Workforce Perspectives on HEE's Multi-Professional Framework for Advanced Clinical Practice in England, and its Implementation

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2 Executive Summary

2.1 Scope of the report

This is the initial report on the findings of the research around Advanced Clinical Practice (ACP) in the Barking Havering and Redbridge University Trust (BHR) with a view to develop a trust specific implementation tool for the newly developed Health Education England; Multi-Professional Framework for Advanced Clinical Practice in England (2017), referred to as the 2017 Framework henceforth.

The research was undertaken between September and October 2019 and utilised focus groups with three participant groups: advanced clinical practitioners, clinical managers and non-clinical managers employed by BHR. The study assesses the following key areas: 1) The advancements of knowledge regarding current workforce challenges including knowledge of ACP, value, and patient outcomes; 2) BHR specific identifiers for development and implementation including around supervision, accountability and pathway guidance.

Efforts were made focus groups to guide participants towards talking specifically about their knowledge and understanding of the HEE (2017) Framework, however discussions regularly shifted toward more action focussed elements around workforce challenges and systemic issues, resulting in a rich data set. Therefore, this report presents, discusses and presents solutions relative to both extant issues and framework implementation.

2.2 Key findings

- Patient outcomes including care pathways are expediated by ACP. There are high levels of satisfaction and low levels of complaints reported by patients with feelings of enhanced accessibility to care.
- ACPs are widely acknowledged as the most flexible workforce within BHR and there is palpable enthusiasm for continued development and utilisation of the role.
- ACPs feel valued by patients and have a developing experience of value linked to colleagues and the organisation.
- Value is measured, in part, by the visibility of BHR planning for the future of the ACP role, in addition to the building of infrastructure around it.
- Perceived value by ACP staff is key to staff retention and is strongly linked to the freedom to practice autonomously. Practice autonomy is inextricably linked to medical buy-in.
- ACP within BHR meets most areas of practice required for ‘four-pillar working’, as identified by the HEE (2017) framework. Areas for significant improvement include autonomous practice and research.
- General knowledge of ACP is low, with immediate colleagues of the same base profession best understanding roles. Knowledge does not always increase with exposure to ACP. Low levels of knowledge is linked to low levels of acceptance of the role.
- ACP does not have a distinct budget nor identified place on a rota. This presents barriers to role understanding and acceptance, and thus for planning and education.

- Lack of knowledge, infrastructure and inappropriate utility of ACPs has led to clearly identified concerns around the acceptance of ACP by medics, who are reported to see ACP staff as a direct threat to their profession. This is discussed here as 'medical buy-in'.
- Low levels of medical buy-in is a significant barrier to successful ACP. This prevents autonomous working, reduces universal perceptions of value, and causes unnecessary patient delays and in some cases serious incident reports and failure to achieve national targets.
- There is no standard approach to supervision of ACP staff across BHR leading to inconsistency and perceived insecurity.
- Quality support via supervision is key to ACP staff retention having prompted exodus of staff previously qualified.
- Understanding of accountability is not well developed, beyond that of personal clinical accountability, with limited knowledge of organisational accountability as standard across participant groups.
- There are no agreed practice pathways or guidance across BHR in relation to ACP. This leads to departmental variations in role scope and utility both within and between departments.
- Visible BHR foresight around career progression and the identification of development pathways is key to staff retention.
- ACP pay banding is not consistent across BHR and creates issues when converting more senior or experienced members of staff into qualified advanced practitioners.

2.3 Key recommendations

- Urgently improve knowledge and understanding of advanced clinical practice across BHR to achieve improved planning and working practices. Also reducing the potential for licensing breaches.
- Improve opportunities to practice autonomously by reviewing processes, thus enabling adherence to the HEE (2017) Framework, the meeting of national targets and continued positive patient experiences.
- Plan, promote, enable, and make visible research activities and opportunities to achieve adherence to the HEE (2017) Framework requirements for four-pillar working.
- Achieve medical buy-in via the development of 'medical champions' and working groups to educate, develop practices, and inform the building of infrastructure around ACP practice.
- Develop and implement robust infrastructure to underpin and surround advanced clinical practice. This should include training plans to manage expectations, improve experienced and perceived value, improve staff retention, achieve medical buy-in via evidence based robust BHR practice frameworks, improved visibility of trust foresight, identified career progression pathways, ACP specific rostering and interdepartmental working agreements.
- Promote recognition and acceptance of the role, and thus value, via visibility of change, consideration of identifiable job titles, and the use of standardised uniforms.

3 Aims & Objectives of the Project

This research was commissioned by the Barking, Havering & Redbridge NHS University Trust (BHRUT) to inform the development of a bespoke implementation tool for the Health Education England's: Multi-Professional Framework for Advanced Clinical Practice in England (2017 Version) as required Nationally by October 2020. The overall objectives were:

- To generate empirical evidence to inform BHRUT's future development of an evidence based, bespoke implementation tool

- To advance knowledge of the current workforce and work-based practices by mapping those involved in ACP and the surrounding infrastructure.

- To advance knowledge of NHS workforce challenges through advancing understanding of organisational knowledge and value surrounding ACP practice and how this affects patient outcomes, via the analysis of lived experience.

- To develop BHRUT specific identifiers for development, particularly in relation to supervision and accountability practices, to enable future pathway guidance to be created.

Health Education England's aim was to build upon the definition of Advanced Clinical Practice in England by building on previously completed works across Britain. This was with a view to a consistent understanding of ACP across the health and care sectors. The framework:

- Identifies and articulates the core *capabilities* required of ACPs across health and care sectors. This includes adaptability to change, the creation of knowledge and application of it in order to creatively problem solve in circumstances of complexity and uncertainty.

- Requires that ACPs be able to develop and evidence specialist *competencies* relative to their area of specialism through knowledge, skills, and behaviours.

- Establishes the four-pillars of ACP namely: Clinical Practice, Leadership and Management, Education, and Research as applied to their area of practice.

4 Background & Contexts

4.1 National Context

Previously the NHS have not employed a professional framework that underpins Advanced Clinical Practice across all health and care professions in the UK. The ACP title has instead been treated as role or as institution specific in its function and level of required competence. However, in 2017 Health Education England (HEE) released the Multi-Professional Advanced Clinical Practitioner Framework which establishes a set of core capabilities and competencies across disciplines and situates the ACP title as a 'level' of advanced practice. This 'level' more specifically, is situated as the capability and competence of professionals to work at the level of advanced clinical practice that demonstrates adaptability to change, the ability to generate new knowledge, apply advanced knowledge and demonstrate advanced levels of complex decision making ability under complex or uncertain contexts. Therefore, the framework stipulates that ACPs should be able to develop and evidence competencies through knowledge, skills and behaviours surrounding the 'four-pillars of ACP practice' as provided by the framework. These pillars are Clinical Practice, Leadership & Management, Education, and Research. The educational element is set at HE Level 7 or MSc/MA equivalent.

There is a significant dearth of literature around the implementation of the HEE 2017 Multi-Professional Advanced Clinical Practitioner Framework and thus the contribution to knowledge of this research will be significant. In this forward thinking project BHR aimed to tackle this national issue, in order to develop a bespoke implementation tool for BHR, by collecting data from multiple stakeholders employed by BHRUT, representing the multi professional employee base including both clinical and non-clinical populations. This was with a view to exploring attitudes, experiences, and values of the workforce in relation to Advanced Clinical Practice (ACP) and the impending implementation of the new multi professional framework both locally and Nationally.

N.B. It is important to note that this research was planned as a dual phase, mixed methods study both utilising qualitative and quantitative data to elicit maximum participant engagement and to ensure that service provision was not adversely affected during the data collection period. However, due to participant recruitment delays, phase two, the quantitative phase of this research, is not yet completed. Therefore, this report focuses on the data collected in phase one; the qualitative data.

5 Methodology

In order to adequately explore lived experiences and understandings of both organisational and individualistic representations of 'value' it was important to collect data qualitatively resulting in rich or 'thick' data as discussed by Geertz, (1973). Since it was the group perception and experience that was of interest, it was decided that focus groups would be used for data collection.

Focus groups are a qualitative methodological approach to gather data from groups of individuals who have shared experience of a 'situation'. Thus, as the name denotes, 'focusses' on that 'situation' and are particularly helpful in assisting with organisational decision making processes (Stewart & Shamdasani, 2015), and have routinely been used in Nursing research. Focus groups do, however, have limitations and the analyses are often weighted toward consensus in the data (Barbour, 2008). Steps, such as constant comparative methods, have been utilised in the data analysis process here to mitigate for this limitation, thus improving robustness.

Group interactions are also a predominant feature of focus group research with an objective of understanding group dynamics. Whilst it was not a primary objective of this research to explore these, inter group dynamics have been analysed and inferred. Additionally, it is important to recognise that interactions amongst focus group participants can be directly affected in terms of nature and dynamics by design. This includes: a) group composition, b) intrapersonal influences, and c) research environmental factors (Stewart & Shamdasani, 2015).

