Exploring Advanced Clinical Practitioner's experience developing clinical competence and opinions on role identity

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STUDY PROTOCOL

Contents

1. PROJECT SUMMARY

There is an urgent need to reshape the NHS workforce to equip it to meet the changing demands of the population it serves and deliver the vision set out in the Next Steps on the NHS Five Year Forward View (2017)[1] and recently published NHS Plan (2019)[2]. One of the key elements to this is the continuing development, support and utilisation of Advanced Clinical Practice (ACP) roles.

Advanced Clinical Practitioners are educated to Masters Level in clinical practice and assessed as competent in practice using their expert clinical knowledge and skills[3]. They have the freedom and authority to act, making autonomous decisions in the assessment, diagnosis and treatment of patients[3].

Locally the development of ACP roles has been supported by funding from 2015 onwards from Health Education Yorkshire and the Humber. Trainee Advanced Clinical Practitioner posts have been introduced across Barnsley, Doncaster, Rotherham and Sheffield in a wide range of clinical settings. These include Critical Care, Hospital Out of Hours, General Practise and Emergency Care.

Although the level of education and assessment of competence are common for ACPs working in all areas, training and supervision varies between primary and secondary care, specialties and sites. Previous work by the authors used online questionnaires to ascertain how the ACPs felt about their education, supervision, confidence and competence when assessing and treating patients (appendix 1). This identified huge variability in their experience of training and supervision, with apparent lack of formal education supervision for those working in the Primary and Community Care settings. Knowledge gaps in assessing and treating patients with mental health problems were also identified.

This project is a follow on from this work, using a qualitative study design to further explore the experience of ACPs, and specifically:

- Factors that have influenced their clinical competency achievements.
- Training experience, both in clinical practice and external education opportunities e.g. simulation.
- Experience of educational and clinical supervision and its benefits.
- Self-identified knowledge gaps, with a focus on managing patients with mental health conditions.
- Their role identity as part of the NHS workforce going forwards.

The study will be managed by the School of Health and Related Research (ScHARR), University of Sheffield in collaboration with the South Yorkshire and Bassetlaw Faculty for Advanced Clinical Practice (SYB-ACP) and Sheffield Teaching Hospitals NHS Foundation Trust (STH).

Focus groups will be conducted with a sample of ACPs working in Primary or Secondary Care in the Yorkshire and Humber region. All of the sessions will be video-recorded, transcribed verbatim and analysed thematically using NVivo.

The findings of the study will be written up for review and used to inform improvements to supervision and training locally. Findings will also be disseminated through peer-reviewed scientific journals and appropriate clinical and/or academic conferences.

2. BACKGROUND

Advance Clinical Practitioners (ACPs) are an increasingly important part of the NHS workforce. Coming from a range of professional backgrounds such as nursing, pharmacy, paramedics and occupational therapy, they have additional skills and knowledge to take on expanded roles and scope of practice.

Their exact role varies according to the clinical setting, specialty and site, but all should be characterised by the following level of practice:

- MSc level qualification
- Autonomous decision making: an ability to work independently and as part of a clinical team
- Ability to manage undifferentiated patients (discrete from Specialty Practitioner who manages a single condition/pathology e.g. asthma nurse)

2.1. Health Education England definition of Advance Clinical Practice

The following ACP definition which can be applied across professional boundaries and clinical settings, has been developed by Health Education England, in association with its multidisciplinary partners[4]. This has been developed to provide clarity for employers, service leads, education providers and healthcare professionals, as well as potential ACPs practicing at an advanced level. The definition serves to support a consistent title and recognises the increasing use of such roles across the NHS.

"Advanced clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence.

Advanced clinical practice embodies the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people's experience and improve outcomes."

2.2. Specific Specialty Curricula

Some clinical specialties have developed specific, bespoke curricula for ACP training. For example, the Royal College of Emergency Medicine (RCEM) (2015) has developed a training programme for ACPs[5], requiring them to demonstrate a wide range of competencies, which are assessed locally by a medical consultant supervisor, followed by a final external assessment.

3. RESEARCH OBJECTIVES

The principle research purpose is to:

Explore ACPs' experiences of how they develop clinical competence and their opinions on role identity.

The above encompasses the following objectives:

- To gain insights into factors that have influenced their clinical competence achievements in the following areas: -
    - Training experience, both in clinical practice and external education opportunities e.g. simulation.
    - Experience of educational and clinical supervision and its benefits and disadvantages.
    - Self-identified knowledge gaps, with a focus on managing patients with mental health conditions.
- To seek views on the role identity of ACPs as part of the multi-disciplinary team and NHS workforce going forwards.

4. Research Design and Methods

4.1. Design and Setting

A small-scale exploratory study using a qualitative design will be used to conduct four focus group sessions with ACPs who are currently working with in the South Yorkshire and Bassetlaw region..

The focus groups will be undertaken at two locations, The University of Sheffield and the Hilton Garden Hotel Doncaster Racecourse, to maximise attendance and will commence in November 2019. Each focus group will last two hours.

The focus groups will be facilitated by two independent researchers, who have no previous connections with the participants, to encourage open discussion of issues.

4.2. Eligibility Criteria and Sampling

Those participating in the focus groups sessions must fit the following eligibility criteria:

- Qualified ACP or trainee ACP who has completed at least 1 years (FTE) of ACP clinical training
- Currently working in this role within either Primary or Secondary Care and based in South Yorkshire and Bassetlaw.

4.3. Recruitment

Ideally up to 32 ACPs will be recruited to participate in the 4 focus groups. South Yorkshire and Bassetlaw Faculty for Advanced Clinical Practice (SYB-ACP) will act as gatekeepers. Using ACP email distribution lists held by the SYB-ACP, an invitation to participate in the study will be sent to ACPs on behalf of the Study Team. The email will include:

- Invite to participate in the focus groups briefly outlining the study and details of date, times and locations of the focus groups
- Participant information sheet
- Web link to a short online questionnaire and contact details form

ACPs that wish to participate will be directed to click on the web link which will take them to the online survey tool, Qualtrics (www.qualtrics.com). Participants will be asked to complete a short questionnaire to confirm eligibility and record basic details such as gender, age group, length of experience in ACP role, etc. Contact details and availability to attend the focus groups will also be requested. Participants that are not eligible to participate will be informed immediately after completing the questionnaire and no further information will be requested.

The study will also be advertised on social media (Twitter, Facebook) and those expressing an interest will also be sent the study invitation email, participant information sheet and web link to the online questionnaire and contact details form. Participants not able to access the information online, will be sent a study pack (invitation letter, participant information sheet, questionnaire, contact details reply slip and stamp-address reply envelope) by post.

Participants will be selected based on who responded to the study invitation first and who is available to attend the dates of the focus groups. Members of the study team will contact participants (telephone or e-mail) to confirm the date, time and location of the focus group. If there are more potential participants than slots available in the focus groups, a member of the study team will contact the participant (telephone or e-mail) to inform them of alternative focus group slots (if available). If these are not suitable, the participant will be thanked for their interest but informed that they will not be participating in the focus group sessions.

Focus groups will take place as soon as sufficient numbers of participants are recruited. Due to the work schedules of participants being recruited, it is anticipated that focus groups may need to be held outside of normal working hours for convenience (for participants) and to maximise attendance.

4.4. Focus group schedule

A focus group schedule will be designed and agreed before the sessions for consistency between groups and to ensure that research objectives are achieved. At the end of the focus group session, participants will be asked to provide feedback about how well they felt the process worked, in order to understand the focus groups from their perspectives and identify any strengths/limitations of the study.

4.5. Data collection

All of the focus group sessions will be recorded using a video camera to make it easier to identify participant voices during the transcribing process. Participants will be made aware of the video recording and the reason for it on the information sheet, during the first contact with the researcher and prior to the focus group commencing. . Written informed consent will be obtained for all research participants at the start of each focus group. Focus groups will be undertaken in a private room at The University of Sheffield or at the Hilton Garden Hotel, Doncaster RaceCourse.

4.6. Analysis

Data from the focus groups will be video-recorded, transcribed verbatim and analysed thematically. NVivo software will be used for data analysis, and development of themes to answer research

questions in understanding about the factors leading to the ACPs development of clinical competence and their role identity.

Analysis will be on-going and iterative involving concurrent data collection and analysis, with systematic efforts to check and refine developing categories of data.

Qualitative data will be interpreted using Thematic Framework Analysis. This will follow the five stages of Thematic Framework Analysis including familiarization, identifying a thematic framework, indexing, charting, mapping and interpretation.

5. ETHICAL CONSIDERATIONS

This study raises six key ethical considerations, namely: informed consent; confidentiality and anonymity; potential risks and burdens to research participants; safety of research staff; and participant reimbursement.

5.1. Recruitment

Participants will be contacted via email from the study team with the full relevant information regarding the study and details of their potential involvement. Those responding to social media (Twitter) posts will be sent identical information. We will ensure the relationship between a potential participant and recruiter is free from undue influence. We will ensure that there is no coercion or unacceptable inducement to participate in our study. We will ensure that we collect the minimal amount of personal data before receiving consent.

5.2. Informed consent

All potential participants will be provided with full written information about the study and how any information collected will be used. They will be reminded that participation is entirely voluntary and that they can withdraw from the study at any time. However, due to the nature of conducting focus groups, it is not possible to delete any contributions that the participant makes during the course of the session should they wish to withdraw from the study part way through the focus group session. Participants will be made aware of this at the time of consent.

Formal written consent will be obtained for all research participants. Before the focus group the researcher will complete the consent procedure, explaining the study and making sure each person fully understands what they are agreeing to.

5.3. Confidentiality and anonymity

Personal information (e.g. name, email and contact telephone number) will only be accessed by members of the study team as a means of contacting participants once the individual has agreed to find out more about participating in the study. The study team will only have the contact details of those who have agreed to participate as the initial contact will be made by the SYB-ACP.

Research participants will be given an explanation about how the data will be processed and an understanding that the data gathered in the study will not be reported, discussed or made available in such a way that will enable them to be identified. Locations of work will not be attributed to

comments and broad terms categorising individuals roles only will be used to describe staff participants to prevent the ability to identify participants.

Research participants will never be named in any publications and thematic analysis of responses will be conducted at an aggregate level. Pseudonyms will be used in the focus group transcripts so as not to identify participants.

5.4. Potential risks and burdens to research participants

We do not envisage that the focus groups will cause any undue stress or embarrassment to the participants. Only experienced researchers will be used who have the skills and experience to conduct focus groups sensitively. In line with an approach of an on-going consenting process the focus group facilitators will be skilled at reading non-verbal and verbal communication to pick up quickly if a participant is becoming distressed.

If a participant becomes upset, for example they have a poor experience of training or supervision, they will be asked if they are happy to continue and may take a break or leave the focus group session altogether. Depending on the issue raised, they would be encouraged to contact their GP, occupational health department or supervisor.

5.5. Safety of research staff

A team approach to risk management will be adopted and any concerns will be communicated to the Chief Investigators in the first instance. Both focus group coordinators would have mobile phones and although focus groups may potentially be held outside of normal working hours, they will take place in pre-booked rooms within the University of Sheffield or the Hilton Garden Hotel, Doncaster Race course, both of which have 24-hour security.

5.6. Participant reimbursement

There is a risk that the research process may inconvenience participants. Therefore, participants will be offered refreshments at the session and a £40 high-street shopping voucher on completion of the focus group to compensate them for their time and effort and to thank them for their participation in the study.

6. DATA HANDLING

Personal data will include the contact details for ACPs who have expressed they wished to participate in the study.

There will be a master file (Microsoft Excel Spreadsheet) located at The University of Sheffield that associates a named participant with a study ID (unique number). The master file will only contain contact details, confirmed eligibility and basic demographic data and the study ID. This study ID, rather than names/addresses will be used as the key on all other documents that associate data with an individual. In this way someone outside the study would not be able to identify an individual participant.

The master file will be password protected and held in an access restricted project folder on The University of Sheffield secure shared networked filestore. The master file will be stored in a separate

location to the rest of the study documentation (e.g. focus group transcripts). Only named members of the study team will be able to access files containing the participant's personal data.

Following each focus group, the video recording will be uploaded straight on to a computer stored in a locked office located at The University of Sheffield. Once the video recording has been uploaded it will be deleted from the video recorder. Transcripts of the video recordings sent via e-mail will be encrypted and in the transcripts participants will be referred to using a study ID, not people's names. The video recordings will be deleted after they have been transcribed by a transcriber (allocated member of the ScHARR Transcriber Team) and the transcripts quality checked by members of the study team.

After the study has finished the anonymised transcripts will be kept for 5 years and then destroyed.

7. PATIENT AND PUBLIC INVOLVEMENT

The PPI group linked to the SYB-ACP will be approached to seek their advice on the recruitment materials that will be produced for this research project (e.g. patient information sheets), as well as their advice on the focus group schedule to gather their thoughts on the suggested questions and structure of the focus groups.

8. PROJECT TIMESCALES

We anticipate undertaking this study within 8 months commencing November 2019 as follows:

- Months 0-2: Obtain ethical approval, study set up, focus group preparation
- Months 1-4: Participant recruitment
- Months 3-6: Undertake focus groups, commence data extraction and analysis
- Months 7-8: Final write-up

9. PUBLICATION AND DISSEMINATION

The findings will be disseminated through peer-reviewed scientific journals and appropriate clinical and/or academic conferences.

A final report will be prepared for the SYB-ACP.

10. PROJECT MANAGEMENT

The research is led by the School of Health and Related Research (ScHARR) based at The University of Sheffield, who have overall responsibility for project management. The project management group will meet once a month to oversee the project. The following staff members comprise the project management group:

- Julie Perrin, Joint Chief Investigator (Professional Lead Advanced Clinical Practice, South Yorkshire and Bassetlaw Faculty of Advanced Clinical Practice)

- Susan Croft, Joint Chief Investigator (Consultant Emergency Medicine, Sheffield Teaching Hospitals NHS Foundation Trust)
- Maxine Kuczawski, Study Manager (Research Associate, ScHARR)
- Sarah Hargreaves, Focus Group Lead (Research Associate, ScHARR)
- Veronica Fibisan (Study Administrator, ScHARR)
- Suzanne Mason (Professor of Emergency Medicine, ScHARR)
- Kirsten Clinton (Nurse Consultant, Emergency Department, Sheffield Teaching Hospitals)

All members of the study team will be involved in the study – developing the protocol, study documentation, analysis and report write-up. Specifically:-

- Susan Croft and Maxine Kuczawski will be responsible for the day to day running of the study.
- Sarah Hargreaves and Maxine Kuczawski will manage the focus groups.
- Julie Perrin and Kirsten Clinton will check and assess quality control of the focus group transcripts.
- Sarah Hargreaves will undertake the analysis, with support from Julie, Perrin, Kirsten Clinton and Maxine Kuczawski.
- The final stages of preparing and writing the final report will involve all members of the study team.

The research sponsor is the University of Sheffield.

11. COSTING SCHEDULE

(The following costing schedule excludes staff costs)

Stage	Item	Detail	Unit cost, £	Quantity	Total cost, £
Focus groups	Venue hire	● University of Sheffield ● Hilton Garden Hotel, Doncaster Race course	-	-	0.00
	Staff travel	Focus groups, Meetings, etc			200.00
	Catering	Refreshments and buffet food (£10.75 *10)	107.50	4	430.00
	Participant incentive	High street voucher	40.00	32	1280.00
	Study documentation	Participant Information sheet, Consent forms, etc	0.2	64	12.80
Dissemination	Report printing	-	0.20	50	10.00
	Journal publication		2800.00	1	2800.00
TOTAL COST					4732.80

12. FUTURE RESEARCH

It is anticipated that the findings from this research will be used to help prioritise areas of research for ACPs in the future.

13. REFERENCES

1. NHS England. Next steps on the NHS five year forward view, 2017. Available from: https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf (Accessed 06/07/19)
2. NHS England. The NHS Long Term Plan, 2019. Available from: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf (Accessed 06/07/19)
3. Royal College of Nursing. Advanced Level Nursing Practice – Introduction, 2018. Available from: https://www.rcn.org.uk/professional-development/publications/pub-006894 (Accessed 06/07/19)
4. NHS Health Education England, Advanced Clinical Practise. Available from: https://www.hee.nhs.uk/our-work/advanced-clinical-practice (Accessed 25/08/19)
5. Royal College of Emergency Medicine, Royal College of Nursing, NHS Health Education England. Emergency Care Advanced Clinical Practitioner Curriculum and Assessment, Version 1.0, April 2015.

14. APPENDIX 1

Title: An evaluation of competence and confidence of Trainee Advanced Clinical Practitioners

Reference no - 8249

Authors:

Julie Perrin, Professional Lead Advanced Clinical Practice, South Yorkshire and Bassetlaw Faculty of Advanced Clinical Practice

Susan Croft, Emergency Medicine Consultant, Northern General Hospital

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Background

There is an urgent need to reshape the NHS workforce to equip it to meet the changing demand from the population it serves and deliver the vision set out in the Five Year Forward View (Nuffield Trust 2016) and recently published NHS Plan (2019). Advanced Practice roles can deliver benefits for patients through more patient focussed care whilst benefits for staff are related to more rewarding roles and enhanced career pathways.

Opportunities to develop the current workforce to meet the needs of the future health service by developing new roles have been supported regionally by funding in 2015 onwards from Health Education Yorkshire and the Humber. Trainee Advanced Clinical Practitioner posts across Barnsley, Doncaster, Rotherham and Sheffield in a wide range of settings including Critical Care, Hospital Out of Hours, General Practise and Emergency Care have been introduced. Within the training posts, there have been different approaches to training were taken including time given for training/education and differences in clinical specialty exposure. McDonnell et al (2013) identified in a small cohort study that supernumerary education for ACPs resulted in increased confidence and preparedness for practice.

The study aimed to use a questionnaire to ascertain how the ACPs felt about their education, supervision, confidence and competence when assessing and treating patients.

Methods

A validated electronic questionnaire, based on EDit 1 was distributed via e mail in 2017/2108 to 110 Advanced Clinical Practitioners both in training and one year post qualification working across the South Yorkshire and Bassetlaw region. The questionnaire used both multi-choice questions and free text to collect the following information:

- Demographics – age, gender, duration of training
- Confidence managing different patient groups according to presenting complaints (scale from 1-9 where 1 is least confident and 9 is most confident)
- Confidence performing clinical skills (scale 1-9)
- The impact certain factors would have had on improving their confidence (e.g. clearer guidelines, improved teaching etc.)
- Supervision – supervisor contact
- Teaching/training/feedback

The ACPs were identified by clinical leads in the four local NHS Trusts. Responses were submitted anonymously via an electronic link.

The questionnaire was redistributed a further 2 times via e mail with a supporting letter from the Medical Lead of the South Yorkshire and Bassetlaw Faculty of Advanced Clinical Practice requesting support for the completion.

Responses were collated and themes identified.

Results

There were 24 respondents, a response rate of 21.8%. The sample size was too small to undertake any formal statistical analysis. The mean age of respondents was 36.3 years (range 25-57 years) and the majority (70.8%) were female. Their working hours were between 22.5 and 40 hours per week (mean 31.3 hours) and the length of their training varied between 6 months and 2 years.

The ACPS had undertaken placements in a variety of settings – General Practice, Radiology, Hospital Medicine, Paediatrics, Orthopaedics, Hospital Surgery and Emergency Medicine.

Presenting complaints and clinical skills

The ACPs were most confident managing general medical conditions (e.g. diarrhoea and vomiting, cellulitis, shortness of breath). They were least confident managing acute mental health problems (see figure 1).

With regard to clinical skills – they were most confident performing a clinical assessment and phlebotomy related tasks. They were less confident interpreting results (ECG and x-ray interpretation), see figure 2.

Figure 1: Trainee ACPs subjective confidence managing patient groups according to presenting complaint

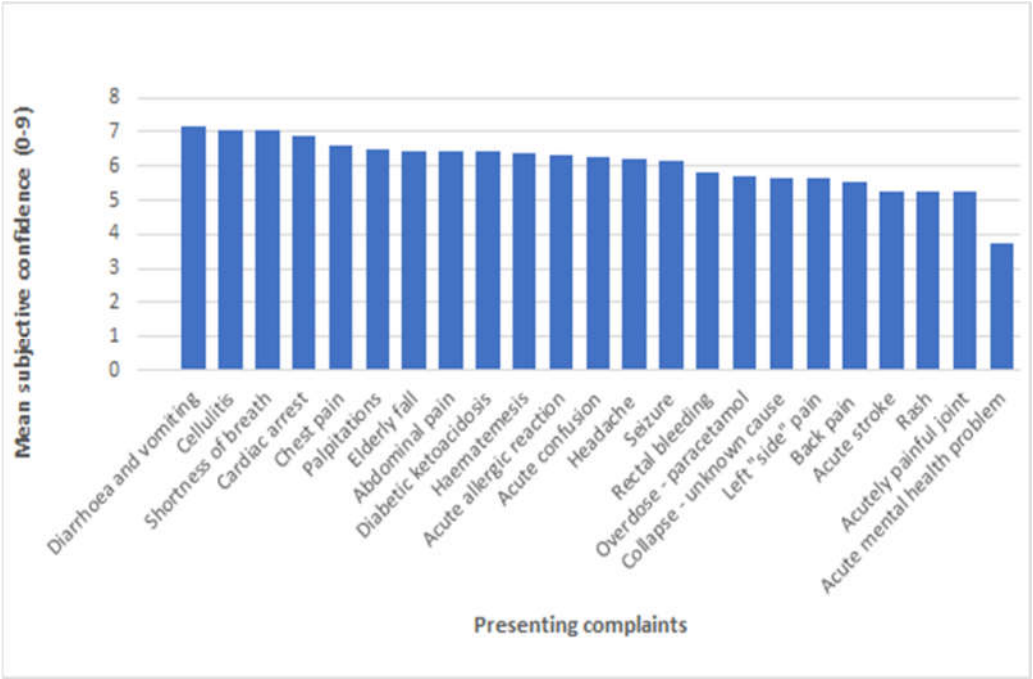
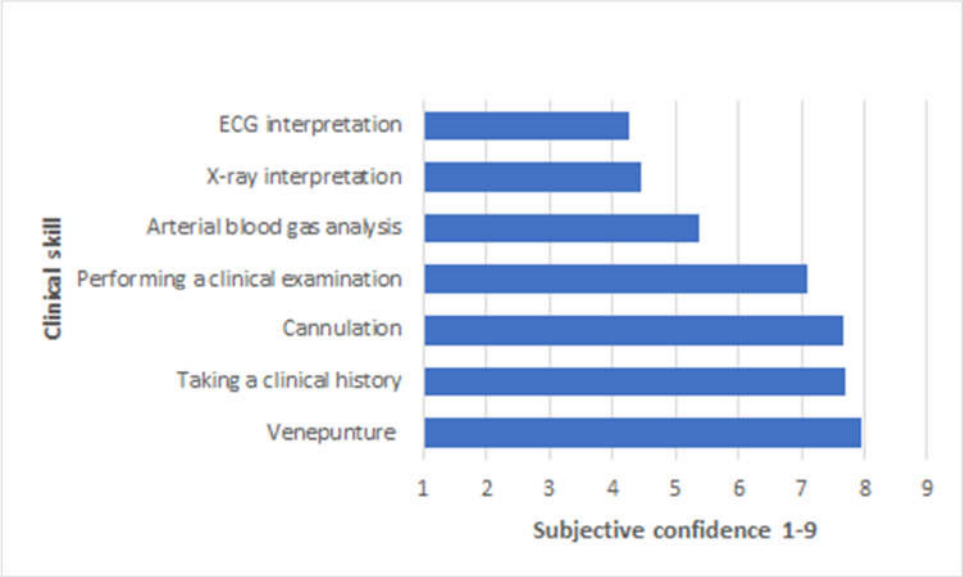


Figure 2: Trainee ACPS subjective confidence in performing clinical skills



Improving confidence

The factor they felt would most improve their confidence was more supervision. Clearer guidelines, better teaching and increased experience managing the condition were also felt by the majority to have improved their skills.

The majority of ACPs felt they had sufficient time and time to make the appropriate decisions about patient care.

Supervision

4 ACPs (16.7%) stated that they did not have a clinical supervisor. The 2 ACPs who had undertaken placements in General Practice (100% of those with placements in GP) stated they had no supervisor.

The time spent with clinical supervisors or in direct contact with a senior medic varied substantially between ACPs. Those that had supervisors had one to one contact with them between 0 and 20 hours/month (mean 2.75 hours/month), with direct contact with a senior medic between 0 and 108 hours/month (mean 6 hours/month).

Teaching /training/feedback

Most ACPs identified having “just a little amount” of formal teaching sessions and training in the last 6 months, but felt that they had a “moderate amount” of feedback about their quality of work.

Themes identified from free text responses

- **Variability (mostly lack) of training, supernumerary time, placements and supervision**
  "I have not had any supernumerary time at all and no clinical supervision"
  "Supernumerary periods disorganised and disjointed"
  "Have to use my own initiative to learn"
  "Training has made me more confident taking a history and clerking"
  "My ACP supervision was excellent"

- **Extended responsibilities in their roles that they feel unqualified/untrained for**
  "Asked to cover FY1 bleeps overnight, with no formal training in the specialties being covered, this is a particularly concerning trend"
  "Addition of site responsibilities…..is frankly the most stressful part of my job. Lack of training in this area is concerning"

- **Lack of formal feedback mechanisms**
  "Lack of feedback from parent teams means you only become aware of mistakes you've made"

- **Disparity within workforce**
  "Disparity of pay between us and other ANPs within the Trust is concerning"

Discussion

The response rate to our questionnaire survey was disappointing. Despite our efforts to explain the questionnaires importance and engage staff, less than a quarter of ACPs responded. Perhaps in future, incentivising staff to complete questionnaire or including as a compulsory part of their appraisal process may improve response rates.

The ACPs who responded had undertaken placements in a variety of areas, in both Hospital and Community settings. Their roles and therefore training, experience and supervision in these settings obviously differed, but we were unable to fully analyse this as the sample size was insufficient. Instead, patterns, themes and trends were identified.

There was a huge variation in the amount of supervision the ACPs received both from a senior clinician or educational supervisor. Worryingly, four trainees identified that they had no identified educational supervisor. These included the two trainees who had community placements in General Practice. This apparent isolation is a worrying feature particularly as the ACPs identified that greater supervision was the factor that impacts most on their confidence. Subsequent information gathered by the Medical Lead and Professional Lead for Advanced Practice support this concern by highlighting that in general ACPs receive less support and supervision within the Primary and Community care setting. As a direct result of this, HEE have funded a 2 year project to develop and provide a support programme for practitioners in these areas in addition to placements and development of Mental Health services as identified within the NHS Long Term Plan (2019)

Most ACPs felt more confident managing medical presenting complaints/conditions than psychiatric presentations. The experience and knowledge required for assessing different presenting complaints/conditions obviously relates to the area in which the ACP works, but some psychiatric experience is increasingly necessary when working in GP, ED and inpatient areas. Perhaps this is an area where additional training should be focused.

In the free text sections, there was obvious variability in the training/supervision highlighted. ACPs also felt that they were on occasions, asked to take on additional roles such as site responsibility for which they had not formal training. Most ACPs felt that they received a moderate amount of feedback, but others felt that this could be improved if it was formalised. It would be interesting to see if these experiences and opinions were shared by the junior doctor workforce.

Recommendations

1. A formal clinical supervisor for each ACP should be mandatory.
2. Inclusion of mental health education within the training programme.
3. Use focus groups to further explore variability in time and requirements to gain clinical competence.

References:

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