Post covid-19 reflections on "Workforce perspectives on Health Education England's 'Multi-professional Framework for advanced clinical practice in England', and it's implementation. (2020)". A participant validation study.

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Contents

Introduction 2
The Research Team 2
Focus Group 1 – Advanced Clinical Practitioners (ACP) 3
The 2020 Report 3
Changing Landscape: Covid and Junior Doctor Strikes 4
Value 5
Focus Group 2: Clinical Managers (CM) 5
The 2020 report 5
Changing Landscape: Covid and Junior Doctor Strikes 6
Value 6
Focus Group 3: Non-Clinical Managers (NCM) 7
The 2020 Report 7
Changing Landscape: Covid and Junior Doctor Strikes 8
Value 8
Summary 9
Interim Recommendations 10
References 11

Introduction

This research was conducted with Barking Havering and Redbridge University Trust (BHRUT) staff and focuses on experiences of Advanced Clinical Practice and the implementation of Health Education England's (HEE) Multi-Professional Framework for Advanced Clinical Practice (2017) within the Trust. More specifically this research follows on from the first phase of this project in which the report '*Workforce Perspectives on HEE's Multi-Professional Framework for Advanced Clinical Practice in England, and its Implementation*' (2020) was released. This second phase revisits the previous report, asks for feedback on the findings and considers what the current picture within BHRUT is today. This research has been completed with the intention of providing an empirical basis for a BHRUT created bespoke implementation tool for the aforementioned HEE (2017) framework.

Data was collected between July and September 2023 and was conducted via six, one hour, focus groups with three distinct participant groups: Advanced Clinical Practitioners (ACP; n=14), Clinical Managers (CM; n=16) and Non-Clinical Managers (NCM; n=6). Initially three focus groups were facilitated by Research Fellow Laura Hamblin, however due to Junior Doctor strike action on the day of data collection multiple interested participants were unable to attend. Thus, three further focus groups were facilitated by BHRUT research team member Saneela Muhammad: two with ACP and one with CM. There were no further interested participants from the NCM group. All participants gave informed consent for their data to be used in subsequent reports and publications.

Each session commenced with a short 10-minute PowerPoint presentation in which participants were reminded of the key findings and recommendations of the Phase 1 Report *Workforce Perspectives on HEE's Multi-Professional Framework for Advanced Clinical Practice in England*, *and its Implementation* (2020) which was re-shared at the point of invite. All participants were given a printed copy of the executive summary and were invited to engage with it during the session. This report is referred to as 'The 2020 report' henceforth.

Following the presentation all participants were asked broadly similar questions that centred on three key topics of interest. This commenced with reflections on 'The 2020 Report' before moving on to experiences of ACP during the 'changing landscape' nationally, post 2020. This included discussions around the Covid-19 pandemic and Junior Doctor strikes. Participants were then asked to consider the concept of 'value' and reflect upon its meaning, and ways of creating and highlighting value around ACP within BHRUT.

This report presents the findings relating to the discussions (the 'data') in these focus groups.

The Research Team

Principle Investigators (PI):	Professor John Turner (UEL), Kenye Karemo (BHRUT)
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Research Team (RT):	Saneela Muhammad (BHRUT), Vicki Leah (UEL).

Focus Group 1 – Advanced Clinical Practitioners (ACP)

This section includes data taken from across the three ACP focus groups and considers each of the predominant areas of interest individually. ACPs were also asked a fourth question relating to their feelings about BHRUT today. Illustrative quotes are included in quotation marks and italics.

The 2020 Report

- Participants had knowledge of the 2020 report and had largely engaged with the pre-circulated documents.

- ACPs largely felt that the 2020 report reflected what they had experienced within BHR and stated that the highlighted issues were ongoing: *"these observations are still concerns and things that I would probably highlight still"*

- Recognition was made of the fact that recommendations had not been implemented and visible change was not occurring.

- Participants were vocal about the desire for a dedicated ACP network.

- Trainee ACPs discussed needs that were distinct to that of qualified peers. With specific emphasis on the issues pertaining to achieving competency as required to qualify: *"It's really frustrating … how can we get all the other [competencies] if we don't get support from others? … we're the one who is looking for our placement".*

- Trainee ACPs highlighted a desire for further educational support to underpin and support more difficult areas of the qualification, which prevented some from qualifying. This provision is reported to be standard in some other Trusts.

- Issues of supervision and mentoring were discussed, and it was strongly felt that there is a need for a lead practitioner within BHR. Consideration of the differing needs of Trainees should be made.

- The lack availability, visibility and willingness of appropriate clinical case supervision was highlighted as having an impact on patient care and safety in decision making, thus leaving ACPs unable to appropriately manage or discharge patients.

