



Report

The development of advanced clinical practitioners in NHS organisations providing acute, community and emergency services in London: an evaluative interview study

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1. 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.*”¹

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 systems² and also relationships between professions³. The study design was in the interpretative tradition⁴, using semi-structured interviews⁵ 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 thematically⁵.

¹ HEE Multi-professional framework for advanced clinical practice in England 2018. Accessed last May 2019 <https://www.hee.nhs.uk/our-work/advanced-clinical-practice/multi-professional-framework>

² Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P. and Kyriakidou, O., 2004. Diffusion of innovations in service organizations: systematic review and recommendations. *The Milbank Quarterly*, 82(4), pp.581-629.

³ Abbott A. *The System of Professions – a Study of the Division of Expert Labour*. London: University of Chicago Press. 1988

⁴ Crotty, M. *The foundations of social research: meaning and perspective in the research process*. Thousand Oaks, CA: Sage; 1998.

⁵ Seale, C. et al. *Qualitative research practice*. London: Sage. 2004.

2. 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

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.

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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 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 Plan⁶ 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 adults,
- Opportunities created by external funding for training cohorts of ACPs,
- Developing career opportunities to retain experienced staff,
- Roles developed by individuals and then integrated into services.

“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 myselfAnd 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 myself.” (ACP 7)

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.

3. 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)

⁶ NHS England. The Long Term Plan. 2019. <https://www.longtermplan.nhs.uk/>

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,
- 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, midwives 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.
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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.
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4. 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,
- 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:

- a) the lack of workforce planning and resulting absence of business cases for ACP positions,
- b) 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,
- c) 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)

5. 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 (unprioritised):

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.

6. 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.