advanced Clinical Practice worldwide

The potential benefits of ACP roles for nurses and other health professions have been widely debated and the creation of such roles proposed as a solution to many healthcare challenges, particularly in primary care, health education and health promotion ((Bryant‐Lukosius et al.2004; Lowe et al 2012; Iglehart 2013). Numbers of ACP roles are increasing in many countries (Pulcini et al 2010; Lowe et al 2012) with an estimated 70 either having advanced practice nursing roles currently or are aiming to do so (ICN 2019).

ACP roles have also been taken up by a range of allied health professionals, notably in Australia (Queensland Department of Health 2013) and Ireland (Fennelly et al 2018). Advanced practice pharmacist roles are found in Australia, the United States (Waddell et al 2016) and Canada (Shalansky 2019) and are reported as moving to increasingly diverse areas of practice in both inpatient and community settings (Shalansky 2019).

### Research Summary

Systematic reviews of advanced practitioner treatment compared to medical treatment across a range of specialities have identified equivocal or improved clinical outcomes and patient satisfaction (Newhouse et al 2011; Donald et al 2013; Morilla-Herrera 2016), although confusion is common as to the terminology used to describe these advanced practice roles (Lowe et al 2012; Jokiniemi et al 2012).

### Mental Health, Community Healthcare and ACP Roles

ACP (or similar) roles have been established within mental health and community healthcare settings in a number of countries. In the United States, there have been nurses trained as ‘Advanced Practice Registered Nurses’ (APRNs) specialising in mental health for many years. An explicit driver for the creation of APRN roles there has been to compensate for a shortage of psychiatrists (Delaney 2017) and most APRNs are employed in non-traditional services, i.e. those whose primary function is not to provide mental health service, but do so when necessary (Dew 2014). APRNs are required to hold a post graduate qualification. Most APRNs can provide a variety of interventions, including diagnosis and management of both acute and chronic mental illness, prescribing, and psychotherapy (Delaney et al 2018).

Nurse consultant roles have been developed in the UK since 1999 and similar roles exist in Australia and Hong Kong and have similarities with APRNs in the United States (Jokiniemi et al 2017). In the UK, the role requirements heavily overlap with those of ACPs (Department of Health 1999; Health Education England 2017). Consultant roles are open to other health professions, as well as nursing. Non-medical consultants work in both mental health and community health services in England, with 174 nurse consultants reported as working in mental health or learning disability services (NHS Direct 2017).

### London Mental Health and Community Healthcare Services

There are ten mental health service providing NHS trusts in London, half of which also provide community healthcare services, which are also provided by some acute trusts and by specialist community health care trusts.

### Study Aims

To explore issues that may support or restrict the development of effective Advanced Clinical Practice roles in mental health and community healthcare services in London

### Timescales

The study took place between July and October 2019.

### Methods

The approach was a mixed, qualitative methods service evaluation, comprising

1. A focus group with executive directors of nursing from London mental health trusts to identify key issues for ACP development. These issues would then be further explored in semi-structured interviews with other staff. Directors of nursing were included as being trust board members likely to have high interest in and influence on the creation of ACP roles, with executive responsibility for Nursing, and frequently for Allied Health Professions.
2. Semi-structured individual interviews, conducted face to face or by phone, with senior staff whose views could potentially influence the introduction of ACP roles into two NHS trusts providing mental health service and community health care services. The two trusts were identified through convenience sampling, utilising existing professional links.

The roles below were the basis for initial selection of interviewees, based on the author’s understanding of who might be influential in planning or delivering ACP roles. Directors of nursing in the two trusts also offered other suggestions based on knowledge of their own trusts.

* + Director of nursing
	+ Director of Human Resources/Workforce Lead (or equivalent)
	+ Allied Health Professions Lead (or equivalent)
	+ Senior medical lead
	+ Senior operational manage
	+ Any current ACPs.

The semi-structured interview schedule (appendix 4) was devised by the author based on international literature concerning the development of ACP type roles, previous studies in England regarding advanced roles and skills specifically in mental health services (Dobel-Ober and Brimblecombe 2016: Brimblecombe et al 2019) and the issues raised by the directors of nursing in the focus group.

1. Additional focused interviews took place with other purposively selected individuals engaged in specific aspects of ACP development, to gather different perspectives on ACP development from that of the participating trust staff and to further inform issues that had been raised by the other two cohorts of participants.

Interviews were face to face if possible or by phone if the interviewee preferred or if the availability of participants would not otherwise have been manageable within project timelines. Potential interviewees were contacted by email, explaining the purpose of the study, that interviews were voluntary and that either electronic recording or contemporaneous handwritten notes would be taken with participants’ permission. Offers of further explanation before interview were made.

### Ethical Issues

The study constituted a ‘service evaluation’, rather than research, as it was not seeking to generate generalizable information (Health Research Authority 2017). No patients/service users were involved in the study. No names are used in this report, although participants were made aware that of the possibility that they may be identified by their roles.

### Data Recording

Key issues arising in the discussion with the nurse director group were recorded in contemporaneous hand written notes by the author. At the end of the meeting, the author fed back his perception as to the key issues raised, to allow the group to comment. A written summary of key points was also distributed later to participants and a request made for any corrections or amendments. None were received.

Semi-structured interviews were electronically recorded where feasible, otherwise contemporaneous handwritten notes were made. There was no formal process of participants validating the handwritten notes made, although the author attempted to verbally summarise his understandings of what had been said at points throughout the interviews, thus allowing the participant to correct specific misunderstandings.

### Analysis

Qualitative data from semi-structured interviews were subject to thematic analysis to identify, interpret and report themes, to make complex data simpler to present and understand (Braun & Clarke 2006). Software was not used for analysis as the data was relatively simple to categorize. The author read and reread interview transcripts and notes in order to become familiarised with the data before developing descriptive codes for the text, capturing the overarching themes, which were then reviewed to ensure that they were derived directly from the comments made by participants, by revisiting the raw data (Graneheim and Lundman 2004; Lincoln and Guba 1985).

### Results

Twenty individuals participated in total. Ten directors of nursing participated, 8 in the Focus Group and 3 in individual interviews (n = 3), one director of nursing being in both the group and in an individual interview. Ten other participants had individual interviews or, in one case, a paired interview. Three individuals who were neither directors of nursing or from the participating trusts were also interviewed individually.

The director of nursing focus group and 6 individual interviews were carried out face-to-face, the remainder were by phone. Participants from each of the prioritised categories for inclusion were interviewed, with the exception of current, formally recognized ACPs, as these were reported as not currently existing in the participating trusts. Attempts to meet with a soon to qualify ACP was unsuccessful in the study time period, otherwise all requests for individuals to participate were consented to.

### Participants

10. Directors of nursing/chief nurses (one outgoing and one incoming from the same trust)

1. Senior operational manager

1. Director of human resources

1. Assistant/deputy directors – in staff development, workforce and/or education roles

2. Senior medical leaders/managers

1. Allied Health Professions Lead

Interviews for individuals from other organisations were purposively arranged to gather different perspectives on ACP development from that of the participating trust staff, as early interviews had shown that neither participating trust had yet reached the point of having any formally recognised ACP roles. The additional interviews were with:

* University ACP Course Lead
* Trust nursing workforce lead (not from the two sample trusts)
* Mental Health Lead, Royal College of Nursing

These additional interviews focused on specific issues that these participants were likely to be able to comment on.

Participants were randomly allocated a participant number, which is used to demonstrate the source of specific quotes below. Where the quoted participant’s role is important to the context of the quote, this is referred to in the text.

### Themes

Seven themes were identified through the process of thematic analysis. The themes identified are not discrete, in that some data could have been placed in more than one thematic category. Pragmatic decisions to include any particular piece of data in one theme, rather than another, were informed by the aim of the thematic analysis, i.e. to make complex data simpler to present and understand.