5.1 Participants

Careful consideration was given to the selection of appropriate participants for this research so as to ensure that the diversity of shared experience and views were captured appropriately from across BHR (King, Horrocks and Brooks, 2019). Participants across the two phases of this study were pre-identified at BHRUT and allocated to one of the following four categories which were labelled as follows:

1) Advanced Clinical Practitioners
2) Clinical Managers
3) Non-Clinical Managers
4) Doctors

For 'Phase One' of this research, participants were identified and placed into one of three categories, 1-3 above. Category 4 (Doctors) were not included in phase 1. Advanced Clinical Practitioners (ACP) were identified as either holding an ACP qualification or working toward one whether, or not, they were working in an ACP role. Clinical Managers (CM) were identified as clinicians with departmental management responsibilities which included the management of ACP staff. Non-Clinical Managers (NCM) were identified as individuals with management responsibilities outside of the clinical arena but that surround Advanced Clinical Practice.

There were 11 ACP participants (10 female, 1 male), 6 CMs (all female) and 7 NCMs (6 female, 1 male). Job roles spanned a mixture of departments throughout the Trust and had representatives from multiple professions.

In practice, there were two attendees in the ACP category that neither had an ACP qualification nor worked in an ACP role. Both attended due to having MSc level qualifications and additional skills that were not readily utilised by their department.

5.2 Design & Procedure

It was planned that this research be conducted in two phases. Phase one comprised of a total of three focus groups lasting between 1-1.5hrs in duration. These were conducted with ACPs, CMs and NCMs separately. Each participant group were asked broadly similar questions that centred on the key areas of interest, however, these differed slightly and were related to their specific role (see Appendix 2-4).

Participants were approached using purposive sampling strategies as determined by the partner institution (BHRUT). They were recruited by circular email through the BHRUT internal email system and were sent corresponding participation details including date, time and location, and consent documents.

Medical staff, 'Doctors' were not included in phase one of this research. This was a decision taken by BHRUT based on the potential impact on service provision and expected engagement.

The planned second phase utilised questionnaires (Appendix 5-8), which mapped onto questions asked in focus groups. This meant there were four separate questionnaires which explored the same issues but from the differing professional perspectives of ACPs, CMs and NCMs as per phase 1. Phase two additionally surveyed Clinical Doctors. Unfortunately, due to recruitment delays within the partner institution, phase two of this project has not been completed and therefore, is not included in this report. [1]

The questionnaire element of this research has notable methodological advantages in that participants being asked to speak openly about their experiences in front of their peers and in a workplace setting, presents significant barriers to free and full expression (Brannen, 1992). The questionnaire was therefore, designed to take a mixed method approach to data collection allowing for both quantitative measures of experience and qualitative narratives to be expressed freely (see Appendix 5-8). It was originally planned that this data would be collected and a preliminary analysis performed prior to focus groups. This was with the aim to facilitate expanded discussions of dominant themes from the survey data. Therefore,

[1] Efforts were made to circulate questionnaires to all participant groups prior to the focus group sessions, however, delays in BHR prevented this. Plans were therefore, revised and attention to focus groups was prioritised. Researchers felt it was of continued importance to gain the perspectives of doctors due to their pivotal role within departments. However, there was considerable hesitance displayed by BHR over making unrealistic requests on their time by asking for focus group participation. Therefore, questionnaires are of particular importance moving forward with priority effort made toward recruiting doctors.

although the research deviated from this initial plan, it is important later, to use the survey to further explore some of the themes of interest.

5.3 Ethics & Materials

After ascertaining that NHS ethics approval was not required, an application for ethical approval was submitted to the University of East London Research Ethics Committee and was approved on 28 August 2019 (ETH1819-0174). Ethical considerations included participant information sheet content, informed consent, data confidentiality, data storage and the potential for participants to be adversely affected by their participation in the research (since it was directly linked to their employment experiences). A participant information and informed consent document was prepared and is included in the Appendix 1.

Focus groups were conducted on the premises of Queens Hospital Romford, the participants place of employment, and were run by the UEL researcher (LH). Proceeding the commencement of the focus groups, the researcher explained the reasons for the study, the requirements of participation and explained the informed consent procedures. Three ocus groups were conducted All participants were invited to provide written consent prior to commencement. During summation of the focus groups, participants were given details about the second phase of the research and encouraged to take part.

Upon request by the external collaborator, the focus groups were observed by a trainee member of BHR education research staff.

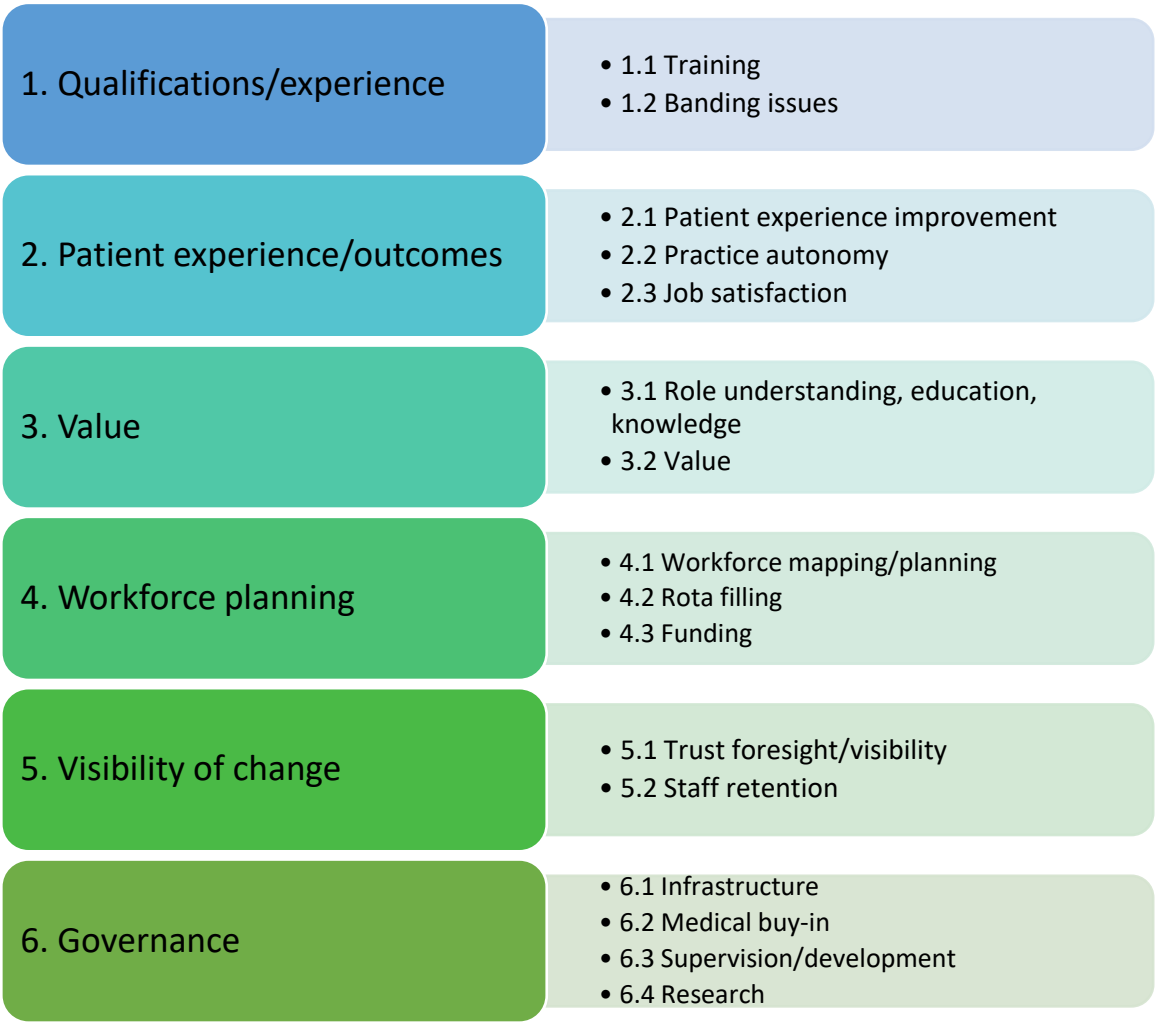
5.4 Data Analysis

Data analysis was conducted using the inductive method of Thematic Analysis (Braun, and Clarke, 2006). This was with an aim to explore attitudes, feelings, and values around the subjects of interest. Therefore, providing an analysis driven by the lived experience of those who participated.

6 Findings

Six key areas of interest were identified within the data referred to as ‘themes’, each containing several ‘subthemes’, sixteen in total. This section, therefore, handles data on the thematic level and presents information and defining features about each in turn. Data from across the participant groups is delivered collectively except where comparisons between participant groups where appropriate and significant data was apparent.

Figure 1: The 6 main themes and associated subthemes



6.1 Theme 1: Qualification & Expectations

6.1.1 Subtheme 1.1. Training

The decision to train as an Advance Clinical Practitioner was discussed throughout the focus groups, not only when asked directly about it. This is a pivotal point in establishing a way forward for BHR both in terms of recruitment and staff retention.