- The issue of rotas was again raised with some division over perceptions of natural fit for ACPs on a rota, whether that be on nursing or medical rotas. It was highlighted that differential consideration should be paid to working practices in departments where a medical model is not followed such as Occupational Therapy.

- There continues to be evidence of ACP qualified staff having no ACP role within BHR at the point of qualification. Regardless, of the absence of an ACP role, in one example an individual was being asked to perform tasks that would fall under an ACP remit and not under the job title for which they were employed. This occurred periodically in this example to meet the needs of the department.

- Pay banding issues remained a barrier to job satisfaction and caused unnecessary delays to patient care pathways. There was disparity between departments and pay scales leaving

practitioners unable to fulfil the full scope of their practice competencies, including prescribing, in some departments.

- ACPs remained a highly motivated and passionate workforce whose enthusiasm for patient centred practice enhancements was palpable. Passion was reported to be less focussed on medical advancements, rather patient care development.

- ACPs had various ideas for service development in which ACP could be utilised beyond their currently utilised scope of practice. These included:

    - ACP led stroke outpatient clinic

    - ACP led maternity outpatient blood pressure clinic

    - ACP led holistic cancer care follow-up clinic for female patients in recovery (10 years) to include reviews, monitoring activities and counselling

    - Making gynaecology an ACP led unit to free medics to focus on areas of need and reduce breaches

- The Emergency Department (ED) had established a rota for non-clinical days where ACPs engage with research, thus engaging with the 4 pillars of working as required by the HEE national framework.

- The desire for further developed career progression pathways was palpable with a demand for consultant ACP role creation: *"there is no development! You're an 8A, top 8A, you go nowhere. You know, you are in charge of Junior Doctors on a daily basis. You know you are a registrar".*

- Need for Trust led continuous training provision, akin to that of clinical colleagues, was highlighted: *"You just still need continuously {sic} learning … you cannot stop at one point and work as an ACP, because every day [there are] new diseases, new conditions… There's no funding"*

- Easy identification of ACP staff was again discussed and the idea of an 'ACP' or 'Trainee ACP' badge was preferable to a uniform change. This was deemed pertinent for collegiate identification purposes more than for patients.

Changing Landscape: Covid and Junior Doctor Strikes

- Although personal experiences of *"trauma*" was acknowledged in discussing experiences of patient care during COVID, experiences of ACP were largely discussed as positive for personal development, recognition, and scope of practice.

- Junior Doctors strikes whilst presenting challenging working environments were felt to have afforded ACPs opportunities for learning and to showcase skills and capabilities.

- Tensions relating to renumeration linked to Junior Doctor strikes were highlighted. The reducing financial offer and disparity of pay between ACP and medical colleagues lead to resentment and negatively impacted willingness to support the services.

Value

- Value was difficult to explicitly define and was considered a multifaceted concept including issues of role and individual acceptance, autonomous working permissions, medical buy-in, Trust buy-in. Value perceptions were observed to decrease around issues of the perception of "*hole plugging*" for medical workforce shortages, renumeration inconsistency, support, and budgeting.

- In discussing value, it was observed that ACPs were hesitant to deny that they are a valued workforce. This is distinct from the 2020 report findings where participants strongly reported that ACPs were not valued. Those who reported feeling valued were from departments where it was felt that they had established good supervision and support structures.

- Where it was observed that participants spoke about feeling valued within departments/teams, this was often where a clinical member of staff had advocated for or supported the role.

- Positive value experiences were not readily discussed in relation to the Trust or when referring to interdepartmental working practices.

- Participants felt that this research work was the start of evidencing some perceptions of value within the Trust.

- To improve feelings of value immediately, participants advocated for: progression to consultant ACP; recognition of being a trainee; standardisation of banding for qualified and trainee staff to avoid skill blocking including prescribing; structured approach to role recognition; structured guidance through qualification from the Trust; protected time to achieve competencies and four pillar working; and continued training provision.

Focus Group 2: Clinical Managers (CM)

The 2020 report

- Participants reported no or low levels of knowledge surrounding the 2020 report and the 2017 HEE Framework. Those who did felt the findings were highly representative of what is continuing to happen now.

- Many CM participants had very limited knowledge of ACP roles and level of practice

- CMs had a desire for Trust-led benchmarking for role scope and definition with a view to improve role expectations and understanding.

- Knowledge to be improved via definition of medical/nursing ownership and responsibility for management and planning. Space for self-directed learning via CPD where roles do not already exist. Some feeling that ACPs have to lead the way in creation of their own role and scope of practice, then leading to collegiate exposure and understanding. ACPs could give presentations to teams to highlight scope. Sense that role continues to evolve. Some sense of needing to understand role equivalence and banding and how it fits in with what was already existing, need to understand specific ACP accredited course.

- Where internal information is shared, it isn't reaching all staff.

- Networking opportunities for CMs around ACP was desirable.

- Highlighted need for improved understanding to ensure staff are managed, enabling autonomous practice, and to evidence value.

- Issues of medical buy-in or lack thereof was discussed. *"Resentment"* was cited as a specific barrier to role commissioning and autonomous practice.

Changing Landscape: Covid and Junior Doctor Strikes

- Participants struggled to discuss what they experienced of ACP during the covid period due to lack of ACPs within their departments. Some reflections made on the experience of other Trusts, where ACP trainees reverted to base profession or nursing roles as additional role requirements could not be fulfilled due to absence of medical staff to sign off. This return to nursing roles was reflected in the BHR experience.

- During Junior Doctor strikes ACPs were seen as "*the foundations of making it work*".

- Perceptions of ACP differs between strike and non-strike times, with underutilisation being the predominant experience outside of strike days: *"During the strikes things are different to non-strike times … the team are underutilised still for their skills. In doctor strikes is very different, surprisingly [IRONY]"*. Medical buy-in tensions were more strongly observed outside strike times.

- All participants identified scope for an ACP within their department.

Value

- Methods to in increase perceptions of value were discussed. Participants identified a "*chasm*" between saying 'we (BHR) value' and actually 'valuing'. Feeling that there is a spoken cultural value system that says BHR value evidenced based practice and measurement of impact. However, it was not felt that this happens in reality.

- Highlighted a need to hear the ACP voice across the organisation and from the bottom to the top of organisational structures and governance.

- Advocated for a CM level, networked approach, to share learning for the training of ACPs who need more specialised skills within departments (rather than the ACP generic skillset).

Highlighted a need for those, with those skills, who can indeed deliver this training at CM level, hence advocating for the network approach. Particularly when creating roles where they don't currently exist.

- Value could be increased by highlighting the worth of the *"nurse's eye"* whilst caring for patients. It was felt that this would reflect extant research around how patients value ACPs.

- Need for strategic workforce planning with forward projection for 2-3 years considering what the anticipated patient care pathway looks like.

- Discussion of need for the Trust to develop and provide additional support to trainee ACPs to provide additional niche training or support including for colleagues whose base profession falls outside of the generic stranding in the ACP qualification.

Focus Group 3: Non-Clinical Managers (NCM)

The 2020 Report

- It was agreed that the content of the report accurately reflected what was happening around ACP within BHR at the time and continued to reflect current experiences.

- One participant reflected that they found the report "*sad*" due to the apparent misconceptions around the role scope resulting in poor utility and opportunity lost for both staff and the Trust. Reference was also made to loss of funds in training and associated loss of staff.

- Career progression was highlighted as a continued area of concern requiring clarification and implementation.

- A formalised, triangulated approach to the identification of scope of practice was seen as a priority need to implement report findings.

- Participants felt that NCM work should and could be supported by the involvement of the Project Management Office (PMO).

- Concern over skill loss once qualified, and not in an appropriate post, was recognised and caused concern. Participants advocated for a renewed system for commissioning of training which identified a service need to be reviewed by a panel, who then recruited the trainee and created a role.

- Role funding processes were reported to continue to be reactive rather than proactive.

- Availability of roles was linked directly to effective utility of qualified professionals now; rather than only utilising skills during times of crisis.

- The easy identification of ACPs was reiterated as a need, and uniforms or staff badges were discussed, with badges being seen as a viable option what could be executed swiftly. This was seen as a way to improve collegiate awareness and understanding.

- ACPs continue to be spoken about alongside Junior Doctors in relation to workforce planning. This is further highlighted in times of crisis and Junior Doctor strike action.

- ACPs continue to be seen as a flexible workforce that can be used to "*rota fill*" and move across both nursing and medical rotas.

- Some dissonance between the role being medical or nursing continued, with debate around natural fit. It was highlighted that from an HR perspective they cannot be medical as this would require contractual changes.

- NCMs reiterated a desire for ACP forums, with an expressed wish to include learning opportunities for non-ACP staff.

- Peer to Peer and Lead practitioner mentoring approaches to support and develop were suggested as a way forward with ensuring role development.

- Value was linked to perceptions of patient safety with participants highlighting that the ACP skill set regularly enables the safe running of operations without a full medical workforce.

Changing Landscape: Covid and Junior Doctor Strikes

- From an NCM perspective hubs were set up and staff were redeployed as appropriate. It was felt that ACPs were not a consideration in that planning.

- ACPs were seen as huge support during strike times for the medical teams.

- Flexibility of the workforce is very *"exciting"* particularly in the current climate.

- Perception of safety of ACP led services is influenced by need (i.e., in times of Junior Doctor strikes). Thus, safety perception is influenced by medical culture.

Value

- Appreciation of ACP value is felt to be shown by recognition of their flexibility in terms of skills availability *"I don't think they fit in one bracket, which I think is ridiculously exciting"*

- Perceived value from medical colleagues is driven by perception of necessity. Without absolute necessity, ACP is viewed negatively:

> *"In my experience with ACPs and I'll just be really honest, particularly with medical colleagues, it seems that the ACPs are, when you really need them, they are absolutely willing and able and can plug a gap on rota and can fill the safety issue. If we don't absolutely have the necessity for them then there is a very different perspective"*

> *"Look at the Junior Doctors' strikes, there is no question about whether an ACP can be on the ward and provide a safe service. Outside of the Junior Doctors' strike, it would be different"*

- Value was again linked to trust, and specifically sometimes trust of specific individuals.
- It was strongly felt that value could be improved by visibly identifying the umbrella under which ACPs fit (i.e., defined, and categorised under medical or nursing teams and in rotas).
- Having a lead practitioner or line manager would also improve ACP experiences of value as well as acceptance.
- Consistent definition of ACP is needed to reinforce perceptions of value.
- Pay banding should be reviewed across specialisms to improve experiences of value.
- Feeling that the Chief Medical Officer (CMO) needs to be made aware of the challenges. If ACP is given CMO protection, then the role in the culture of the hospital will automatically be perceived as valuable. It is also believed that this will enhance the experience of ACPs.
- In terms of workforce planning, if ACPs can be evidenced to reduce vacancy rates and reduce agency staff expenditure then the perceived value organisationally will explicitly increase and culturally should increase medical buy-in.
- Visible profile-raising events such as days or workshops with case examples of ACP would raise awareness and profile of the role.

Summary

Knowledge of advanced clinical practice remains low in areas. However, there is an increasing awareness of how non-clinical managers can and should be engaged in the support and development of the role and related individuals.

Participants felt that the 2020 report reflected their experiences accurately. It was also agreed that the experiences remain largely the same to date. This is with the exception of times where there were additional unexpected service pressures such as during the covid pandemic and Junior Doctor strikes. During these times, ACPs felt that they had welcome opportunities to practice autonomously and to the full extent of their skills and competencies.

There remains some disagreement over where ACPs fit within the workforce; be that medical or nursing. However, there is a strong agreement across all participant groups that a lead practitioner would improve working practices, supervision, and recognition of the role.

Medical buy-in appears to have increased in some departments with some individuals reportedly supporting the role. However, this remains an area for development with reports that during times of crisis, levels of buy-in increase but drop to pre-crisis levels once the pressure has passed.

Value has several constructions and continues to be influenced by medical and Trust buy-in. There is an appetite for networking and shared learning initiatives, in addition to formalised profile-raising opportunities.

The discussions showed an overall increase in observable consideration and thinking about ACPs roles, value and place within the participant groups. There is an appetite for change and many practical suggestions for implementation were shared.

The issue of medical buy-in was less prominent in the new data, however it is acknowledged that this was a strong focus in the 2020 report and that participants agreed that the issues and recommendations therein remained relevant. In particular when speaking specifically about value experiences, it is evident that this issue (and how to increase and/or reflect better this value) remains a priority. Participants also reported a keenness for research to be extended to medical colleagues.

Recommendations

1. Continue to work with the 2020 report and associated recommendations with particular attention to visibility of change.
2. Identify the needs and experiences of Trainee ACPs where distinct from qualified ACPs and establish organisational support structures including role standardisation, in post support, mentoring and educational support sessions.
3. Re-establish ACP Network with a view to consider how CMs and NCMs may be included for both networking and shared learning opportunities. Consider buddying and specialism swaps to improve skill set.
4. In running an ACP network make space for practical implementation suggestions to be heard, put forward and considered. This should include guidance around supervision skills or newly created ACP roles (throughout training and post qualification).
5. Consider the appointment of a lead practitioner with responsibilities for profile raising, developing scope of practice and standardisation across BHR, plus supervision/mentoring activities.
6. Consider how Trust buy-in can be evidenced through profile-raising activities such as publicised case studies of varied ACP roles, ACP led workshops, ACP awareness day/week.
7. Consider a review and implementation of standardised pay banding for ACPs with consideration of all trainee ACPs receiving the same band upgrade.
8. Consider the creation of 'Trainee ACP' posts to improve staff retention and perceptions of career development and job security.
9. Consider and make visible opportunities for career progression for qualified ACPs within the trust to prevent loss of staff – e.g., to upskill and improve utility.
10. Implement a method to ease identification of ACPs via badge to be worn on uniform.
11. Consider performing a scoping study of potential ACP-led/driven initiatives across departments.
12. Perform a review of continued professional training needs via survey of ACP staff. Consider methods to improve awareness and accessibility of funding requests and standardisation.

13. Previously debates have occurred around place of natural fit for ACP being nursing or medical. Consideration could me made to identifying, treating and supporting ACPs as a distinct, stand-alone workgroup with specific needs and infrastructure.

References

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