### 1. Understanding of the role and framework

Most of the senior staff from trusts were not familiar with Health Education England’s ‘Advanced clinical practice. Multi-professional framework’, only two reporting anything more than very vague knowledge, otherwise there was an acknowledgement that *‘there is some confusion’* (P11). However, all participants were able to offer a view as to what ACP characteristics might be and identify individuals who may have some such characteristics. Where there was an absence of detailed understanding of ACP roles, participants thought of what seemed to them to be similar roles, as in ‘*I’m very familiar with the nurse consultant role, but in terms of the ACP role, not as familiar really.’ (*P19)

Suggested characteristics required for ACPs included having a ‘*quite broad scope of clinical role’* (P19) and having *‘..gone beyond the general nursing qualifications and are engaged in either prescribing or other similar level activity’* (P5). Most participants recognised that post graduate education would be a requirement. Individual characteristics were also suggested as requirements *– ‘.. being able to respond and also having a sort of clinical gravitas’ (P4)* and *‘resilience is important’ (P7).* The level of expertise of ACPs was seen by some as potentially very high *– ‘I suppose the question is how advanced can it be? Well there’s no limit to that is there?’,* with the caveat that it must be *‘… verifiable that the competencies are there and they are clearly defined and clearly mapped against interventions.’ (P5)*

A number of disciplines were cited as potential sources of ACPs, including nurses, psychologists and Allied Health Professional (AHPs), although some participants expressed surprise as to the range of professionals who could, theoretically, become ACPs*– ‘I hadn’t realised it applies to any professional’ (P5).* An AHP Lead commented on the value that having ACPs from varied professions could bring – *‘not only would they have their newly acquired skill set as an ACP, but also all the skills that they bring with them by virtue of their professional background and that would bring with it a wealth of different experience.’(P18)*

### 2. Attitudes

Attitudes towards ACPs and related roles were discussed at length in both the focus group and individual interviews. Most participants agreed that attitudes were changing overall, in that high level clinical roles for non-medical professions were more accepted. Attitudes were characterised as broadly very positive, ‘*London wants it’* (P10) or, more cautiously *‘… it’s no longer an alien concept’* (P8). Professional boundaries were seen as less rigid than in the past – *‘we are far less defined around professions now’* (P5). However, enthusiasm for the role was perceived as not always being matched by consideration of practicalities - *‘services are keen with new roles, but do not always understand the implications’* (P15). There was a context of various new roles being introduced nationally, with consequent pressures on trusts – *‘we are always on shifting sands, with roles changing and new titles coming in’* (P15).

The attitudes of medical staff were seen as particularly important, in that a lack of their support could potentially damage chances of successful introduction of ACPs (see Themes 3 and 5, below). Most participants took the view that medical staff were ‘*generally more welcoming* ‘ (P15) of new roles, possibly because of the shifting workforce picture, with shortages in many areas and specialities - *'Workforce issues have changed' (P1).* Individual examples were given of new ACP type roles being warmly supported by senior medical staff, a director of nursing commented that ‘…*it’s been absolutely great, yes, which really surprised me! So yes, very positive (P19)’.* Conversely, a senior doctor commented that *‘I think some [doctors] are on their high horses, but some aren’t..’ (P4).* Another participant agreed, in that *‘…there will be pockets of varying views’(P2).*

Participants also commented on attitudes of the public towards other professions carrying out work previously only done by doctors. A senior psychiatrist commented that ‘*I suppose the public also makes it more difficult sometimes, because there is this sense that “oh I want to see the Doctor because.......’(P4).* Another commented that *‘If you ask my elderly mother, would you want to see one of those? No, she would want to see a doctor’ (P5).* However, this issue should and could be tackled by providing information – *‘that comes down to it not being widely communicated’ (P9)* and *‘..if I’m a patient and I’m receiving an intervention, I want to know the person who’s carrying it out is competent and properly trained to do the job’ (P5).* An AHP Lead felt that the public was getting more used to nurses taking up some roles previously held only by medics, but queried *‘… crikey! What the reaction would be if that was an AHP, I don’t know.’ (P18)*

A human resources director raised the possibility that some professionals, who might be interested in aspects of ACP roles, could be put off by the generic title ‘ACP’, as this could imply to them a loss of professional identity – as in ‘*’’I’m a nurse first”’* (P2). Other participants made comparisons with care coordinator roles in mental health services, which were perceived as being generally unpopular roles, and have, both, a generic name and generic work requirements. An AHP lead worried that staff would think that ACP roles are *‘all about breeding generic practice’ (P18)*. However, more generic roles were not perceived by all as being necessarily negative – *‘It’s one thing being proud of a profession… but at the end of the day, I wasn’t born as a nurse.’* (P5)

Conversely, there was a view that many non-medical professionals would welcome the opportunity to work towards an ACP role, as *‘people want promotion, but don’t like the drudgery of management and love clinical work’* (P2) and that difficulties in maintaining clinical work is *‘something people often bemoan, in terms of career development’* (P18). A senior manager commented that ‘… *a lot of nurses who are academically inclined … will see it as a real opportunity.’ (P5)*

### 3. Learning from current ACP and other new roles

No participants reported any structured mapping of ACP roles within their trusts using the NHS multi-professional framework to date, although one stated they were looking at this currently (P14). Of the two trusts participating in this study, one trust reported sending a nurse on the ACP course this year, who then had to withdraw, whilst the other had two mental health nurses currently on the course, but the service is *‘struggling ... as to what they do with them and what to grade them’ (P12).*

In the absence of formally defined ACP roles, there were discussions about other roles or skill sets, that were seen as having some common features with ACPs and from which lessons might be learned. A senior manager described the impact of a senior nurse who had led on improving physical healthcare in mental health services and who seemed to have ACP characteristics – *‘He was an incredible resource to us and left us after four years with the state of physical health care in our service being of a higher quality than had been previously.’ (P5)*

A director of nursing (P10) reported having previously experienced an ACP type role, which was developed to provide an alternative to junior doctor out-of-hours cover in mental health inpatient services (10). This had been a financially driven development, but had not be sustained, partially because of the cost of the ACPs themselves.

The director of nursing group considered their learning from the varied success, or otherwise, of non-medical consultant roles that they had worked with, mostly nurse consultants. They considered that some nurse consultants could easily meet ACP criteria, whilst others would not. There was agreement that nurse consultant roles were most successful when they had a clear project focus, but that some tended *‘to drift into roles that maybe don’t fully reflect the clinical aspects of being an ACP’ (P15).* It was considered to be *‘..strange that nurse consultants could not be ACPs in some cases, but that is way roles have developed’ (P20).* There was optimism that new ACPs would be better supported in practice than non-medical consultants, largely due to the current shared concern of trust staff to meet pressing workforce challenges.

A director of nursing talked of her experiences of the nurse consultant role

*What makes it work well is probably having it more as a trust wide type of a role. I think where it is set within clinical services it tends to be in a silo and we lose the benefit (P19)*

In the future, ACPs should go through -

*… a process of carving out .. clinical time and making sure that their priorities are clear*

*…. Getting them linked up with other clinical leads corporately and across the services is key (P19)*

Another director of nursing described the situation in his trust, where relatively high numbers of nurse consultant roles were established, but this was carried out in an unplanned manner ‘..*it was not a strategic development’ (P17),* thus limiting the effectiveness of these posts.

Non-medical prescribing was one advanced skill set that provided some learning from the viewpoint of participants, as well as being a skill set often part of ACP practice. This had, in some trusts, been a development that was not centrally planned, with issues concerning self- selection of candidates to do the training, a loss of qualified prescribers to other roles soon after qualifying (P9; P15) and that *‘..we’ve trained people in the past and then haven’t actually used those skills. It’s been pointless.......’ (P19).* Another challenge had been the occasional difficulty in persuading consultant medical staff to act as supervisor for trainee non-medical prescribers. One trust had now decided *‘to develop non-medical prescribing roles focusing on particular types of service with particular need … rather than being randomly spread...’* (P15). It was felt that this learning should be applied in planning new ACP roles.