ACP participants reported that it was not always a desire driven decision to train, but one that was suggested to them by their management team. This was often linked to a perception of service need, which was not always a reality once training was complete. Therefore, many participants, across the participant groups, discussed concern relating to the reality of ACP

roles not being available after training and the frequent requirement to have to apply for a role when one becomes available. It was reported that with training at least in part being funded by the Trust, this reality creates to feelings of job insecurity, leading to movement of staff both within and outside of BHR. ACP staff and their colleagues report concern over loss of skill if not employed in an ACP role once qualified. This is of particular concern when considering future employment potential with the constant production of newly qualified staff in the workforce. Key words used when discussing this reality include 'frustration', 'insecure', 'urgency' and 'self-sacrifice'.

Furthermore, for ACP staff, the absence of an agreed training contract as standard is strongly linked to feelings of job insecurity and perceived lack of value ascribed to the role. This was repeatedly said to lead to desires to find alternative employment, where ACP pathways are more explicitly valued by the organisation.

Participants in the NCM group suggested that the expectations of trainees should be managed in accordance with BHR projections in relation to role availability. With training often initiated by management, many of these participants felt there was a perceived unwritten expectation in ACP trainees that there will be a job role available once qualified; however, this is not always the case. Related to this point, there was some debate in this group around whether an expectation is indeed reasonable at all. However, it was largely agreed that since BHR were funding the training it is in their interest to retain the staff they have qualified. Therefore, it was suggested that BHR could control for this, and associated feelings of insecurity and diminishing value, with better communication and clarity from the start of training pathways. This will be discussed further under Theme 6.

In addition it was discussed by several participants, and in particular by NCMs, that commissioning management staff do not always understand the individual investment, additional pressure and commitment required both by the individual and the Department to train the ACP workforce. It was suggested that this should be included in trust workforce planning, finance and under the educational commissioning umbrella.

6.1.2 Subtheme 1.2: Banding issues

This subtheme refers to issues raised in discussions around the banding levels of ACP trainee and qualified staff. This does not appear to be standardised across BHR and some conflict exists in relation to profession comparisons; for example, in pharmacy an ACP practitioner would be on the same banding level as a junior level pharmacist. This issue links to concerns over organisational value, as ACP roles and training contracts require increased commitment and workload but often go hand in hand with a pay cut. More visible pay structures are felt to be of benefit here.

6.2 Theme 2: Patient Experiences & Outcomes

6.2.1 Subtheme 2.1: Patient experience improvement

There was an overwhelming sense that Advanced Clinical Practice had a positive impact on patient experience across all participant groups and this was strongly advocated for. Some clear areas of improvement in patient experience were discussed. This included care planning, which was felt could be more robust and consistent, and that the use of ACPs improved care discipline and continuity of care, and significantly expediated patient waiting times.

A general consensus was that BHR did not currently utilise ACPs to their full potential, and reports of interdepartmental working agreements or lack thereof were a significant barrier to effective and autonomous ACP practice. This is said to cause unnecessary delays in patient referral and treatment pathways. There was an overwhelming sense that many of these barriers were caused by the medical hierarchy that exists within the organisation. But also, by limited understanding about the ACP role and capabilities of practitioners. There is also evidence that Serious Incident Reports (SIR) have occurred where these delays have occurred, impacting patients. Thus, participants reported both safety and financial implications for BHR.

When considering the impact on the patient experience related to medical provision, participants felt that robust ACP practice, including teams working cohesively across medical and non-medical rotas, can "capitalise" on their collective expertise and expediate patient discharge without the need for a full medical team. NCM's & CM's alike believed this to have the real potential for decreasing the serious incident reporting that is felt to be regularly occurring due to time lags for diagnosis and treatment, in relation to national standards.

With regard to patient expectations, it was widely reported that patients do not report concerns over being treated by ACP staff rather than Doctors in most cases. Cases where this is of concern is where delays have taken place, often due to previously identified interdepartmental delays. It is reported that ACPs see a large cohort of patients with *"very few complaints"* and could therefore, be utilised more widely enabling medics to focus on more complex cases.

Some ACP staff reported situations of achieved or desired self-directed practice, evidencing that ACPs have a wealth of knowledge and ideas that would assist in the development of further enhancements to positive patient experiences, relative to service improvement needs. There was an appetite for this to be further explored by the trust. Examples from the data are surmised below:

1. Cancer targets are reportedly falling behind. This is due to consultant shortages causing delays in signing off works done by upskilled but not ACP qualified staff. An ACP would improve this.
2. ACP Sonographers to do steroid injections to reduce long waiting times.
3. ACPs to identify osteoporotics and give preventative treatment to reduce A&E admissions.
4. Drop-in clinic for sickle cell crisis, bypassing A&E and avoiding breaking analgesia limits of 30mins and unnecessary admissions. ACPs would be excellent for knowing speciality information about specific diagnoses (such as chest crisis with Sickle Cell Anaemia) when A&E staff may not have the specialist knowledge to accurately prioritise such cases.

5. ACPs in anaesthetics to do clerking and administration of analgesia. Would avoid waiting times before moving on to next steps in the patient pathway; increasing flow and productivity.
6. Ear Nose and Throat (ENT) has only one Doctor. ACP would improve situation there.
7. Desire to link with external ACPs to expand and improve nurse lead clinics and utility of such in the community.

6.2.2 Subtheme 2.2: Practice Autonomy

Autonomous practice was central to the discussion with ACP participants and was a theme that was repeatedly raised throughout all the question areas and shared by all ACP participants. It was felt that the ability to practice autonomously is the most highly desirable element of the ACP role.

The ability to practice autonomously was seen as something which promotes job choice and therefore aids staff retention. Staff reported a preference for roles which enable autonomous practice as a standard way of working and stated that this would be a driving factor for the choice to move into roles outside of the trust.

Practice autonomy was a highly evocative subject area with ACP participants linking, inextricably, to feelings of worth, value, job satisfaction, respect, and trust. ACP practitioners reported overwhelmingly that they loved their base profession and felt great pride that they had additional skills to further the scope and remit of their role. This was discussed in relation to medical issues, but most pertinently in relation to the patient experience. ACPs felt stifled, disabled, and undervalued by systemic and medic driven barriers to the fulfilment of their full potential/scope. Lack of support in this area markedly decreases job satisfaction and leads to undesired movement and loss of staff. It is also important to note that ACP staff largely felt that they had displayed high levels of personal investment, made sacrifices both professionally and personally in order to train, and wanted to be able to use the skills they had worked hard to gain.

Yet the subject of autonomous practice appears to be the most divisive between the groups. There was a sense from the focus groups that whilst it was desired by most CMs, not all agreed. Those that did not presented either limited knowledge about the full potential of the role or discussed both the medic driven and systemic barriers to implementation, particularly interdepartmentally as discussed under Theme 6.

One department stood out from the rest as an example of where ACP practice had been utilised, planned, supported, and implemented well. ACPs in A&E were working with reportedly high levels of autonomy, clear practice guidance and with excellent support from their CMs and medics alike. Although indicative of the wider systemic considerations (see theme 6, subtheme 6.1), problems appear to occur when interdepartmental interactions are required. It was evident that generally, improved autonomy occurs elsewhere within BHR where there is more than one ACP within a given department.

It was unanimously agreed that medical buy-in is pivotal to an ACP's ability to practice autonomously. This was reported as a widespread barrier across BHR. Where medical buy-in

has occurred, for example in surgery, it was said that the potential of advanced clinical practice has been utilised well. Here the medics identified the utility of ACPs and both championed and developed their ACP roles.

6.2.3 Subtheme 2.3: Job satisfaction

ACP staff unanimously conveyed a strong sense of commitment to the roles which they performed and a love for their base profession. Job satisfaction has clear and inseparable links to the practitioner's ability to work autonomously within their role. This also linked strongly to perceptions of trust and value both of which were significant in terms of staff retention. Job satisfaction is additionally affected by perceptions of medical buy-in and the support afforded to them.

Overwhelmingly ACPs were patient centred in their drive for clinical excellence and continued development of the role, and spoke fondly of being able to work for the betterment of the patient experience and trust targets.

When considering career development, there was a consensus that ACP staff favoured patient facing roles rather than staff management roles. Of significant importance was the desire for visible and identifiable career progression pathways.

6.3 Theme 3: Value

6.3.1 Subtheme 3.1: Role understanding / education / knowledge

Understanding of the ACP role differs largely between other professions within BHR including CMs and NCMs, with CMs evidencing clear misunderstandings around the role remit and scope. Understanding does not appear to improve with exposure to advanced clinical practice. Some NCMs had no knowledge of the role at all, including in project management. Thus, CMs were found to have limited understanding of how the ACP role is relative to their job remit. ACPs felt this was directly linked to a paucity of planning and a lack of trust and foresight. There was a reported sense that immediate colleagues, or those with similar professions, best understand ACP. Junior doctors often understand the role well and place value on ACPs as they can provide support in areas of the role where experience over education is required, including, for example, cases of rapidly deteriorating patients.

Educational commissioning appeared to effectively facilitate course funding. However, it was identified that there was scope for commissioning officers to further comprehend specialist role functions and support managers and trainees better in developing an understanding of what is required both to train and to practice. Therefore, discussions were had at the NCM level, around a need for future involvement beyond the current functioning.

