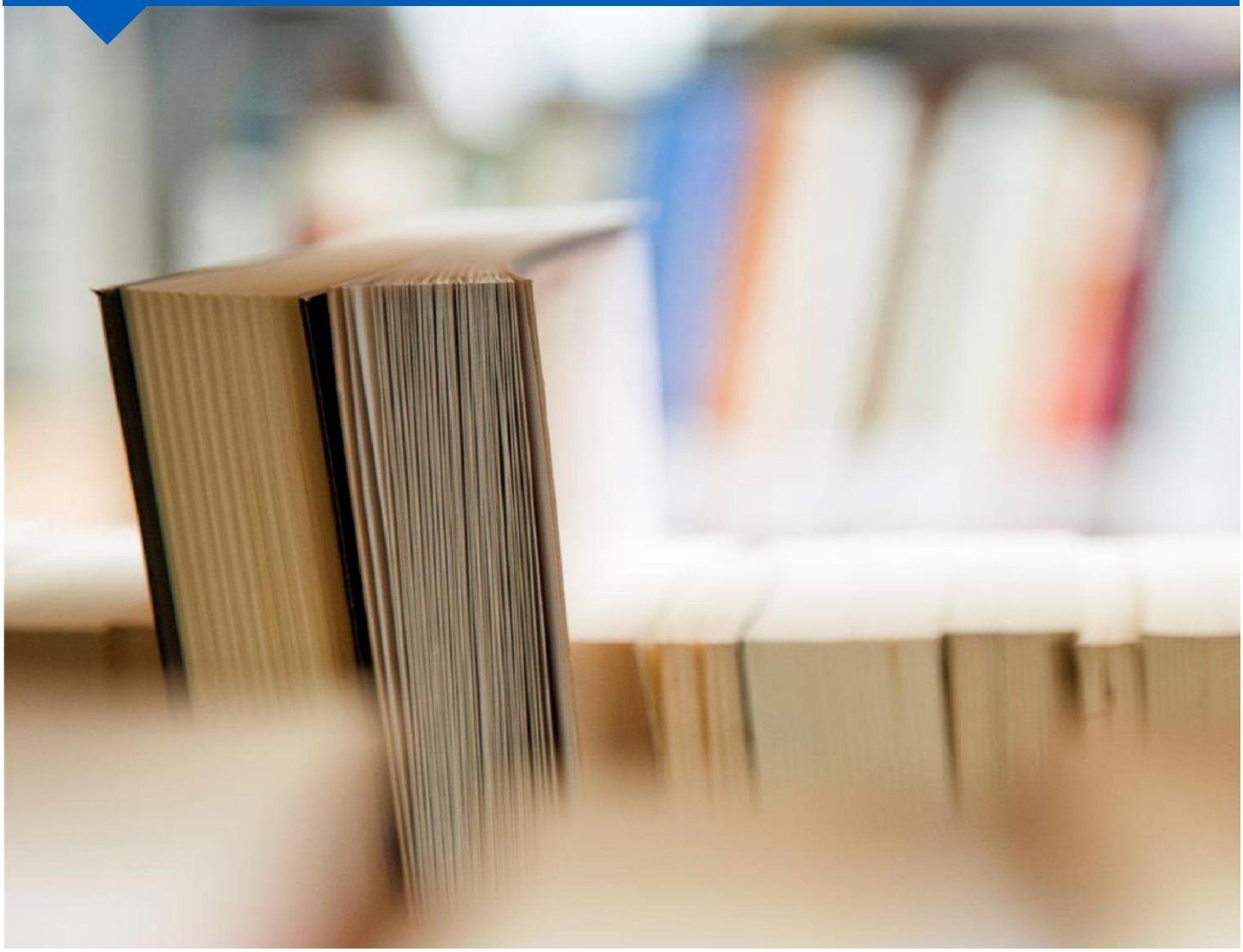
NHS
Health Education England

Enhanced Practice



A workforce Modelling project for Health Education England

A. Leary, September 2019

Contents

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1. Introduction

There is a large multi-professional workforce in health and social care which manages much of the day to day risk of the service and provides complex care to patients. This population is a valuable mission critical resource but has high rates of turnover and retention issues.

Like of other healthcare workforces, it operates at level of complexity and within a sphere.

2. Approach

To gain a fuller understanding of the problem as a concept, soft system methodology (SSM) was applied (Langley et al., 2009; Checkland 1981). SSM originated in systems engineering and has been in use for over thirty years. The workforce overall and its interrelational nature can be thought of as a system that is dynamic and not static.