The recent introduction of nursing associates into one trust had indicated the importance of communicating about the purpose of a new role - *‘Not just around informing staff about the changes and the new roles, but also our patient groups. Are they understanding the difference?’* (P11).

### 4. Pre-requisites for development

Most participants cited Board level and Directorate managerial and clinical leads as being those roles most influential in decision making about ACPs. A director of nursing was adamant that *‘it has to come from the top’* (P19). Otherwise, there were few examples given of groups outside a trust that might have particular powers to influence, one example being a *‘..workforce subcommittee in the STP’* (P4).

Before anything else, trusts have to know *’what is needed*’ (P9), to have spent time ‘….*just identifying the need to begin with …. identifying the problem’ (*P5). The various professions and management ‘*need to have a shared vision’* (P10) that is clear as to the ACP role and the contribution that it will/can make. This opinion was endorsed by all in the director of nursing group, as was the view that the introduction of ACP roles should be framed in a positive way, rather than negatively, in particular that ACPs are not there simply because the trust could not employ doctors - ‘*we have got to get the messaging right’* (P1), *‘we aren’t training you to fill gaps in other professions, this is a unique professional role’* (P7) and that ‘*this brings a real opportunity to properly improve and provide the best possible care.’*(P9)

Once a plan was in place, then the next prerequisite was to have staff able to become ACPs. All participants believed that there were some individuals currently employed in services who could progress into ACP training and the role fairly quickly. A senior psychiatrist commented that

*I could identify people right now who are in relatively junior positions, who I would say “that person would be great in one of those roles.” Give them the right training and whatever and experience. (P4)*

However, a common caveat was that although there may be some suitable staff currently, *‘…. I just don’t think there are many of them’* (P18) and ‘[We are] *not tripping over nurses ready to train to be an ACP’* (P15) (see Theme 5 below).

The lead for a university based ACP course, specifically for mental health practitioners, described further prerequisites for candidates, that they ‘*need to have a massive amount of support from their organisation’* (P7) and an ongoing supervisory relationship for the whole course period, provided by a medical or non-medical consultant or an ACP.

### 5. Challenges

Identification of the creation of ACP roles based on a plan to meet a defined service need was seen as currently problematic. The reality in some trusts was that training had started in a haphazard manner - ‘… *3 people currently in training, but what are we doing with them? No planning!'* (P8).

The challenge of not having enough staff ready to move into ACP training and posts, (as identified in Theme 4 above), was exacerbated, in the view of the Royal College of Nursing Mental Health Lead by there being *‘a large gap in clinical and educational preparation to enable nurses to be ready to complete a Masters ACP course’* (P13). There was also a risk that the development of new ACP roles, without suitable safeguards, could perpetuate the major underrepresentation of black and minority ethnic nurses in senior NHS roles (P13).

A related challenge was from the linked issues of cost and funding. A director of nursing pointed out that a likely consequence of creating new, relatively highly graded posts was the loss of other posts (P1). The question of what grading would be applied was seen by some participants as significant, in terms of affordability, and there were different expectations as to what grading might be, varying between band 7 and band 8B on the Agenda for Change pay scale (P11).

There were some perceived challenges as to who would provide mentorship and supervision to ACPs (P11). However, this issue was not seen as unresolvable - *'Supervision can be a challenge, but this can be solved'* (P8). Use of peer group supervision was one approach that was mentioned several times and an HEE commissioned supervision reflection group for trainee ACPs was seen as having been effective in supporting staff and reducing dropouts from the ACP course (P20). Medical staff would also play a role, particularly in supervising those ACP trainees who were completing non-medical prescribing training as part of the course, although caution was expressed by one participant due to past experiences of there being ‘*…issues re: medical sign up' (P10)*

A further challenge arose from the requirement to review all staff currently perceived or named as being in an ACP role. One trust was reported as having *‘numbers of staff with fancy titles, including ‘advanced’ who have not done the course’ (P15)*. A specific concern was that ‘*We don’t want to knock those that are working as clinical specialists, but they are unlikely to match ACP criteria’ (P14).* Furthermore, there could be financial challenges should many such posts ultimately require extensive additional training and regrading.

The nature of the ACP training was cited as potentially challenging in two ways. Firstly, academic requirements may be too difficult for some practitioners with no recent academic experience (P7). Secondly, the course itself might be too focused on physical health care, rather than on mental health (P18), with a director of nursing noting that current courses typically provide non-medical prescribing training, which may be unsuitable for some mental health ACPs, whereas there may be a need for psychological treatment skills training instead (P20).

### 6. Opportunities

Participants perceived many opportunities for ACP roles to be developed. Sometimes this was expressed in general terms, with the director of nursing group agreeing unanimously that opportunities existed, for both nurses and AHPs, in both mental health and community health services. Specific suggestions by individuals included roles in crisis/home treatment (P19), substance misuse (P5), Asperger’s Syndrome (P20), community older people’s (P11) services, working as Approved/Responsible Clinicians under the Mental Health Act (P8) and in intermediate care teams, where *‘it could be a nurse, it could be a physio, it could be an OT.’* (P18)

A workforce development lead from a trust that was further along than other trusts with plans for ACPs, described their ambition to develop ACP nurses in community mental health teams who would have specialist clinical knowledge of mental health issues, good understanding of the interface with physical health care issues and who would be non-medical prescribers running run clinics with a broad remit, so that service users/patients could be saved from ‘*seeing a junior doctor, consultant and a care coordinator for a review and having as many as three appointments’* (P9).

It was reported that the next mental health ACP course to run at a local university will have several pharmacists attending for the first time (P7), indicating a perception by at least some employers of ACP opportunities for that profession. An opportunity might also exist for speedier implementation of ACP roles by targeting staff groups requiring less development to be ready, for example *‘district nurses who previously trained as ‘nurse practitioners’ (P15)*. More generally, community health services were reported as being *‘more advanced in developing new roles, less medically and more nursing /AHP led’* (P15). An AHP Lead commented that

*‘I absolutely think there are AHPs working .… using skills that you would associate with advanced practice. I don’t think they would recognise that in themselves, but I think that’s just because they are dreadfully modest.’* (P18)

Suggestions were made that geographical factors may influence opportunities for new ACP roles, with some vicinities having greater need and more possible opportunities (P1; P10). This was particularly mentioned by trusts which run additional services outside of London.

Shortages of medical staff were cited as providing opportunities (P12) – *‘… medics are leaving to retirement – it provides gaps to fill ...’* (P2). There was some caution around how this should be framed and communicated (as in Theme 4 above) and there was some unease expressed as to ACPs covering trainee doctor activities*, with ‘risks of negative ‘stand in’ connotations*’(P7), and a lack of congruence with ACPs being expected to be work at a higher level of practice.

A different type of opportunity was seen as arising from the need to make staying in healthcare professions more attractive, particularly in those that with shortages currently, such as nursing. As in theme 2 above, several participants noted that most non-medical professions have little opportunity to develop a clinically focused career beyond a certain grade and can thereafter gain promotion only into more managerial roles – *‘choice of a low grade or going into management’*(P15), *‘…once people get beyond band six … that’s a waste…a massive waste’* (P4). Trusts are, therefore, likely to wish to support the development of ACP roles as part of a more appealing career structure (P10).

Sometimes, although a clinical area might be seen as potentially being able to use ACPs beneficially, this might not be a priority due to other circumstances

*….one that springs to mind instantly is Community Health Specialist Services, but they are quite well off in terms of professionals and leadership ….* (P19)

In this participant’s trust, a comparison was made with another clinical area, the acute mental health pathway, where

*... we struggle with recruitment and medical practitioners …… So that would be good, to strengthen the clinical leadership there (P19)*

Opportunities, as above, were typically framed as being generic, i.e. open to any profession or for nurses and AHPs. Psychologists and psychotherapists were rarely specifically mentioned. When specifically asked about such roles, some noted that their current grading might equate with ACPs pay in the future and that promotion to a relatively senior grade in these professions was not as linked to having to take up managerial roles as for nurses and AHPs. One participant wondered whether there would be any interest in taking up an ACP role in this context (20).