Widespread confusion over the role has reportedly caused tensions: between "*what an ACP thinks they can do, what their medics think they can do, practically what their rotas allow them to do and what they are signed off to do by the Trust*". It was broadly felt that medical staff do not understand the difference between ACPs and junior doctors, and from a HR

perspective ACPs are regularly used as replacements for this workforce. A generalised lack of understanding can lead to legal issues with some ACP staff reporting having been asked to complete procedures that they are not covered to perform.

ACP participants felt that a generalised lack of understanding leads to low levels of confidence in the competence and capabilities of the practitioners and, therefore, creates barriers to practice including around interdepartmental working practices and autonomous working. NCMs suggested that job titles had an impact on understanding of roles, with notable variation applied across the trust and ascribed to the same or similar levels of practice. Therefore, a restructuring of job titles was suggested to make role remits more readily identifiable.

The 2017 HEE framework was discussed in relation to advancing understanding. However, participants reported concerns over discrepancies between the expectations placed upon ACP practice by the framework and the reality of working within BHR and an individual's ability to perform the role to its full extent, including four-pillar working. Therefore, it was felt that moving forward, distinctions needed to be acknowledged between practice level knowledge, divisional level practice guidance, and regulations.

6.3.2 Subtheme 3.2: Experiences of value

It was identified that perceptions of value were influenced by a variety of factors including peers, the organisation and patients; each are addressed separately in this section.

It was widely agreed by all participants that patients appropriately valued advanced clinical practice although they did not have a developed understanding of what it was. Patients appeared to be driven by quality and timely responses and ACPs have been evidenced to aid in these processes. It was suggested that clearly identifiable uniforms, as worn in the A&E department, aid in patient identification of ACP practitioners. This visibility of the role was seen as a positive thing both to practitioner perceptions of value and the visible value placed upon ACPs by the organisation fostering a feeling of trust.

When asked whether colleagues appropriately value ACP practice it was suggested that the role needs to be fully understood before appropriate value can be attributed. This viewpoint garnered strong agreement amongst all participant groups. When specifically discussing hierarchical issues in relation to perceptions of value and the medical workforce, it was stated that value is explicitly linked to the perception of clinicians and their willingness to work with, rather than against, and supervise ACP staff (see Theme 6, subtheme 6.2: Medical buy-in) . As previously mentioned, it is believed that visible Trust standards will improve perceived value and staff retention. CMs identified that ACPs were the most flexible workforce and this attribute was highly valued. An interesting observation, which was made repeatedly throughout the data, was that recognition of value is filtered down through the medical hierarchy and usually requires consultant initiation.

Perceptions of value were strongly linked to feelings of trust. ACP staff feel most valued when they are able to practice autonomously. It is believed that currently autonomous working practices only occur when the ACP is trusted as an individual.

Perceptions of organisational value were strongly linked to the hierarchical structures as discussed in this report. It was also strongly linked to the practice guidelines surrounding ACPs on the ground and BHR's willingness to develop this, particularly in light of the new HEE (2017) framework.

6.4 Theme 4: Workforce Planning

6.4.1 Subtheme 4.1: Workforce mapping/planning

Although it was clear that significant work had started in this area, there was consensus in the data that workforce planning had been largely neglected in relation to the push to qualify ACP members of staff. This is evidenced by the absence of roles available once an individual qualifies and the issues over clarity of career progression pathways.

It is reported that in some departments there are staff working beyond MSc level and are currently working on three of the pillars; with the exception of research. However, there is no funding for them to qualify as ACP staff. Therefore, these staff members are not being utilised to their full potential due to issues with workforce mapping and could easily be converted into ACP qualified staff.

Visionary planning was advocated for in all focus group settings and it was suggested the ACP professionals should be seen and supported to be individuals working at the top of their licences. However, limited knowledge held by HR is contributing to workforce planning paucity.

6.4.2 Subtheme 4.2: Rota filling

The issue of rotas for ACP staff was raised by all participant groups, despite not being a question asked of focus group members. It was reported that there is not a standardised approach to the handling of ACPs across the organisation, with ACPs being placed on medical and non-medical rotas dependant on which department they are based in. One department reported having their own separate rota. It was suggested that this can be problematic for a number of reasons, which will be broken down henceforth.

It was reported that initially ACPs were seen by BHR *"as a way of removing expensive agency staff from the workforce*". Sadly, this perception of ACPs being used to *"replace medics"* has had a negative impact on relations between them and the medical workforce.
A pervasive sense of *"rota filling"* and *"hole Plugging"* has continued; with ACPs reporting that they are often used to compensate for gaps in the medical rota when Junior Doctors are in training. There is concern that rota filling does not recognise the differing working practices of Advanced Clinical Practice and some felt that there is no natural place for ACPs.

The identified issues are reported as "extremely damaging", as beyond the sense of 'threat' they have implications for recognition of the role and its value. Therefore, participants felt

that a standard identified line on a rota for ACP staff would be beneficial both for morale, but also for the promotion of and acceptance of the role.

6.4.3 Subtheme 4.3: Funding

It was identified that outside of educational commissioning, there is no ringfenced budget for ACPs as reported by all participant groups. This presents various barriers to successful recruitment, retention, development and practice. Examples of funds being drawn from medical budgets were given and it was reported that this further exacerbates feelings of threat as experienced by medics in relation to ACPs replacing medics. Thus, worsening acceptance of the role.

It was acknowledged that BHR have historically wasted funding on the training of ACPs who have left the organisation after training. Reasons were linked to availability of roles upon qualification amongst other issues. However, it was reported that recent directives require that ACPs have an identified ACP role prior to the commencement of training. Although the researcher has not checked this 'fact', it is acknowledged that this should go some way in protecting against the loss of BHR training funds. Participants from across the three focus groups discussed issues around the dissertation funding required of individuals, to convert the ACP qualification into a full MSc. It was felt that due to high levels of personal sacrifice required by the individual to train, information about this element should be made more readily available at the onset to alleviate pressure and manage expectations leading to improved sense of value.

Discussions around the historic use of ACPs to replace agency medics in the workforce, thus removing high agency fees, was linked to the cost of training ACPs. It was acknowledged that ACPs are not cheap to train, particularly when considering supervision and the achievement of four-pillar working, in addition to training fees. It was therefore, felt that ACPs should be considered supernumerary whilst in training, as their benefit is realised once working to their full potential.

6.5 Theme 5: Visibility of Change

6.5.1 Subtheme 5.1: Trust foresight – Visibility

It was identified that visible change is required in order to effectively implement HEE's (2017) framework. These changes centre on the Trust's ability to demonstrate foresight and proactivity in their approach to ACP. For change to happen BHR would need to increase education around the role to enhance understanding, utility and acceptance. It was clear from the focus groups that there was a sense that understanding of the role is changing and developing but that further change should be led by BHR initiatives; and it was acknowledged that this requires time. Additionally, perceptions of improved value were reported in direct response to the execution of this research project which was seen as an exercise that will improve value based perceptions in the wider workforce,

It was suggested by NCMs that role development issues could be addressed via the creation of a visible and identified group whose purpose it is to develop the new roles. This does not

currently appear to happen due to lack of clarity about whether the ACP roles are medical or not. Additionally, there was a strong sense all participant groups that ACPs are missed in terms of financial / budgetary planning and do not have an identified budget; again due to them not being identified as belonging to any one workforce.

6.5.2 Subtheme 5.2: Staff retention

Issues around staff retention were discussed broadly across all three participant groups and it was clearly identified that there is a stark distinction between now and approximately 3 years ago, when ACPs left BHR en masse. Lived experiences around this issue were explored and participants recounted that qualified staff chose to leave BHR for several reasons. These included a reported lack of organisational and departmental support, low rates of medical buy-in, absence of structure and a lack of acceptance for the role within teams. There is a sense that acceptance levels have improved, although this point was mainly made by A&E staff.

Reasons that ACP staff were retained were also discussed. Reasons raised included localised medical buy-in, an identified line on a rota, opportunities to develop process and to engage in quality improvement projects, and the freedom to practice autonomously.

Ways forward were additionally discussed, with participants widely promoting the need for staff, particularly ACP qualified staff, to be able to visualise future role success within the department and across BHR. This point was particularly related to a sense that there has not been the Trust buy-in for ACP practice which was said to have been observed in other Trusts. All participants also advocated a need for a clear BHR vision for ACP staff, including demarcated progression pathways once competent and experienced, and identified routes for advancement beyond the role; possibly to consultant level. In terms of supervision it was suggested that ACPs should have a lead practitioner by whom they can be mentored. This practitioner should know the system, including on an educational level. They can provide one to one support and both encourage and facilitate four-pillar working.

6.6 Theme 6: BHR Lead Standardisation/Governance/Practice Frameworks

6.6.1 Subtheme 6.1: Infrastructure

It was identified that there is no current visible infrastructure that underpins nor supports the advancement of ACPs across BHR. A lack of identified structure links to and underlies many of the themes addressed within this report; and was viewed as key to BHR development generally, with participants reporting that successful advanced clinical practice requires an evidence based and standardised approach. There was a consensus that BHR has thus far approached ACP reactively rather than proactively, identifying and responding to issues after they have occurred. It was agreed that moving forward BHR should work proactively to establish protocols and career progression pathways, achievable via robust practice structures. Absence of infrastructure was identified as the second largest barrier to success, after medical buy-in, and it was felt that this relates to both internal and interdepartmental processes and the development of interdepartmental working agreements.