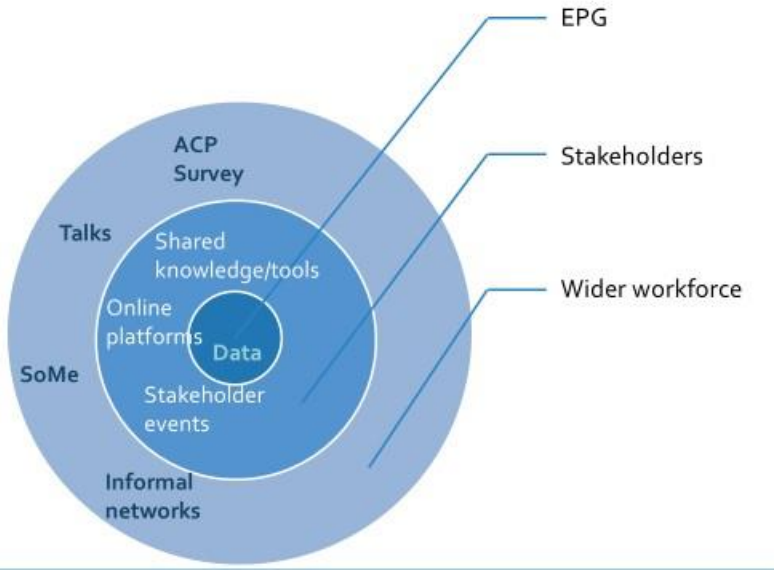
One of the principle approaches of SSM is understanding the real-world situation with all the players involved in determining this. It also uses an approach that asks specific questions. This process is often shortened to the term CATWOE.

CATWOE was defined by Peter Checkland (1981) as part of SSM. It is a checklist for thinking and a technique that other industries use to identify the what they are trying to achieve, what are the problem areas and how is the solution going to affect the business and people involved in it.

This is an iterative process that allows us to understand the real world and build explanative models. The iterative process began with data collected by one of the authors over a number of years. This data consisted of activity data of “work as done” (Hollnagel 2015).

Data was collected or utilised from the sources shown in Figure 1.

Figure 1 the sources of data.



Step One: Identifying the problem

The problem was pre identified by HEE. The Enhanced Practice Group (EPG) was brought together to understand the problem and look at potential approaches and solutions.

Step Two: Problem situation described

A large functional workforce with no specific boundary. Negative implications due to mode of implementation of advanced clinical practice (ACP). A group of demand meters but not pace setters. Different levels of complexity of practice that are service or individually driven

No apparent relationship between job titles and complexity of practice-lots of professions, job titles and areas of practice.

Signals from the workforce that they felt disenfranchised.

According to the data in cancer and other areas there is an established level of complex practice which is not “advanced” but for which there is significant demand.

This workforce is significant-will the market tolerate a significant shift in practice or employment?

We currently model workforce as a service, not safety critical industry

Relies on Division of labour and “skills buckets” rather than demand/risk modelling and workload redistribution.

Step Three: Root definitions (this is a statement that concisely describes a system of interest)

1. What the system will do?
2. How it is done?
3. Why it is being done (long term aim)?

From this emerged the questions:

- Is this the right direction? Have we identified the issue?
- Is enhanced the right word?
- What are the alternatives?
- What education is needed to support enhanced level practice?
- What educational level is enhanced practice? How does this differ from the education that is already in place?
- How does this overlap with advanced practice?
- Enhanced practice as a route to advanced and an end in itself?
- What are Public and workforce perceptions?
- What are our key messages?
- What are the key needs of the workforce and citizens?

The application of CATWOE

Customers The customers are the end users of the service (patients, families, colleagues, employers and others with a stake in the role).

Actors The workforce currently doing high volume, complex work that is not "advanced" according to the ACP Framework (HEE 2017).

Transformation To identify this group, its purpose, its edges and its situation with respect to other workforces and customers.

Weltanschauung (is this the right thing to do?) The stakeholders (customers) say this is the right thing to do.

Owners of the process The HEE Enhanced practice steering group.