### 7. Future support

In the context of little pre-existing knowledge regarding the ACP multi-professional framework

amongst the staff interviewed, it was seen as important by some that there was more active communication with trusts in the future regarding this important development, *‘repetitive communications’* (P2) were essential. The most important change that was needed, mentioned by several participants, was a change of attitude to workforce design in their trusts, where they would be ‘*.. challenging ourselves to think completely differently. “Why do we need that? What can we do differently?”’ (P19) and ‘I really think with blue sky thinking we could turn it on its head’ (P11)*

There was discussion with the director of nursing group, and in several interviews, as to the balance to be maintained in workforce planning between local ownership (geographically or by speciality/service line) and the advantages of adopting a whole trust approach. There was a tendency in some trusts for service areas to *‘go off in tangents’* and *‘we do different things in different service lines ... rather than thinking programmatically*’ (P15), making overall management of workforce development difficult. A senior manager thought that there should be a process of local identification of a problem and then having a trust structure and framework within which to address the problem (P5). Similarly, a director of nursing expressed the view that –

*I think there needs to be both, doesn’t it? Have a trust wide approach to things, but being able to innovate within the service line (P19)*

A workforce lead from one trust described the early stages of an innovative approach to workforce planning, whereby a facilitator worked with a range of staff from a service line, encouraging them to start off with a blank canvas, to identify *‘where they really would aspire to be’* (P11) and then narrow down to practicalities, such as funding, later. More generally, the value of having someone external to a service coming in to facilitate any workforce review was noted, as *‘…sometimes it may be that other people can come along and see things that you can’t.’ (P4).* There was general agreement that to get workforce planning to the right place *‘will need some infrastructure’*(P20).

The need to develop staff in a planned, long term fashion was recognized by most participants, a *‘..need for workforce development to develop staff towards being at a point where they can access and successfully complete the course.’(P7).* This was in the context of a relatively high ACP course dropout rate (P7). For some promising individuals it would be better to take an iterative approach to development, for example, by gradually expanding the scope of their role, with relevant training attached, as *‘you can overwhelm people by putting them into a completely new space’ (P20).* For staff who already had taken some relevant modular training, for example the non-medical prescribing course, the question to address would be *“so what sort of top up?”* was required and what might be the best route forward for those individuals. It was suggested that different professions might have different needs, for example it would be useful *‘..to have something bespoke for mental health AHPs, who might be aspiring to an ACP route, but would need something in between’ (P18).* Although identifying funding for training and support might be challenging, apprenticeship pathways could potentially be developed to help support this (P15).

Comments were made that it would be important for trusts to delivering visible activities that would encourage ACP development, as well as supporting long term development opportunities - *‘We need to progress specific posts ….it’s more tangible’(P16*). In particular, having established and visible role models would be of value in itself. Opportunities should be used to share good practice and case studies, ‘*a lot of people will see things and say ‘why aren’t we doing that?’’(P2*). Such discussions could happen between trusts, as well as internally *– ‘discussing challenges and possible solutions would be good’ (P2)*

The idea of having evaluation built into the process of creating new ACP roles was widely supported, *‘… it would be understanding exactly what would we be expecting to see from these individuals and having some form of framework to actively evaluate this’(P9).* This should include *‘focus groups and work with patients and staff about how they feel that role is working’ (P11).* Quantitative measures could include waiting times, length of stay and incidents relating to physical health (P18), with a caveat that if there are very small numbers of ACPs, using such measures might be unrealistic*.*

**Discussion**

This study provides information as to how issues concerning ACP development are perceived by a sample of senior staff from a group of NHS trusts in London. The identified themes provide a framework to convey the issues seen as important by participants.

#### Understanding of the role and framework

Responses clearly suggest that, to date, there has been relatively little knowledge of Health Education England’s ACP multi professional framework within trusts and that they are in very early stages of thinking about how to ACP roles and for what purpose. The general lack of detailed understanding as to requirements for ACPs echo findings from international research, where lack of role clarity has been commonly identified as a major challenge to the development of similar roles (Lowe et al 2012; Jokiniemi et al 2012). A study of mental health nurse consultants in England has also identified similar issues (Brimblecombe et al 2019). Although the purpose of the current study was to understand and not influence, one unplanned outcome was that the process of this study appeared to have inadvertently raised the profile of the ACP framework, according to informal feedback received, particularly from the director of nursing group*.*

#### Attitudes

The idea that the attitudes of various groups might influence the creation and sustainability of ACP roles was widely asserted. Much of the discussion focused on medical attitudes and perceptions were varied, although most saw a warming of attitude toward new advanced non- medical roles compared to the past. Even when there were negative attitudes experienced, they were seen as being in small enclaves and did not reflect the general state of affairs. Undoubtedly, engagement from and support from medical staff with new roles is of significance and there has been a history of objections to new roles for other professions that cut across traditional work boundaries, for example for non-medical prescribing (British Medical Journal 2005) and non-medical responsible clinician roles under the mental health act (Oates et al 2018).

The issue of genericism, proved to be a complex one, with there being support for the idea that old role barriers should breakdown and perhaps overlap more, but some participants were uncomfortable at any loss of professional identity or they were concerned that potential ACPs may have such a concern.

The attitudes of service users/patients were speculated upon and it was noted that various roles that replace some aspects of medical activities, e.g. practice nurses, are now well established in the NHS. The importance of understanding roles clearly was seen as applying as much to service users/ patients as to service colleagues, and indicates a need for steps to be taken so that recipients of care receive suitable assurance regarding ACPs being suitably qualified and experienced.

Overall, much is left unknown as to attitudes towards ACP roles, from many groups, including patients/service users and front line clinical staff, particularly from those professions not heard from in this study, e.g. psychologists.

*Learning from current ACP and other new roles*

In the absence of having experience of working with established ACPs, participants were able to consider other relatively new roles and suggest possible learning for ACP introduction from them. Generally, new roles were seen as having had difficulties in becoming established, for a range of reasons, including attitudinal ones (as above). Studies of patterns of deployment of nurse consultants and of nonmedical prescribers in mental health services suggest marked differences between trust as to numbers of and, possibly, enthusiasm for such roles (Brimblecombe et al 2019; Dobel-Ober and Brimblecombe 2016). In both cases, a lack of mental health service specific empirical evidence of effectiveness was suggested as one reason for such variability. Such a lack of speciality specific research evidence may also undermine attempts to spread ACP roles.

#### Pre-requisites for development

Participants largely had had a common understanding of prerequisites for commencing ACP development, e.g. active board level support, clear information as to the nature and requirements of the role, engagement with staff to produce a shared vision, careful assessment of need and finding good candidates for such roles, although many of these features were not yet in place in trusts. However, the very active engagement of director of nursing in this study does suggest strong interest in the potential of ACPs and the enthusiasm shown for how they could be applied in future practice may be interpreted as demonstrating energy for change in trusts at Board level.

#### Challenges

Challenges to introducing effective ACP roles were identified from previous and current experiences. These were largely practical issues related to workforce planning and workforce development processes, resource issues and concerns about dealing with sensitive staff issues such as grading. The number of processes to manage does suggest a significant demand on trust time is required, including workforce planning, human resources, professional leadership and educational lead time, as well as a high level of commitment to be able to work through such a range of challenges.

#### Opportunities

The most striking characteristic of suggestions as to which clinical areas would benefit most from, or be most suitable for, ACP roles was the diffuse nature of answers received. Very few areas were cited more than once. This may be an artefact of no detailed work yet having taken place in trusts on this issue yet, or that the ACP role is not understood clearly enough to make judgements accurately or alternatively, that the role offers such wide possibilities that it is understandable that such diffuse examples are given.

Another type of opportunity frequently discussed was how to identify less challenging ways to develop ACP roles, particularly by finding staff who might be seen as someway along an ACP developmental pathway already. However, this approach could potentially lead to some tension between the two priorities of, firstly, having good ACP candidates available and, secondly, only developing ACP roles where they are most needed.

#### Limitations

The original time table for this study was that it would take place after the HEE/Ipsos MORI National Survey of ACPs was complete, so as to use survey data to focus the qualitative study. A delay in the release of the Census meant this was not possible and created an overlap between the two processes, somewhat limiting time available for both. Consequently, the semi structured questionnaire that was used in the qualitative survey was not informed by any Census data.

A major limitation to this study was that the two participating trusts were still in the early stages of developing ACP roles and consequently were not able to provide comments on implementation based on their experience. There was a lack of existing ACPs about to talk about their experiences and to be identified as examples of good practice. Whether existing senior clinical posts meet most or some of the criteria for ACP roles was not clear, as no formal process of evaluation of the ACP criteria was in place. This position seems common across London’s mental health Trusts.

The limited number of participants in a qualitative study such as this cannot produce generalizable data regarding the views of staff in London Trusts, although there was representation of most relevant senior trust roles and the influential role of director of nursing was well represented, justified by its influence over workforce development, leadership of the largest workforce, nursing, and, typically, having Board level responsibility for AHPs. However, the professional background of participants was undoubtedly heavily skewed towards nursing.

Ideally, all interviews would have been face-to-face and recorded fully and transcribed. However, time schedules, and availability and preferences of participants meant that this was not possible in many cases. During interviews, the thoughts expressed by participants were fed back to them by the interviewer to try and ensure that their meaning had been understood, but there was not a formal process of sharing transcribed or handwritten notes post interview.

The study was commissioned to explore staff understandings of issues regarding the development of ACP roles and therefore service user/patient views and experiences were not included. Participants were selected from staff roles most likely to be influential on trust wide workforce processes, so ‘frontline’ staff were not selected. These criteria mean that two very important perspectives on ACP roles are not included here.

**Conclusions**

This brief study has provided an insight into views as to factors potentially influencing the development of ACP roles in London trusts providing mental health and community healthcare services. There was general enthusiasm for the potential of ACPs, from a range of professions, to make a major contribution to both mental health and community health services and there was no single profession or area of practice seen as being uniquely suitable for such a role. Generally, the view was held that the medical profession was more supportive of such roles than in the past, although this was still a topic that needed careful consideration. Overall, it was felt that long term developmental programs were needed to support staff to be ready for ACP roles in the future

#### Implications for future action

Although findings from a small qualitative study cannot be widely generalizable, the themes derived from the participants in this study echo many of those from recent research undertaken in the UK and other countries and tentatively suggest a number of actions to support the successful introduction of ACP roles, including more engagement with trusts regarding the NHS ACP multi-professional framework, active engagement within trusts between clinical professions and service user/patient representatives regarding new roles, sharing learning across organisations and developing a standardised approach to evaluate the effectiveness of ACP posts.

# Appendix 3: A Qualitative Study into Stakeholders’ and Advanced Clinical Practitioners’ (ACPs’) Views and Experiences of Advanced Clinical Practice in Acute and Community NHS Trusts in London

Authors:

Dr Linda Collins l.collins@sgul.kingston.ac.uk

Professor Helen T Allan h.allan@mdx.ac.uk

Centre for Critical Research in Nursing & Midwifery

Department of Adult, Child & Midwifery

Middlesex University

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**Introduction**

The problems in delivering quality health services with a workforce fit for purpose are shared by health and care providers across the capital (Allan, 2019). Other specific drivers which shape workforce development in the UK specifically include:

* The priorities set out in the 2019 NHS Long Term Plan (<https://www.health.org.uk/the-nhs-long-term-plan>);
* Increasing the attractiveness of the health care professions and increasing health care student numbers
* Increasing placement expansion
* Implementing professional standards across the health professions
* Delivering student attrition and improving retention in nursing and midwifery (REPAiR <https://www.hee.nhs.uk/our-work/reducing-pre-registration-attrition-improving-retention>)
* Improving retention from early career to retirement.

Advanced clinical practice and the recruitment and training/education of ACPs are thus part of a wider workforce development strategy in England (HEE, 2017):

“*securing the supply of staff that we need to deliver high quality care; training, educating and investing in the workforce to give new and current staff the professional flexibility and adaptability to meet the*

*needs of patients; providing career pathways for all staff rather than just 'jobs'” (HEE, 2017).*

In 2017 HEE, in collaboration with a range of professional colleges, published a framework that described parameters for advanced clinical practice in the NHS in England, the ‘Multi-professional framework for advanced clinical practice in England’. This framework built on previous work within the NHS in the UK and international approaches to advanced clinical practice.

### What is Advanced Clinical Practice?

In England, HEE which is responsible for workforce planning and training is supporting the development of ACP roles in all types of professional groups (nurses, midwives, allied health professionals and health scientists). In a joint statement with NHS Improvement, HEE has defined advanced clinical practice as “*delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master’s level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence*.”(HEE, 2018)

Advanced Clinical Practice is defined as that which is:

*‘…delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master’s level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence.*

*Advanced clinical practice embodies the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people’s experience and improve outcomes.….’ (HEE 2017)*

### International Developments in Advanced Clinical Practice

Specialist and advanced clinical practice roles have been well established in the USA (Kleinpell et al., 2012) and Canada (Bryant-Lukosius, 2004) for over 40 years. These roles are well evaluated by patients (Begley et al., 2013) although there continues to be confusion among patients about titles and what the role encompasses between employers. Despite the UK’s lack of real progress in this area across the health care professions, ACPs practicing at a recognised advanced level are seen as potentially crucial to developing the NHS workforce fit for the future (Brook & Rushforth, 2011). The current work on advanced clinical practice builds on earlier work by the UKCC in this field 1996-1998 on higher levels of practice, advanced and specialist practice and the post-registration education and practice (PREP) framework (Waller, 1998). An example of this early work is by Allan & Barber (2004; 2005) who reported fertility nurses undertaking higher levels of clinical practice roles such as sperm aspiration, embryo transfer and egg collection in In Vitro Fertilisation in private and NHS settings. However, this early work was never fully evaluated nor implemented within regulatory frameworks and is only in late 2000s that NHS trusts in England are including ACPs in work force planning and funding posts in advanced clinical practice.

### Evidence for ACP

It is evident that the nursing profession have been delivering advanced clinical practice within the capacity of specialist nursing roles, but this has been overshadowed by the professional title of clinical nurse specialist (Leary et al. 2017). However, ACP visibility among allied healthcare professionals (AHP) has also been classified as clinical specialist, but the evidence of their advanced practice has been merited on leadership skills and practice (McGowan et al. 2019).There are a small number of systematic reviews of advanced nurse practitioner interventions compared to medical interventions across a range of specialties. The results are not compelling on measures of clinical outcomes or patient satisfaction (Newhouse et al 2011; Donald et al 2013; Morilla-Herrera 2016). These reviews do show that confusion is still common as to the terminology used to describe these advanced clinical practice roles (Lowe et al 2012; Jokiniemi et al 2012). There are again a small number of evaluations of physiotherapists in advanced clinical practice posts (Desmeules et al., 2012; Fennelley et al., 2017).

### A National and Regional Agenda for ACP: Census of ACP in England 2019

Following the publication of the HEE professional framework for advanced clinical practice (2018) and to address the lack of evidence around ACPs’ interventions, what contribution ACPs make to health improvement and what contribution ACPs could make in England to a workforce for the future, HEE have commissioned IPSOS MORI to conduct a national census of NHS trusts in England. The census was designed to provide a snapshot of the spread of advanced clinical practice roles and associated issues. The census of ACPs went live on the 27th of August 2019 (due to report early 2020). To complement this national work, the London HEE team commissioned three higher education institutions (HEIs) to undertake qualitative evaluations - study 1. Drennan et al., study 2. Brimblecombe, study 3. Allan & Collins - concerned with factors influencing the development of ACPs. The evaluation questions addressed were:

1. What has influenced the development of advanced clinical practice roles?
2. To what extent are NHS acute, community and emergency services employing and deploying ACPs?
3. What are the factors influencing the success or otherwise in introducing and sustaining ACPs in the workforce?
4. Is there documentary or published evidence of the value, or otherwise, of advanced clinical practice roles and of patient perceptions of ACPs?

IPSOS Mori, a market research company, developed the electronic survey. The survey was shared with NHS organisations who employed ACP leads, educational leads, recruitment officers and ACPs. Subsequently, interviews were carried out to inform the survey data. Five higher education institutions (HEIs) conducted the interviews across greater London to find out what was in place to support ACPs’ education and the future development for existing and new ACPs. In total, there were eight interview questions that the HEIs used as part of the interview process.

For those NHS trusts in North London, Middlesex was commissioned by HEE to act as Census Lead and undertake qualitative evaluative interviews with stakeholders including ACPs. Ethical approval was granted by the Middlesex University School of health and education ethics sub-committee on the 7th of October 2019 and four individual and three joint interviews (10 participants in total) were conducted. We interviewed in five acute north London trusts which reflect acute general hospital trusts and specialist acute trusts. Participants’ positions within trusts are shown below:

* Assistant Chief Nurse
* Head of practice learning
* Director of children’s nursing
* Education Business Manager
* Commissioning lead
* Head of Multi-professional Development
* Chief Nurse
* Head of Education (Academic and Apprentices)
* Advanced Clinical Practitioner Nursing
* Advanced Clinical Practitioner Dietetics

Interviews were conducted either face-to-face or via video/telephone depending on participants’ availability. They were audio recorded and transcribed verbatim by an administrator. Transcripts were analysed thematically; emerging themes were shared between the two authors. The findings presented in this report highlight similarities in responses from stakeholders across the five north London NHS trusts. The experiences reported by the two ACPs deepen our understanding of the facilitators and barriers to introducing ACPs into the NHS workforce in acute trusts in London.

**Findings**

We present these findings in three sections:

1. Stakeholder views and experiences of ACPs in four themes:
* Why introduce ACPs?
* Spread of ACPs
* Factors supporting the development, maintenance and growth of ACPs
* Factors inhibiting the development, maintenance and growth of ACPs
1. ACPs’ views and experiences of advanced clinical practice and their roles within NHS trusts
2. Potential actions for the future

#### Stakeholder views and experiences of ACPs

#### Why introduce ACPs

The main reason to having introduced ACPs given by all stakeholders in senior positions in the five trusts was to address shortage in recruiting and retaining junior doctors:

*“Primarily help source the reduction of junior doctors”*

*“Service need where there is difficulty recruiting medics”*

*“[address] waiting targets”*

One stakeholder said they used ACPs to support existing teams; not using them to introduce new services or reconfigure services. Some of the participants said they had a long history of employing ACPs “*Well established ACPs*” and argued that they considered “*a lot of specialist nurses in sub-specialty roles”* performing at advanced level. They considered these ACPs brought a clinical link between surgical and medical teams and could assist in developing challenging workforce development issues.

Other responses to why these stakeholders had employed ACPs were that ACPs:

* Had potential for workforce development
* Offered an opportunity to enhance the quality of care for patients and their families
* Offered opportunities for staff to enhance skills, develop professionally and [put together a coherent] career pathway
* Had an ability to enhance the workforce and used skills in the best way possible
* Offered a career pathway with structured educational framework.

In one specialist trust, stakeholders said ACPs were highly valued by patients and their practice had built on specialist nursing roles.

#### Spread of ACPs

Our sample was not representative of all trusts as it included two specialist acute hospital trusts. These trusts both had a history of employing nurse specialists (complex gastroenterology, radiology, neonatal care, children’s ambulatory and short episodic care, community, oncology) and specialist physiotherapists (adult musculoskeletal) and nurse consultants. Stakeholders saw ACPs as complementing these strata of the nursing and AHP (albeit only physiotherapists were cited) workforce. One of the acute general trusts had employed an ACP in neonatal unit for 10 years and in their emergency department for three years. This trust said they intended to use ACPs in the community where ACPs would be the first point of contact in GP surgeries for patients. Ambulatory care was another priority in training and employing ACPs.

Stakeholders used specialist nurses in these areas to support junior doctors for x-rays, blood transfusions, prescriptions and teaching. While stakeholders felt that advanced clinical practice in their trusts had started in nursing, ACPs would soon be introduced into allied health professions. For one trust, being recognised as an ACP was seen as a route for career development for specialist nurses in post who were already looking for masters programmes.

All trusts felt that ACPs ( mainly in nursing but including the physiotherapy and dietetics ACPs) had developed within services to fill gaps in service. This was described as “*spreading organically due to service needs and demands”*. And most participants felt that there was a need for more ACPs within their trusts across health care professions as they could see benefits for the trust in terms of patient satisfaction and retaining skilled experienced HCPs in the trust.

#### Factors Supporting the Development, Maintenance and Growth of ACPs

There were some positive statements about the impact of ACPs and advanced clinical practice on patient care:

*“ACPs have stayed in their role in the surgical area and seen as a progression route for them”*

*“Enhance quality and continuity of care”*

*“Provide an additional enhanced level of care”*

*“The impact has been positive in the emergency department”*

*“Impact on the team is noticed with valuing skills and contributions of ACPs. Valuing skills of all ACP team members”*

*“They are an integral part of the work force in the emergency department, musculoskeletal department and respiratory”*

*“ACPs are taking on more responsibility”*

*“Helping increase capacity to see and treat patients”*

*“A recent presentation done by gynaecology ACPs and are part of doctors training in the clinical speciality”*

*“Has enhanced the multidisciplinary team working*”

Participants in one trust said their trust was “*seeing the value it brings the organisation”* and were able to describe their perceptions of what that value might be although none of them had evaluated their ACP workforce but aspired to (see below in potential actions). The factors which stakeholders we interviewed felt were supportive of developing, maintaining and growing their ACP workforce included:

* The leadership, practical and research skills of ACPs. ACPs are able to see and treat patients independently in the community or hospital settings.
* Growing nursing population with potential to develop as ACPs and in some trusts a view that emerging AHP cohorts were also emerging as potential ACPs.
* Good for patient quality of care particularly in the emergency department, musculoskeletal service and podiatry service.

*“ACPs were able to build relationships with patients as they had more time than junior doctors and provided continuity of care”*

“*Patients have found it useful having a prompt response from ACPs*.”

*“Patients feel supported and [had] good input from someone who is familiar with them with continuity of care”*

*“Patients and families are used to seeing ACPs”*

All those interviewed could see that the ACPs employed in their trust enabled them to build a workforce with “*the right people, right skills and right place”*. Another perceived value of ACPs was that stakeholders believed they “*Bridged gaps in knowledge depending on area of expertise”* in existing teams. This was particularly emphasised as the case in emergency care. And where ACPs had been introduced and were seen as of value in other areas (see above), plans were in place to expand ACPs to other priority areas of service delivery in trusts. To “*continue to expand the role of ACPs” in:*

* care of frail elderly
* musculoskeletal first point of contact practitioners
* surgery, ITU and orthopaedics.

Lastly, stakeholders felt that they could learn from other trusts across London and saw that HEE could assist in dissemination of good practice:

*“We could learn from other organisations that are ahead with ACPs”*

*“Understanding the art of the possible and being inspired by other organisations”*

#### Factors Inhibiting the Development, Maintenance and Growth of ACPs

Of course, there were challenges to the development, maintenance and growth of ACPs in these five trusts. Largely these originated in the confusion and lack of awareness generally about advanced clinical practice and the roles of ACPs working within existing teams and across team boundaries (musculoskeletal, emergency care were cited as examples). While the advantages were described for retaining skilled staff in trusts through ACP career development, it was felt that these careers had not been mapped out sufficiently in workforce plans. In one trust, a significant project was happening with the strategic lead and business partners for people working in the operating department as part of a career map scheme. The main areas which inhibited advanced levels of practice and ACPs themselves were i) ensuring commitment across the trust to developing advanced clinical practice and ii) evaluating ACPs’ impact on service delivery.

#### A Commitment to Advanced Clinical Practice and Employing ACPs Throughout the Trust:

While a commitment from the trust Board might be in place, an operational strategy was not in place in all the trusts; there needed to be more detail about how these roles will move forward:

*“We don’t all fully understand the opportunities of ACPs, as we have not put a focus on it and explored the art of the possible”*

*“Senior executive engagement and support with the chief nurse, chief operating officer and chief medical officer has significantly helped push the culture through the organisation”*

Support from all staff including senior medical staff and senior nursing staff particularly support for non-medical AHPs in developing ACP roles. They felt they needed buy-infrom:

*“… senior level, appreciating what practitioners bring to the trust”*

*“medical colleagues who will do clinical supervision”*

*“education team”*

Support from senior clinical colleagues in multi professional[[1]](#footnote-1) teams was key to developing ACPs because these senior clinicians would supervise ACPs initially:

*“The difficulties have been ensuring they have senior supervision support in the workplace”*

*“The supervisory element is a challenge”*

Challenges were described in working together with pharmacy teams and other health care professions. One method to address this was to raise awareness of potential of ACPs for developing the workforce. Sessions had been introduced in one trust to begin to address this. Support and governance would assist in increasing commitment described above. And of course, some individual senior clinical staff were supportive:

*“The medical consultant workforce showing support, understanding and interest has helped”*

#### Evaluating the Impact of ACPs:

Stakeholders felt there was as a need for a clear set of evaluation criteria as they were unsure of the financial risks and felt that good clear governance structures to support roles were missing because of the largely organic way these ACP roles had been introduced and initially funded. Evaluations of ACPs were few and ad hoc:

*“The surgical area has done some evaluations.”*

*“Feedback is obtained from clinical nurse specialists”*

*“There has not been a formal evaluation on perceptions”*

*“That [effect of ACPs] is unknown”*

In one trust, the case for the financial commitment from the trust was seen to be underplayed:

*“Lack of understanding how long it takes to get someone to practice independently to the standard and level required”*

And other mechanisms for financing these new posts were described largely due to the absence of *“a business case for employing and developing an ACP”* and a view that *“Finances are a limiting factor”.* A particular limiting factor is “*money for backfill and salaries”.*

The stakeholders said that managers had to ensure “*Protected time during the training”.* It is clear that some innovative methods to finance ACPs and their training and support have been used in these trusts:

*“It’s great to have the support from HEE financially as that has enabled people to be put on courses and release staff as well”*

*“Without the financial support, there wouldn’t have been many training places”*

*“We have used our CPD money to also support and supervise those in ACP training as well”*

*“We have also helped ACPs train with a modular approach rather than a two-year programme”*

*“Some of our ACPs are being paid through the medical rota and helped with workforce gaps and reduced cost with trust grade doctors”*

#### ACPs’ views and experiences of advanced clinical practice and their roles within NHS trusts

The two ACPs interviews are presented as case studies in Box 1 and 2. The main commonalities across both interviews in their experiences which are relevant in light of the stakeholders’ views above are:

* Both these ACPs were in the early stages of training and had some issues with their training, particularly the dietician ACP
* Sole ACP in the unit but support from across the trust from other ACPs
	+ Reported resistance to their ACP role from colleagues outside their immediate teams and juniors they worked with
	+ Personal drive and commitment to career and developing the service for patients and families
* Developed ACP role (prior to acquiring funding) from specialist practice role
* Buy-in from managers, the trust Board crucial to developing the ACP role
	+ Funding for training came after started in role
	+ Active resistance from medical colleagues and misperceptions of ACP role
* Evaluation in trust to identify impact of role

The outstanding difference of course is in the education/training for ACPs which is designed for nurses rather than AHPs. There is some frustration here for the AHP/ACP but the drive and orientation to developing a career, and resilience perhaps, means this individual has been able to cope with this inhibiting factor.

Box 1

ACP A: Nursing

This ACP had been in current role for 5 months working as a respiratory ACP within a specialist tertiary centre. It is a new role to set up what could be offered as part of the respiratory service. There are very few respiratory ACPs in the country. The role is in its infancy with could be offered as part of the role in the future.

A nurse by background and dual trained. Experienced nurse with over 10 years qualified Two undergraduate degrees and in the process of doing a master’s in advanced clinical practice with partner university.

Had various specialist titles and roles before becoming an ACP and felt that there were limitations within the specialist nursing roles such as prescribing. It’s fortuitous that ACP roles have come about due to medical shortages. Started the role and then was later able to apply for funding from HEE to do the ACP training. Funded by HEE for the first 2 years. The ACP position is part funded from the doctors pay roll.

Advanced clinical practiced has been well established within the employing trust and have seen the impact ACPs could have on the patient journey. There has been some confusion about what the role is and can offer. Some consultants have embraced the ACP role. But all stakeholders in his team and he himself are clear that ACPs/nurses provide advanced clinical practice and are not *mini doctors*. Some medical colleagues not working closely with the ACP question the correctness of decisions and prescriptions of the ACPs. It has been said by colleagues that should not do certain skills or activities. Overall this ACP feels there are some positive responses towards the role.

Evaluation work is underway of his service to show impact ACPs are having in the trust and service:

* Code the work ACPs do.
* Quantify the number or how many patients ACPs see.

There is buy-in from management which supports the development of the role and an ACP lead who checks how things are going in the role. Importantly, there is a network of ACPs with the inclusion of Allied Health Professionals in the trust which offers peer support.

HEE need to put in clear guidance for employers as to what their responsibilities are. Guidance on what ACPs can and cannot do after they finish the course.

Box 2

ACP B: Dietetics

Clinical lead in dietetics and employed as ACP in trust for 3 years. Completed the first module in prescribing and is the first AHP prescriber at trust. Currently works in clinical service as a band 7 specialist dietician dealing with managing own patient case load. Qualified 10 years ago and became an ACP through specialist practice route. Always felt there was the lack of promotion options/pathways for AHPs.

Education/training as ACP: competed prescribing module at xxx university but it was designed for nurses and therefore It lacked basic pharmacology knowledge and also knowledge of patient population. i.e. the course presumed a nursing U/G grounding in anatomy and physiology, health and illness and medicines management. Was only AHP among a cohort of nurses. Feels strongly there needs to be a curriculum which is designed for AHPs. There has been opportunity to accredit prior learning (APL) from some of her dietician education into further modules on her ACP course. Some aspects of the course were not meeting her learning needs.

HEE should tailor curriculum and ensure fair support across ACP students as all study was done in own personal time. Very little understanding of what dieticians do generally and even less as ACPs.

Support from senior trust colleagues not in immediate team, is a big issue, which this ACP struggled with. Immediate seniors who have recently left, i.e. band 8s, were not that keen on her developing on a different path to them. Those seniors had developed through specialist practice rather than ACP route. Support from immediate team members who are junior and keen to progress themselves was more evident. Support from immediate medical lead is excellent although some do not know what an ACP is. There is good support from trust’s education team and from other ACPs. Feels personal advanced communication skills help to manage resistance towards the ACP role within the team and wider within the service.

#### Potential action to take ACPs forward and embed in NHS trusts’ workforce

The stakeholders and ACPs we interviewed were clear in what action was needed to support the development of advanced clinical practice generally and ACPs as a group in the workforce. The ACPs felt that HEE needed to commission curricula which specifically meet ACP needs especially those ACPs who come from non-nursing backgrounds. Piggy backing existing programmes is not adequate. Continued support for ACPs is required both in terms of mentoring, supervision but also recognising the personal investment which is required to a) train b) develop their skills to feel confident c) continue practising in the face of resistance from trust colleagues.

The stakeholder interviews show that these issues are being considered by senior trust managers and education leads. They felt that there is a need to look at services and identify where professionals will fit. They felt that ACPs are developed more in the community and well established but needs to be developed for acute settings. But more work was needed to:

*“Understand the process and benefits of the role”*

And introduce clear human resource elements to employing ACPs:

*“Identify ACPs clearly within the electronic staff records systems”*

*“At the moment ACPs do not have a discreet occupational code”*

*“Keep tabs of ACP qualifications and clinical capacity”*

There are plans amongst these stakeholders’ trusts to develop an ACP governance structure; to benchmark skills; and evaluate ACP roles to see if they broaden access to patients, thereby increasing capacity and reducing hospital admissions:

*“Developing criteria to evaluate impact”*

*“for HEE to lead on developing ‘national criteria”*

 *“mapping of practitioners to a framework will support a national standard”.*

Where not already in place, plans to have ACPs leading and supporting other ACPs and to develop a policy for ACPs. One idea for informal sharing, mentoring and peer support included:

“S*et up an ACP forum for discussions, learning and group clinical supervision”*

In terms of education/training, stakeholders felt there was a need for more training to assist experienced health care professionals to obtain an ACP post; and protected continuous learning time where learning could be integrated into their role.

**Discussion**

The ACP role has grown significantly, more so within specialist departments where expert knowledge and skills are needed and there is a history of specialist practice in ACP roles – predominantly nursing but also physiotherapy and recently, dietetics. Advanced clinical practice has grown organically to support the doctor’s role, enhance services, and fill gaps in the junior medical workforce. It was evident that the employing and training ACPs was felt intuitively (largely) to enhance the quality of service provision and develop a workforce with expert skills and knowledge. The general view from the interviews was the need to expand the ACP workforce and understand the benefit that ACPs contribute to an organisation through governance, benchmarking, clear conditions of employment and evaluation with recognised measures of patient outcomes. There is a need to expand the role within various clinical departments, but support from senior members of staff will facilitate this. There needs to be a clear set of guidelines and criteria for developing the roles and the future of the role. Informal non-measured impact has been noted by stakeholders around additional enhanced level of quality care, ACPs taking on more responsibility and as a result, an identification of continuity of care and an advanced level of multi-professional working. There have been some informal clinical evaluations by staff members, but a formal evaluation by patients’, service users and carers is required. Not least, an accepted measure of effectiveness is yet to be developed.

Some of the factors inhibiting the development of the ACP role is that there is no clear governance structure in place that supports the development of the role within trusts. Lack of fully understanding the role hinders the development of business cases for developing and training ACPs. Financial implications are a common factor and lack of support from other members of the inter-professional team is an inhibitor. Support from HEE has contributed to the development of the role as well as support from trust education teams has helped. Financial support with the help from the medical rota has contributed to ACP salaries. Some of the difficulties are protected training time, the supervisory element during and after training and not having a clear ACP strategy within the trust. There is a need for protected continuous learning time along with continued support for ACPs. Developing and providing more opportunities for the ACP role is essential as well as help and support from HEE.

A notable feature of the findings and particularly the ACPs interview data are the degree to which professional boundaries between medicine and nursing continue to be difficult to negotiate for ACPs. It is interesting that this was also the experience of the dietician ACP. These ACPs described their efforts to boundary work (Allen, 2009) in order to create alliances, build up goodwill, and show a positive impact. ACP 2, the dietician, hinted at the emotional cost of this as an individual. However, these inter-personal and inter-professional resistances are perhaps best summed up by one of the stakeholders referring to teams as multi-professional not inter-professional. Multi professional describes teams working in silos with separate, unintegrated professional *knowledges* which make sharing and support of and in practice difficult (Allan et al., 2014)

**Conclusions**

There was general agreement from stakeholders and ACPs for the need to expand the workforce with the training, development and recruitment of ACPs. Although ACPs were recognised as contributing and providing the skills and knowledge needed for care provision, there was a general consensus that further support and training was needed following completion of ACP training. Quality health services with a workforce fit for purpose is a goal shared by health and social care providers across the capital and the development and employment of ACPs needs to integrate into other workforce programmes such as CapitalNurse.

Governance structures in place for employment of ACPs are urgently needed to support ACPs. A structured and robust approach to their employment and organisational support and vision rather than an over-reliance on the individual ACP to cope with resistance and a lack of tailored education/training opportunities is urgently required.

Trusts need to map career pathways across London, across specialist areas of clinical practice and track individual career development across the working life.

Development of programmes tailored to meet ACPs’ learning needs and requirements, rigorous supervision and continuing mentoring systems in practice need to urgently develop with partnership between HEIs and trusts. Some thinking about models of learning and teaching which integrate learning at advanced level. At present this seems to be largely down to the individual ACP to foster his/her own optimum learning environment. Lastly, quality standards by HEIs offering such programmes need to be developed between HEIs and trusts.

# Appendix 4: Semi- Structured Interview

*NB: this is only a guide, aim to help participants identify and explore any issues that they consider may influence the development of ACP roles*

**No.**

**Main questions**

**Possible follow ups/prompts**

1. What is your understanding of ‘advanced practice’?

|  |
| --- |
| Explore, then provide HEE definition if required. |

1. What is your personal view of this conception of advanced practice?

|  |
| --- |
|  |

1. How well do you think the concept is understood in the Trust, by profession, managers, HR, etc?

|  |
| --- |
|  |

1. If necessary, then what do you think could improve understanding of ACP within the Trust?

|  |
| --- |
|  |

1. What forms of advanced practice are you aware of in the Trust currently/planned?

|  |
| --- |
| List by Clinical area and Profession |

1. How well, or otherwise, do you think they are functioning?

|  |
| --- |
|  |

1. Are you aware of how their effectiveness is being evaluated?

|  |
| --- |
|  |

1. Has there any feedback from patients, or other professions about new advanced practice roles?

|  |
| --- |
|  |

1. How does the Trust’s (or service’s) approach to AP support meeting organisational aims – business, workforce or strategic?

|  |
| --- |
|  |

1. What role has the interviewee had in any development of ACPs in that trust’s workforce?

If none, then why do they think so?

|  |
| --- |
|  |

1. What/who has promoted
2. The development of advanced practice in the Trust, or
3. Not introducing advanced practice

Who, or which roles, have most influence within the Trust regarding AP development?

Explore by profession if possible

Explore how decisions have been made

Are you aware of any support externally, e.g. from HEE? If yes, then has that contributed to the development of the role in the Trust?

|  |
| --- |
|  |

1. What might change the current position of the Trusts regarding advanced practice, e.g. increasing or decreasing numbers or scope of the role?

Explore by profession if possible?

|  |
| --- |
|  |

1. Would some form of external support be helpful, e.g. by HEE?

|  |
| --- |
|  |

1. Do you think that there are a range of views about the value, desirability or safety of advanced practice in the Trust?

Explore, discuss by profession if possible.

|  |
| --- |
|  |

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1. Interestingly none of the stakeholders spoke about inter-disciplinary teams or working; rather they referred to multi-disciplinary working and teams. We come back to this point in the discussion as it has some bearing on changing attitudes to ACPs in teams and potential future actions. [↑](#footnote-ref-1)