Participants advocated for a top down, Trust lead, approach to the development of a bespoke BHR practice framework, to both define and promote ACP pathways. Three key elements were identified in discussions:

1. Supporting individuals – leads to enhanced skill development and value experience
2. Recognition of the role – leads to enhanced value experience and perceived value from the medical workforce. Also, would allow for the medical workforce to focus on the more complex cases and expediate patient timelines.
3. Clarification of the role remit, limits/boundaries, and expectations – perception that this would lead to improved staff retention.

As understood from the focus groups, settings in BHR with developed practice frameworks can be identified, these departments reported the use Royal Colleges and their curriculum to underpin robust practice guidelines, assessment, and supervision of ACP staff. CMs felt this should be a starting point for BHR development.

Continued professional development and further educational issues were discussed. Recognising that individual ACPs regularly have differing skill sets, it was felt that confusion over ACP competencies and capabilities often leads to minimised utility. Therefore, participants suggested that BHR should establish a minimum threshold, within and across departments, above which all ACPs will all be qualified. It was felt that this could eradicate core concerns and associated confusion. In addition to the ACP qualification, CPD courses were identified as a potential vehicle by which ACPs can achieve and evidence a minimum accepted skill base for working within and across BHR settings. There was some support for education days to be run alongside junior doctors.

When considering achieving four-pillar working, participants highlighted that there is no current provision for ACP staff to conduct research related activities; and that more generally, research planning is not clearly identified. It was felt that this should be made more visible and included in rostering.

6.6.2 Subtheme 6.2: Medical buy-in

Barriers to successful practice were discussed throughout all focus group sessions. These discussions overwhelmingly included unprompted reference to what participants coined 'medical buy-in'. This refers to the issue of medics not accepting nor utilising the ACP role and in many evident cases, blocking or hindering practice, and refusal to support the staff members. Participants reported that ACPs within the trust are perceived as a direct *"threat*" to the medical profession, by the medics themselves. It was also stated that "*territorialism and tribalism*" exists as a barrier to the advancement of working relations. Additionally, as previously mentioned, there was a consensus that there is generalised misunderstanding and a lack of knowledge around advanced clinical practice which feeds into distrust of the role and low confidence levels in ACP competence and capabilities. Buy-in has been achieved in some areas through utilisation of the curriculum of the appropriate Royal Colleges. Although there are examples in surgery and A&E of where medical buy-in has happened and ACP

practice has been supported or championed by medics, it does not appear to have been successfully executed across the whole organisation thus far.

There is an overwhelming feeling that organisation wide medical buy-in is essential for the successful utilisation and advancement of advanced clinical practice. Particularly in relation to interdepartmental working and staff retention as can be seen in subtheme 5.2.

Interdepartmental practices and improvements were discussed to enable full application of the new 2017 framework which it wasn't felt could be achieved with current working practices. Participants unanimously advocated for the development of a top down approach to the implementation of a BHR wide structure to standardise ACP accepted referral and other similar pathways. For example, between ACPs and radiology. It was believed that this would promote interdepartmental working practices and expediate patient care progression. Underpinning this with a standardised approach is believed by participants to enable demonstration of evidence-based practice quality, which is seen as important for promoting medical buy-in. There is evidence of some departments having already executed in house training for such cross departmental referrals. This standardised approach is supported by those participants responsible for Serious Incident Reporting (SIR) as negative implications for patients do arise from such fragmented practice.

Potentially unnecessary intra departmental working practices were also discussed that have direct implications for patients. For example, in histopathology the scientists interpret the test results, however delays occur due to the necessity for a Doctor to sign the report off. Many similar examples can be identified across the organisation and it was felt that by enabling ACP staff to safely do work like this, processes would be expediated and medical workloads would be reduced whilst enhancing patient experiences.

When discussing ways to promote change it was broadly felt that medics needed to be included in research and educational projects, such as this piece of research, in order to develop awareness and understanding of the role and its value. NCMs advocated for 'medical champions' to be identified across departments and the formation of working groups where development plans for ACPs can be discussed. It was believed that this would foster a sense of control and ownership over departmental advancements. Importantly it would also serve as an educational tool that would promote ACP utility across the organisation leading to improved support and supervision for the ACP role and framework driven organisational developments. NCMs advocated for a patient centred approach to engage the medical workforce and drive forward this reform.

6.6.3 Subtheme 6.3: Supervision and ACP Development

It was identified that there is no standardised supervision process for ACPs whilst training or post qualification. Thus, the quality of supervision has differed widely and was cited as a barrier to job satisfaction and person retention. Supervision was seen as closely linked to experiences of quality support. It was felt by participants that to develop the ACP role within BHR, robust supervision arrangements should be developed, implemented, and made visible both to ACPs and staff more widely. When considering such arrangements, it was suggested that the 360° feedback model receives positive feedback elsewhere and could be adopted.

Varying viewpoints were discussed around who is best placed to supervise ACP staff; be that a senior ACP from within the same department, or where necessary outside of it, or whether the supervisor should be a clinical staff member, as they are already 'signed off' as educational supervisors. There was no consensus reached on this issue, however it was agreed that there is scope for senior ACP roles to be developed and for them to take on this role as BHR advances. Consensus was achieved in discussions around considerations for 'training of the trainer' in order to ensure that those responsible for supervision are adequately appointed, in support of the role and equipped for the responsibility. Some felt that the training of ACP supervisors should be modelled on that as provided by Royal Colleges, or that BHR should consider their requirements when developing the supervisory role.

6.6.4 Subtheme 6.4: Research

It was identified across all participant groups that ACP research within BHR is currently non-existent. Therefore, it was felt that this would be a significant area for improvement and planning in order to both support and encourage ACP staff to achieve and sustain compliance with the four-pillar working guidance. There was some feeling that research training should be included in standardised approaches to Continued Professional Development (CPD) for all ACP staff. It was reported that a perception exists within the organisation, that research is expected of the doctor role but not of nurses, or more specifically ACP staff. Therefore, it was felt that this would need fostering and the CPD pathway would be beneficial here. Consideration would also need to be made, when planning, for research time on rotas.

7 Recommendations

A number of key recommendations emerged from and can be suggested by the data from the focus group discussions. Many of these points are implied or raised in the previous sections, but are summarised here as points for consideration and exploration:

- Further develop processes around ACP practice to achieve compliance with HEE's Multi-Professional Framework for Advanced Clinical Practice in England (2017) particularly in relation to autonomous practice and research.
- Work on increasing perceptions of value should continue with particular focus on the inclusion of medics to achieve medical buy-in and improve staff retention.
- Establish and implement training plans in addition to training agreements as standard across BHR. These should recognise the level of commitment and input required both by the trainee and organisation; and should both establish and manage expectations of trainees in relation to support arrangements and career progression once qualified.
- Review renumeration related banding issues and highlight in training agreements.
- Review where ACPs can be best utilised to expediate patient timelines and relieve medics from less complex cases or unnecessary processes. This will aid in achieving national targets and reduce related serious incident reports.
- Review interdepartmental working and referral requirements to develop agreed BHR practices, thus enabling and promoting autonomous working.