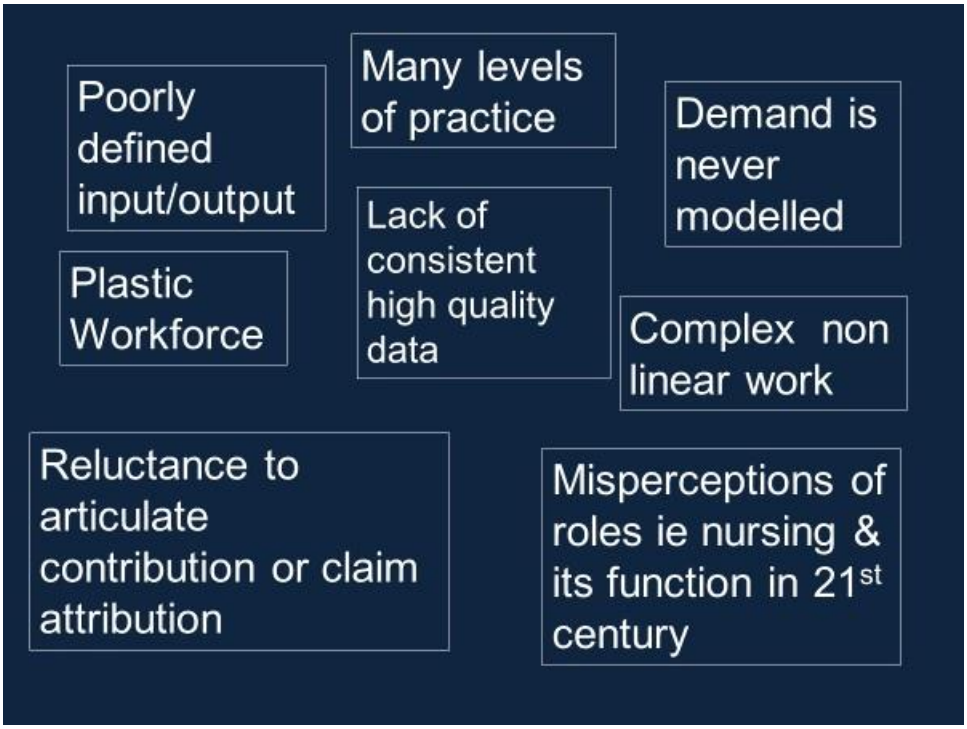
Environmental constraints The context (before advanced?) the labels (why not specialist?) the wider policy issues and constraints including funding and culture/value of work as done.

Step 4: Conceptual Modelling

After the identification of the issue to be examined a conceptual model/explanative model of the real world was constructed.

The current workforce in health is a complex system. It is hard to model for several reasons. These include the factors shown in Figure 2.

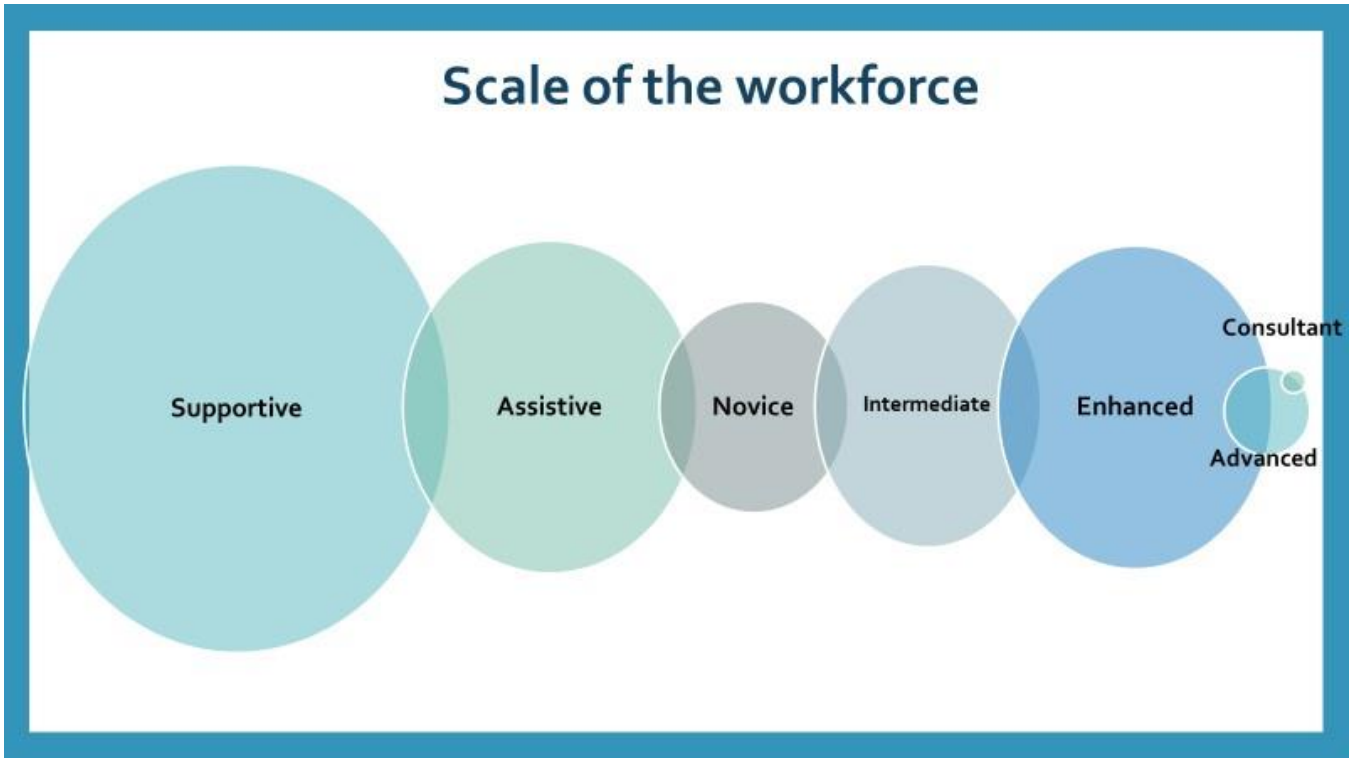
Figure 2 Factors that make defining and modelling the workforce challenging (Leary and Dix 2018)



3. Understanding the current workforce

There is no robust data collection which depicts the levels at which people are performing. Pay grades can be misleading as workers may be under or, more frequently, over performing. Some data is available, for example we know how many HCPs register each year from training programmes, but without destination data its not possible to say where they go to work. Using several sources of data such as data from NHSD, HEE, NHS Employers and other agencies a multi-professional "best guesstimate" was constructed and is shown in Figure 3.

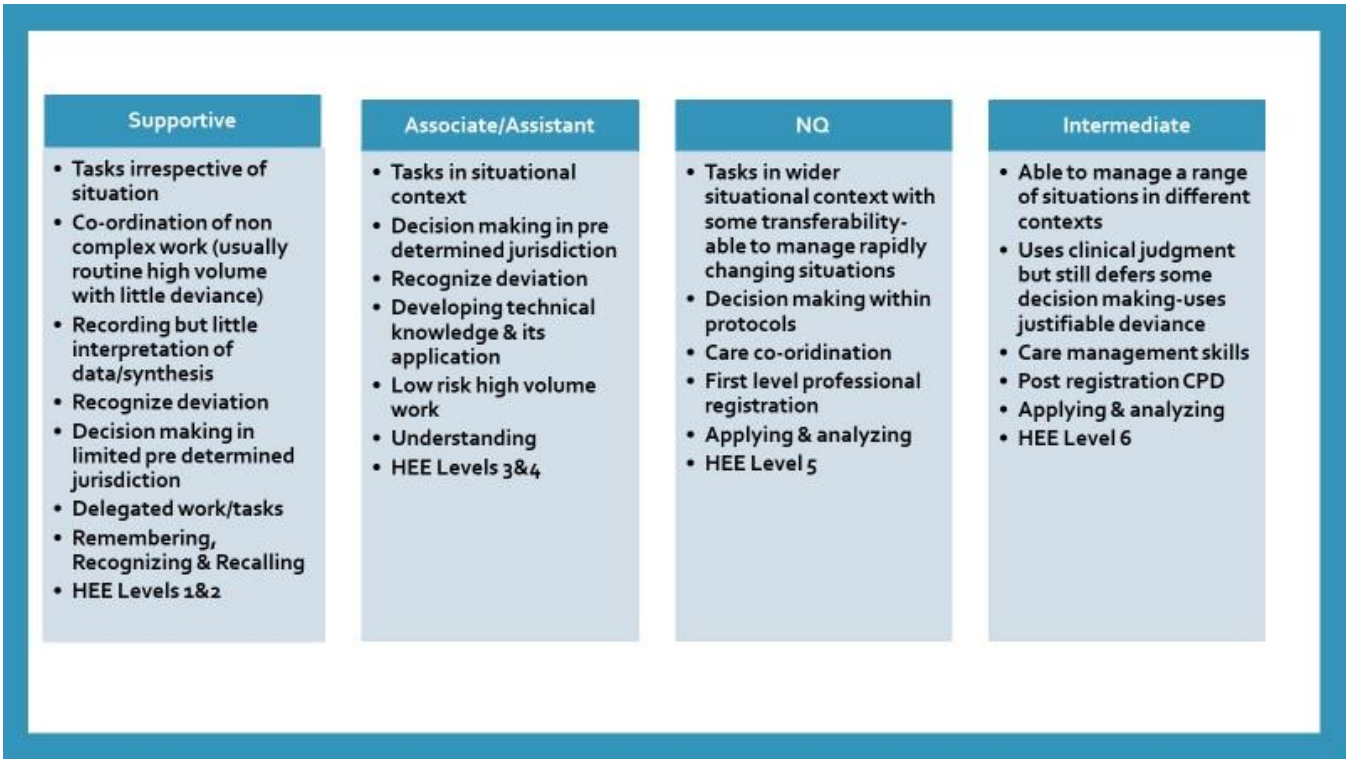
Figure 3 An estimation of the distribution of the nursing AHP and HCP workforce by level of practice.

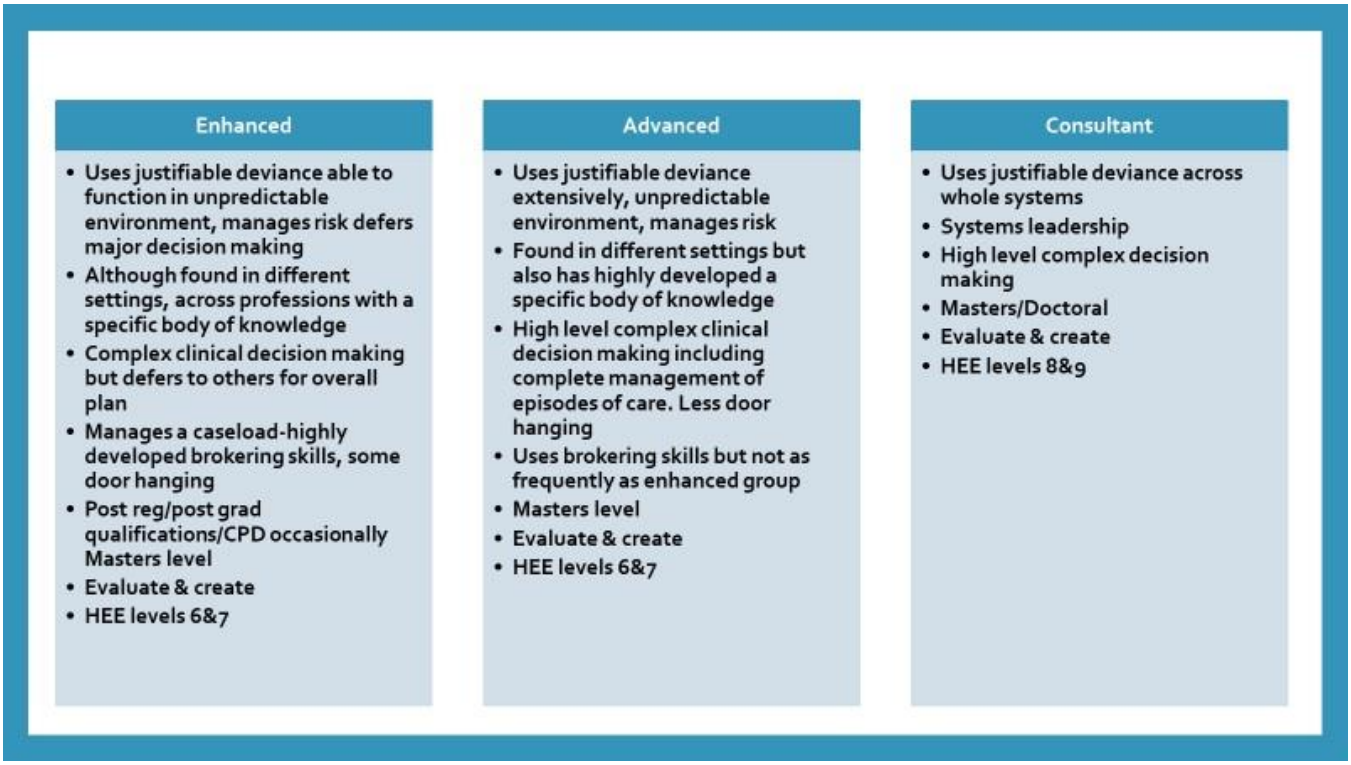


4. Understanding the work as done

A data/literature mining exercise was done to determine different levels of practice in the real world. The data comes from around 45,000 workers in 27 organisations. It was then compared to the literature particularly the work of Benner (1984), Dreyfus and Dreyfus (1986) and Bloom (Anderson et al 2000). The workforce sediments into seven areas or levels of practice (which overlap). These are shown in Figure 4.

Figure 4 The emerging real world levels of practice.


Supportive
• Tasks irrespective of situation
• Co-ordination of non complex work (usually routine high volume with little deviance)
• Recording but little interpretation of data/synthesis
• Recognize deviation
• Decision making in limited pre determined jurisdiction
• Delegated work/tasks
• Remembering, Recognizing & Recalling
• HEE Levels 1&2
Associate/Assistant
• Tasks in situational context
• Decision making in pre determined jurisdiction
• Recognize deviation
• Developing technical knowledge & its application
• Low risk high volume work
• Understanding
• HEE Levels 3&4
NQ
• Tasks in wider situational context with some transferability- able to manage rapidly changing situations
• Decision making within protocols
• Care co-oridination
• First level professional registration
• Applying & analyzing
• HEE Level 5
Intermediate
• Able to manage a range of situations in different contexts
• Uses clinical judgment but still defers some decision making-uses justifiable deviance
• Care management skills
• Post registration CPD
• Applying & analyzing
• HEE Level 6


Enhanced
• Uses justifiable deviance able to function in unpredictable environment, manages risk defers major decision making
• Although found in different settings, across professions with a specific body of knowledge
• Complex clinical decision making but defers to others for overall plan
• Manages a caseload-highly developed brokering skills, some door hanging
• Post reg/post grad qualifications/CPD occasionally Masters level
• Evaluate & create
• HEE levels 6&7
Advanced
• Uses justifiable deviance extensively, unpredictable environment, manages risk
• Found in different settings but also has highly developed a specific body of knowledge
• High level complex clinical decision making including complete management of episodes of care. Less door hanging
• Uses brokering skills but not as frequently as enhanced group
• Masters level
• Evaluate & create
• HEE levels 6&7
Consultant
• Uses justifiable deviance across whole systems
• Systems leadership
• High level complex decision making
• Masters/Doctoral
• Evaluate & create
• HEE levels 8&9

5. Who are the Enhanced Practice workforce in the real world?

Several examples of enhanced practice across professions are given here.

Ken is a community occupational therapist working with a palliative care team at a hospice. He assesses patients and maximises their function with the aim of improving quality of life. He offers a range of complex interventions post assessment from working/brokering with the local authority on adaptions to relaxation techniques and breathlessness management. He works closely with the multidisciplinary team for example with specialist nurses on symptom control.

Clare is a physiotherapist specialising in back pain. She manages a caseload of patients and provides primary treatment as well as referring to other members of the multidisciplinary team, for example surgical colleagues. Clare is undertaking an advanced clinical practice course including prescribing which she hopes will help her manage more complex patients and complete episodes of care, allowing the service to expand.

Bhavin is an optometrist working in a satellite centre of a large acute Trust. He sees first contact ophthalmic patients performing a full assessment and either treats/advises or refers onto an ophthalmic consultant.

Simon is a registered nurse working in interventional radiology. He is a non-medical prescriber. It allows him to provide better access to medicines such as pain relief before, during and after procedures, thereby releasing consultants so they can continue with procedures.

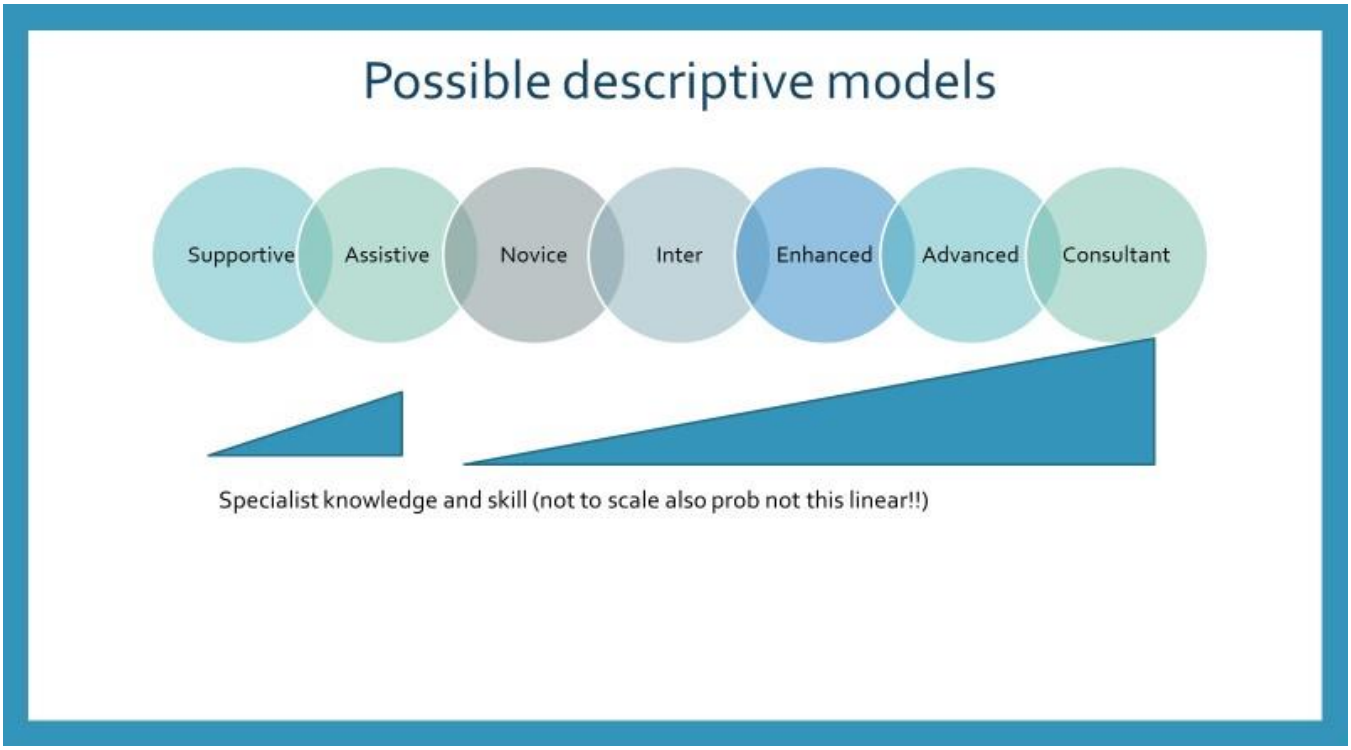
Breda is a Lead Play Specialist. She leads a play service at a large acute Trust which employs four other play specialists working across different children and young adult services. She is an expert in distraction therapy for children in cancer services. She works as part of a multidisciplinary team.

6. Why not “specialist”?

Within the EPG and stakeholder groups the “why not specialist”? question for this level of practice was discussed. This was also discussed opportunistically with wider workforce groups such as professional associations. This included specialist professional groups.

The initial data indicated that specialist outside of medicine and some specific professional roles (for example District Nursing and Health Visiting) was distributed across different levels of practice. A descriptive model is shown in Figure 5. Lack of data means this model is limited but “specialist” knowledge was articulated for example in the support worker workforce. As specialist knowledge is articulated across all levels of complexity there was a consensus not to use “specialist” as a level of practice. This challenge has been articulated before in the literature-particularly in nursing.

Figure 5 There is a probable gradient of specialist knowledge across levels of practice.



7. The bigger picture-the context of the Enhanced Practice Workforce

A workforce within a complex system is not static and the levels of practice and complexity reflect this. The enhanced practice workforce is contextualised here with the other levels of practice**.** Table 1 shows how the workforce is currently emerging i.e. a range of academic qualifications, overlap in levels of practice as represented by the four pillars.

Table 1: A matrix of context for Enhanced Practice

	HEE Level	Example role/KSF band	Academic range From	To	Leadership	Professional Development	Clinical academic careers
Intermediate-enhanced-Advanced	7 & 8	Advanced to consultant	Masters/PhD or Professional doctorate	Post-doctoral specialist qualifications	Systems Leadership	CPD	Clinical lectureship Post-doctoral/PI/Senior clinical lectureship/Chair
	7	Advanced Practice Role	Post grad diploma/Master's Degree	PhD or Professional doctorate	Service leadership	CPD Accreditation	Clinical lecturer Research studentships
	6-7	Enhanced Practice Role	Post qualifying/Graduate certificate/Diploma	Masters	Service leadership	CPD	Studentships Evidence based practice
Assistive-novice-intermediate	5-6	Intermediate Role	CPD and Study days	Post qualifying/Graduate certificate/Diploma	Leadership of self and others	CPD	Studentships Evidence based practice
	5	NQ preceptored role	Degree or baseline qualification for role.	CPD and Study days	Leadership of self and others	CPD/preceptorship Registration or membership	Evidence based practice
	4	Assistant/Associate practitioner	Certificate of Higher Education	Foundation degree	Leadership of self and others	In house CPD	Evidence based practice
Pre-employment-supportive-Assistive	3	Senior supportive roles	14-19 Advanced Diploma/Principal Learning	Certificate HE	Leadership of self and others	Care certificate/Skills	Research awareness & evidence based practice
	2	Supportive roles	14-19 Higher Diploma BTEC Firsts	Care certificate	Self-awareness	Care certificate/Skills development	Evidence awareness in practice
	1	Apprentice entry level (non-clinical staff)	14-19 Foundation Diploma BTEC Firsts	BTEC Higher or similar	Self-awareness	Learning and skills development	

This needs further development but the stakeholders welcomed this approach and it has tested well.

8. Lessons from implementing The Advanced Practice Framework

A separate piece of work (Appendix A) was undertaken to examine the experience of implementation of the ACP framework. Several issues were identified which could be beneficial learning points for the implementation of any new frameworks

.
Some headlines:

ACP being a "new" job rather than an area of practice appears to have an effect-positive and negative.

ACP being the only option for clinical progression is seen as negative.

ACP role being unclear and confusing to stakeholders

There is a spectrum of advanced role from working within clinical rotas to advancement in ones original professional sphere

Initial findings are in Appendix A.

9. Answering the questions-the views of the stakeholders

Is this the right direction? Have we identified the issue?

The stakeholders felt that the issue had been identified and that this was the right direction to take. The stakeholder workshops concluded that the project was important.

Is enhanced the right word?

Most stakeholders felt this was the right word. One stakeholder felt it might be confusing, Two professional groups used a differently terminology but did not object to Enhanced as a descriptor. Although there was some discussion of reclaiming the term 'specialist', ultimately, the group agreed that 'enhanced' is a good term as it has not been used before. The term 'enhanced' provides a distinction from simply number of years in a role or competencies and tasks.

There was agreement that 'enhanced' should be used to describe the level of practice rather than act as a title. The definition of the 'enhanced' practice should span the four HEE pillars, but it is not necessary that each level will be equally proportioned.

What are the alternatives?

There was consensus on Enhanced however alternatives such as specialist were considered and eliminated.

What education is needed to support enhanced level practice?

Post qualification education was important.

What educational level is enhanced practice? How does this differ from the education that is already in place?

Post qualification was the consensus. In the real world data this was usually a post graduate level qualification. The group agreed that enhanced practice would be best placed at a postgraduate level. It was noted that there should be flexibility in the educational requirements needed to practice at this level as a large part of the workforce may be lost if academic requirements are too rigid. Learning could be supplemented by partaking in in-house training, workshops and mentoring programmes, as this would enable practitioners to develop the core capabilities that allow them to practice at this level – eg transferrable skills, thinking and decision-making – as tasks can be learnt.

To demonstrate the development of core capabilities, the group agreed that a portfolio of evidence consisting of reflections and case studies would be useful. Rather than representing the skills and experience a practitioner has at a specific point in their career, portfolios should be representative of their capabilities across their career. The group agreed that revalidation to reflect on previous experience should also be included.

It was noted that, given the large number of practitioners in the workforce practicing at an 'enhanced' level, training would need to be completed in-house. However, this raises questions around consistency, credibility and a possible strain on the training workforce.

How does this overlap with advanced practice?

This level of practice fuses well with advanced practice. It was noted that exploring the border with advanced practice raised several new questions to be mindful of. Specifically, participants noted advanced practice has manifested into two branches with advanced practitioners either undertaking more complex work within their area of focus or stepping out of their traditional area to take on roles previously done by other professions, such as junior doctors. It was therefore asked whether this will be the same in enhanced practice. It was also noted that it may be easier to define the space around enhanced practice to understand what it isn't before exploring the border.

Enhanced practice as a route to advanced and an end in itself?

Although Enhanced is a precursor to Advanced it should very much be valued as a highly functional level of practice and service delivery. There is value in practicing at the 'enhanced' level and it is a legitimate endpoint. Some practitioners may prefer the brokering aspect of practice rather than being decision-makers. Therefore, skills practitioners at this level possess should be recognised and valued.

What are Public and workforce perceptions?

The public and workforce perceptions were favourable.

What are our key messages?

That this workforce is valued and necessary.

What are the key needs of the workforce and citizens?

To be able to access the services of a large, functional workforce and for the system to retain that workforce.

Employers
Defining this level of practice will be important in enabling employers and the rest of the healthcare workforce to recognise the value and work of these practitioners. A clear understanding of 'enhanced' practice will help employers understand the structure of their workforce and utilise skills in the most productive way possible which will be cost effective, improve retention and improve patient experience. This will be though contextualising all levels of practice to meet employers' requirements.

The workforce
For practitioners working at this level of practice, it will provide a sense of legitimacy, making them feel recognised and valued for the work they do. There will be a need to provide clarity on what this new level of practice means to and for the workforce, noting that this is not merely a box ticking exercise. It should be explained that there is a clear progression pathway should

practitioners want to transition into advanced practice. The language used must reiterate this group's value in the workforce.

Citizens
It was noted that the public will not understand the differences between practitioners working at an enhanced level compared to another level of practice. However, patients will understand enhanced practice can offer consistency of care and time, which they value greatly.

10. Glossary

ACP - Advanced Clinical Practice
EPG - Enhanced Practice Group
HEE - Health Education England

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SOR Achieving World-Class Cancer Outcomes: The Vision for Therapeutic Radiography

CSP Draft Capabilities RCOT The Career Development Framework: Guiding Principles for Occupational Therapy Royal College of Occupational Therapists

13. Stakeholders

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