

# Developing advanced practice in clinical care: analysis of physical and online workshops

## About Clever Together

Clever Together want to see a positive transformation in the health and care system that serves the UK. Our vision is to support transformation in performance and culture, helping develop and enable leadership in health and care at a national, regional and organisational level. We work as a platform for change for the leaders and communities we serve and for those who work in our team.

Our values are to be brave in our approach, rigorous with data and evidence and playful with new ideas and innovation.

We host en masse conversations, giving leaders unique insight into what their staff or stakeholders think; and why they think it. We bring rigour to our analytics using qualitative thematic analysis. We give leaders power by bringing collective insights of their staff or stakeholders to organisation culture, policy ideas, performance and innovation.

## Using this report

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## 1. About this report

This is a report prepared by Clever Together for Health Education England on advanced clinical practice in healthcare.

We have undertaken two separate but linked pieces of work for HEE on this topic:

1. We facilitated a workshop on 25 September 2018 to help develop a better and shared understanding of advanced clinical practice amongst senior leaders and representatives of the different sectors and professional groups.
2. Using the feedback gathered from stakeholders during the 25 September workshop, we developed an online platform to ‘crowdsource’ views from as many people as possible with an interest in advanced practice. We were keen to build on the physical workshop and test key themes and understand some of the issues within advanced practice for a wider range of groups and individuals.

This report provides a summary of the key points raised at the workshop in September (which informed the high-level structure of the online conversation) and provides a detailed analysis of the contributions from those participating in the online platform. The online workshop opened on Monday 29 October 2018 and closed on Tuesday 20 November 2018.

The executive summary is in two sections: the physical workshop and the online workshop. The conclusions are based on an overall picture considering both workshops.

## 2. Executive Summary

The development and establishment of professions within healthcare have traditionally had long gestation periods. The current recognised and regulated healthcare professionals in the United Kingdom vary in their origins, but whether like medicine they can be traced as far back as Hippocrates or we look to modern incarnations such as Florence Nightingale and ‘modern’ nursing, they have tended to emerge over decades at least, and often centuries, into our current modern framework.

This has changed. In the case of some professions, this changed because with the advent of the National Health Service in the last century, Parliament decided regulation (including registration) was needed for professions such as opticians. In other cases, professional groups emerged from the development of practice and law makers decided that regulation was deemed necessary to enable practitioners to operate with greater autonomy - particularly when in patient facing roles. Regulation of pharmacy technicians is one such group.

Arguably we are seeing a different pattern emerge where new professional groups are created by policy makers, or employers (often, although not always, the NHS), in response to the needs of patients and to support efficient and effective delivery of health and care services. The decision to create a new professionally regulated role of Nursing Associates is one example. The emergence of Advanced Clinical Practitioners is an example, where a new professional group has emerged out of several different regulated healthcare professions.

This has created a new policy conundrum. Unlike Nursing Associates, there is no blue print for their creation and therefore no ‘magnetic north’ to explain their purpose or regulatory framework to define their knowledge, skills and competence. And unlike newly regulated professions, such as pharmacy technicians, ACPs are already established healthcare professionals; regulated, with a professional standards, regulatory accountability and quality assured initial education and training.

Our aim, through the facilitation of two workshops (one physical workshop and one online workshop) was to explore the issues raised by the emergence of ACPs and to help policy makers consider how best to support the development, deployment and impact of this group of healthcare professionals.

### Our approach

#### **A facilitated workshop**

We brought together key interest groups to flush out some of the key issues, as they saw them, and to ensure when we had a wider conversation with all those with an active interest in advanced practice, the right issues were being raised. Our feedback from HEE was that significant progress had been made through the development and publication of the Multi-professional framework for advanced practice, but that this was only an initial step and that there was much more to do to understand and respond to the emerging issues.

The workshop we facilitated on behalf of HEE demonstrated that while there is great enthusiasm for what ACPs are already delivering in healthcare, there were a number of emerging issues and concerns. And while the idea of a new ‘Academy’ to provide leadership for advanced practice was discussed, the group was clear that before deciding an Academy for Advanced Practice was ‘the solution’, further work was needed to understand and define the ‘problem’ an Academy would be solving. This led us to layer-up the themes at the workshop and reflect that the next phase of our exploratory work should ask a much wider audience about how advanced practice is impacting patient care, explore the implications to the workforce, and ideas about enhancing assurance mechanisms.

## Our online workshop

Over a period of three weeks we hosted an online workshop where we ‘crowdsourced’ ideas about advanced practice. Participants were able to submit ideas about the questions below, comment on the ideas submitted and also use voting buttons to express support or disagreement. The workshop was anonymous, although we were able to collect participant data to support analysis of contributions through the use of a gateway questionnaire.

The online workshop posed the following questions to participants which were developed using feedback from the preceding physical workshop:

1. What impact could the development and deployment of advanced clinical practitioner roles have on patient care if they were scaled across England?
2. What are the key workforce implications for NHS organisations and other providers of care in the development of advanced practice, and how can they exploit the opportunities provided by advanced practice?
3. If we were to develop and deploy advanced practice, fast and at scale, what key actions need to be taken to build the right assurance mechanisms and ensure effective future planning and coordination?
4. Do you have any other ideas or comments about the development of advanced clinical practice and how it can be developed to serve patient care and population health effectively both now and in the future?

## What we heard

The report sets out in detail the feedback given by participants to the online workshop, but some clear messages on each of the questions above emerged from the ‘crowd’.

Question area	Summary feedback
Impact on patient care	<ul style="list-style-type: none"> <li>• The crowd saw huge potential for the development of advanced practice to have a positive impact on patient care</li> <li>• They saw opportunities for efficiency gains both within organisations and across health systems</li> <li>• There was a clear consensus that development of advanced practice would have a positive impact on patient outcomes in healthcare</li> <li>• The development of the advanced practice workforce would also provide indirect benefits to patient care through innovation, improvements in research and improved education and training</li> </ul>

<p>Workforce implications</p>	<ul style="list-style-type: none"> <li>• There was a strong emphasis on the need for action on advanced practitioner workforce planning</li> <li>• ACPs were seen as an untapped resource and development of this group would improve retention (as well as patient outcomes)</li> <li>• Employer contributions demonstrated a desire for this professional group but the crowd felt there's much more needed to be done to clarify and standardise roles, job titles and career pathways</li> <li>• Leadership was also called for, particularly in making the positive case for this group, not just seeing ACPs as risk mitigation (i.e. workforce shortages in medicine)</li> </ul>
<p>Assurance mechanisms</p>	<ul style="list-style-type: none"> <li>• There was a clear message in this section that more needed to be done to provide assurance to the public, to employers and to fellow healthcare professionals</li> <li>• The need for greater consistency in education outcomes from HEIs and greater coordination with employers for work-based learning were clear messages</li> <li>• Strengthened national regulation featured prominently in the discussion, often as a potential solution to variation in education and practice standards. Contributors from nursing referenced the need for NMC to take a lead while others saw opportunities to boost existing frameworks (professional body credentialling, employer-based leadership and governance or revalidation within current professional regulation)</li> <li>• The idea of an Academy was discussed with some views for it, and some against.</li> </ul>
<p>Other ideas</p>	<ul style="list-style-type: none"> <li>• A desire for leadership was both explicit and implicit in large parts of the conversation with a desire from participants for clarity</li> <li>• Concern was expressed that a degree of certainty was needed about the future of advanced clinical practitioners if professionals were to invest their time in developing their skills and qualifications and if employers were to provide their investment and planning</li> <li>• A number of participants commented about the lack of innovation which was hampering efficient deployment of ACPs. Specific comment was made about the nature of primary care where the gatekeeper role of GPs was seen by some to hamper innovative and more efficient delivery models.</li> </ul>

This report draws several conclusions based on the contributions made by participants. We are clear that there will be other work ongoing in relation to advanced practice and so our conclusions should not be seen as definitive, but just one contribution to a much wider debate. However, the feedback has provided a very rich picture of the opportunities and risks with some clear indications where action can be taken for patient benefit both by national organisations, employers, HEIs and others with an interest in developing advanced clinical practice.

### 3. Background

#### Background

The [NHS \(in England\) Multi-professional framework](#) for advanced clinical practice in England described the high-level imperative for a new approach to development and assurance for advanced clinical practitioners. The health and care system is rapidly evolving to deliver innovative models of care to meet the increasing demands of individuals, families and communities. Not only has the education and training of traditional professional and clinical groups changed rapidly in recent years to account for the changing requirements of employers, patients and the public, so too has the emergence of new specialisms, including the role of advanced clinical practice.

For the first time, a framework has been produced which sets out an agreed definition for advanced clinical practice for all health and care professionals and articulates what it means for individual practitioners to practise at a higher level from that achieved on initial registration.

However, there remain many challenges before the emerging roles in advanced clinical practice deliver to their full potential. HEE has been exploring how it can provide the necessary governance, oversight, support and coordination of functions at a national level to ensure the role flourishes, workforce planning improves and, ultimately, patient care is enhanced.

In December 2017, HEE published a draft consultation on a ten-year workforce strategy, *Facing the Facts: Shaping the future*<sup>1</sup>. This consultation document set out several ambitions for the workforce, as well as describing the imperative for changes.

The consultation document set out HEE's belief that Advanced clinical practice (ACP) is an increasingly effective and attractive workforce solution to several issues. It further highlighted the offer of a new way of working in a new career allied to a better understanding of workforce capabilities and supporting better senior decision making within teams. This attractive option is why HEE believe the uptake of advanced clinical practice is increasing.

As the consultation explained, increased demand in the health and care system increases the importance why teams have all the support they need. ACP roles enhance the skills and flexibility of clinical teams across the full range of health and care settings. These practitioners are already working across several key areas including placing the most appropriate clinicians earlier in pathways to maximise self-care and prevention, helping staff to work to their full trained capability and across professional boundaries and 7-day working to name but a few. The consultation highlighted case studies from a range of professional groups working in advanced practice as well as initiatives already underway in sectors such as radiology and pharmacy.

More recently, the case to expand advanced clinical practice continues to be made elsewhere. For example, the Nuffield Trust report on the future of acute care in smaller hospitals<sup>2</sup> highlighted the importance of developing these roles.

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<sup>1</sup> <https://www.hee.nhs.uk/our-work/workforce-strategy>

<sup>2</sup> <https://www.nuffieldtrust.org.uk/research/rethinking-acute-medical-care-in-smaller-hospitals>

## Aims

It is this context which provided the background to the work HEE commissioned Clever Together to undertake. The agreed aims for the physical and online workshops were to:

- Develop a better and more detailed understanding of advanced clinical practice and how developing this area can benefit patients.
- Identify the challenges in developing advanced clinical practice in the workplace including the implications for employers.
- Enable us to consider what further assurance is needed in the education, training and supervision of those in advanced practice roles.
- Consider whether some form of supporting infrastructure is needed to develop advanced practice further, identify what its purpose would be and what roles it should undertake. While HEE have openly discussed the potential for an 'academy' for advanced practice, they were clear in commissioning this work that this was only one possible option for exploration.

Although the draft workforce strategy sets out a broader aspiration for advanced practice and imperative for a new approach to workforce development, the workshop we hosted with leaders from advanced practice highlighted the barriers that remain to any rapid expansion and deployment of this part of the workforce. Our online workshop was designed, to ensure we have a much better and deeper understanding of how advanced practice currently operates and to generate ideas for further enhancements, mitigation of risks and ideas for innovation.

## 4. Methods

### Physical workshop

The purpose of the workshop was to bring together a group of interested parties, with a knowledge of advanced practice, to help flesh out some of the issues which would need consideration, or resolution before advanced practice could be developed and deployed at scale across the health and care sector.

The group was asked to consider several fundamental questions:

- i. What benefits would be delivered if we got ‘this’ right (i.e. addressing the issues around advanced level practice and the role of the advanced clinical practitioner)?
- ii. What would the costs (including opportunity costs) be of not doing anything?
- iii. What are the significant gaps in knowledge and questions to which we need the answers to?

The physical workshop was supported by graphical facilitation, drawing on the Delphi method (where a series of questions are posed of experts and answers are iterated and improved). In this case, the group was asked a series of questions about advanced practice through different lenses (the public; employers; practitioners; other health care professionals; educators) and then to consider the challenges around developing advanced practice including the purpose and function of any oversight body.

The feedback from the physical workshop was captured on posters (with a mixture of contemporaneous notes and *post-it* stickers) which were later coded and layered into a summary analysis. This is included later in this report. We used the findings from this workshop to develop the questions for the online workshop.

### Online workshop

In seeking to understand better the current issues surrounding advanced clinical practice and with the explicit objective of meeting the aims set out above, we used crowdsourcing as a qualitative research methodology. Quantitative research methods are particularly useful at identifying the ‘what is’ of a phenomenon. For example, how many Advanced Practitioners operate in health and care, or which staff groups are moving into clinical areas or different parts of the health system, or indeed the experiences of staff over time or the impact on particular populations over time. But this form of research is less helpful in identifying the ‘why’ of a phenomenon, or generating ideas and solutions from those actively participating in the topic or issue being explored. This is where crowdsourcing can be particularly helpful.

What is crowdsourcing? Crowdsourcing has three core elements: an organisation having a task it needs to be performed; a community voluntarily willing to perform the task; and the potential to create results that are of mutual benefit for the organisation and the community<sup>3</sup>. Unlike the Delphi technique, which relies only on the opinions of a small number of specialists (used in part for the physical workshop), crowdsourcing can harness the opinions of a wider range of people to address “messy problems which require a diversity of opinion”<sup>4</sup>. It can, therefore, be useful in supporting management decision

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<sup>3</sup> (Brabham, 2013b).

<sup>4</sup> (Flostrand, 2017).

making by exposing real life experience of participants and their collective insight; and identifying or evaluating potential solutions. In short, it can deliver insight into complex issues.

Like any methodology, crowdsourcing is not without its challenges. By facilitating the exchange of ideas, compared to a survey in which opinions are expressed in individual isolation, it creates the potential for ‘crowd think’, where minority opinions are ignored, and ‘crowd hijacking’, where the crowd uses an initiative to push its own agenda. Both the design of the platform and the techniques used to analyse the feedback are intended to mitigate the risks of this form of bias.

### How the online workshop was hosted

A bespoke online platform was created with a unique URL, [advancedpractice.cleverttogether.com](http://advancedpractice.cleverttogether.com)

It was an open platform meaning anyone could participate, subject to providing basic information about themselves (for the purposes of data analysis, the platform is anonymous, and no data is presented to HEE where there is a risk of individuals being identified)

Once participants filled out basic registration information, they were then invited to contribute to the debate which was framed around three key themes where a challenge question was posed to encourage debate:

Challenge theme	Challenge question
1. Benefits to patient care from the development of advanced practice	What impact could the development and deployment of advanced clinical practitioner roles have on patient care if they were scaled across England?
2. Workforce implications for employers now and over the next 5 to 10 years	What are the key workforce implications for NHS organisations and other providers of care in the development of advanced practice, and how can they exploit the opportunities provided by advanced practice?
3. Building the right assurance mechanisms for advanced practice roles	If we were to develop and deploy advanced practice, fast and at scale, what key actions need to be taken to build the right assurance mechanisms and ensure effective future planning and coordination?
4. Any other ideas, needs or comments	Do you have any other ideas or comments about the development of advanced clinical practice and how it can be developed to serve patient care and population health effectively both now and in the future?

## How did we generate interest in the conversation?

Clever Together has run online workshops for dozens of organisations. For many of them, such as NHS trusts, the target audience is their staff and while generating interest and encouraging participation may be challenging, it is a private ‘closed’ conversation with a specific ‘captive’ group. For this workshop, we expected it to be a challenge to generate interest from a diverse group. Due in large part to HEE’s existing networks the conversation proved to be extremely popular.

To generate interest, HEE used existing mailing lists for individuals interested in Advanced Practice. In addition, third-party organisations promoted the conversation to their members. These included NHS Employers and the NHS Partners Network (part of NHS Confederation). There was also a particularly high interest on social media in general and specifically Twitter. For example, one tweet from Clever Together about the launch of the workshop in October generated 12.9k impressions and was retweeted 145 times.

## The Gateway questionnaire

Although participation in the workshop is anonymous, we asked several ‘gateway’ questions of those registering. The purpose of this was to enable us to analyse responses, broaden understanding of the contributions made and conduct some data analytics to draw insight into the ideas, who generated them and assist the development of conclusions. For example, we wanted to check whether contributions were being made from a wide variety of professions, including those working in advanced practice and those who are not. We asked questions about:

- The role of the contributor (specifically if they were a manager, registered healthcare professional, administrator, or other)
- If they are working or training in advanced practice
- If they are a healthcare professional, which profession are they from
- What kind of employer they work for (e.g. acute trust, local authority etc.)
- Gender
- Age

## Coding and analysing responses

As with most online and crowdsourced workshops, participation could take several different forms:

- Participants could register, fill in the gateway questionnaire and observe the conversation
- Participants could propose ideas or make comments on ideas
- Participants could use the vote buttons to indicate support or not of any contribution

When the online workshop closed, all the data from the platform was downloaded, and every contribution was read and coded by a team at Clever Together. The coding was reviewed by another member of the team for quality assurance purposes. It is important to acknowledge that there will always be differences in views about what code to apply, but taking a thematic approach ensures greater consistency and enables us to be confident in the conclusions we draw from the conversation.

We developed and iterated four coding frames (more detailed available in the appendix) which were:

1. **Geography:** A coding frame to understand whether the idea or comment made was focused on national, local and regional, or individual level activity
2. **Profession:** A coding frame to understand whether the contribution was focused on, or related specifically to, a single professional group or multiple professions.
3. **Policy theme:** A coding frame to understand the policy theme being discussed (such as education, regulation, cost-effectiveness, workforce planning etc.)
4. **Meta-themes:** A coding frame to understand meta-themes from the conversation, specifically, whether what was being proposed was emphasising action to be taken, impact expected, development of advanced practice, or oversight required.

## 5. Analysis of physical workshop

The purpose of this session, hosted by HEE and facilitated by Clever Together on 25 September, was to explore the current landscape for ACPs by discussing the challenges and opportunities from the perspective of different stakeholders. The discussion was structured around the following three following questions:

- i. What benefits would be delivered if we got ‘this’ right (i.e. addressing the issues around advanced level practice and the role of the advanced clinical practitioner)?
- ii. What would the costs (including opportunity costs) be of not doing anything?
- iii. What are the significant gaps in knowledge and questions to which we need the answers to?

### Key issues in advanced practice

The issues below were identified as part of the discussion on advanced practice. Opportunities and risks within each of the identified issues were debated, discussed and captured.

#### **Patient outcomes**

Much of the discussion in the workshop centred on a positive ambition for the delivery of enhanced patient care. Participants felt that developing and deploying the ACP role would help deliver improved outcomes for patients with increased clinical effectiveness, continuity for patients, and a clinically-led model.

#### **Workforce and workforce planning benefits**

Many opportunities were identified around the workforce. It was felt that development in this area could create an enhanced and flexible workforce. Reference was made to the associated benefit of supporting Clinical Nurse Specialist (CNS) and ACP retention and keeping staff in clinical work rather than pushing those staff who want progression towards management roles. Some participants felt there were opportunities for primary care if more services were led by advanced practitioners rather than dominated by General Practice.

#### **Education and training**

Participants felt that creating both a baseline and standardisation in education provision would be a real opportunity. This would include standardisation across content, quality assurance and delivery of assessment. Challenges were raised about training and accreditation including questions about whether a new body could be established to provide guidance on job levels and grades, provide better oversight of education and training, support practice development, as well as helping to triangulate the development of the various forms of assessment.

The challenge of overcoming confusion in education pathways alongside the need to maintain flexibility was also surfaced, as was the question of how to accredit work-based elements of learning and development. Various comments were made about the challenges of assessing capability, developing different education approaches (including modular approaches), and how to ensure equivalence assessment and transferability.

#### **Addressing variation**

There were lots of ideas about standardisation and the need to address variation in the quality of care. These included specific ideas on job titles and job descriptions. There was a general feeling among participants that a new body could:

- Act as a central repository of knowledge and best practice
- Provide standardised practice or competency frameworks
- Develop a faculty-type function
- Address variations in standards

### Governance and/or regulation

Participants felt a new ACP body could help bring consistency (through enhanced leadership, governance or management) to advanced practice. It has the potential to increase the confidence of other professions, provide guidance on supervision and risk management, and provide a voice around UK-wide issues. Mention of regulation was also made as an opportunity to support credibility and confidence (including introducing legally protected titles). One comment referenced the opportunity that this could provide in “giving teeth” to the policy agenda.

### System challenges and cost implications

The challenge of getting the ‘system’ ready was raised. This included the need for better stakeholder engagement and ensuring ACPs were integrated into national, regional and local workforce strategies. Concerns were raised about the challenge of demonstrating value. This was linked to the need for funding staff and the need for evidence of cost-effectiveness. The potential costs of establishing an ‘academy’ or similar body in HEE were also raised.

### Consideration of a new oversight body

Participants in the physical workshop were asked to consider what they thought the purpose of a new oversight body would be and what issues would need to be considered before any new body or function was put in place.

Different groups were asked to consider the purpose of any new body. Participants felt that the purpose would be something akin to the following:

*“To support safe and effective care for people by overseeing the standards for advanced clinical practice and leading practice development.”*

Participants felt that the following functions were not currently being carried out effectively by any single body or organisation so the following list would be worth considering:

- Co-ordinating and facilitating (including managing the issue of equivalence).
- Continuing practice, education, and supervision.
- Governance of implementation of the multi-professional framework for advanced practice.
- Leadership voice - any new body should be:
  - Conceived as a repository of knowledge and best practices
  - Developed as a channel for communications, engagement and awareness-raising
  - Used as a key two-way link to employers and regulators
- Provision of standards and guidance for practice and education (including guidance on equivalence).
- Registration (although participants recognised there were risks and further consideration needed as to whether this was necessary and what scope registration should take).

## Important areas for consideration

The participants at the workshop felt the following key points would need to be considered by key decision makers:

- **Developing stakeholder support:** to determine whether an academy should be established, and what its functions should be, it will be necessary to bring together a network of professional organisations to the table, bringing the overarching functions and principles together into one mandate.
- **Leadership and education:** a key demand will be for the enabling of education in practice. For this, the framework will require effective leaders who can play both a supporting and enabling role.
- **Standards:** if a body or group is to set standards of practice, it will be necessary to set an assessment/evaluation of those standards and the extent to which they are being met. To properly implement assessments of the standards we will need to think about evaluation pathways, and how we can incorporate new standards within the existing framework:
  - education standards
  - practice standards
  - employer standards
- **Accreditation and recognition:** quality assurance mechanisms and endorsements.
- **Voice:** any new body should act as a home for advanced practice.
  - this brings up issues of 'membership' vs registration challenge
- **Continuing Professional Development (CPD):** building professionalism and development of practice.
- **Accountability:** ensuring accountability for advanced practitioners was felt to be an important issue for employers.

## 6. Online workshop: participation statistics

### Overview of the conversation

Set out below in Table 1<sup>5</sup> is the data summarising the numbers of ideas presented and comments made for each of the ‘challenge’ areas.

While there were large numbers of contributions for each of the challenge questions, there were more ideas and comments submitted to the challenge question on patient benefit, than the other questions combined.

This section excludes ideas and comments “seeded” onto the platform in advance.<sup>6</sup>

Table 1

Challenge name	Idea	Comment
Benefits to patient care from the development of advanced practice	79	407
Workforce implications for employers now and over the next 5 to 10 years	54	154
Building the right assurance mechanisms for advanced practice roles	39	159
Any other ideas, needs or comments	58	145
<b>Total</b>	<b>230</b>	<b>865</b>

### Contribution by role

The table below presents the number of ideas proposed and comments made by role. These are derived from the gateway questions. We attempted analysis looking at contributions from employers, but the methodology was problematic given the challenge of defining who was an employer. As Table 2 demonstrates, a significant majority of ideas and comments came from healthcare professionals, with the next largest from educators.

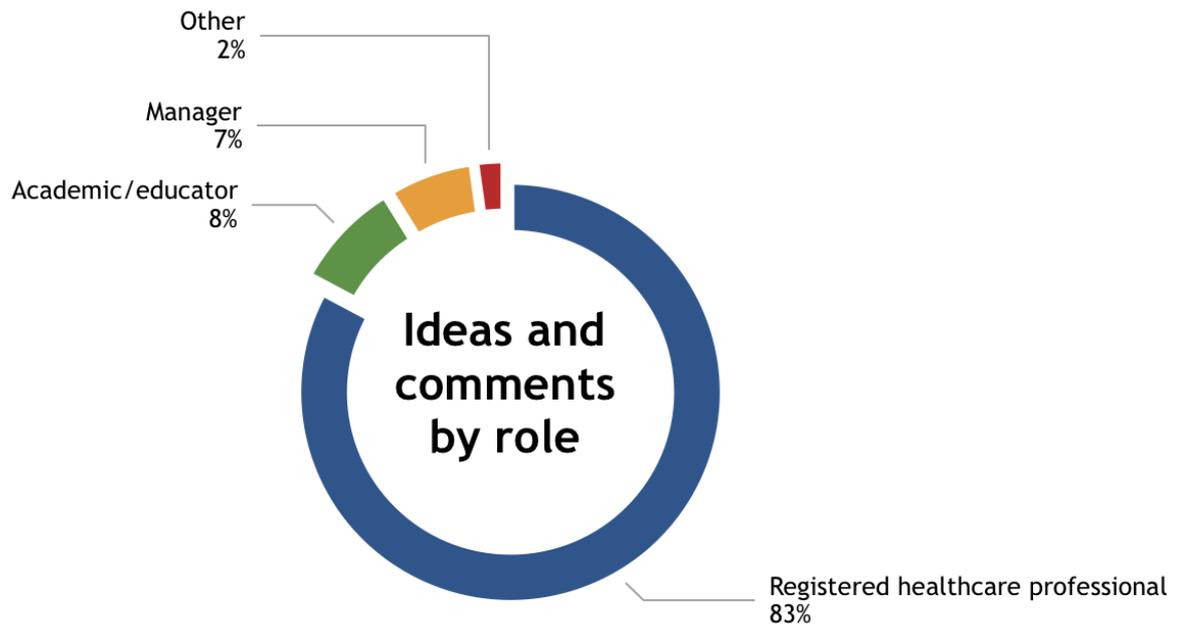
Table 2

Role	Idea	Comment
Registered healthcare professional	192	715
Academic/educator	21	71
Manager	12	60
Other	5	19
<b>Total</b>	<b>230</b>	<b>865</b>

<sup>5</sup> Due to rounding, numbers presented throughout this document may not add up precisely to the totals provided and percentages may not precisely reflect the absolute figures.

<sup>6</sup> Once the questions were agreed by the team at HEE, the Clever Together posted a number of ideas on the platform to ‘start the conversation’. These ideas were drawn from the physical workshop so represent views of stakeholders. However, we removed these from these data tables, but are included in the analysis of contributions in chapters 7-11.

Figure 1



### Contribution by employer type

The table below uses data from the gateway questionnaire to show the number of ideas and comments submitted, broken down by the primary employer of those making the contributions. The largest number of contributions came from those working within NHS trusts, and within that group, acute trusts.

Table 3

Primary employer	Idea	Comment
NHS - Acute Trust	103	348
NHS - Ambulance trust	2	15
NHS - Community Health	10	49
NHS - General Practice	13	39
NHS - Mental Health	9	23
NHS - Primary Care organisation	4	30
Arm's Length Body/NDPB	44	191
Higher Education Institute	17	68
Independent Sector	12	19
Membership body	1	23
Regulatory Body	0	4
Other	15	56
<b>Total</b>	<b>230</b>	<b>865</b>

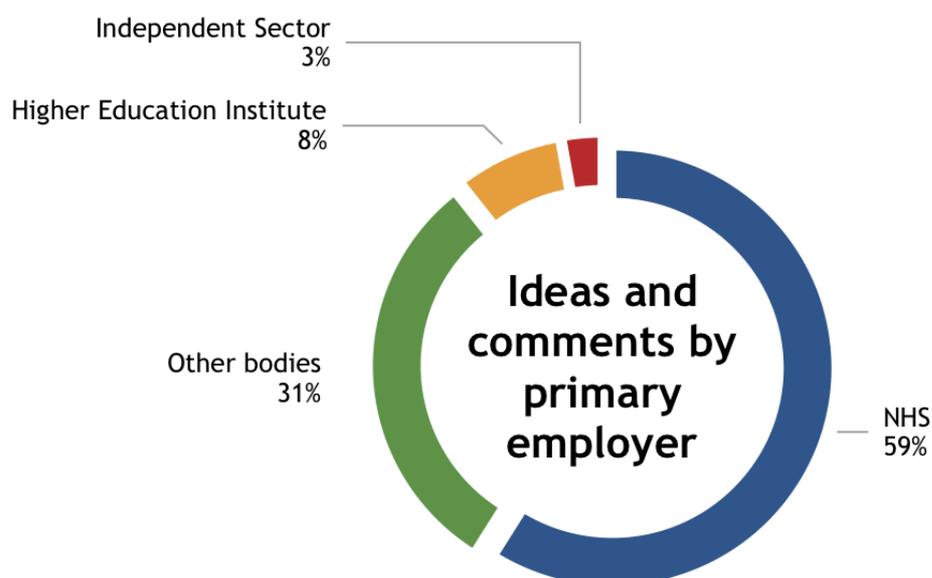


Figure 2

### Contribution by profession

Table 4 below sets out the number of contributions (ideas and comments) to the conversation, by professional group or role. We have combined contributions from Allied Health Professionals as aggregating contributions is more useful for analysis than small, single figure contributions from the professions that make up AHPs. We see that no single profession dominated the conversation although nurses were the single largest contributor by profession, reflective of their size as a profession.

Table 4

Profession/role	Idea	Comment
Nurse, midwife or health visitor	92	271
Allied health professional	117	516
Pharmacist	10	16
Doctor	3	22
Other/not applicable	8	40
<b>Total</b>	<b>230</b>	<b>865</b>

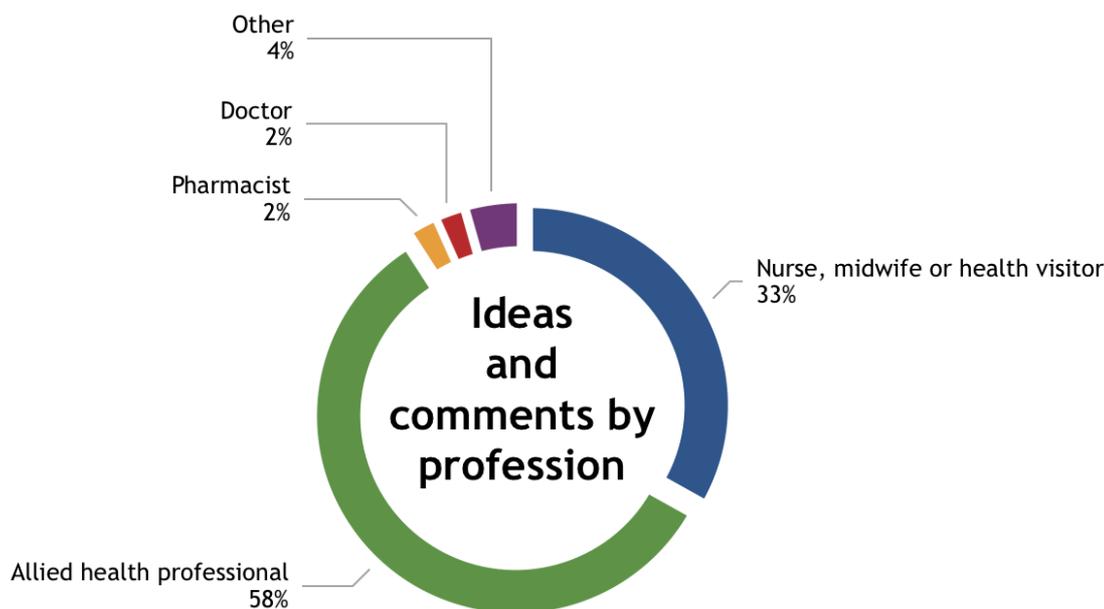


Figure 3

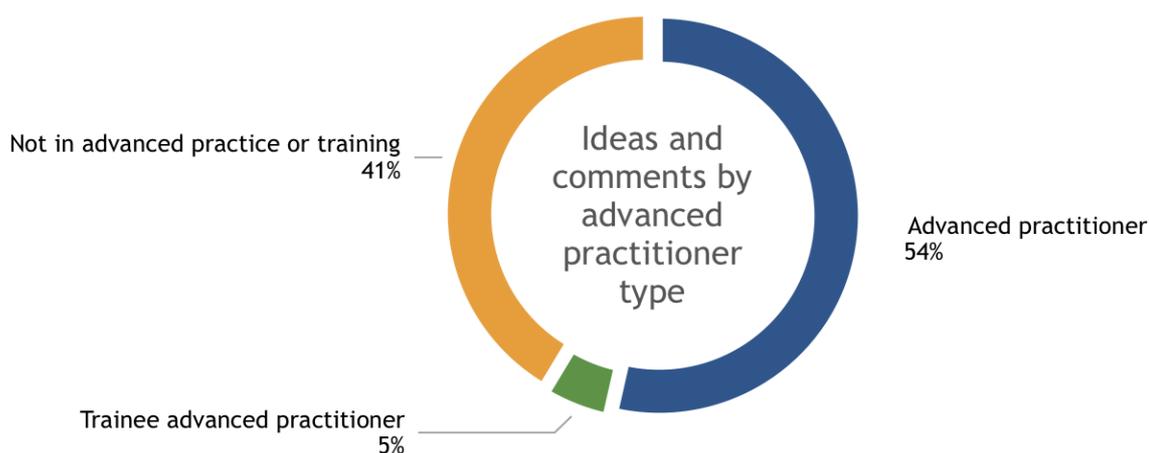
### Advanced practitioner contributions

The table below looks at how contributions were made by those who were advanced practitioners, in training or education to undertake advanced practice roles and those who are not advanced practitioners. Although a clear majority of contributions were made from those in advanced practice, there were a considerable number who were not.

Table 5

Advanced practitioner type	Idea	Comment
Advanced practitioner (or equivalent)	125	477
Trainee advanced practitioner	21	36
Not in advanced practice or training	84	382
<b>Total</b>	<b>230</b>	<b>865</b>

Figure 4



### Demographics: participants' ages and genders

The pie chart shows that over three-quarters of participants were female. Twelve participants preferred not to give their gender.

Table 6

Gender	Count
Female	1,553
Male	461
Prefer not to say	12
<b>Total</b>	<b>2,026</b>

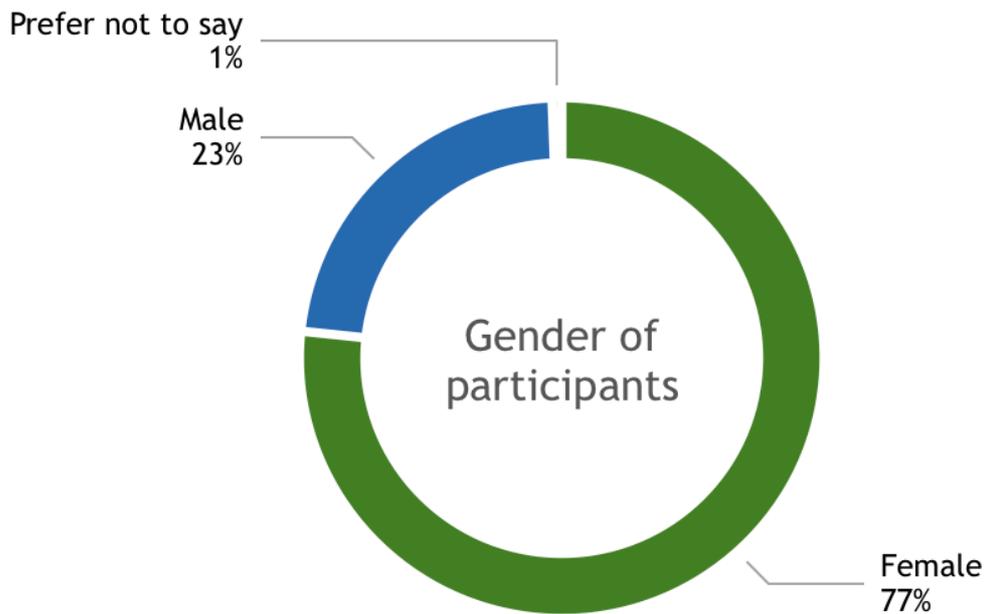


Figure 5

We looked at the demographics to consider whether there were any unusual patterns of contributions based on age. The table below shows a normal distribution of contributions by age group, with over 90% of contributions coming from participants aged between 30 and 59.

Table 7

Age	Count
21 and under	1
22-29	73
30-39	503
40-49	747
50-59	633
60-65	61
66 and over	8
<b>Total</b>	<b>2,026</b>

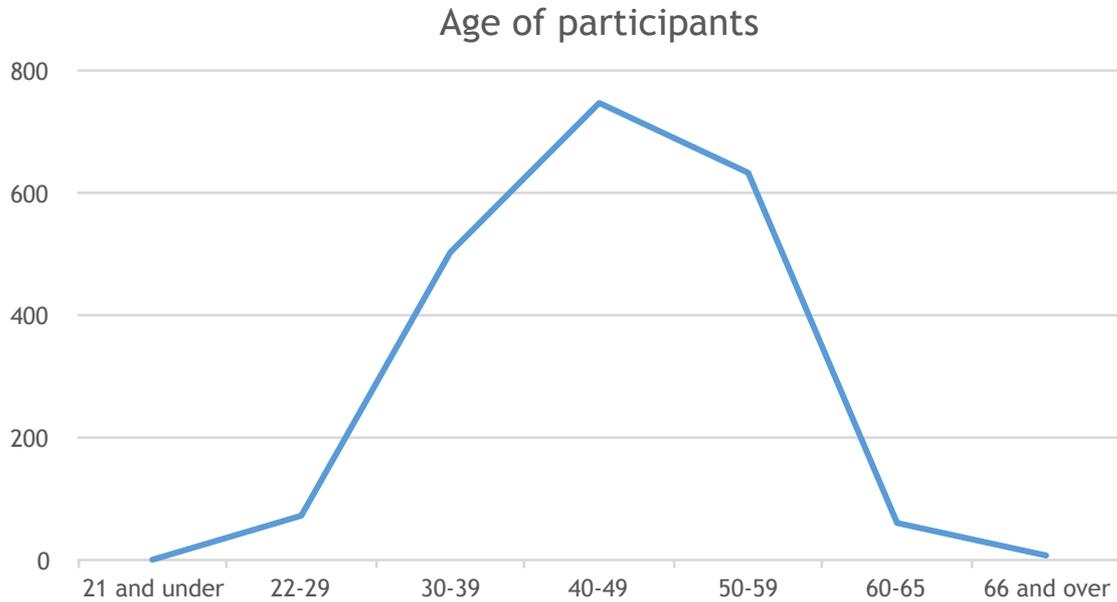


Figure 6

### Contributions by country

Participants were asked to state in which country they were based. Most contributions came from England, unsurprisingly given HEE’s remit and stakeholder communications. There were, however, a number of contributions from other parts of the United Kingdom. 19 identified as being based outside the UK. There were several references in the conversation to advanced practice in other parts of the world. We also see from the map below, which shows where people logged onto the platform, that interest was not solely UK based (although this demonstrates logins, not where people are usually based).

Table 8

Country	Count
England	1,929
Wales	35
Scotland	34
Northern Ireland	9
Other	19
<b>Total</b>	<b>2,026</b>

Participant Geography

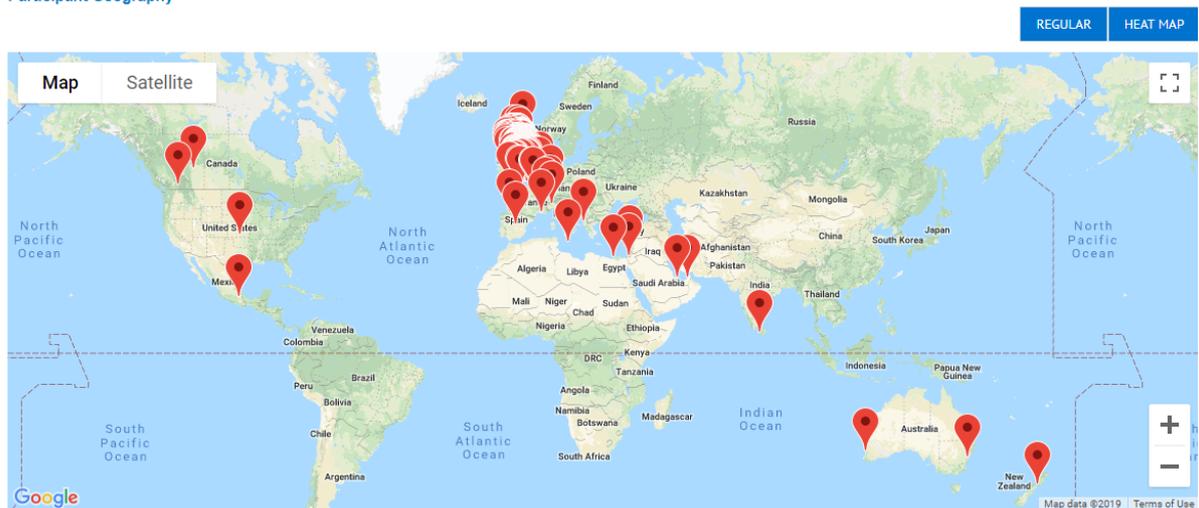


Figure 7

## 7. Analysis of online workshop: an overview

The online workshop generated high levels of interest and provided a rich picture of advanced practice. Over 2,000 people joined on the online workshop. Of those that actively contributed, 741 active participants shared over 5,995 contributions to the debate - new ideas, commenting on those ideas, or voting to indicate their support or disagreement with views presented.

Participants were asked to add their contributions under four broad ‘challenge’ questions:

- **Patient benefit:** What impact could the development and deployment of advanced clinical practitioner roles have on patient care if they were scaled across England?
- **Workforce implications:** What are the key workforce implications for NHS organisations and other providers of care in the development of advanced practice, and how can they exploit the opportunities provided by advanced practice?
- **Assurance mechanisms:** If we were to develop and deploy advanced practice, fast and at scale, what key actions need to be taken to build the right assurance mechanisms and ensure effective future planning and coordination?
- **Any other ideas:** Do you have any other ideas or comments about the development of advanced clinical practice and how it can be developed to serve patient care and population health effectively both now and in the future?

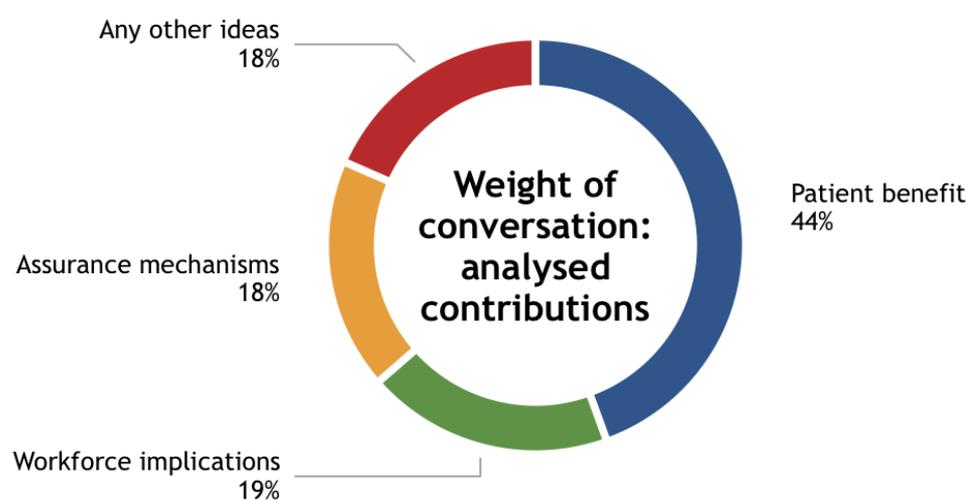


Figure 8

Every single idea submitted, or comment made was analysed. Four thematic frames emerged, against which every idea or comment was coded.

1. **Geography:** A coding frame to understand whether the idea or comment made was focused on national, local and regional, or individual level activity
2. **Profession:** A coding frame to understand whether the contribution was focused on, or related specifically to, a single professional group or multi-professions.
3. **Policy theme:** A coding frame to understand the policy theme being discussed (such as education, regulation, cost-effectiveness, workforce planning etc.)
4. **Meta-themes:** A coding frame to understand meta-themes from the conversation, specifically, whether what was being proposed was emphasising action to be taken, impact expected, development of advanced practice, or oversight required.

Analysing the data through these frames helped us to generate a more sophisticated view of the conversation and to ensure our analysis is valid, accurately reflects the views of the participants (your crowd) and is not driven or unduly influenced by personal or pre-conceived views. The coding frames used are referenced below and set out separately in the appendices.

## 8. Benefits to patient care

### Overview of the patient benefit conversation

The crowd was asked to consider the impact on patient care of the development and deployment of advanced practitioners if they were to be scaled across England. There were 4,175 contributions to the question on patient benefit which represented 58% of the total conversation.

The coding of ideas and comments revealed a clear picture that the crowd felt there were significant opportunities to benefits to patient care, with 60% of the ideas and comments under the patient benefit challenge question highlighting the potential *impact*. 18% of the contributions focused on the *development* of advanced practice. A further 15% highlighted specific *actions* to be taken with just 8% relating to *oversight*.

Table 9

#### Benefits to patient care from the development of advanced practice

Action	15%
Development	18%
Impact	60%
Oversight	8%

### Impact of advanced practice on patient benefit

When we examine the contributions submitted to the patient benefit conversation that were more *impact* focused, we see the crowd placing an emphasis on the following themes:

- impact through efficiency gains;
- impact on quality; and,
- impact through innovation

#### Impact through efficiency gains

Participants repeatedly pointed to improvements in care that could be brought about by greater utilisation of advanced clinical practitioners (ACP). Several comments highlighted the opportunities already being exploited to work across boundaries, in multi-disciplinary teams and making fundamental contributions to helping people to maximise self-care, prevention and to stay in work.

Several participants referenced the work undertaken by advanced clinical practitioners and that the development of integrated care systems had the potential to provide more opportunities for ACPs to add value across health economies and not just in individual trusts.

There were numerous contributions about the opportunities to deliver more efficient and effective primary care using ACPs and arguing for a re-think of the role of general practice

as the ‘gatekeeper’ for primary and often secondary care. The comment below reflects this sentiment.

*“One way to work in partnership rather than having a GP as a gatekeeper is through an enhanced primary care model. This consists of a broad, skill mixed team including admin, advanced practitioners from nursing, physio, paramedics, mental health, complex care, GPs, social work, voluntary sector, health coach. Decisions are made in a ‘huddle’ / team case review about who is best placed to work with an individual. This reduces duplication, allows the right input first time and allows H&SC professionals to work at the top of their licence.”*

There were also multiple examples of specific therapeutic areas where advanced practice was already delivering efficiency gains and service improvements, such as musculoskeletal disorders and osteoporosis management.

#### Impact on quality

When looking at opportunities to have an impact on quality (reflecting the assessment criteria used by CQC: effective, caring, responsive and well-led), again, numerous examples were given by contributors indicating that scaling these sorts of activities across the country could have a major impact on the quality of care (as well as expansion of ‘model’ services). Several contributions to the debate highlighted the opportunities from advanced practice roles for ACPs to provide patient assessment autonomously including therapeutic and diagnostic procedures in areas where there are recognised skills gaps.

#### Impact through innovation

There were many contributions which highlighted the opportunities to innovate and deliver patient benefit. Participants highlighted opportunities to deliver care in more effective ways by expanding the role of advanced practice, for example with increased prescribing rights or qualifications, but participants also highlighted were the role of innovation and technology, such as the comment below.

*“ACP’s will have a really important role as innovators. Having the skills and capacity to develop and test new devices, technologies and systems of work via rigorous, theory-based research is pivotal to the advancement of healthcare, especially in this time of digital revolution. Involving service users in the development of these new innovations is key, and ACP’s clinical backgrounds mean they are accustomed to listening to their clients in this way already. Its second nature to them.”*

#### Development of advanced practice for patient benefit

Although other parts of the conversation (particularly the section on workforce development) focused more heavily on the development of advanced practice, there were 96 ideas or comments which made the link between development of advanced practice and patient benefit. In the contributions submitted to the patient benefit conversation that were more development focused, we see the crowd placing an emphasis on the following themes:

- development of careers; and,
- development through research

#### Development of careers

Many of the contributions highlighted the link between patient benefit, national workforce challenges and the need for career development opportunities for advanced practice. A common theme throughout the conversation was the untapped potential of ACPs in clinical

roles, but a frustration that the lack of opportunities for career development will have an impact on retention.

*“All too often currently, AHP staff with significant knowledge, experience and expertise need to move away from clinical practice (i.e. into management or research) in order to progress. Introduction of appropriately recognised and graded ACP posts may therefore help to offer a greater range of career development for staff but also - and most importantly, to retain clinical expertise within clinical areas.”*

The ideas and comments also reflected wider national and local conversations about workforce pressures, challenges around recruitment and retention and the need for the NHS (and other providers) to look at different ways of utilising skills mix in the workforce.

#### Development through research

Several contributions highlighted the importance of research as part of the development of advanced practice. In particular, the important role research plays in providing an evidence base for the value advanced practice can bring, but also in identifying where benefit to patient care can be realised. Emphasis was placed on the need to support advanced practitioners in research roles, as part of the multi-professional framework. The comment below was reflective of several ideas and comments in this area.

*“Having a wider range and greater number of professionals actively undertaking healthcare research, each with their own unique perspective, influenced by their professional background, will result in some excellent advancements in clinical practice. We know that quality of care improves in research active organisations. ACPs have a role of not only undertaking research themselves, but encouraging their team members to read and critically appraise, to stay up to date, and to apply what they learn when seeing their patients. They could be instrumental in creating a culture of evidence informed practice in multiple organisations.*

#### Action on advanced practice for patient benefit

When we examine the contributions submitted under the patient benefit challenge question which indicated some form of action recommended, we see the following themes emerging:

- Action to standardise advanced practice;
- Action to address issues of status; and,
- Action to address workforce planning.

When reviewing the comments, many of them were reflecting a perception that structural changes would need to be made before patient benefit could be maximised. Some of these related to the quality of advanced practice, for example the need to ensure education and training standards were consistently high, others related to the perception of advanced clinical practitioners amongst colleagues, particularly from other health and care professional groups.

The issue of status and of standardisation were often used interchangeably in the conversation with participants often feeling that the status and use of advanced clinical practitioners would never be optimised for patients while there was variability in their education, training, supervision and competencies. This topic also crossed over with that of comments about whether there was a trade-off between training advanced practitioners in increasingly specialist areas, or the need to have advanced generalists to provide effective triage, diagnosis and treatment.

#### Action to standardise advanced practice

Several contributions highlighted the need to standardise advanced practice if patient benefit is to be realised properly. Post-graduate education and training was often seen to have significant variation in course content, while there was also too much variability in work-based learning. This challenge was a theme repeated throughout the conversation.

*‘We need to work on standardising this role across the country, with the skills and role expected to be delivered made more universally accepted. This should be all the way through from the University programs and what they contain, to the day to day role fulfilled. There needs to be more co-ordination across each trust or place of work so that they are identifiable to everyone.’*

Comments also referenced the four pillars (of the advanced practice framework) as being an important tool in bringing consistency and standardising the function. The need to act to standardise through articulation of the role and what it means was commented on several times as the comment below reflects.

*‘Working under the 4 pillars offers a clear role and offers employers ‘bang for their buck’ as the ACP is invested in the clinical area as opposed to passing through. By offering another level in the AP role will give a clear development pathway and aspirational pathway for ACPs but supports a resilient/ sustainable workforce. There is a clear need to articulate/ standardise what we mean by each level in terms of capability/role.’*

#### Action to address issues of status

The need to act to address issues of status were brought up by numerous participants. The comments related both to status in NHS pay grades (with many highlighted differences in grading between trusts and between specialisms), but also - seemingly in a more fundamental way - the need to act to ensure clinical and managerial colleagues gave due recognition to the skills and competencies of advanced practitioners.

*“...We also need to work on recognition of skills brought into the role - ie paramedic versus nursing versus physiotherapist versus pharmacists and not expecting them to do the nursing SCOPE for that specific trust when they have been doing the skill under their regulations for years.”*

*“ACPs are professionals who have developed their skills to a very high standard. The[y] are highly experienced and educated members of a healthcare team who may have the additional skills of being able to diagnose some conditions as well as provide a standard of treatment. As such, they should be empowered to make high-level clinical decisions.”*

Ignorance of the role, the training, the added value ACPs can bring, was seen to be a major inhibitor to utilisation of advanced clinical practitioners and, as a result, to patient benefit.

#### Action to address workforce planning

If patient benefit is to be realised, action needs to be taken around workforce planning according to many participants. Many comments highlighted the need to look at the changing shape of the workforce and the benefits advanced practitioners would bring. Some comments, like the one below, appeared to suggest that the commissioning structures and traditional ways of planning workforce development were ill suited to modern practice of health and care and more based on a medical model which is less flexible, less responsive and inefficient.

*“As many have already detailed, the world is now a different place and Advanced Practice roles are well suited to assist in the changing face of the workforce and the requirements of delivery models.*

*There is still a huge chasm to cross that needs addressing, the lack of political buy in. The tariff seems to still weight commissioning decisions to medical delivery whereas a lot of the areas that would benefit from ACP delivery are then earning less money when the consistency and quality is, in a lot of instances, improved.”*

The comment below highlighted both issues around status, but also the ‘untapped resource of highly skilled’ people represented by advanced practitioners.

*“As a Consultant Podiatric Surgeon, I have been at the forefront of skill development within my profession. We offer a range of foot and ankle surgical procedures that has demonstrated clinical efficiency and cost effectiveness. Yet many of us find it difficult to be accepted and fully integrated by our employing Trusts and job opportunities are rare. If the NHS is to promote multi-disciplinary work and utilise the skill mix that is available boundaries to professional practice need to be broken down. There is a huge untapped resource of highly skilled people in the NHS that have the training and skills to do more but are being held back. If the NHS is to modernise and deliver effective health care efficiently this practice must end.”*

### Oversight of advanced practice for patient benefit

Of the contributions to the challenge question on patient benefit, the fewest were focussed on the need to develop or enhance *oversight*. There were still 50 ideas or comments related to this part of the conversation. Perhaps unsurprisingly, the focus in oversight was on the need for regulation or improved leadership of advanced practice at an organisational or national level.

When we examine the contributions submitted to the patient benefit conversation that were more focussed on oversight required, we see the crowd placing an emphasis on the following themes:

- Oversight through regulation; and,
- Oversight through enhanced leadership

### Oversight through regulation of advanced practice

Although there were differing views about how it should best be done, there appeared to be a consensus amongst the participants that some form of enhanced regulation (be it voluntary or mandatory; national, organisational or local; or through regulation of qualifications or practice) was needed. A number pointed out a perceived relationship between increased direct autonomous delivery of patient care and the push for enhanced regulatory oversight.

The comment below reflects a general theme and view which surfaced repeatedly in the conversation that because advanced practice is growing it needs a proportionate increase in regulation. The comment below reflects this sense of regulatory gap, without articulating what form of regulation (be it systems, legal or professional regulation).

*“Advanced clinical practice is developing, it is becoming increasingly understood and supported by our other health professionals. Advanced clinical practice can stream line patients need[ing] to be seen more efficiently, reducing waiting times for appointments, providing expert care, and focusing on the patient from a bio-psycho-social point of view, enabling the patients to gain access to the right treatment at the right time in the right*

*place - ensuring equality of care provision for all.  
Advanced practice is growing - we need regulation!!”*

While some focused on a general theme of regulation, others, such as the comments below, highlighted the need to have more transparency about the status and qualifications of advanced clinical practitioners. The ability to check the status, through a registration portal was seen as important, from the point of employers.

*“Should we be pushing for the title to be legally protected with a separate register as are midwives? I worry that the tendency to create a title then without a measurable level of education and competence anyone can adopt the title rendering it meaningless in particular the patients. An advanced practitioner should have a post grad / masters level qualification and be a V300 prescribed as entry level to the register. The general public understands what a nurse is and what a midwife is, but I'm not sure they understand what an A C P is, or indeed, what they do.*

*We have some work to do to agree equity of education and competence depending on the route of entry... whether nursing, Paramedic, podiatrist or whatever initial skill set. Credentialising will not cut the mustard. I hope that we are not too late...always difficult to get a genie back into a bottle...”*

Finally, several comments, such as the one below, highlighted the need for some regulatory oversight in relation to knowledge, skills and competencies. This also linked to a broader question about the extent to which the public get their reassurance through an association with a job title. Although the evidence from elsewhere indicates this may be more an issue for colleagues within the health and care system, it was a common theme in the conversation.

*“Scaling up ACP / CP roles, with rigorous assurance of competencies and consistency across profession and clinical area will enable employers, commissioners and the public to value and request more. It is important that the titles can act as a short hand which clarifies comparable expertise and promotes confidence.”*

#### [Oversight through improved leadership of advanced practice](#)

Some of the contributions under the patient benefit question highlighted the importance of professional leadership and the need for oversight to be delivered from ‘within’ advanced practice professions.

*“AHPs often lack a voice as often are not recognised and not represented at Board level. This can mean we have to shout louder to get through levels of bureaucracy even where new roles could be innovative and highly cost effective. This is demonstrated by how few ACP and Consultant Roles have been established despite examples. Better non-medical role development networks are being established but need joining up with leaders.”*

This theme about leadership within trusts at a local and regional level and at a national level is mirrored in the conversation about whether advanced clinical practitioners are a subset of their ‘host’ profession, be it nursing, pharmacy or physiotherapy, or whether they have, or should develop into a distinct professional group.

## 9. Workforce implications

### Overview of the workforce implications conversation

The crowd was asked to consider the workforce implications for NHS organisations and other providers of care in the development of advanced practice, and how they can exploit the opportunities provided by advanced practice. There were 1,173 contributions to the question on workforce implications representing 16% of total conversation.

The coding of ideas and comments under the workforce implications challenge question revealed that 40% of those contributions reflected some form of recommended *action*, while 34% of contributions on workforce were focused on *development* of advanced practice with smaller contributions relating to *impact* and *oversight* of advanced practice. The breakdown is set out in (Table 10)

Table 10

#### Workforce implications for employers now and over the next 5-10 years.

Action	40%
Development	34%
Impact	16%
Oversight	9%

One of the clearest messages coming through in this part of the conversation was that development of advanced practice had to be part of the solution to the growing workforce challenges within the NHS. For each of the recognised challenges in the workforce, participants felt that advanced clinical practitioners were a key part of the solution. Helping to maximise care for increasing numbers of patients with multiple co-morbidities; a flexible workforce group able to support clinical and therapeutic areas with clinical staff shortages; a part of the workforce well placed to work flexibly across primary, community, secondary and tertiary care.

#### Action required in response to workforce implications

When we examine the contributions submitted to the workforce implications section of the conversation that reflected the need or desire for *action*, we see the crowd placing an emphasis on the following themes:

- Action on workforce planning; and,
- Action to bring further standardisation.

### Action on workforce planning

A common theme throughout the conversation is the need to do more to support clinicians, particularly those who wish to see career progression, to stay in clinical roles. A career pathway for advanced practitioners was seen as a positive way of doing this with huge potential to reshape the workforce.

*“There is a massive potential benefit of supporting retention and keeping staff in clinical work rather than pushing those staff who want progression towards management roles. We need to do more to keep clinicians in clinical roles and give them a sense of progression and opportunities for development.”*

There were some words of warning however. The comment below highlights the potential for destabilising the workforce if experienced clinicians move from their current roles into advanced practice without some strategic planning and enough trainees or junior staff coming through.

*“The NHS needs to be careful in their recruitment. Taking experienced and senior professionals from their core professional roles will leave an inexperienced workforce on the front line. Extra training and recruitment should be sought to address this gap left behind to ensure patient care does not suffer. Similarly, there are few Trusts that have developmental roles for ACP’s or PA’s - they qualify and then that’s it; no career progression and no recognition for their development. Nothing to strive towards on a personal level. Those using agenda for change are particularly at risk of losing staff to areas where the scale is not used and where higher pay can be offered.”*

One employer, powerfully described the importance and urgency of this issue, as well as some of the challenges in articulating a vision and the practical reality.

*“As an employer I need this workforce now. Appreciate we need training but training must be focussed on what I need I need help to get the work-based components right and I cannot afford to alienate my existing senior staff who didn’t have these opportunities but are invaluable. I also don’t understand the consultant roles and need similar help to understand how these roles fit.”*

This comment also highlights the challenge - or possible trade-off - between having training bespoke to local challenges and consistent national standards. It also highlights a significant challenge about how you provide opportunities for experienced and skilled staff who don’t have a level 7 qualification but might be carrying out ‘advanced’ functions.

### Action to bring about greater standardisation

References to the need for action on standardisation emerged in both this part of the conversation, but also prominently in the debate on assurance mechanisms. Participants referred to standardisation as something which needed to be looked at in the context of education, functions, career pathways as well as job descriptions. In relation to workforce implications, some comments were popular such as the following simple message about avoidance of variation between advanced clinical practitioner roles in physical and mental health (both in function but also in grade and status).

*“We need more research to understand variation in the way in which these roles are developing across the NHS, especially in areas like mental health.”*

When contributions were more ‘solutions-focused’ presenting options for change, there was greater contentiousness in the responses. The following contribution was well supported (with 21 likes, but also 8 dislikes).

*“The ACP framework has beautifully articulated ACP as a level of Practice so now is the time to be brave and define our other job titles more clearly and adopt them universally - I propose:*

- *Health Care Assistant*
- *Assistant Practitioner / Nursing Associate*
- *Registered Practitioner (Nurse, Physio, Radiographer, etc)*
- *Advanced Clinical Practitioner*
- *Consultant Practitioner*

*Let’s get rid of everything else, it’s got to be better for patients and employers!”*

The challenge around job titles again reflects the competing desires for, on the one hand, flexibility in the role, meeting emerging patient needs and being able to innovate, and on the other hand, certainty about what the role does, consistency of job titles and job roles and building confidence of other professionals through experience in post.

### Development requirements for advanced practice workforce

When we examine the contributions submitted to the workforce implications conversation that were more development focused, we see the crowd placing an emphasis on the following themes:

- Development of careers in the workforce; and,
- Development of higher education to support the workforce.

When we look in detail at the contributions about development and workforce implications, they commonly make points on both the need for career development but also around education, especially continuing education. The comments often related to the role as being new and, as with any new or emerging role, the need to utilise frameworks and development opportunities were seen as important. There were some dissenting views which felt that far from being new, advanced practice had been in place for a long time, the issue was more about recent recognition.

### Developments needed in careers: workforce implications

A common theme throughout the conversation was the need for development of careers and career structure within the advanced practice workforce. The comment below is reflective of the views expressed about the need for career structure in clinical practice.

*“I have been in an AP role in some guise or other for 5 years now as an 8b. I’m struggling to know what my next step is. I have completed my doctorate and would like to progress my career further. If I want to increase my band it’s likely I would have to drop clinical practice and go in to management. Doctors can earn six-figures and remain clinical. This is not the case for ACPs. In order to ensure that we retain the ACPs we have fought so hard to train and recruit, we need to ensure that there is a clear pathway for career progression. ACPs are likely to be ambitious individuals who want to invest in their careers and won’t want to stay static for too long.”*

Contributions also highlighted the conflict that can occur when advanced practitioners are expected to do management work alongside clinical work and whether this was a disincentive to seeking promotion.

The following idea set out a comprehensive set of development ideas for the workforce and highlighted another common theme of the conversation, the need to move quickly to help meet the wider challenges around the NHS workforce.

*“As a consultant nurse of 18 years, we need to identify those individuals that hold the values and entrepreneurial qualities needed to develop ACP’s for our future workforce. Too often exceptional clinicians become disillusioned by the lack of career pathway for them to progress and lead the changes that are needed to retain them in practice.”*

#### Continuing education requirements: workforce implications

A number of comments were made throughout the conversation about barriers to development including a perceived need for more support from employers in training.

*“Why is it that so many AHP posts have no funding to support any CPD activities? This should be standard practice when roles are defined and established. There should be equity with medical CPD funding streams as we are all part of the NHS. Why should AHPs have to undertake additional training in their own time and expense when the post requires them to have these skills. We are always being encouraged to take a leaf out of industry - let’s start by investing in on-going education and development.”*

Participants felt that there were real barriers to the development of advanced practice with a need to: develop robust training and education programmes across organisations; expand values-based recruitment; the need for rotation posts (at band 5) in specialist teams; and, structured career pathways.

#### Impact of the implications for advanced practice workforce

When we examine the contributions submitted to the workforce implications conversation that were more *impact* focused, we see the crowd placing an emphasis on the following themes:

- efficiency; and,
- multi-disciplinary team working

The urgency of developing a credible response to the workforce challenges in the NHS recurs during the conversation. In this section, participants highlighted the need for a flexible workforce able to meet future demands, not just demands of today. Also highlighted was the need for flexibility, working across teams.

#### Impact of efficiency gains

Ideas and comments that were focused towards the impact of the workforce implications for employers over the next 5-10 years, highlighted efficiencies available within organisations, but also over the health system.

*“The role of advanced practice will be key to delivering modern healthcare in a safe cost effective way. People are living longer often and with significant healthcare needs as treatment options and outcome improve. This presents a completely new set of challenges for the care giving workforce. A suitably trained practitioner can give an excellent standard of care no matter their background title but may entail some joined up thinking and thinking laterally.”*

### Impact on multidisciplinary team working

Contributors to the conversation recognised that advanced practitioners do not work in isolation and that any changes to their roles and functions would have an impact on other parts of the workforce. As the following contribution highlights this presents some specific organisational development challenges for employers.

*“Development of advanced practice roles have to be aligned to service developments and not just looked at in isolation as a good thing to do. An OD approach to support the implementation is key. We need to consider the impact on other roles as part of both the immediate and wider teams, as well as across different professions and to consider opportunities for development of the support worker workforce as well.”*

### Oversight relation to workforce implications

When we examine the contributions submitted to the workforce implications conversation that were focused on the *oversight requirements*, we see the crowd placing an emphasis on the following themes:

- regulation; and
- governance

Most of the conversation about oversight featured under the challenge question on required assurance mechanisms. However, there were comments in relation to workforce implications where participants highlighted varying degrees of concern and confusion about the role of regulation and where it should sit, what the risks were and how it dovetailed with educational and organisational governance.

### Oversight through regulation

Several ideas and comments were made in the conversation under workforce implications for employers that highlighted the oversight implications. The contribution below highlights a question for employers and a desire for clarity around the assurance mechanisms.

*“Will employers want and ask for accreditation or equivalent if they do this sets the standards for these roles? This seems vital.”*

This comment reflects a broader concern emerging from the conversation about how employers can be assured about the knowledge, skills and competence of advanced clinical practitioners. There was little reference to the professional regulatory framework advanced practitioners were currently subject to, but an emerging desire for more assurance around education and competence. As the comment below highlights, there was also a recognition that more national regulation is not always desirable but that there were other mechanisms to achieve confidence in practitioners, especially through regulation of education standards.

*“ACP/Cons Practitioners should be appropriately regulated... but also need to avoid jumping through multiple hoops to continually justify level of practice over and above what medical practitioner colleagues are expected to do (or not).”*

*Without taking this agenda seriously, embracing it and implementing a robust system of education, regulation and career pathways, we will be talking about this again in 5 - 10 years' time. To not do so would only allow loss of confidence by the patients we are there to serve, we need to seize this opportunity and show that we are listening and reacting to the impending crisis that is facing our future workforce sustainability.”*

### Oversight through effective governance

The comment below highlights a recognition that oversight is not the preserve of national bodies but that there is a need for effective governance to be implanted by employers. In this example the need for governance around clinical work-based learning (and contact time) is highlighted.

*“Should guidance on minimum / maximum clinical contact time be introduced for ACP so that there is recognition of the wider aspects of the role and protection from 100% clinical activity only? This would also be helpful a precedent for role progression as an ACP will need to develop their experience and credentials in these respective domains to develop the necessary skills for more senior posts”*

There was also specific reference to the need for national level governance and support, specifically a call for a new national body to oversee advanced practice roles.

*“A new body who oversee all roles that are determined as advanced practice ACPs would help address the identity crisis that many ACPs face and also provide equal and fair support specific to the advanced level role.”*

The suggestion that a national body could support the development of the workforce was further expanded in the section of the conversation on assurance mechanisms.

## 10. Building the right assurance mechanisms

### Overview of the conversation on assurance mechanisms

The crowd was asked to consider what assurance mechanisms would be required if advanced practice was developed and deployed fast, and at scale. There were 954 contributions to the question on assurance mechanisms representing 13% of total conversation.

The coding of ideas and comments under the assurance mechanism challenge question revealed that 55% of those contributions reflected a focus on the need for *oversight* with 25% focused on *development* of advanced practice, with a smaller percentage of contributions relating to *action* required and *impact* of advanced practice. The breakdown is set out in (Table 11)

Table 11

#### Building the right assurance mechanisms for advanced practice

Action	15%
Development	25%
Impact	4%
Oversight	55%
Other	1%

### Oversight and providing assurance mechanisms

When we examine the contributions submitted to the question about building the right assurance mechanisms for advanced practice, perhaps unsurprisingly, we see that the crowd placing on the need for *oversight* and the following specific themes:

- regulation; and
- governance

#### Oversight through regulation

Several different topics were raised in which regulation, or the role of regulators was mentioned. Credentialing was raised as a topic for urgent consideration during the conversation. The following comment reflects those comments and advocates professional regulators taking a direct role in checking and publishing lists of credentials of their registrants.

*“Some form of accreditation or credentialing should be a tool used to provide assurance of the qualifications and specialisms of advanced clinical practitioners. Masters level qualification might provide the basic assurance but need to think about ongoing professional development. The professional regulators should be encouraged to check credentials and publish them so patients and employers can check.”*

This theme around continuing education and the role of regulation both in accreditation or assurance of standards was linked as well to the issue of protection of title. The contribution below raises international comparisons and the Nursing and Midwifery Board of Australia's (NMBA) which endorses nurse practitioners (advanced practice) in Australia.

*“Regulation, though not a 'solve it all' idea, is one that may provide a substantial move towards providing clarification around education and training standards, a greater assurance of a 'fitness to practice' at an advanced level, enhanced trust and inter-professional respect and multidisciplinary team working, clearer avenues for discussions around remuneration, some standardisation of role titles, a protection of title(s) and, a potential avenue into creating a career framework and structure that can 'hold on to' practitioners.”*

*“One solution to the first issue may be to create an 'endorsement' of the primary registers of each ACP 'trade' (this is very similar to the Australian model of advanced nursing practice).”*

Specific issues in relation to difference healthcare professions were raised. For example, one contributor highlighted the Royal Pharmaceutical Society Advanced Pharmacy Framework<sup>7</sup> as an example where professional bodies help provide profession specific assurance mechanisms under, or alongside, the HEE advanced practice framework.

Others felt more formal regulatory mechanisms were needed, in part to support the development of advanced practice, as well as giving some level of assurance. The comment below gives a specific example, highlighting a perception that prescribing qualifications were a pre-requisite for development of advanced practitioners.

*“As an ODP, if the ACP role/profession does not gain regulation and with it prescribing for ACPs regardless of base profession my career prospects as an ACP are severely limited. ODPs will not for at least 10 years I would estimate, if at all, gain prescribing. No band 5 or 6 ODP requires prescribing. However an ODP that works at an advanced level of practice as an ACP requires prescribing. Many say that ACP is a level of practice, which is correct, however, it's only a level of practice is you can gain employment as a ACP. Without regulation of ACPs, there will be very few ODPs that want to advance will actually be able to break through the professional glass ceiling that restricts ODPs progression. My development as an ACP very much depends I believe on ACPs gaining regulation and protection of title.”*

#### Oversight through governance

While many in the conversation focused their comments on assurance mechanism towards regulators and strengthened regulation, a theme emerged around the need to look more broadly at governance to provide enhanced assurance with comments on assurance of education and training prominent in the discussion. There were fewer contributions to this part of the discussion, perhaps reflecting the small number of 'regulators' participating in the conversation (only four comments in total were from someone employed by a regulatory body). There was support, however, for enhanced governance in education.

*“Someone needs to set and assure standards for education and training of advanced practice. This is really urgent if we are to retain confidence of patients and employers in these emerging roles.”*

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<sup>7</sup> <https://www.rpharms.com/resources/frameworks/advanced-pharmacy-framework-apf>

There was support for the proposal to consider an ‘academy’ governance model, something which had been explored extensively in the physical workshop. However, others contributing were not so sure with concerns raised about whether, in education at least, the solution is better engagement with HEIs or professional bodies. The comment below highlighted a concern to ensure central coordination doesn’t detract from professional identity.

*“By having a central co-ordination policy is there not a concern of losing profession specificity?”*

*I feel role merge will not only compromise patient care but also make a homogenous profession which doesn't allow for speciality training.”*

The question about how to recognise acquired prior learning also emerged in the conversation, specifically how to maximise the impact of those who practice at an advanced level, but do not have a Level 7 qualification (masters equivalent). The question was raised about whether the advanced clinical practitioner route is closed for those who are unwilling to compete a masters qualification or whether some form of equivalence route or competency test would be considered by any assurance or regulatory body.

### Development of advanced practice through assurance

When we examine the contributions submitted to the question about building the right assurance mechanisms for advanced practice several comments focused on *development of advanced practice* though higher education and supporting career development:

- higher education; and,
- career development

The contributions reflected a range of views about whether the right assurance mechanisms exist and need to be further rolled out across employers, or whether further assurance, particularly at a national level is required if advanced practice is to develop.

### Development through education

When considering how advanced practice could develop further with the right assurance mechanisms in place, participants commented about the existing mechanisms in place. Reference was made to generalist competency frameworks as well as specific role-based competency frameworks at employer level. Views were expressed, however, that there needs to be a “recordable qualification” with comparisons drawn with prescribing qualifications which are approved or recognised by national regulatory bodies.

The need to clarify the respective responsibilities of universities and employers was also highlighted as a barrier to the development of advanced practice. The comment below is reflective of this view expressed by participants.

*“How do we clarify the relationships and responsibilities between universities employers and the individual to ensure that this work-based learning is able to bridge across and ensure robust work-based learning, supervision and support?”*

### Development of advanced practice and career development

The comment below reflects a theme in the conversation about a desire to have a clearly defined career structure, with ACP leadership at the top. However, it also highlights a perception that trusts build posts around individuals, rather than functions required, and

that organisations need to ensure the career development is not designed around the medical professional model but reflects the functions and roles of ACPs.

*“It is important AP roles are based in the role and not an individual. All jobs should have a structure and framework and not be left to operate in silos. The leadership of these roles facilitates the importance of non-medical consultant posts, rather than leadership in the traditional DDN structure which often doesn't fit. Trusts should have a dedicated career pathway for AP regardless of professional background to offer professional support and guidance. These roles are vital in the ever changing NHS & there is not a one size fits all, each are vital from reporting radiographers, msk cats or interference teams, FCPs to those on wards covering medical duties. We are not doctors or trying to be doctors we are professionals on our own right and should have the local structures to support this. You wouldn't have a medical role without a consultant at the helm or senior leadership/ medical director so why accept this as an AP?”*

### Action recommended relating to enhanced assurance

When we examine the contributions submitted to the question about building the right assurance mechanisms for advanced practice several comments focused on the need for *action*. These comments highlighted a desire for greater standardisation across advanced practice. The desire for standardisation was reflected both in ideas and comments about advanced practice specialisms, about recognition between trusts but also about education and training.

#### Action on standardisation

Several ideas and comments were suggested in response to the challenge question about assurance requirements which focused on the need for increased standardisation in advanced practice. The conversation raised question marks about the need to standardise job titles (reported early in this document) as well as consistency across the NHS. However, there was notable support in this section about the need for greater assurance around education and training. This is reflected in the comments below, the first of which relates to higher education, the second to work based training.

*“Could all university's offer similar programmes or major in certain things so there is more standardisation but still, with some room for innovation? We need core content and specialist content, but this means we need lots of some subjects and less of others this will need some coordination in an area but could be much better for employers confused over what courses to send staff on.”*

*“There should be standardisation of training across all sectors. There should be core national requirements, possibly with variation across specialties to ensure flexibility within national roles. There should be a minimum training period for consolidating knowledge and skills.”*

Several comments were also made about the need for more consistency between advanced practice roles in mental health and physical health.

*“Trust need to value the staff they are putting through and place people on the correct banding. Mental health ACPs in the trust I work for are band 7 yet the physical health in same trust are 8a! We have all done the same course. We both have valued skills why not join us together and work collaboratively learn from each other.”*

## 11. Other ideas and comments

### Overview of the conversation on other ideas

In addition to the three broad challenge questions (focusing on patient benefit, workforce implications and assurance mechanisms), we also asked for participants for any other ideas or comments about the development of advanced clinical practice and how it can be developed to serve patient care and population health effectively both now and in the future. Nearly all the comments made under this ‘catch-all’ challenge question could be allocated to the sections on patient safety, workforce development or assurance mechanisms; and as with all of the conversation, the ideas and comments often interlink with other sections.

There were 939 contributions to this part of the workshop, representing 13% of the total conversation.

42% of the contributions made in this section focused on action to be taken, 34% on development of advanced practice, with 12% on impact and 11% on oversight. The sections below provide an overview of some of the ideas and comments made that gained support from the crowd.

Table 12

#### Other ideas and comments about the development of advanced practice

Action	42%
Development	34%
Impact	12%
Oversight	11%
Other	1%

### Action: other ideas and comments

When we examine the contributions in this ‘open’ section asking participants for other ideas, the contributions which emphasised some form of action to be taken were focused on the following themes:

- status; and,
- standardisation

### Status of advanced practice

A recurrent theme throughout the conversation related to the status of advanced practitioners and the rhetorical question about what needed to be done to ensure the function was not seen as purely medical substitution. 68 participants indicated support the following comment:

*“Advanced clinical practitioners (whatever profession we are from) and system leaders need to applaud and explain how we add value within multi-professional- teams. We need to get away from the concept of medical substitution and proudly take the space of experienced proud professionals.”*

The comment above and many others were critical that the concept of medical substitution fails to recognise that although deployment of advanced practitioners helps mitigate emerging risks caused by shortages in the medical workforce, by deploying advanced practitioners, there are significant opportunities to enhance care not just reduce risk. The comment below is one example.

*“The skills and experience I have gained in over 30 years nursing provides a holistic patient centred approach within an advanced practice role, not a medical substitution. This experience provides the basis of my confidence to talk with my patients about very difficult issues relating to diagnosis and prognosis. Rather I see the ACP, advanced practice nursing roles and medical roles working together and learning from each other with mutual respect.”*

There was an acknowledgement that the challenges around shortages in the medical workforce have sometimes created an opportunity for a rethink, but, again, this often fails to recognise that recruiting advanced practitioners can improve patient care.

*“Advanced practice roles have shown their value and are widely accepted. However, there is still a tendency to believe the roles are purely to plug holes left by reduced medical numbers. The advanced practice workforce is a developing workforce, yet there are clear examples of excellence which should be showcased more prominently to show what can be achieved. “*

*“Local needs analysis can identify key areas where advance practice roles could be utilised to enhance patient care and improve services. More needs to be done to assist the development of business cases to help push these forwards, especially in areas not currently up to date with advanced practice developments.”*

#### Standardisation within advanced practice

A recurrent theme in the conversation was about unwanted variability within advanced practice and how to address this. A number of contributions, such as the one below, reflected the challenge about retaining flexibility, but also a desire to bring some form of consolidation to job titles.

*“Is this a title or a level of practice? How do we respectfully support people with different titles to fit into a modernised set of titles, this needs to be worked through, through this work? The NHS careers framework refers to specialist as a title below advanced, yet in service we use the titles interchangeably - we need clear guidance to support people and make sure people are valued through change.”*

#### Development: other ideas and comments

When we examine the contributions in this ‘open’ section asking participants for other ideas, those which had a particular emphasis on *development* of advance practice, were focused on the following themes:

- career development; and,
- education

### Career development in advanced practice

The conversation demonstrated that participants were keen to see both increased opportunities within advanced practice as well as support, guidance and mentorship for trainees. The two comments below reflect this narrative.

*“It would be good to have more clarity on the role and training opportunities, so we have onwards career progression.”*

*“Having a clear Structure for progression into advanced practice will give clear guidance and help retain staff in more junior roles who aspire for Advanced and Consultant practice. More Trainee roles will allow staff to learn from current Advanced Practitioners whilst still developing and gaining the experience needed for such an important role.”*

### Education in advanced practice

There were a number of different ideas and comments in relation to the desire for development and role that education could place. The first of the comments below reflects a theme in the debate about the desire for greater recognition of prior learning and experience. There were mixed views about credentialing in the conversation but here it was seen as fundamental to recognising experience and qualifications outside of the masters level programmes.

*“I feel that the more experienced ones of us are getting a little bit left behind because of the new Uni courses, Modules and credentialing requirements that work-them-up to ACP's. I never had that luxury when I was learning and developing, nearly all of my courses and modules were pre ACP MSc and even Uni accreditation (ie health assessment, minor injuries etc.)... I believe that Credentialing is instrumental in gaining parity, recognition and respect from our medical colleagues. It also provides us with the passport to cross fertilise in different departments, Trusts and environments. However, I still feel that we need to be pragmatic - to respect experience and credibility and not be too L7 credits savvy!”*

Again, a common theme in the conversation around development of advanced practice was a perceived need to address confusion and variation in the advanced clinical practice MSc while also ensuring there are suitable courses for more specific clinical areas, such as mental health.

*“In terms of education there are a vast number of HEI's around the country offering Mental Health 'specific' ACP MSc's, on looking at these they are generic ACP MSc's with often just one MH module. This module seems to vary widely, from focus on assessment, diagnosis and treatment of MH disorders; psychological therapy; developmental aspects of psychiatry; focus on ICD10 criteria, and many more. This suggests to me that there needs to be more work done to define what exactly is advanced practice in mental health, and what is the vision for how it will be used across differing roles and settings to maximise its potential.”*

### Impact: other ideas and comments

When we examine the contributions in this 'open' section asking participants for other ideas, those which had a particular emphasis on *impact* were focused on delivering quality though more effective outcomes and effective use of resources.

### Quality through advanced practice

When carrying out thematic analysis in the open section of the conversation, participants identified two specific ideas which they felt could have an impact, but also reflected the

slowness of the ‘system’ to innovate. These were expanding prescribing qualifications for all advanced practitioners, as well as utilising the workforce better so that advanced practitioners can issue ‘fit notes’.

*“Your ability to prescribe should be based upon your role, not your base profession. If you hold an MSc in advanced practice you should be able to complete your NMP. I also agree that there need to be parity in prescribing rights across the professions.”*

[Fit notes] *It is hard to believe we still have a situation where clinicians best placed in terms of knowledge and skill to advice patients re adapted working and phased return to work cannot do so as it must be done by a doctor. Give APs the tools they need to do their job completely.”*

### Oversight: other ideas and comments

When we examine the contributions in this ‘open’ section asking participants for other ideas, those which emphasised *oversight* were focused on the following themes:

- governance and,
- regulation.

#### Governance in advanced practice

The desire for an academy to help maximise the impact of advanced practice on provide some oversight was raised in this part of the conversation. In particular the desire for an organisation to aggregate research and ensure a firm evidence base is available was highlighted.

*“Use academy to aggregate research opportunity to show impact at scale - we need scale pace and ambition. [It]could... support ACPs in specialities to collect the same data and show aggregate impact across pathways.”*

*It could harness some academics to help the academy so it could also look at job plans and negotiated scope of practice to show changes over time and start to increase research at scale?”*

The following comment also highlights the desire for a national academy to build on the credentialing work of the royal colleges.

*“Credentialing, starting with RCEM and now becoming more widespread. I think the relationship with the medical royal colleges needs to be given careful thought given the impact could be limiting development of governance and standards through a lack of representation with the structure of multi- disciplinary representation at all levels. A national academy could set the TORs?”*

#### Regulation of advanced practice

An issue emerging for the conversation was the confusion about the role of regulation and how it operates with primary registration and the potential for dual registration. The comment below sums the challenge up.

*“As regulated professionals is there complexity if my primary registration is with NMC but advanced clinical practice is registered by the HCPC for example. I have a scope of practice I can negotiate with my employer with a JD and training that reflects my scope? What would this look like - like prescribing? Something new? How much extra would it cost? Does that mean two revalidations? Not sure I know what I think.”*

## 12. Conclusions and recommended actions

### Introduction

One of the most striking features of the workshops, both the physical workshop and the online workshop, has been the passion and the interest in the topic. It is clear from the participants that they feel very sure that:

- Advanced clinical practice can deliver significant patient benefit with the right development.
- If managed well, there are very positive implications for the workforce over the short, medium and long term.
- There is a need to review and enhance assurance mechanisms around education and training; ongoing specialty competence; as well as governance of practice.

### Key messages from the participants

When we look at the coding frame analysing impact, action, development and oversight we can draw some conclusions about the views of the 'crowd'.

### Impact

- ACPs can have a significant impact on the effectiveness of patient care if their knowledge, skills and competencies are maximised and developed by employers.
- Deploying ACPs can help to improve the efficiency and effectiveness of services, especially within the context of multi-disciplinary teams.
- There is untapped potential for ACPs in all parts of the health system, but particularly in primary care with the opportunity to improve efficient delivery of care without the need for GP referral to specialist services either in secondary or community care.
- The ACP workforce could be liberated to respond to many of the challenges the NHS faces, particularly given the workforce challenges and shortages of some clinical groups.
- Consideration should be given to how ACPs could be deployed better, for example enhancing prescribing rights.
- Development of ACP research (both ACP contributions to research as well as research on ACP impact) is critical in building confidence.

### Action

- Action should be taken to align the development of ACP to national and local workforce strategies is key.
- If the benefits of advanced practice are to be realised, action should be taken to bring greater consistency and standardisation to the education and training of ACPs.
- Efforts should be made to consider how greater consistency can be introduced to ACPs job roles across the NHS, with the potential for leadership from national employer organisations or at regional levels and structure.
- Action is needed to improve the recognition, awareness and status of advanced practice. Opportunities should be sought at national and regional levels as well as from employing or commissioning organisations at a local level.

## Development

- xi. The conversation demonstrated a strong desire for the development of clinical career pathways for ACPs.
- xii. If ACPs are to develop further, then employers should consider how ongoing continuing education could be supported in the workplace.
- xiii. National organisations should support employers to develop this part of the workforce, either through promoting understanding of their role, or opportunities for additional education and training.
- xiv. Work should be undertaken to promote ACPs in research.
- xv. Higher Education Institutions and employers should work together to clarify the relationships and responsibilities in education and training of ACPs.

## Oversight

- xvi. There was a strong message from the conversation that the opportunities to deliver innovation and the potential benefits through advanced practice, could not be achieved without more structured oversight.
- xvii. A specific work stream, convened or commissioned by HEE but involving professional regulators, HEIs and employers, should be considered which could look at opportunities to enhance existing regulatory mechanisms as well as longer term developments in regulation.
- xviii. A comprehensive review should be undertaken looking at outcomes of education and training (and the assurance of those outcomes)
- xix. Enhanced national leadership for advanced practice is required, particularly to promote understanding and awareness of what it can do
- xx. Oversight of additional education and training is needed, particularly with regards to credentialling of additional qualifications. The professional bodies and professional regulators should be brought together to develop a shared understanding
- xxi. Any new policy developments to support advanced practice will need to be tested further, particularly with employers, regulators and patients.

## 13. Appendix: the coding frames

### Introduction

Every idea or comment was downloaded from the online conversation and then reviewed using a semantic coding framework. Each idea and comment was initially coded against each of the following three coding frames:

1. A coding frame to understand whether the idea or comment made was focused on national, local and regional, or individual level activity.
2. A coding frame to understand whether the contribution was focused on, or related specifically to, a single professional group or multi-professions.
3. A coding frame to understand the policy theme being discussed (such as education, regulation, cost effectiveness, workforce planning etc).

When reviewing the conversation against these frames a pattern was identified which led to a further coding frame being applied.

4. A coding frame to understand whether what was being proposed was emphasising action to be taken, impact expected, development of advance practice, or, oversight required.

By applying these frames, we mitigate the risk of cognitive bias and ensure each part of the conversation is accurately reflected and helps to ensure conclusions are based on the conversation.

### Coding frame 1

The first coding frame was developed to see if ideas or comments were focused at a geographical or organisational level. The codes allocated were:

- **National:** where the idea or comment appears aimed at system wide change, or where action would be required by national organisations.
- **Local and regional:** where the idea or comment appears aimed at local organisations, including trusts, or groups of trusts.
- **Individual and collective:** where the idea or comment appears aimed at individuals or groups of individuals.

### Coding frame 2

The second coding frame was developed to see if ideas or comments were focused on particular professional groups. The codes allocated were:

- **Medicine:** where ideas or comments relate to medical doctors
- **Nursing and midwifery:** where ideas or comments relate to nurses or midwives
- **Dentistry:** where ideas or comments relate to member of the dental team
- **Allied health professions:** where ideas or comments relate to AHPs
- **Healthcare science:** where ideas or comments related to healthcare scientists
- **Pharmacy:** where ideas or comments related to pharmacists or pharmacy technicians
- **Social care workers:** where ideas or comments related to social workers

- The wider workforce: where ideas or comments related to parts of the workforce not specified, including administrators, managers, assistants or leaders
- Multi-professional: where ideas or comments relate to more than one professional group, or all professional groups

### Coding frame 3

The third coding frame was developed to provide insight into the policy focus of the conversation. The codes allocated were:

- **Career development:** the opportunities for ACPs to develop in their career, especially clinical careers
- **Coordination:** including the need for a national body to coordinate the development of advanced practice, particularly between professional groups
- **Cost implications:** comments or ideas where the costs, or cost savings, in development of advanced practice were highlighted.
- **Education (Continuing):** ideas of comments where continuing education and training were mentioned, including revalidation.
- **Education (Higher):** contributions about formal education at an HEI
- **Efficiency and effectiveness:** including improvements to service delivery, and integration between services and parts of the system
- **Governance:** national governance such as the need for an academy, leadership, including on professional development; also local clinical governance
- **Innovation:** development or changes to service delivery especially into areas traditionally carried out by non-ACPs, particularly doctors (e.g. prescribing)
- **Leadership:** including ACPs in leadership roles, and need for leadership for advanced practice
- **MDT working:** benefits from more effective team working
- **Public health:** including the role of ACPs in improving health for populations
- **Quality:** ideas of comments relating to quality especially safety, experience and outcomes (we initially used codes for *caring*, *responsive*, *safety*, *well-led* and *effective* but these were layered up to a single quality code)
- **Regulation:** desire for enhanced national regulation including credentialing, protected titles and registration
- **Research:** need for research into ACP contributions or opportunities for ACPs in research roles
- **Standardisation:** need for standardisation in job roles, titles, descriptions and training
- **Status:** raising awareness and status of ACPs including addressing knowledge gaps and understanding
- **Workforce planning:** including workforce planning, and recognition and use of ACP roles within services and service planning both now and in the future.

## Coding frame 4

The fourth coding frame was applied only after the initial semantic coding had been completed. We wanted to test a hypothesis that meta-themes had emerged across the conversation. The codes we applied were:

- **Impact:** where the ideas or comments indicated some specific outcome or expected outcome
- **Action:** where the ideas or comments indicated a desired action or series of actions
- **Development:** where ideas or comments were focused towards the development of advanced practice as a whole
- **Oversight:** where ideas or comments related to an oversight function or desire for oversight.