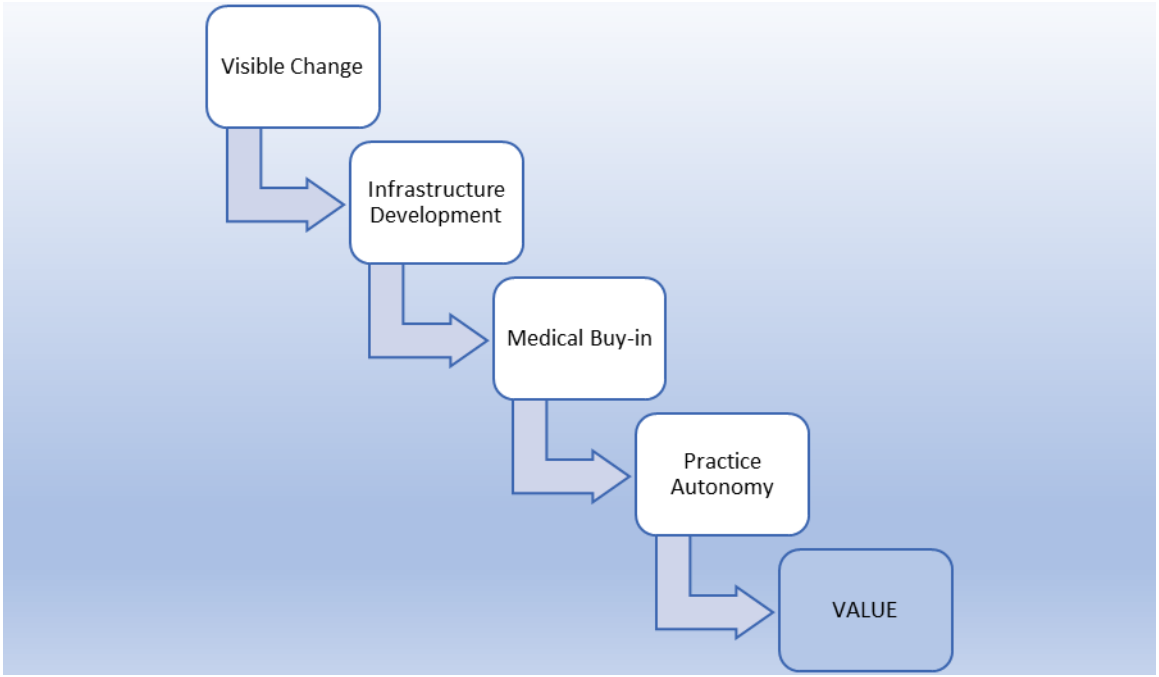
- Prioritise achievement of medical buy-in. This will lead to advancements in ACP utility, retention, and improved experiences of value. This could be achieved via the identification of medical champions and the establishment of working groups to educate, develop practices, and inform the building of infrastructure around ACP practice.
- Urgent attention should be given to the development of knowledge around ACP across BHR in order to avoid further licensing breaches.
- Continued and enhanced efforts to develop understanding of advanced clinical practice will benefit the workforce including for NCMs who will be better placed to work proactively, and to include ACPs in planning exercises.
- There is scope for development of the educational commissioning role to include additional in-training support, and advice sessions for commissioning CMs.
- Consideration should be paid to the review of job titles relating to levels of ACP practice which could be standardised across BHR. This would aid identification of practice capabilities and competencies, and aid interdepartmental working practices.
- Consideration should be paid to making ACP practice more visible and readily identifiable through the use of aids such as standard uniforms or similar identifiers across BHR.
- Identifiable organisational value can be achieved and filtered down through the medical hierarchy via the establishment of practice guidance and associated infrastructure being built around, and in support of ACP practice; including identified and documented career progression pathways.
- Identification of a specified place on a rota should be made to enable full utility and recognition of the value of advanced clinical practice.
- A review of funding structures should be conducted, and consideration paid to the future development of specified ACP budgets. This will enhance experiences of value, and role security and reduce tensions between medics and ACPs.
- Making change visible should be a priority to BHR to achieve belief in trust buy-in. This includes working proactively toward the development of the ACP role and surrounding infrastructure as well as the remedying of current workforce challenges.
- Lead practitioners should be identified, and peer-to-peer mentoring should be established.
- Infrastructure development should include planning around standardised approaches to supervision and support including the identification of supervisors and appropriate training.
- Demarcate space on rotas for research and make more visible research opportunities to achieve four-pillar working.

8 Summary model

Running through the focus group data and the emergent themes, and above recommendations, is a core need for value: for the role to be valued at all stages of development of the individual, in organisational and departmental planning and management, locally and nationally. Figure 2 demonstrates how the achievement of each key recommended element will feed into and facilitate the next stage of development, leading to the ultimate outcome of increased value, both experienced by the ACP and perceived by their

colleagues and the organisation. The data highlights this clear pathway to value from the voices of participants, and this is summarised below in figure 2.

Figure 2: Summary model of action focused development, leading to increased value experiences.



9 References

Barbour, R. S. (2008). *Doing Focus Groups*. London, Sage Publications Inc.

Brannen, J. (1992). *Mixing Methods: Qualitative and Quantitative Research*. Hants: Ashgate Publishing Ltd.

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2). pp. 77-101.

Geertz, C. (1973). Thick description: Toward an interpretive theory of culture. *In the interpretation of Cultures: Selected Essays*. New York, USA: Basic Books.

Health Education England. (2017). Multi-professional framework for advanced clinical practice in England. *London: Health Education England*.

King, N., Horrocks, C., and Brooks, J. (2019). *Interviews in Qualitative Research*. 2nd edn. London: Sage Publications Ltd.

Stewart, D. W., and Shamdasani, P. N. (2015). *Focus Groups: Theory and Practice*. 3rd edn. London, Sage Publications Inc.

Appendix 1: Participation Documents & Informed Consent

University of East London
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University of East London (UEL)
Stratford Campus, Water Lane, London, E15 4LZ

Research Integrity

The University adheres to its responsibility to promote and support the highest standard of rigour and integrity in all aspects of research; observing the appropriate ethical, legal and professional frameworks.

The University is committed to preserving your dignity, rights, safety and wellbeing and as such it is a mandatory requirement of the University that formal ethical approval, from the appropriate Research Ethics Committee, is granted before research with human participants or human data commences.

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Partner Institution: Barking Havering and Redbridge University NHS Trust (BHRUT)
Funded by: Barking Havering and Redbridge University NHS Trust (BHRUT)

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

University of East London

Pioneering Futures Since 1898

Project Title

Multi professional perspectives on the implementation of Health Education England's Advanced Clinical Practice Framework (2017 version)

Project Description

This research is concerned with the future implementation of the Health Education England Multi Multi-Professional Advanced Clinical Practitioner Framework (2017 version) and aims to explore attitudes, experiences and values from multiple professional perspectives including clinical and non-clinical staff involved in the structures around Advanced Clinical Practice (ACP).

Research Aims

To generate empirical evidence to inform BHRUT's future development of an evidence based, bespoke implementation tool to underpin the implementation of Heath Education England's Multi-Professional Advanced Clinical Practitioner Framework (2017).

To advance knowledge of the current workforce and work-based practices by mapping those involved in ACP and the surrounding infrastructure.

To advance knowledge of NHS workforce challenges through advancing understanding of organisational knowledge and value surrounding ACP practice and how this affects patient outcomes, via the analysis of lived experience.

To develop BHRUT specific identifiers for development, particularly in relation to supervision and accountability practices, to enable future pathway guidance to be created.

Should you agree to partake in this study you would be required to complete either;

1) An online survey based upon the aims and objectives of this study. This involves a number of questions to which you will be asked to provide your feedback either by selecting your desired response and/or by providing short written answers. The survey has been designed to take no longer than 30 minutes of your time. Once you have given your consent you will be sent a link to the survey via email with instructions and a copy of the aforementioned ACP Framework for you to peruse ahead of time.

2) Attend a focus group. This session will involve 6-10 individuals with a similar job role to yourself who will be invited to openly discuss questions related to the aims and objectives of this study. These are expected to last 1 - 1.5hrs in duration.

You may also take part in the survey if you wish to and if you wish to, you will need to give consent to take part in the survey. Once you have given your consent, you will be sent a link to the survey via email with instructions and a copy of the aforementioned ACP Framework for you to peruse ahead of time.

It is not anticipated that your participation will involve and hazard or risk of harm. In order to protect your identity from your employer, they will not be present during the studies and your identifiable information will be removed from the data and known only to the UEL research team. The partner institution (BHRUT) will not have access to this information (further info below).

Your involvement in this study will in no way prejudice or put at risk your employment with your employer, our partner institution, BHRUT. Indeed, it is anticipated that the open feedback you provide during the survey, will aid the development of BHRUT and will deliver direct benefits to your employment experience.

Confidentiality of the Data

For the purposes of anonymity it is our intention to ensure that your data is fully de-identified. This means the removal of any identifying data including any mention of names, times, identifiable events and locations. This data will be replaced with coding, only known to the UEL research team and will not be shared with BHRUT. Your name and job role information will be collected for categorisation and comparison purposes only and once de-identified your data will be stored only with a unique reference number. This will be given to you at the point of engagement.

Where the research involves your participation in person, you will only be in contact with the UEL research team. Data will be de-identified at the point of transcription and again not shared with BHRUT as above.

Where possible, your confidentiality will be maintained unless a disclosure is made that indicates that you or someone else is at serious risk of harm. Such disclosures may be reported to the relevant authority.

Digital data including audio files will be stored on a UEL encrypted device and will be accessed by password only. Sharing of data will be done via UEL managed online shared drives and will again be password protected. Files containing identifiable information will be stored separately and under password protection. This will only be available too the UEL team.

Data will be kept in accordance with relevant legislation and will be kept no longer than is necessary for the purposes of the project. This will be a maximum of 10years.

Location

Should you choose to partake in the survey, this can be done wherever you have internet access and is convenient to you.

Should you partake in a focus group, sessions will be held at Queen's Hospital, Romford.

Remuneration

There is no offer of financial benefit for your involvement in this research.

Disclaimer

Your participation in this study is entirely voluntary, and you are free to withdraw at any time during the research. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason. Please note that your data can be withdrawn up to the point of data analysis – after this point it may not be possible.

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University Research Ethics Committee

If you have any concerns regarding the conduct of the research in which you are being asked to participate, please contact:

Catherine Hitchens, Research Integrity and Ethics Manager, Graduate School, EB 1.43
University of East London, Docklands Campus, London E16 2RD
(Telephone: 020 8223 6683, Email: researchethics@uel.ac.uk)

For general enquiries about the research please contact the Principal Investigator on the contact details at the top of this sheet.

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UNIVERSITY OF EAST LONDON

Consent to Participate in a Programme Involving the Use of Human Participants.

Project Title: Multi professional perspectives on the implementation of Health Education England's Advanced Clinical Practice Framework (2017 version)

The 'UEL Research Team': Laura Hamblin, Prof John Turner & Jane Perry

Please tick as appropriate:

	YES	NO
I have read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.		
I understand that my participation will be audio recorded in the case of involvement in a focus group.		
I understand that my involvement in this study, and particular data from this research, will remain strictly confidential as far as possible. Only the researchers involved in the study will have access to the data.		
I understand that maintaining strict confidentiality is subject to the following limitations: In the event that disclosure of harm, or risk thereof, is made in relation to you or someone else. Such disclosures may be reported to the relevant authority.		
I understand that in the event of publication an anonymised quotation could be used.		
I understand that it is the intention to disseminate research findings through internal reports, presentations, conferences and peer reviewed academic publications.		
Would you be happy for one of the UEL research team to contact you to partake in further research in the future?		
It has been explained to me what will happen once the programme has been completed.		
I understand that my participation in this study is entirely voluntary, and I am free to withdraw at any time during the research without disadvantage to myself and without being obliged to give any reason. I understand that my data can be withdrawn up to the point of data analysis and that after this point it may not be possible.		
I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.		

University of East London

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Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Participant's Contact Details

.....

Investigator's Name (BLOCK CAPITALS)

.....

Investigator's Signature

.....

Date: .....

Appendix 2: Focus Group Questions for Advanced Clinical Practitioners, including students (ACP).

1. What is your profession?
2. What do you understand about the role of an ACP within your profession?
    a. How were you trained?
3. Why did you choose to become an advanced clinical practitioner?
4. What do you understand about Health Education England's ACP framework which was implemented in 2017?
5. What does the ACP Framework mean for you in your role?
6. What are your perceptions about the 2017 ACP framework and its impending implementation?
7. What are your thoughts around the framework in relation to your CPD?
8. How well do you feel the 2017 ACP framework defines the role you perform?
9. How well do you feel that the wider team working around you understand your role?
    a. How does this affect your practice?
10. What are your experiences of your role in relation to service delivery?
    a. Outcomes
    b. Patient experience
11. What challenges do you perceive that you could encounter in relation to the framework?
12. What are your thoughts about ensuring that professional support arrangements are effective?
13. What are your thoughts on accountability?
    a. Professional
    b. Managerial
14. What are your reflections on clinical supervision?
    a. What works well?
    b. What doesn't work well?
    c. What are the preferred methods?
15. Thinking about accountability, how does this work within your department and what works well?
16. Do you feel valued?
    a. Organisationally
    b. Patients
17. What are your reflections regarding ACP staff retention?
    a. Those that leave do so because?
    b. Those that stay do so because?

Appendix 3: Focus Group Questions for Clinical Managers (CM).

1. What is your role within BHRUT?
2. What do you understand about the role of ACP within your department?
3. What are your observations/perception of how they fit within the workforce?
4. What are your expectations of the ACP role?
5. What are your thoughts or experiences on the role of ACP's and service delivery?
6. What is your level of awareness of HEE's 2017 ACP Framework and what do you understand of it? *(can be given copies after this question in order to discuss further)*
7. What does the ACP Framework mean for you in your role?
    a. What are your perceptions about the 2017 ACP framework and its upcoming implementation?
8. What are your thoughts around the framework in relation to CPD?
9. What are your thoughts around the framework in relation to workforce planning?
10. What challenges do you perceive that you could encounter in relation to the framework?
11. What are your thoughts about ensuring that professional support arrangements are effective, including accountability?
12. What are your reflections on clinical supervision?
    a. What works well?
    b. What doesn't work well?
    c. What are the preferred methods?
13. Thinking about accountability, how does this work within your department and what works well?
14. Do you feel that the ACP role is appropriately valued?
    a. Organisationally
    b. Patients
15. What are your reflections regarding ACP staff retention?
    a. Those that leave do so because?
    b. Those that stay do so because?

Appendix 4: Focus Group Questions for Non-Clinical Managers (NCM).

1. What is your role within BHRUT?
2. What do you understand about the role of ACP within your department?
3. What are your observations/perception of how they fit within the workforce?
4. What are your expectations of the ACP role?
5. What are your thoughts or experiences on the role of ACP's and service delivery?
6. What is your level of awareness of HEE's 2017 ACP Framework and what do you understand of it? *(can be given copies after this question in order to discuss further)*
7. On first impressions what does the ACP Framework mean for you in your role?
    a. What are your perceptions about the 2017 ACP framework and its upcoming implementation?
    b. CPD?
    c. Workforce planning?
    d. Challenges?
8. Thinking about accountability, how does this work within your department and what works well?
9. Do you feel that the ACP role is appropriately valued?
    a. Organisationally
    b. Patients

Appendix 5: Questionnaire Questions for Advanced Clinical Practitioners and Students

This questionnaire asks you to think about and in some areas discuss thoughts, experiences of the 2017 Health Education England's Framework for Advanced Clinical Practice. You have already been sent a copy of this via email. If you have not already done so, please take a short time to familiarise yourself with this document. Click here to download.

All the following questions relate to your experiences relative to your employment by BHRUT.

18. **What is your…**
    a. **Age?**
    b. **Gender?**
    c. **Base Profession (e.g. Nurse)?**
    d. **Job title within BHRUT?**
    e. **Time in Post?**
    f. **Are you ACP…**
        Qualified
        Student

19. **What training route did you undertake to reach Advanced Clinical Practitioner?**
    MSc level ACP course
    PGDip ACP course
    Specialist practitioner
    Other MSc level course
    On the job training
    Other?

20. **Why did you choose to become an advanced clinical practitioner?**
    Career progression
    Financial compensation
    Service need
    To expand upon the level of service I am able to give
    Other?

Please specify:

21. **Prior to today, were you aware of Health Education England's Advanced Clinical Practice Framework as published in 2017?**

    No awareness
    Some awareness (knew it existed but knew little of it)
    Aware (knew about it but never read it)
    Fully aware (knew about it and had read it)

22. **What is your level of understanding of the aforementioned 2017 ACP framework?**

Excellent Good Moderate Poor No Understanding

23. What does or might the 2017 ACP Framework mean for you personally, in your role?

Please discuss:

24. How do you feel about the implementation of the 2017 ACP framework which is due to be completed nationally by October 2020?

Extremely Positive 2 3 No Opinion 5 6 Extremely Concerned

Please provide further details:

25. Do you agree that the 2017 framework will provide robust <u>support</u> for ACP's CPD development?

Strongly Agree Agree No opinion Disagree Strongly Disagree

Please provide further info:

26. Do you agree that the 2017 framework will provide robust <u>encouragement</u> of ACP's CPD development?

Strongly Agree Agree No opinion Disagree Strongly Disagree

Please provide further info:

27. How well do you feel the 2017 ACP framework defines the role that you perform?

Extremely well 2 3 Neutral 5 6 Extremely Poorly

28. How well do you feel that the wider team working around you understand your role?

Extremely well 2 3 Neutral 5 6 Extremely Poorly

29. Does the wider level of understanding about your role impact on your performance?

Big Negative Impact
Moderate Negative impact
No impact
Moderate Positive Impact
Big Positive impact

30. **<u>How</u> does the wider level of understanding about your role impact on your performance, if at all?**

Please discuss:

31. **Based on your practice experiences, to what extent do you agree with the following statement?**

Advanced Clinical Practitioners <u>improve</u> service delivery in relation to <u>patient outcomes</u>

Totally Agree 2 3 Neutral 5 6 Totally Disagree

32. **Based on your practice experiences, to what extent do you agree with the following statement?**

Advanced Clinical Practitioners <u>improve</u> service delivery in relation to <u>patient experiences</u>

Totally Agree 2 3 Neutral 5 6 Totally Disagree

33. **What challenges do you perceive that you could encounter in relation to the framework?**

Please list examples:

34. **What are your thoughts about ensuring that professional support arrangements are effective?**

Please discuss:

35. **What are your thoughts on accountability?**

Please discuss:

36. **Do you agree that clinical supervision with ACP's currently works well for all involved?**

Strongly Agree Agree No opinion Disagree Strongly Disagree

Please provide further info:

37. **Based on your experiences, do you feel valued as an ACP on an organisational level?**

Yes Neutral No

Please give an example that exemplifies your opinion:

38. Based on your experience, how well do you feel the ACP role is valued on an organisational level?

1. Extremely valued
2. Well Valued
3. Moderately valued
4. Neutral
5. Moderately undervalued
6. Undervalued
7. Extremely undervalued

39. Based on your experience, do you feel that the ACP role is valued by patients?

Yes Neutral No

Please give an example that exemplifies your opinion:

40. Based on your experience in BHRUT, what are your reflections regarding ACP staff retention?

Those that leave do so because…

Those that stay do so because…

Appendix 6: Questionnaire Questions for Clinical Managers

This questionnaire asks you to think about and in some areas discuss thoughts, experiences of the 2017 Health Education England's Framework for Advanced Clinical Practice. You have already been sent a copy of this via email. If you have not already done so, please take a short time to familiarise yourself with this document. Click here to download.
All the following questions relate to your experiences relative to your employment by BHRUT.

1. **What is your…**
    a. **Age?**
    b. **Gender?**
    c. **Profession?**
    d. **Job title within BHRUT?**
    e. **Time in Post?**

2. **What do you understand about the role of ACP within your department?**

3. **Based on your observations of ACP practice, to what extent do you agree with the following statement?**

    ACP's fit well into the current BHRUT workforce.

    Strongly Agree Agree No opinion Disagree Strongly Disagree

Please feel free to provide any further observations here:

4. **What are your expectations of the ACP role?**

5. **Based on your observations of ACP practice, to what extent do you agree with the following statement?**

    Advanced Clinical Practitioners improve service delivery?

    Totally Agree 2 3 Neutral 5 6 Totally Disagree

6. **Prior to today, were you aware of Health Education England's Advanced Clinical Practice Framework as published in 2017?**

No awareness
Some awareness (knew it existed but knew little of it)
Aware (knew about it but never read it)
Fully aware (knew about it and had read it)

7. **What is your level of understanding of the aforementioned 2017 ACP framework?**

Excellent Good Moderate Poor No Understanding

8. **Do you believe you need to have any level of understanding of the 2017 ACP framework for your role?**

Yes No Maybe Don't Know

Please state why:

9. **How do you feel about the implementation of the 2017 ACP framework which is due to be completed nationally by October 2020?**

Extremely Positive 2 3 No Opinion 5 6 Extremely Concerned

Please provide further details:

10. **Do you agree that the 2017 framework will provide robust <u>support</u> for ACP's CPD development?**

Strongly Agree Agree No opinion Disagree Strongly Disagree

Please provide further info:

11. **Do you agree that the 2017 framework will provide robust <u>encouragement</u> of ACP's CPD development?**

Strongly Agree Agree No opinion Disagree Strongly Disagree

Please provide further info:

12. **What are your thoughts around the framework in relation to workforce planning?**

Please discuss:

13. **What challenges do you perceive that you could encounter in relation to the framework?**

Please list examples:

14. What are your thoughts about ensuring that professional support arrangements are effective?

Please discuss:

15. Do you agree that clinical supervision with ACP's currently works well for all involved?

Strongly Agree Agree No opinion Disagree Strongly Disagree

Please provide further info:

16. Based on your experiences, do you feel that the ACP role is valued on an organisational level?

Yes Neutral No

Please give an example that exemplifies your opinion:

17. Based on your experience, how well do you feel the ACP role is valued on an organisational level?

8. Extremely valued
9. Well Valued
10. Moderately valued
11. Neutral
12. Moderately undervalued
13. Undervalued
14. Extremely undervalued

18. Based on your experience, do you feel that the ACP role is valued by patients?

Yes Neutral No

Please give an example that exemplifies your opinion:

19. What are your reflections regarding ACP staff retention?

Those that leave do so because:

Those that stay do so because:

Appendix 7: Questionnaire Questions for Non-Clinical Managers

This questionnaire asks you to think about and in some areas discuss thoughts, experiences of the 2017 Health Education England's Framework for Advanced Clinical Practice. You have already been sent a copy of this via email. If you have not already done so, please take a short time to familiarise yourself with this document. Click here to download.
All the following questions relate to your experiences relative to your employment by BHRUT.

1. **What do you understand about the role of ACP within your department?**

Please discuss:

2. **Do you have any involvement with ACP within your role?**
   Yes No

If yes, please state what:

3. **Based on your observations of ACP practice, to what extent do you agree with the following statement?**

   ACP's fit well into the current BHRUT workforce.

   Strongly Agree Agree No opinion Disagree Strongly Disagree

Please feel free to provide any further observations here:

4. **What are your expectations of the ACP role?**

5. **Based on your observations of ACP practice, to what extent do you agree with the following statement?**

   Advanced Clinical Practitioners improve service delivery?
   Totally Agree 2 3 Neutral 5 6 Totally Disagree

6. **Prior to today, were you aware of Health Education England's Advanced Clinical Practice Framework as published in 2017?**

   No awareness

Some awareness (knew it existed but knew little of it)
Aware (knew about it but never read it)
Fully aware (knew about it and had read it)

7. **What is your level of understanding of the aforementioned 2017 ACP framework?**

Excellent Good Moderate Poor No Understanding

8. **Do you believe you need to have any level of understanding of the 2017 ACP framework for your role?**

Yes No Maybe Don't Know

Please state why:

9. **How do you feel about the implementation of the 2017 ACP framework which is due to be completed nationally by October 2020?**

Extremely Positive 2 3 No Opinion 5 6 Extremely Concerned

Please provide further details:

10. **Do you agree that the 2017 framework will provide robust <u>support</u> for ACP's CPD development?**

Strongly Agree Agree No opinion Disagree Strongly Disagree

Please provide further info:

11. **Do you agree that the 2017 framework will provide robust <u>encouragement</u> of ACP's CPD development?**

Strongly Agree Agree No opinion Disagree Strongly Disagree

Please provide further info:

12. **What are your thoughts around the framework in relation to workforce planning?**

Please discuss:

13. **What challenges do you perceive that you could encounter in relation to the framework?**

Please list examples:

14. Based on your experiences, do you feel that the ACP role is valued on an organisational level?

Yes Neutral No

Please give an example that exemplifies your opinion:

15. Based on your experience, how well do you feel the ACP role is valued on an organisational level?

15. Extremely valued
16. Well Valued
17. Moderately valued
18. Neutral
19. Moderately undervalued
20. Undervalued
21. Extremely undervalued

16. What are your reflections regarding ACP staff retention?

Those that leave do so because:

Those that stay do so because:

Appendix 8: Questionnaire Questions for Doctors

Doctors – Questionnaire

This questionnaire asks you to think about and in some areas discuss thoughts, experiences of the 2017 Health Education England's Framework for Advanced Clinical Practice. Please take some time to familiarise yourself with this document. Click here to download.

All the following questions relate to your experiences relative to your employment by BHRUT.

1. **What is your…**
    a. **Age?**
    b. **Gender?**
    c. **Profession?**
    d. **Job title within BHRUT?**
    e. **Time in Post?**

2. **What do you understand about the role of ACP within your department?**

3. **Based on your observations of ACP practice, to what extent do you agree with the following statement?**

    ACP's fit well into the current BHRUT workforce.

    Strongly Agree Agree No opinion Disagree Strongly Disagree

Please feel free to provide any further observations here:

4. **What are your expectations of the ACP role?**

5. **Based on your observations of ACP practice, to what extent do you agree with the following statement?**

    Advanced Clinical Practitioners improve service delivery?

    Totally Agree 2 3 Neutral 5 6 Totally Disagree

6. **Prior to today, were you aware of Health Education England's Advanced Clinical Practice Framework as published in 2017?**

    No awareness

Some awareness (knew it existed but knew little of it)
Aware (knew about it but never read it)
Fully aware (knew about it and had read it)

7. **What is your level of understanding of the aforementioned 2017 ACP framework?**

Excellent Good Moderate Poor No Understanding

8. **Do you believe you need to have any level of understanding of the 2017 ACP framework for your role?**

Yes No Maybe Don't Know

Please state why:

9. **How do you feel about the implementation of the 2017 ACP framework which is due to be completed nationally by October 2020?**

Extremely Positive 2 3 No Opinion 5 6 Extremely Concerned

Please provide further details:

10. **What are the current procedures for assessment of ACP competency skills within your department?**

11. **How might ACP competency assessment procedures be improved?**

Please discuss:

12. **What support arrangements are currently in place within your department in relation to the building of ACP capabilities?**

13. **How might ACP capabilities support be improved?**

Please discuss:

14. **Do you agree that the 2017 framework will provide robust <u>support</u> for ACP's CPD development?**

Strongly Agree Agree No opinion Disagree Strongly Disagree

Please provide further info:

15. **Do you agree that the 2017 framework will provide robust encouragement of ACP's CPD development?**

Strongly Agree Agree No opinion Disagree Strongly Disagree

Please provide further info:

16. **What are your thoughts around the framework in relation to workforce planning?**

Please discuss:

17. **What challenges do you perceive that you could encounter in relation to the framework?**

Please list examples:

18. **What are your thoughts about ensuring that professional support arrangements are effective?**

Please discuss:

19. **Do you agree that clinical supervision with ACP's currently works well for all involved?**

Strongly Agree Agree No opinion Disagree Strongly Disagree

Please provide further info:

20. **Based on your experiences, do you feel that the ACP role is valued on an organisational level?**

Yes Neutral No

Please give an example that exemplifies your opinion:

21. **Based on your experience, how well do you feel the ACP role is valued on an organisational level?**

22. Extremely valued
23. Well Valued
24. Moderately valued
25. Neutral

26. Moderately undervalued
27. Undervalued
28. Extremely undervalued

22. Based on your experience, do you feel that the ACP role is valued by patients?

Yes Neutral No

Please give an example that exemplifies your opinion:

23. What are your reflections regarding ACP staff retention?

Those that leave do so because:

Those that stay do so because: