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Rome Wasn't Built in a Day – The Impact of Advanced Practitioners on Service Delivery and Patient Care in Greater Manchester

Final Report - January 2009

Commissioned by:

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Abbreviation List

AdP	Advanced Practitioner
AHP	Allied Health Professional
AMP	Advanced Midwife Practitioner
EMA	Emergency Medical Admission
ESP	Extended Scope Practitioner
EWTD	European Working Time Directive
HDU	High Dependency Unit
ICU	Intensive Care Unit
LOS	Length of Stay
OOH	Out of Hours
PCT	Primary Care Trust
SHA	Strategic Health Authority
WBL	Work Based Learning

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Executive Summary

1 Background

Since 2005 a team from Acton Shapiro and supported by colleagues from the Department of Health Sciences, at the University of York has been evaluating the introduction of the Advanced Practitioner (AdP) role across Greater Manchester. The AdP role is clinical in focus and seeks to address medical staff shortages and to develop local services to respond to needs in a client-centred way. Its development is a strategic and planned approach, forming part of the Delivering the Workforce project of Greater Manchester SHA (now part of NHS North West). The evaluation focused on the first two cohorts of AdPs in training.

There are four final reports from the evaluation of the implementation and impact of Advanced Practitioners across Greater Manchester:

- *Evaluating the Implementation and Impact of Advanced Practitioners across Greater Manchester* - Summary of Findings
- *Developing Advanced Practitioners the Greater North West Way* - Lessons for Universities and Education Commissioners
- *You're Not Alone* – The Experience of Becoming and Advanced Practitioner in Greater Manchester

and this report

- *Rome Wasn't Built in a Day* – The Impact of Advanced Practitioners on Service Delivery and Patient Care in Greater Manchester which focuses on the impact the AdP roles have had on service delivery and patient care and so will be of interest to both service managers in NHS trusts and PCTs and commissioners, as well as the SHA workforce development team and professional bodies. The report summarises the relevant findings from the overall evaluation and describes the work with five case study trusts conducted in the final year of the evaluation.

2 Early Changes and Challenges

- **Acceptance and understanding of the role** - during their first year in training, AdPs from both Cohorts 1 and 2 described mixed levels of understanding and acceptance from colleagues. Those from the AdPs' immediate teams were most likely to understand and accept the role but this was rarer beyond the AdPs' close colleagues. Once the trainee AdPs had reached their second year, the majority felt that their role was being accepted and understood at least by colleagues within their immediate team but there were still lower levels of comprehension and acceptance amongst their wider networks of colleagues. Throughout the two years, patients/ clients were generally reported as being accepting of the role, though it was thought that not all understood it.
- **Impact on colleagues** – during both their first and second years Cohort 1 and 2 trainees indicated that the main areas in which they were having an impact on their colleagues were through affecting their workloads and being used as a resource.
- **Evidence of service change** - the second year impact work highlighted that difficulties were being encountered in monitoring the effects of the posts and collecting concrete data to support the introduction of the roles. The second year trainee AdPs thought their roles were having an impact through providing continuity

and holistic care to patients/clients and improving the patient pathway/package of care.

3 Seeing the Benefits

Five case study trusts were selected covering the main aims or reasons why trust had established AdP posts. The approach used in each case study varied but a common framework of questions/topics was used. Brief details of the case study trusts are given in the table below.

Trust	Number of AdPs	Aims of the AdP roles in case study
Bolton Primary Care Trust	7 qualified and 4 in training (3 work with older people in care home and are the focus of the case study)	Providing a co-ordinated approach to the care of older people in care homes and reducing hospital admissions.
Salford Primary Care Trust	11 qualified (4 work for Salford Health Matters and were the focus of the case study)	Replace GP time and reduce pressure GPs caused by GP recruitment difficulties.
Stockport NHS Foundation Trust	6 qualified (3 Advanced Midwifery Practitioners and 2 physiotherapy Extended Scope Practitioners in Orthopaedics were the focus of the case study)	In midwifery, achieving European Working Time Directive (EWTD) and improving the quality of the patient experience. In orthopaedics, increase in clinic capacity and reducing waiting times for patients (including achieving 18 week wait target) were key.
Pennine Acute Hospitals Trust	3 qualified (the case study focuses on the AdP based in the High Dependency Unit at NMGH)	Reduce pressure on junior doctors based on ICU and improve the assessment and management of HDU patients.
Bolton Hospitals NHS Trust	10 qualified and 9 in training (The case study focuses on the AdPs based in A&E at Royal Bolton Hospital)	Reduce emergency admissions; provide an opportunity for nurses to lead the workforce transition needed to achieve the EWTD; ensuring a safe, quality service for patients in A&E.

Overall the case studies showed that the AdP roles were fulfilling all or some of the aims that had originally been set out for them, but the extent to which these aims were being achieved did vary. Findings from each of the case study trusts are briefly described below.

Bolton Primary Care Trust

Key Achievements

- Reduction in the number of unplanned admissions to hospital from nursing homes
- Reduction in GP visits to nursing homes
- Stronger team approach to palliative care and more flexible and appropriate end of life care
- Better training and support for nursing home staff leading to enhanced skills and confidence
- More responsive prescribing arrangements
- Better access for nursing home residents to other healthcare services including palliative care doctors, physiotherapy and dentistry

Factors thought to have affected impact included:

- dissemination and marketing of the role both by the PCT and the AdPs themselves
- good mentorship
- effective utilisation of work-based learning (WBL) and academic learning
- the AdPs building up good relationships with nursing home staff and local GPs
- having three AdPs working in nursing homes which led to better continuity of care
- the AdPs' ability to build up good relationships with clients and their families
- the AdPs' ability to be independent sources of support/advice to clients and families
- the flexible and committed attitude of the AdPs.

There were some factors which were thought to have delayed the impact of the roles e.g. lack of funding once initial money had run out, uncertainty about whether there were roles open for the AdPs, lack of support for the role and time pressures whilst in training.

Salford Primary Care Trust

Key Achievements

- Improved access to primary health care services in an area where GP recruitment and retention has been difficult e.g. through extended hours
- Better engagement of patients in 'hard-to-reach' groups
- Better support for practice nurses and scope for career progression
- Stronger inter-professional working
- Greater patient choice and increased satisfaction
- Reduced stress amongst GPs and improved GP recruitment

Factors affecting impact:

- the clarity of the role and the objectives of the post
- the skills of the AdPs in clinical practice, leadership, negotiation and communication
- the positive attitude of other staff towards the AdPs

- the support provided from other AdPs in SHM
- regular education sessions for all clinical staff in SHM
- quality of mentors and individual's relationship with mentor
- opportunities for preceptorship.

Stockport NHS Foundation Trust

Key Achievements

- Reduced waiting times for orthopaedic patients and a significant contribution to achieving the 18 week target
- Better access to specialist skills for junior staff, including junior doctors
- More cost-effective, efficient and flexible service delivery
- Senior doctor time freed up for extra surgery sessions and a significant contribution to achieving the European Working Time Directive
- Improved continuity of care, fewer 'hand-offs' and a smoother care pathway for patients
- Improved communication between physiotherapists and doctors and midwives and doctors

Factors which were thought to have been involved in achieving changes included:

- engagement and buy-in from managers and consultants
- support for those doing the role from colleagues, managers and medical staff
- having a 'critical mass' of AdPs
- the 'bridging' nature of the role - between doctors and midwives/physiotherapists
- the work-based learning element of the MSc
- raising awareness of the role
- undertaking the non-medical prescribing course
- the AdPs' previous clinical experience, motivation and confidence, proactive approach, availability and clinical skills.

Delaying factors included lack of sufficient finances, the AdPs having to be part of the 'numbers', colleagues' resistance to the role and the AdPs not being able to prescribe.

Pennine Acute Hospitals Trust

Key Achievements

- Fewer calls to the ICU medical team to attend HDU patients
- Better support and training for HDU nursing staff
- More consistent use of 'management plans' for patients and better coordination of care
- More timely and responsive interventions (e.g. swallowing assessment for patients following removal of a tracheotomy)
- Fewer inappropriate admissions to HDU
- Improved communication between HDU nursing staff and doctors in referring medical teams

Factors considered important in achieving changes:

- good support from medical mentors
- progressive thinking of the AdP
- existing good relationships
- the support of the Critical Care Directorate
- supernumerary status whilst in training
- positive marketing of the role by the AdP and supervising consultant
- the AdP's ability to negotiate with the medical teams, interpersonal skills and clinical knowledge/confidence in that knowledge
- the AdP not having his/her 'own patients' to look after.

Some key factors were thought to have delayed the impact of the post:

- the AdP not always being able to work in the role and being pulled into the 'nursing numbers' to cover for staff shortages
- the isolation of the AdP in the unit
- the lack of a resident medical team in HDU
- the lack of certainty concerning funding
- the dearth of support from those high up in the trust
- lack of understanding of the role by some members of the nursing and medical staff.

Bolton Hospitals NHS Trust

Key Achievements

- A much improved patient journey through A&E with better continuity of care/fewer 'hand-offs', earlier treatment and a short 'length of stay'
- More holistic assessment of A&E patients and more appropriate investigations
- Perceived reduction in emergency admissions
- Reduced pressure on A&E doctors time in a department where recruitment of middle grade doctors was difficult
- An important source of expert advice for nursing staff

Factors important in achieving changes:

- leadership and promotion of the role at a strategic level
- good, ongoing communication throughout the trust
- good support for AdPs in training from management, Champion etc
- the experience and skills of the AdPs
- the personality and drive of the AdP in A&E
- the 'bridging' nature of the role; combining the skills of the doctor and the nurse.

A number of factors were thought to have delayed the impact of the posts:

- the absence of forward-looking workforce planning at a strategic level
- the lack of a clear direction for the role
- financial pressures
- the lack of sufficient numbers of AdPs to have a significant impact
- the A&E AdP having to be in the nursing numbers due to staff shortages
- the inability of the A&E department to 'compartmentalise' the job
- lack of authority to order all necessary investigations e.g. radiology.

4. Findings and Recommendations

Three Key Findings

- Advanced Practitioner roles are having a positive impact on patient care and service delivery in their trusts and the majority to appear to be achieving some or all of the objectives originally set out for them
- The AdPs' capacity to work beyond their base profession (i.e. being 'advanced' practitioners as opposed to highly skilled nurses, midwives or AHPs) is significant in achieving that impact
- The SHA's original vision that the development of AdP roles should be service driven, and as such a 'critical mass' of AdPs would be needed for these roles to have maximum impact on service delivery, has proved to be correct

Impact in relation to the five main reasons for creating the AdP posts:

Ensuring better access to services – better engagement with hard to reach groups, reduced waiting times and improved access to primary health care services both in and out of hours.
Improving activity and service delivery – greater continuity of care, fewer hand offs and a smoother care pathway for patients.
Addressing governance and compliance issues – reduced number of unplanned admissions to hospital, achievement of the 18 week target, achievement of the Gold Standard for end of life care, reduced avoidable A&E attendances, compliance with the EWTD.
Increasing workforce productivity – improved training and support for other staff, including junior medical staff and staff from partner organisations.
Enhancing patient experience - by giving patients greater choice in their care.

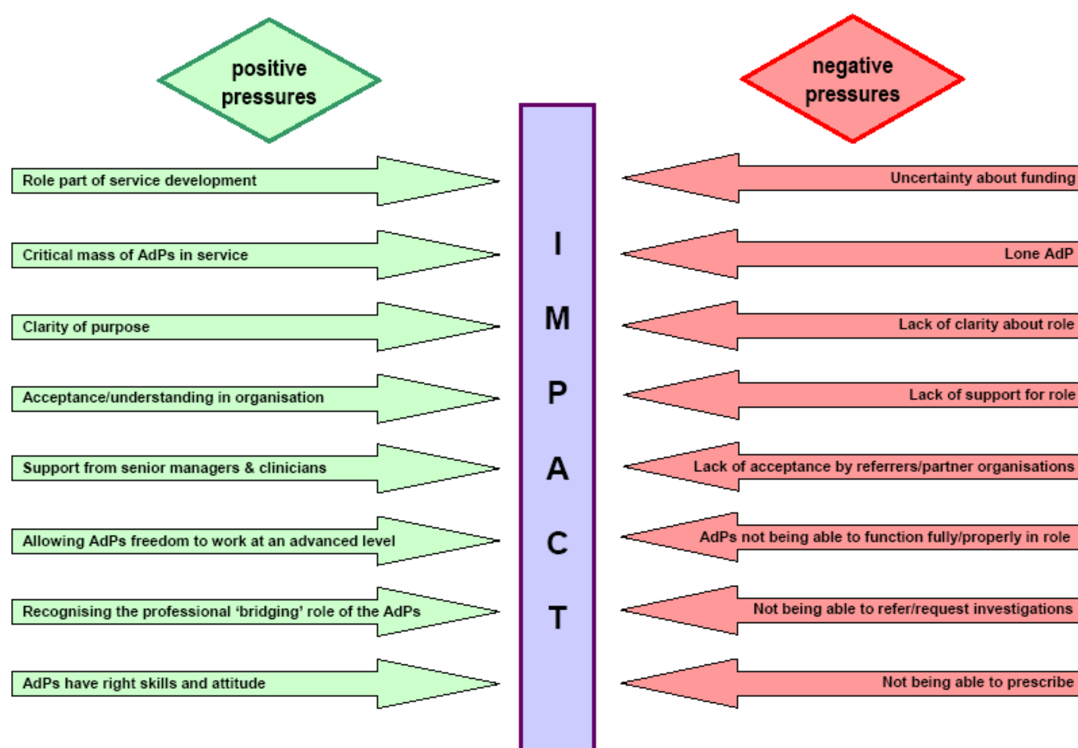
Maximising Impact

- Linking AdP roles to service development – the evaluation shows that these roles work best when they are service driven. This increases acceptance of the role and integrates the AdPs within the service.
- Ensuring 'critical mass' – whilst 'lone' AdPs can make a difference, the impact of the role could be much greater if there was a cadre of AdPs within the service.
- Being clear about the purpose of the AdP roles – clarity about the purpose of the role has many 'knock on' consequences and it cannot be over emphasised as a factor in maximising the impact of roles.
- Promoting AdP roles in the wider organisation – it is essential that trusts make a real commitment to actively promoting their AdP posts.
- Securing support from senior management and senior clinicians – this is essential because they play a vital role in ensuring that the systems needed for AdPs to work effectively are in place and in ensuring that the roles are accepted and supported.
- Allowing/enabling AdPs to work at an advanced level – one of the most common reasons given for AdPs and their colleagues feeling that their roles were not achieving maximum impact was that they were either not allowed or not enabled to work consistently at an advanced level.

- Clinical governance and Continuing Professional Development – there is a need for trusts to be clear about the clinical governance arrangements for the AdP posts prior to their implementation and there may also be a necessity for new professional support arrangements to be developed. The North West AdP Forum is seen as valuable for peer support.
- Recognising and supporting the 'bridging' role of AdPs – the bridge was most often between their base profession and medical staff but sometimes between non-medical professions (e.g. nursing and AHPs).

Figure 1 below illustrates how these factors can be positive and negative pressures on the impact of AdP roles.

Figure 1 Maximising Impact – Positive and Negative Pressures



There is no doubt that Advanced Practitioner roles can have a significant impact on service delivery and patient care. They also have an important place in initiatives to reshape services and the wider workforce. However, the impact of these roles depends on trusts recognising they do not exist in isolation. For them to be effective, they have to be understood and accepted by colleagues and partner organisations, systems and processes have to change to enable them to function, but above all they must be embedded in the needs of the service.

Chapter 1
Introduction

1.1 Background

In 2005 Greater Manchester SHA (now NHS North West) introduced the Advanced Practitioner (AdP) role across the city, as part of their wider Delivering the Workforce project designed to modernise and increase the size of the clinical workforce. In the Spring of that year the SHA also commissioned a three-year evaluation of the implementation and impact of the Advanced Practitioner role across Greater Manchester. The evaluation has been carried out by a joint team from Acton Shapiro and the Department of Health Sciences at the University of York.

The AdP role, which should be client centred, clinical in focus and driven by service need, is intended to develop or change the delivery of services and address medical staff shortages. Registered health professionals undertaking preparation for AdP roles across Greater Manchester are required to develop skills and knowledge to work competently beyond their base profession to a set of common core characteristics established by the SHA. All AdPs in training must successfully complete a two-year, part-time Masters Degree in Advanced Practice, delivered by the Universities of Bolton and Salford and based on an ethos of work-based learning and assessment of competence.

The evaluation focused on the implementation and early impact of the first two cohorts in AdP training, who started in February and September 2005 respectively. In total 120 AdPs commenced training in these two cohorts – 70 in cohort 1 and 50 in cohort 2. During the three-year evaluation period, several strands of quantitative and qualitative data have been drawn and analysed from a variety of sources, with detailed findings reported annually. With the evaluation drawing to a close, rather than writing a single composite final report, the team was asked by NHS North West to prepare a series of shorter reports, each focusing on a different key audience. In this way it is hoped that the experiences and lessons learned in Greater Manchester can be most effectively disseminated.

1.2 The Focus and Coverage of this Report

There are four final reports from the evaluation of the implementation and impact of Advanced Practitioners across Greater Manchester:

- ***Evaluating the Implementation and Impact of Advanced Practitioners across Greater Manchester* - Summary of Findings** which brings together the findings from all aspects of the evaluation and highlights a number of key lessons relevant to both local and national bodies.
- ***Developing Advanced Practitioners the North West Way* - Lessons for Universities and Education Commissioners** focuses on the local model adopted for preparing Advanced Practitioners and so is of particular interest to education commissioners, HEIs running (or considering running) advanced practitioner courses, and human resources and workforce managers in NHS Trusts and PCTs.

- ***You're Not Alone* – The Experience of Becoming and Advanced Practitioner in Greater Manchester** which focuses on how Advanced Practitioners viewed their personal progress and development throughout the process of training and once qualified as AdPs and so is of particular interest to Advanced Practitioners themselves, those considering becoming Advanced Practitioners, senior clinicians, workforce managers in NHS trusts and PCTs, the SHA workforce development team and professional bodies.

And this report

- ***Rome Wasn't Built in a Day* – The Impact of Advanced Practitioners on Service Delivery and Patient Care in Greater Manchester** which draws on five case studies to explore the impact AdP roles have had on service delivery and patient care. The report will be of interest to both service managers in NHS Trusts and PCTs and commissioners, as well as those involved in workforce development and professional bodies.

This report focuses on the impact of the AdP roles have had on service delivery and patient care and so will be of interest to both service managers in NHS trusts and PCTs and commissioners, as well as the SHA workforce development team and professional bodies. The report summarises the relevant findings from the overall evaluation and describes in detail the achievements, challenges and learning which emerged from the in-depth work with five case study trusts conducted in the final year of the evaluation.

With the programme open to all NHS Trusts (both acute and mental health) and PCTs, and to staff registered in all non-medical health professions, AdP roles have been established in a wide range of clinical settings, and with diverse aims. However, drawing on data collected in the impact survey conducted in the second year of the evaluation[1], we were able to identify five main aims or reasons for creating AdP posts. These were:

- Ensuring better access to services
- Improving activity and service delivery
- Addressing governance and compliance issues
- Increasing workforce productivity
- Enhancing patient experience.

The five case study trusts were selected to ensure that all five of these aims were covered (although many posts had more than one aim). The approached used in each case study trust varied but a common framework of questions/topics was used for all the data collection. In total, 24 interviews were conducted, 8 people were involved in small discussion groups and a number of others contributed by email or telephone. Some of the trusts also provided supporting information, ranging from monitoring data to presentations to boards, which was extremely helpful.

The report has three main chapters. Chapter 2 gives a brief overview of the early impact of the advanced practitioner roles, when the AdPs were still in training. In Chapter 3 the five case studies are presented. For each case study we briefly describe the background to the AdP roles, the drivers for establishing them and the influence of the Delivering the Workforce programme. We then consider in some depth the impact the posts have had on colleagues, service delivery and patient care and finally we examine the factors that have affected impact and explore lessons for the future.

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[1] Acton Shapiro (2007) *Evaluating the Implementation and Impact of Advanced Practitioners across Greater Manchester – Progress and Challenges*

Chapter 4 draws together the conclusions from all the work on impact and makes a number of recommendations which trusts, commissioners and the SHA may wish to consider.

Chapter 2
Early Changes and Challenges

This chapter gives a brief overview of the early impact of the advanced practitioner role during the time when the AdPs from Cohorts 1 and 2 were still in training. For more detail please see the relevant previous reports.

2.1 Acceptance and Understanding of the Role by Colleagues

2.1.1 Year 1

During their first year in training, AdPs from both Cohorts 1 and 2 described mixed levels of understanding and acceptance from colleagues. Those from the AdPs' immediate teams were most likely to be accepting of the role and understand it, facilitated by good communication, close collaborative working, personal knowledge of the AdP(s) and a sense of the potential benefits of the role. Understanding and acceptance were rarer beyond the AdPs' close colleagues but those in Cohort 2 indicated that the growing number of trainee AdPs was making the roles more visible. Where the roles were less well accepted or understood, this was thought to be due to factors such as resistance to change, scepticism about the purpose of the role, worries about competition and resentment or confusion around the meaning of the 'advanced practitioner' title and its role and functions.

2.1.2 Year 2

Once the trainee AdPs had reached their second year, the majority felt that their role was being accepted and understood at least by colleagues within their immediate team and a few specifically commented on the support and encouragement they received from their colleagues. Where the AdP role was not thought to be understood or accepted within the team this was considered to be mainly related to a lack of clarity in the purpose of the role or changes in direction linked to service provision. Understanding and acceptance of the role amongst wider networks of colleagues was reported as still being lower than that within the AdPs' own teams. Positive role promotion, both by the AdPs themselves and by their employing organisations, was thought to be beneficial for increasing acceptance and understanding in the wider context.

2.2 Acceptance and Understanding of the Role by Patients/Clients

Throughout the two years, patients/clients were generally reported as being accepting of the role, though it was thought that not all understood it. Things which had helped to cement their acceptance included trainee AdPs giving full 'top to toe' assessments and being able to assist clients with a range of health and social issues. Continuity of care was also thought to be a beneficial factor in increasing acceptance. Where patients/clients did not understand the role, one possible reason may have been that other professionals' lack of understanding was inadvertently communicated to the patients/clients. Some AdPs felt that it did not matter too much whether patients fully understood the role, provided that their needs were being met with good quality care.

2.3 Impact on Colleagues

In both their first and second years, Cohort 1 and 2 trainees indicated that the main areas in which they were having an impact on their colleagues were through affecting their workloads and being used as a resource.

- **Workloads** – there were both positive and negative impacts on workloads; either relieving medical staff of some of their responsibilities or causing colleagues to have to work extra hours to cover for study leave.
- **Acting as a resource –** trainee AdPs were being used as a resource through being seen as experts and role models who were available for support and advice and who could also take the lead in service delivery and patient care.

Some impact was being seen on team structure i.e. new teams were being built around the AdP role. In a number of instances, the role was also improving communication and collaboration within teams. In some cases, however, the AdP role was thought to be having little impact on colleagues, either because the AdP was not yet working in the role or, conversely, because the qualification was seen as validating existing practice.

2.4 Evidence of Service Change

From the trainee AdPs' viewpoint, the most frequently mentioned ways in which they thought their roles were having an impact were through:

- providing continuity and holistic care to patients/clients
- improving the patient pathway/package of care
- increasing patient contact time
- reducing waiting lists and times
- providing speedy and appropriate referrals
- reducing emergency admissions
- reducing length of hospital stay (LOS).

A range of evidence of impact was described by some AdP Champions and managers, including:

- a reduction in the number of patients with one or more emergency admissions
- a reduction in the number of emergency medical admission bed days
- patient and carer satisfaction with service
- a reduction in hospital admissions and LOS
- improved continuity of care.

However, only four Champions/managers (who were responsible for six trainee AdPs) returned data to support their assertions that they had evidence of impact. This dearth of evidence was explained in part by the findings of the impact work done during the second year of the evaluation, which highlighted that difficulties were being encountered in monitoring the effects of the posts and collecting concrete data to support the introduction of the roles. There were thought to be a number of reasons for this, including problems with clearly defining the AdP role and not being able to separate out the impact of the posts from that of other team members or service initiatives.

Chapter 3
Seeing the Benefits

The data used for this chapter have been drawn from interviews with colleagues, managers and trust Champions from the five case study trusts.

[N.B. Quotes are followed by the role of the person quoted in square brackets.]

3.1 Bolton Primary Care Trust

Bolton Primary Care Trust (PCT) serves a population of approximately 261,000 and is one of 14 PCTs within Greater Manchester. Its vision is to:

> *"commission and provide excellent health services that are built around the patient, and to develop and deliver effective, community-based approaches to keeping people healthy".*[2]

3.1.1 Background to the advanced practitioner roles

There are seven qualified AdPs working within Bolton PCT (BPCT) – three from Cohort 1 and four from Cohort 2. There are also four AdPs in training. The three AdPs from the first cohort all work to support private nursing homes and the following case study focuses on these AdPs. Three of the Cohort 2 AdPs work in children's services and one is in adolescent health. The four AdPs in training all work in different areas: under 19s substance misuse, the breast care unit, district nursing and the musculoskeletal service. Although this case study focuses on the AdPs from the first cohort, many of the issues are pertinent to all the AdPs and trainee AdPs employed by BPCT.

Service drivers

Initially, the AdP posts were intended to cover the shortfall in out of hours (OOH) and unscheduled care provision due to the then new GP contract[3] and GPs opting out of OOH care.

> *"We didn't have a clear idea what the first cohort would end up doing so we just saw them as being somewhere in unscheduled care. It evolved over time into the nursing home role."* [service manager]

The development of the AdP role in nursing homes began with an intravenous (IV) infusion pump pilot in two nursing homes and was aimed at preventing clients who needed this intervention having to be admitted to hospital; this service was then extended to a number of other nursing homes. The IV infusion pump pilot instigated negotiations about what other support AdPs could provide to clients and nursing home staff to reduce transfers to hospital from the homes.

> *"All the way through we haven't been sure what would happen to the AdPs as far as their role was concerned but what we have done is met with them on a regular basis and reassured them how much we value their role within the organisation and I suppose that [we] have kept an eye out for opportunities for them."* [trust Champion]

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[2] www.nhs.uk/ServiceDirectories/pages/trust.aspx?id=5HQ

[3] 'Investing in General Practice: the new General Medical Services Contract' (DH, June 2003)

3.1.2 Objectives of the advanced practitioner posts

Initially, Bolton PCT's objectives for their Cohort 1 AdP posts were to:

- reduce visits to A&E and admission to hospital
- skill up staff to treat patients at home or in Intermediate Care
- reduce number of GP home visits.

These objectives were set when the AdP role had been intended to provide for the shortfall in OOH and unscheduled care provision. More recently, in a presentation to management by the AdPs working in nursing homes, the aims of the service were stated as:

- co-ordinated approach to the care of older people in care homes
- acute intervention
- enhanced disease management
- end of life care – symptom management
- end of life – preferred place of care
- improved education of care home staff
- reduced hospital admissions.

It was thought that the AdPs had fulfilled some of these aims in their first full year of working in the role in nursing homes. They had developed good partnership working arrangements with GPs, nursing home staff and the rapid response team. They were intervening through anticipatory prevention of admissions (e.g. IV antibiotics) and therefore they had seen a reduction in unscheduled hospital admissions from the nursing homes they were working in. They had also achieved a reduction in hospital deaths of nursing home patients.

> *"Having the AdPs has totally changed the care pathway for these patients."*
> [nursing home manager]

It was felt by the staff from the nursing homes that the AdPs had fitted in very well and become part of their teams. In one of the homes, they had been working towards the Gold Standards Framework[4] for end of life (EoL) care and the AdPs had played a part in this process. The AdPs' ability to prescribe was seen as particularly valuable, as previously the nursing homes had had to contact the GP to prescribe and then take the prescription to a pharmacist to get the medication.

[4] See www.goldstandardsframework.nhs.uk

3.1.3 Impact

Key Achievements

- Reduction in the number of unplanned admissions to hospital from nursing homes
- Reduction in GP visits to nursing homes
- Stronger team approach to palliative care and more flexible and appropriate end of life care
- Better training and support for nursing home staff leading to enhanced skills and confidence
- More responsive prescribing arrangements
- Better access for nursing home residents to other healthcare services including palliative care doctors, physiotherapy and dentistry

Data had been collected by the AdPs themselves in relation to the number of unscheduled hospital admissions from the nursing homes they were working in. This data had been used to make a case to the PCT Board for further funding and extension of the role to more nursing homes in the Bolton PCT area. The number of deaths of nursing home patients in hospital was also being monitored, as was the number of GP visits to the nursing homes.

Impact on colleagues

GPs – initially some of the GPs who provided medical care to the nursing homes had been resistant to the AdP role but they had become more positive when they saw what the benefits of the role were. Before the AdPs started working in the nursing homes, the GPs generally had to visit almost daily to see patients but after the introduction of the role, their visits had reduced to about once a month. Often they had had to visit for relatively minor problems. The AdPs could do most of the same things that the GPs could do but they brought added value because of their enhanced communication skills. The GPs were thought to pay less attention to the small details that mattered to older people.

Nursing home staff – the palliative care team and the AdPs had brought a range of skills to the Gold Standards Framework for EoL care and they had given joint training sessions for the nursing home staff which had helped to raise skill levels. Early intervention and anticipatory prevention of admissions had reduced the number of crises in the nursing homes which had hence made life less stressful for staff and made their workload more manageable. Initially, some of the staff in the nursing homes had been worried about the AdPs and how they might impact on their work but because of the AdPs' personalities and skills, and also the way they approached their work with the homes, this had not turned out to be an ongoing problem. It was thought that the AdPs had enabled the homes to get better access to a range of services such as specialist palliative care doctors, physiotherapy services and dentistry. They had also had a positive effect in breaking down barriers between the nursing homes and NHS services which had created a more open culture in the homes.

Impact on service delivery

Improving care – working with the AdPs had helped the nursing homes improve the care (especially EoL care) that they provided. This was partly due to the AdPs passing on their skills to nursing home staff; they provided training and were also available for support, such as when longstanding patients died. Care for terminally ill patients had become much more flexible and they were able to respond more quickly to problems e.g. through providing suitable medication more rapidly.

Increasing awareness – it was thought that there was much greater awareness amongst staff about the AdPs and what they could do, especially in areas such as Urgent Care; the AdP roles were now firmly embedded in the PCT's Urgent Care Strategy.

Fewer call-outs and emergency attendances – evidence showed that the role had led to fewer GP call-outs and fewer A&E attendances of nursing home patients. The AdPs had high level clinical and diagnostic skills so they could see a patient, assess them and diagnose them without having to call out a GP.

> *"It's a combination of the enhanced diagnostic and assessment skills which an 'ordinary nurse' wouldn't have, and their prescribing skills that make the difference".* [senior nurse in palliative care]

The OOH service had improved because it had changed from being provided by a GP co-operative to a PCT provider service which had facilitated different approaches. The PCT did not have to negotiate with an external company but could make its own decisions about how to deliver the service. This had made it easier to incorporate the AdP role.

> *"The out of hours support has been another big thing. Before when you rang out of hours for a GP you never knew what you were going to get. The first thing they used to say was 'admit them' but there is no conversation like that anymore."* [nursing home manager]

Impact on patients

Better end of life care – it was thought that patients were receiving much better EoL care and were often able to die in the nursing home instead of having to go into hospital or a hospice. This was due in part to the AdPs' ability to prescribe the right medication when it was needed.

> *"The drugs are now ready when we need them…that has been one of the biggest impacts."* [nursing home manager]

It had been possible previously to enable clients to stay in the nursing home when they were dying but it had been difficult to get the necessary support in place and families had sometimes found the process traumatic.

Continuity of care – the AdPs were going into the nursing homes every day and so they were able to get to know clients very well. This meant that they could pick up on problems very quickly and intervene, avoiding crises.

Fewer hospital admissions and A&E attendances – colleagues and managers hoped that if the AdP service could be expanded to include more OOH work then it may be possible to reduce A&E attendances further. Many patients also did not want to be admitted to hospital. There were a number of clients who had lived in a particular nursing home for quite some time and wanted to die there with people they knew rather than in hospital. The feedback from patients' families was also reported as being very positive. One of the nursing homes had recently been inspected by the Commission for Social Care

Inspection (CSCI) and they had been very positive about the AdPs' involvement in the home.

How the role has improved care

Many of the nursing home clients were confused and found going to hospital distressing, especially when they had to wait in A&E. Previously, if a client had a fall in one of the nursing homes, the staff would probably have taken them to A&E just to be safe. With the AdP service, it was possible for the client to be reviewed in the home and not necessarily have to go to A&E at all.

3.1.4 Factors affecting impact

Facilitating factors

Various factors were thought to have been important in achieving changes in relation to the introduction of the AdP role. These included:

- dissemination and marketing of the role within the organisation and in the wider health community, both by the PCT and by the AdPs themselves
- good mentorship
- effective utilisation of work-based learning (WBL) and academic learning
- the AdPs building up good relationships with nursing home staff and local GPs
- having three AdPs working in nursing homes which led to better continuity of care and meant they had a greater presence within the service
- the AdPs' ability to get to know clients well and build up relationships with them and their families
- the AdPs' ability to be independent sources of support and advice to clients and families
- the flexible and committed attitude of the AdPs.

Even though there was uncertainty initially with regard to exactly where the AdP role would fit into the service, it was felt that the PCT had developed quite a structured approach to managing this uncertainty. They had actively sought out roles for new AdPs and had ensured that any new AdP role was clearly located within a specific service. They were also concerned to match the trainee AdPs' skills and enthusiasms with the posts they were looking to create. The idea of working in nursing homes and focusing on EoL care had come from the AdPs themselves and their vision had meant that the service had been successful. Managers felt that it had been important to work with the AdPs in order to shape their roles and ensure that they were not *"sucked back into a routine role"* where their skills would not be utilised to the full [trust Champion].

Delaying factors

There were some factors which were thought to have delayed the impact of the roles. Funding was seen as an issue; although the initial money was helpful, once this ran out, it was difficult to get some managers to agree to training AdPs. It was suggested that 'bridging money' would be useful in order to get posts better established. Making sure that there was a role for an AdP in a particular service area was sometimes a problem as was getting the backing of their service manager. Even if someone was interested in advancing themselves, their service needed to be willing and/or able to release them for the training and give them support.

> *"It can fall at that hurdle because we might have someone who has a vision and is keen to progress but when we put it to the manager they say 'the workload is too heavy' or 'what will that mean for the service or other staff?'."* [PCT service manager]

The trust Champion was concerned about the pressure that trainee AdPs were under while they were doing the course. Having to combine two study days with three days in their normal role (which may involve managing a caseload or staff) was thought to put them under too much pressure. The WBL learning had also caused problems at times. The PCT could not always place trainees in the areas that would be suitable for them to gain the skills they needed, although all trainee AdPs had had at least one day working in a GP practice.

The need to achieve national and/or local targets was thought to have caused problems in some areas:

> *"We've had to say that the three AdPs have a caseload of 80 per WTE, which is a nonsense when you are talking about end of life care because each case takes up a huge amount of time. So we've had to keep dormant cases on their books because as far as the commissioners are concerned they have to have 160 cases between them but it's completely meaningless in terms of patient care".* [anon]

3.1.5 Learning lessons and looking to the future

The role of the AdP in nursing homes was thought to be working very well but there were a number of areas where it was believed things might have been done differently initially or where improvements could be made in the future.

- **Strategic planning**

It was felt by some that the PCT should have taken a more organisational perspective on developing the roles initially although it had been difficult to know exactly how they were going to be utilised best within the service. It was thought that there was an awareness of the AdP role in the wider organisation and also *"higher up the system"* because the PCT had referred to the AdPs in various strategies [service manager]. The PCT's new Urgent Care Strategy was likely to re-shape services over the next few years and the AdP role would be part of the new pattern of services for urgent and unscheduled care. One of the PCT Directors was leading this work and looking at how care pathways will change. It was felt that work needed to be done to plan how the AdPs would fit into the strategy and ensure that there were enough AdPs trained to fulfil these roles when they are needed. It was thought that the possible result of this could be that AdPs will be trained in areas in which they will not ultimately be working.

- **Expansion of the service**

At the time of the case study interviews, the AdP service only covered four nursing homes but it was hoped that this could be extended to all 14 nursing homes in the BPCT area. It was thought that this would decrease GP visits to nursing homes even more, with the possible result that the enhanced service payment that the GPs received for nursing home clients could be released to part fund the AdP service. Future expansion of the service could also mean that there could be AdP cover in the evenings and at weekends. The AdPs themselves had recently given a presentation to the PCT management setting out their vision for the future of the service. They proposed that, along with extending the service to all nursing homes in Bolton and increasing the cover to evenings and weekends, they would have a clinical focus in the two main areas of EoL care and acute intervention and also that they would develop partnerships with the

PCT and secondary care providers to develop and enhance patient pathways. Their main objectives were stated as being to reduce hospital admissions in relation to acute intervention and EoL care and also to improve EoL care for nursing home patients.

- **Issues with 'advanced practitioner' title**

At a national level, the continuing ambiguity surrounding the title 'advanced practitioner' was thought to be a problem. The title was being used for a variety of roles that were not necessarily at the same level. The efforts which the SHA had made to standardise the use of the term and create some clarity, at least for the North West region, were appreciated. Registration for AdPs was also seen as an issue. Those interviewed believed that it needed to be sorted out nationally as AdPs do not, as yet, have the option of dual or additional registration.

- **Clinical governance arrangements**

Although some clinical support was being provided for the AdPs by both the GP mentors that they had had in training and by a consultant for older people, there was a concern that other professional support mechanisms, such as the local Nurse Practitioner Forum, were insufficiently specific to the AdP role. A recent opportunity had arisen for the AdPs to attend GP clinical education sessions at the Royal Bolton Hospital but again these were not completely relevant to the AdP role. The new North West AdP Forum was, however, thought to be very valuable for peer support. It had been set up partly to address issues of accountability in advanced practice, as some AdPs were uneasy about the implications of taking on new clinical responsibilities. Bolton PCT had made their support for their AdPs' actions clear in their job descriptions but there was still concern among some of the AdPs.

3.2 Salford Primary Care Trust

Salford PCT is one of the14 PCTs in Greater Manchester and was established on 1 April 2001. It serves a population of more than 232,000 and considers that its role is *"not simply about providing the best healthcare services, it's also about delivering the right mix of health promotion activities with social care services".*[5]

3.2.1 Background to the advanced practitioner roles

At present there are 11 qualified advanced practitioners working within the Salford PCT boundaries. Seven of them are employed directly by the PCT but there are four who now work for a Community Interest Company (CIC) called Salford Health Matters (SHM) which provides primary care services across three sites in Salford (Little Hulton, Charlestown and Eccles). Three of the AdPs who work for SHM were trained through Salford PCT. There are AdPs at all three SHM sites and they function exactly the same as the general practitioners (GPs) working in the company. The AdPs are called 'Primary Care Specialists' at SHM so that they are not confused with assistant practitioners.

The AdPs who are still employed by the PCT are working in a variety of roles and settings including as community matrons and primary care AdPs, and in audiology and physiotherapy. One is a nurse clinician in cardiac services who is employed jointly between the PCT and Salford Royal NHS Foundation Trust. There are also two trainee AdPs within the PCT.

[5] From the trust website at www.salford-pct.nhs.uk/aboutthepct.asp?id=15

This case study focuses on the AdPs working at SHM but some issues raised relate to all the AdPs working in the Salford PCT area.

Service drivers and intended benefits for patient care
For SHM, the main reason for developing the AdP role was the difficulty in recruiting GPs. Salford was *"struggling to get anyone to work in the area"* [GP]. The main benefit to patients was to be through improved access to services. GPs were oversubscribed and patients were unable to get appointments. Because the service was so pressured there were clinical problems in practice; patients were not being seen soon enough or being followed up properly. There was a necessity to expand the service and the introduction of AdPs was seen as a suitable means to this end. It was thought that AdPs would bring very different skills to the job but that it was *"about alternative ways of working"* [GP].

3.2.2 Objectives of the advanced practitioner posts

Salford PCT's stated key objective for their AdP posts in general practice was to improve access in areas where it was difficult to recruit and retain GPs. It was felt at SHM that this objective was definitely being met and that the AdPs were going beyond it. They were seen as bringing *"added value"* [GP]. The AdPs' clinics were just as booked up as the GPs'; they were able to manage themselves and their workload because of their advanced skills.

3.2.3 Impact

Key Achievements

- Improved access to primary health care services in an area where GP recruitment and retention has been difficult e.g. through extended hours
- Better engagement of patients in 'hard-to-reach' groups
- Better support for practice nurses and scope for career progression
- Stronger inter-professional working
- Greater patient choice and increased satisfaction
- Reduced stress amongst GPs and improved GP recruitment

The impact of the posts at SHM was not being formally measured, although a patient survey was carried out in 2007. Baseline data collection was not carried out because those in the service considered that it was too pressured before the AdPs were introduced; *"the agenda was so massive we didn't have the luxury to stand back"* [GP]. Those at SHM regret not having collected baseline data however. They have observed that the AdPs' appointments always fill up first; an indication that patients are happy with the service they provide.

Impact on colleagues
The impact of the AdP role on colleagues within SHM was generally reported as being very positive. The AdPs were very supportive to other staff and the whole team were able go to them for advice, from the GPs to the receptionists.

GPs – some were thought to be sceptical at first but had been won over by seeing how the AdPs worked in practice and the new direction the service was going in. They highlighted the change that had been effected by the AdP role in relation to the amount of time they had available. It was thought that previously there had never been enough

time to do anything properly but since the AdPs had been in post it had been *"a lot more relaxed"* [GP].

> *"[They have] certainly taken the pressure off me."* [GP]

Practice staff – the practice nurses found the AdPs a very useful source of help and back up and considered that they had *"the patience to listen"* [practice nurse]. It was felt that relationships in the team had changed since the AdPs had been there; they had a *"levelling effect*" [GP], breaking down the hierarchy between GPs and receptionists, for example, and improving relationships between practice nurses and doctors. The difference in the nature of the AdP role from that of the practice nurse was recognised – *"they're far more advanced than I am"* [practice nurse]. It was thought, however, that AdPs were a good role model for career progression for nurses.

Impact on service delivery

Accessibility – this had been improved by the introduction of the AdP role at SHM. They had a lot more appointments to offer patients and they were able to open extended hours. The GPs believed that they would not have been able to do this without the AdPs. The AdPs saw patients for 15 minutes instead of 10 minutes which was attractive to patients, especially those with more complicated problems.

Improved engagement with 'hard-to-reach' groups – because of the AdPs' exceptional communication skills. Once these patients had developed confidence in the service through the first consultation, they were more likely to come back and continue to engage with the service.

Acting as a 'hub' – care was thought to have improved because the AdPs were able to link across medical, nursing, allied health professional (AHP) and administrative roles.

Improved patient safety – prior to the introduction of the AdP role, it was thought that the service had been *"dangerous"* [GP].

Recruitment of GPs – this had improved since there had been AdPs in the practice; they wanted to come and work with the AdPs. The support provided for other members of staff was also seen as an attraction for potential job candidates.

Impact on patients

Patients were described as being *"extremely positive"* about the role [practice nurse]. They did not find it difficult to accept the AdPs who had always given a very clear definition of the role and had never pretended that they were doctors. The AdPs had successfully gained the patients' confidence. They had improved quality and patient satisfaction and increased clinical effectiveness. It was thought that patients did not get *"half attention"* from the AdPs but *"full attention"* [GP]. Many patients were reported as asking specifically for an AdP when they made an appointment; they had the *"caring side"* as well as the medical knowledge [nurse]. The AdPs had a different consultation style to the GPs and it was thought that many patients found them *"more approachable"* [nurse].

How the role has improved care

It was reported by colleagues that the AdPs' ability to communicate revealed psychological barriers in patients that the GPs were unaware of. Patients were willing to *"open up"* to the AdPs who were then able to get to the *"bottom of problems"* [GP]. Patients often told the AdPs about what was happening in the rest of their family and hence gave them a broader view. This openness was attributed to the AdPs' communication skills and the way the role combined that of the GP and the practice nurse into one. An example was given of how the AdPs combine the nursing and medical roles in a practical situation. An AdP made a home 'GP' visit to an elderly lady who was bed-bound. Not only did the AdP perform the functions of the GP through history-taking, examining and diagnosing, she also performed nursing tasks such as making sure the patient's bed was in a suitable position for watching the television and going to the shops for her.

3.2.4 Factors affecting impact

Facilitating factors

A number of factors were seen as important in relation to achieving improvements in care as a result of the introduction of the AdP role. These were:

- the clarity of the role and the objectives of the post
- the skills of the AdPs in
  - clinical practice
  - leadership
  - negotiation
  - communication
- the positive attitude of other staff towards the AdPs
- the support provided from other AdPs in SHM
- regular education sessions for all clinical staff in SHM
- quality of mentors and individual's relationship with mentor
- opportunities for preceptorship.

Those within SHM welcomed the AdP role and the value it would bring to the service. It was felt that there *"weren't any doors that they had to push against"* [GP] and so this facilitated the role's introduction.

Delaying factors

Some problems were experienced in relation to the involvement of Salford PCT in the implementation of the role. Colleagues of the AdPs in SHM felt that the PCT was uncertain about the boundaries of the role and struggled to allow the AdPs to function fully in their advanced capacity. The PCT were thought to be happy to allow the AdPs to function like GPs when there was a shortage but preferred them to perform like nurses when there were enough. SHM found that it was easier to implement the role effectively once the AdPs were not under the management of the PCT. In the wider context, the Champion described problems when implementing some of the other AdP roles across the PCT. In relation to community matrons (CMs), the make-up of the service kept changing; the Champion commented that *"it doesn't look anything like it did when it started".* In some areas there were also difficulties in finding suitable mentors

and supervisors. These were linked to a lack of clarity about the purpose of the role and a lack of infrastructure in place to support and integrate it.

3.2.5 Learning lessons and looking to the future

Colleagues at SHM believed that the AdP role was working *"extremely well"* [GP, practice nurse]. Certain issues were highlighted, however, as areas for further improvement or development.

- **Skill mix and critical mass**

The AdPs liked working with the GPs and *vice versa*; they were a source of support to each other. The AdPs also supported one another and having more than one in the group meant that they did not feel isolated. The GPs wanted to have more AdPs in SHM: they would not be able to replace the GP role entirely, as their skills were different (and there were also some issues around certification), but they were complementary. The GPs in SHM believed that other practices should look at their skill mix; *"the days of just GPs are numbered".*

- **Mentorship and support**

Some of the student AdPs had poor mentorship but colleagues believed that this could have been improved by ensuring that mentors believed in the role and were aware of the commitment involved. One of the GPs felt that the trainee AdPs should have been given more guidance and assistance in finding mentors; many of them were left to arrange it themselves. It was important, however, that the AdPs had a say in who acted as their mentor because the relationship needed to be good. A system of 'filtering' practices which might host trainee AdPs would help to highlight what their attitudes towards the role were. Some colleagues were concerned that a number of middle managers in the PCT were ignorant about the role, its purpose and what the AdPs needed in terms of support. It would have been beneficial for them to be better educated about the role. There had been some wider dissemination of the AdP role in primary care but this had focussed on presentations to other AdPs, nurses and students. One of the AdPs at SHM was also working with Bolton University to increase the profile of AdPs.

- **Sustainability**

Colleagues of the AdPs at SHM believed the role to be sustainable. Patients liked the role and financially it offered good value for money (even on an Agenda for Change banding of 8a, an AdP was only half the cost of a GP). SHM wanted to become a training site for AdPs and they were planning to introduce more qualified AdPs into the company.

3.3 Stockport NHS Foundation Trust

Stockport NHS Foundation Trust (SFT) serves a population of approximately 350,000 people with most of its acute services being delivered from Stepping Hill Hospital. SFT was one of the first 10 Foundation Trusts in the country.

Stepping Hill Hospital's maternity services received a 'best performing' score in the Healthcare Commission's Review of Maternity Services published in January 2008.

3.3.1 Background to the advanced practitioner roles

At present there are six qualified AdPs working in SFT. Three of these are employed in maternity services and two are in orthopaedics – these five are from the first cohort of AdPs. Four AdPs are still in training.

This case study focuses on the AdPs working in maternity services and those working in orthopaedics. In maternity services, the AdPs are called Advanced Midwife Practitioners (AMPs); midwifery being the base profession of all these AdPs. In orthopaedics, the two AdPs were initially physiotherapists and are part of a larger group of specialist physiotherapists called Extended Scope Practitioners (ESPs). There had already been ESPs in the department for over 10 years. Their role had originally been to work alongside orthopaedic consultants in their clinics to relieve some of the pressure on them. Over time, some of the ESPs started to run their own clinics and take emergency referrals when the surgeon was absent. Since this time, a number of ESPs have been trained to replace doctors in the orthopaedic clinics. At the time of the case study interviews, there were eight ESPs in the department, including the two who had undertaken the NHS North West AdPs training. The two AdPs ESPs had the same role as the other six ESPs but it was felt by the divisional manager and ESP colleagues that the AdPs had more credibility in their role because they had the formal academic training to back up their clinical decisions.

Service drivers

The trust Champion indicated that the main service driver for the AdP roles in SFT was the introduction of the European Working Time Directive (EWTD).

Other drivers included:

- National initiatives
  - the 18 week target[6]
  - the four hour A&E target[7]
- The need for improvements in the quality of patient care - *"quality, first and foremost"* [midwifery service manager]
- Skill mix considerations
- Promotion of normality in maternity services
- Increased clinic capacity

Intended benefits for patient care

These were thought to vary according to the area the AdP was working in. In maternity services, the quality of the patient experience was important, as was reduction in intervention, the promotion of positive birth outcomes and safer practice on the labour ward. For orthopaedic patients, a reduction in waiting time was the main intended benefit.

3.3.2 Objectives of the advanced practitioner posts

Maternity services – the objectives of the midwifery AdP posts were to:

- promote normality in childbirth
- reduce intervention rates for women in labour
- increase patient satisfaction
- improve quality
- reduce adverse intrapartum effects
- reduce junior doctors' out of hours (OOH) working.

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[6] The NHS Improvement Plan set out the aim that "by 2008 no one will wait longer than 18 weeks from GP referral to hospital treatment" (Department of Health, 2004).

[7] The NHS Plan (Department of Health, 2000) stated that by December 2004, all A&E patients should be discharged, admitted or transferred within four hours of arrival.

In relation to whether these objectives were being met, it was thought that the AdPs were not having the *"full effect"* because it was difficult for them always to get the experience they needed [midwifery manager]. The reasons for this were thought to include:

- **Not always being able to work as advanced practitioners** – being counted in the midwifery 'numbers' was seen as the *"biggest hurdle"* but when the AdPs were out of the midwifery establishment and on the SHO rota, it was hoped that they would begin to have more impact. One of the obstetric consultants felt that the AMPs were frustrated by trying to do a normal midwife's job and carry out the role of the AMP at the same time. As a tangible sign that the AMPs were different to the other midwives, they had recently introduced a system whereby their names were written up on a separate section of the board to say who was on duty that day – the AMPs were now listed underneath the medical staff. It was not thought that the midwifery AdPs were having an effect on reducing junior doctors' hours at the time of the case study interviews but that should change once they were working on the SHO rota.
- **Not having or only just achieving the non-medical prescribing qualification –** the midwifery AdPs had either only just qualified as non-medical prescribers or still did not have the qualification but it was hoped that holding this qualification would help them to work more autonomously in their role and have a greater impact.
- **Needing to consolidate –** the role was still new and there was a need to sometimes *"run their decisions by the Reg."* [delivery suite co-ordinator].

The objective of promoting normality was not thought to be exclusive to the AMPs; all midwives should promote normality. One of the staff midwives, however, felt that they were very successful in achieving this objective – they were *"less likely to jump in".*

In relation to increasing patient satisfaction, it was thought that the continuity of care that the AMPs could provide (through being able to perform certain interventions that previously only doctors could do e.g. ventouse delivery) was having an impact on this objective.

Orthopaedics – in orthopaedics, the key objectives were to:

- reduce waiting time for orthopaedics outpatient appointments
- reduce orthopaedic outpatient waiting lists
- release orthopaedic surgeons to undertake more surgery
- ensure sufficiently skilled practitioners are available to replace medical staff in orthopaedic clinics.

The AHP manager was confident that the AdPs were achieving these objectives. Their input had enabled the trust to meet its 18 week target and had also increased clinic capacity. There were a large number of patients who never saw a doctor and were managed throughout their whole course of treatment by an ESP. There were no set criteria for which new patients were seen by a doctor or by an ESP:

> *"It all depends on the confidence the consultant has in the ESP – it's a very individual and specific arrangement. It was one of the reasons that I welcomed a formal academic course - the two physiotherapists from here who completed it have some legitimacy".* [AHP manager]

The other ESPs believed that the AdPs were definitely fulfilling their objectives when they were working in the orthopaedic clinic. They were running clinics that were previously run by consultants which was freeing up consultant time for additional theatre work, which in turn was contributing to reducing waiting lists.

The trust Champion was confident that in general the AdPs were achieving their objectives; they were all taking on responsibilities that were traditionally doctors' roles. Hence, the role had extra breadth but the depth had also increased. The Champion was not sure if this was related to the greater knowledge base that undertaking the MSc had given the AdPs or if it was more to do with developing a different way of thinking.

3.3.3 Impact

Key Achievements

- Reduced waiting times for orthopaedic patients and a significant contribution to achieving the 18 week target
- Better access to specialist skills for junior staff, including junior doctors
- More cost-effective, efficient and flexible service delivery
- Senior doctor time freed up for extra surgery sessions and a significant contribution to achieving the European Working Time Directive
- Improved continuity of care, fewer 'hand-offs' and a smoother care pathway for patients
- Improved communication between physiotherapists and doctors and midwives and doctors

Monitoring impact

Maternity services – the impact of the midwifery AdPs was not being measured formally, although basic statistics, such as how many ventouse deliveries the AdPs had performed, were recorded. The Head of Midwifery described the data collection as *"a bit ad hoc".* General audit data was collected but it was thought that when the AdPs were on the SHO rota, more specific impact data would be collected.

Orthopaedics – the clinic 'templates'[8] enabled the trust to monitor the activity of the AdPs and the other ESPs. The department's monthly monitoring reports showed clearly what the ESPs were doing and so they were particularly useful for demonstrating how much doctor time they were freeing up. They were also able to put a price tag on any ESP activity and thus demonstrate their financial and service benefits to the trust. Because the ESPs were paid on a band 8a, it was necessary to justify their increased cost over normal physiotherapists (band 7) by showing the financial savings of the role.

The trust Champion was not aware of any impact data being collected in relation to the other AdPs in SFT. She thought there were difficulties in separating out the impact of the AdPs from the rest of their teams; it was *"hard to pin it down".*

Impact on colleagues

The trust Champion believed that colleagues of the AdPs were benefiting from the role through different ways of working. In many cases, the impact on medical colleagues was positive and had reduced their workload because the AdPs were able to provide care and treatment without having to call a doctor. It was thought that there had been criticism from some colleagues in the beginning but that was improving and the role was becoming more accepted as people understood it more.

[8] At Stepping Hill, all clinics had a template which gave the number of new and follow-up appointments it would include. Initially, the ESPs had only follow-up patients but more recently they have had their own new patient template.

Maternity services – one of the managers reported that a number of colleagues found it difficult to grasp the new role initially and that everything was *"fraught with confusion"*. It was thought that there had been no collective vision as to where the role fitted in; medical and midwifery staff alike had not really known what the role was for.

> *"Both midwives and doctors have been suspicious."* [consultant]

Medical staff – the majority of medical staff were supportive although junior doctors still feared that the AdPs were taking some work away from them. But with junior doctors doing fewer hours and receiving less training, it was thought that they should utilise the AdPs' knowledge and availability to teach them. The obstetric consultants saw the AdPs as an asset and were also keen to encourage the middle grade doctors (registrars etc.) to work with the AdPs to enhance care. The AdPs were thought to be confident enough to challenge medical staff if necessary.

Midwifery staff – it was reported that there had been some conflict and resentment in the early stages between the delivery suite co-ordinators and the AdPs (they saw what the AdPs were doing as more of a medical role and thought they were trying to be like doctors) but it was felt the differences had been resolved and they were now a *"great support"* [midwifery manager]. The co-ordinators themselves reported that the AdPs were a very useful resource for advice and expert knowledge and acted as intermediaries between the midwives and the registrars. The co-ordinators also considered the AdPs to be very useful for facilitating operative deliveries. The AdPs were seen as a role model for all the midwives through support and mentoring; they were not afraid to challenge their midwifery colleagues and make them think about their practice. Although the staff midwives found the AdPs useful as sources of advice and support, they did not see them as any different to the delivery suite co-ordinators or approach them in a different way. They felt that the AdPs had not impacted on them any more than knowledgeable, senior midwives would do. The AdP was seen as an extra senior person who could help with complications and review patients. When they were not there, the midwives had to wait for a doctor to come and hence it took longer for decisions to be made and care to be implemented.

Orthopaedics – the trust Champion reported that there were some difficulties in relation to the AdPs working as ESPs in the orthopaedic department because they were working at different levels in different areas. In the orthopaedic clinic they were on a band 8a but when they were working in the physiotherapy department they were on a band 7. This was thought to cause problems with some colleagues.

Medical staff – the orthopaedic consultants were generally enthusiastic about the ESP role and wanted *"more and more of those kinds of people"* [trust Champion]. The ESPs were reported as doing a substantial amount of training of junior doctors:

> *"Because they [the ESPs] don't move on every six months like the junior doctors they are a stable element in the clinics now and when the junior doctors arrive they have very little knowledge and a short period of time in which to gain it so they often work alongside the ESPs".* [AHP manager]

The ESPs who were not AdPs felt that the orthopaedic doctors in clinic benefited from having a team member who was working in a medical capacity but also had the skills and knowledge of a physiotherapist. The doctors would seek their advice about whether a patient's condition would respond to physiotherapy or would need surgery.

> *"The roles have greatly improved the understanding between the Physiotherapy Department and the Orthopaedic Department, so when we*

> *send patients back to consultants we have a better idea of what we are hoping they will do. Also the Consultants take it more seriously".* [ESP]

Physiotherapy staff – one of the managers reported some jealousy from physiotherapy colleagues. They were thought to be unhappy about the AdPs going out of the department for training and hence reducing the number of senior staff available. It was also thought, however, that within the physiotherapy department the AdPs had raised skill levels which had led to an overall improvement in the quality of patient care. They acted as a specialist resource for junior physiotherapists, who could go to them for advice.

Impact on service delivery

The trust Champion thought that the trust was benefiting from the introduction of the AdPs; patients were getting a more streamlined service and length of stay had reduced for certain conditions. For example, patients with infections could be prescribed antibiotics much earlier and did not have to wait for doctors. She thought that there was still a need, however, to continue to be clear about what the difference was between the AdP's role and the doctor's role. Because the AdPs were paid on band 8a, it was necessary to prove their worth in financial terms. The creation of the posts had financial implications but these had to be weighed against the benefit to the service.

Maternity services – the AdPs were thought to be *"enriching the midwifery establishment"* [midwifery manager]. They were impacting on service delivery through:

- More efficient delivery of care, essentially because the AdPs could do everything that the SHOs did. They were able to see a woman through from start to finish without ever having to call a doctor and could perform certain medical interventions, such as fetal blood sampling and ventouse delivery.
- Acting as assistant in theatre which was particularly useful when two theatres were in use and there were not enough doctors to staff both.
- The occurrence of fewer adverse incidents; they provided back up for senior staff and expert support.
- Their effect on recruitment and staff retention and on midwives' development in general; the AdP role was seen as a new path of career progression.

Some colleagues felt that the role would be more beneficial once the AdPs were working on triage. On the delivery suite, the difference between a doctor and an AdP reviewing a woman was minimal according to some staff midwives; it was still another professional coming into the room and the doctors were viewed very favourably anyway.

Orthopaedics – the physiotherapy AdPs were having an impact on service delivery through:

- Freeing up doctors' time for extra surgery (shown by the monthly monitoring reports of ESP activity in the orthopaedic clinics). They were clearly replacing doctor time in both outpatient and fracture clinics and were able to see both new and follow-up patients; the surgeons often did not see patients until they operated.
- Financial benefits demonstrated through pricing up the cost saving of every patient seen by an ESP. The trust just *"has to do the maths"* to see the financial and service benefits the ESPs bring [AHP manager].
- The AdPs' greater understanding of the structure of the NHS and government policy as well as its relevance for clinical staff; the 18 week target was thought to have been accepted more readily because the AdPs were able to discuss its importance with colleagues.

- an improvement in communication between the specialties and clinics being much more multi-disciplinary.

Impact on patients
The trust Champion felt that the care provided by AdPs was possibly more patient-centred than that provided by junior doctors. The AdPs were thought to be better at communicating with patients and have better 'people' skills; they provided an *"accessible and timely service delivered in a patient-focused way"*. The nurse AdPs were able to offer a quicker, more comprehensive service and this was set to improve even further when they had started to provide an out of hours (OOH) service.

Maternity services – the Head of Midwifery believed that there was some way to go in terms of impact of the AdP role on clients in the maternity service and that they were *"still to reap the benefits".* One of the managers, however, was certain that the AdPs had had a positive impact on the women in their care, although there was not much quantitative evidence to support this e.g. there was no data to suggest that caesarean section rates were reducing. One of the obstetric consultants described the benefit to women in the maternity department as *"timely intervention and appropriate investigations".* The AdPs were very thorough with history taking and assessment but they also had all their prior midwifery experience to draw on. They were also able to provide:

- continuity of care in situations where previously a doctor would have had to intervene
- quicker discharges and admissions; a woman could often be seen by just one clinician instead of two or more
- improved antenatal care; the AdPs were able to do more than the co-ordinators and they did not necessarily have to involve medical staff at all
- reviews of women that staff midwives would previously have asked an SHO to see; because the AdPs were more available, women were seen and treated much more quickly.

Orthopaedics – the AdP role was leading to:

- patients being seen quicker in clinic and getting a better service *"on a micro level"* [trust Champion]
- clinical benefits for routine physiotherapy patients because the AdPs were able to recognise abnormal pathology and take action by using their links in orthopaedics:

> *"they can expedite referral and treatment quickly"* [AHP manager]

- a smoother patient pathway and greater continuity of care because patients saw fewer clinicians
- improved quality of care in the orthopaedic clinic because the doctors were willing to ask the ESPs about their views on managing a patient and would accept their judgement
- raised skill levels in the physiotherapy department which had led to an overall improvement in the quality of patient care:

> *"When I see a patient in the [physiotherapy] department I'm looking at them not only as a physio but also how I would look at them in clinic and what would be available to them."* [ESP]

3.3.4 Factors affecting impact

Facilitating factors
A number of factors were thought to have been involved in achieving changes in relation to the introduction of the AdP roles in SFT. These were:

- engagement and buy-in from managers and consultants
- support for those doing the role from colleagues, managers and medical staff, particularly consultants
- having a 'critical mass' of AdPs
- the 'bridging' nature of the role - between doctors and midwives/physiotherapists
- the work-based learning element of the MSc – developed clinical skills to an advanced level
- raising awareness of the role through, for example, reporting on the activity of the ESPs in the orthopaedic clinics
- undertaking the non-medical prescribing course
- the AdPs'
  - previous clinical experience
  - motivation and confidence
  - proactive approach
  - availability
  - clinical skills.

The trust Champion believed that forward thinking about service development on the part of managers and consultants in SFT was an essential factor in facilitating the impact of the AdP roles. Good planning was necessary, as was the enthusiasm of senior medical staff right from the beginning. Although there were some consultants who were less keen earlier on, they had been won round once they had seen the benefits of the role.

Delaying factors
Financial constraints – one of the most significant delaying factors as far as the Champion was concerned was a lack of sufficient finances. Although there was backfill money provided, it was not thought sufficient to cover the post of, for example, a senior ward sister. In addition, although two days per week were backfilled, the other three were not so it was difficult for the trainee AdPs to gain sufficient experience when in the clinical environment. The Champion acknowledged that it would be financially unviable to fund them full-time but the problem of how to deal with it remained. One of the obstetric consultants advocated supernumerary status for the trainee AdPs but the department were unable to achieve this. There were also some continuing funding problems once the AdPs were qualified. In the maternity department, the AdPs were funded from the midwifery budget but they were often freeing up doctors' time, not midwives'. There was some indication, however, that once the AdPs had moved onto the SHO rota, they would then be funded from the medical budget.

Professional status – there had been some problems in relation to the status of AdPs in maternity services; the midwifery profession sees all midwives as 'advanced' and autonomous. This had led to some dispute in the department but the current Head of Midwifery was very keen on the role and wanted to see it developed.

Not working in the Advanced Practitioner role – another significant factor which was thought to have delayed the impact of the AdP posts in midwifery was that the AdPs had been working as part of the midwifery establishment rather than as AdPs for a high percentage of the time. This was mainly related to midwifery staffing levels; the AdPs often had to work as delivery suite co-ordinators because of shortages.

> *"The biggest problem they've had is still having to work as midwives".* [consultant]
>
> *"Demand on the ward has hindered their ability to do what they're trained for."* [staff midwife]

It was hoped that once the AdPs were on the SHO rota, this problem would be resolved.

Staff attitudes – some colleagues in maternity services felt that resistance on the part of some midwives, doctors and managers had had a delaying effect in relation to the impact of the role; their attitude towards the role had made it more difficult for the AdPs to function effectively. Some midwives, however, believed that there was still not enough understanding about the role, particularly among new midwives.

Inability to prescribe – this had delayed the impact of the roles in maternity but once the AdPs had completed the non-medical prescribing course this issue would be resolved. Unfortunately, in orthopaedics this would not be the case because the legislation in place at present does not allow physiotherapists to be independent prescribers. They can be supplementary prescribers but they still have to get a doctor's signature. This situation was frustrating for the ESPs and restricted their work in the orthopaedic clinic.

3.3.5 **Learning lessons and looking to the future**

The trust Champion was positive about the success of the AdP role in SFT but indicated that there was some variation across the roles; some were thought to be working better than others. This was to do with the personalities of the people involved but also how well the role fitted into the service. On the whole, the Champion believed them to be *"very valuable members of staff".*

There were some issues, however, which those interviewed highlighted as areas needing consideration if the role was to be fit for purpose in the future.

- **Role development**

Colleagues in the maternity department felt that the midwifery AdPs were *"not working as yet to their full potential"* [midwifery manager] but it was thought that this would change once they were on the SHO rota. They would then be able to develop their own *"road plans"* [consultant]. Being on call at night would also help them to maintain their clinical skills and competence. One staff midwife was ambivalent about whether the role was making much difference – *"I don't think it's had a huge impact"* – she/he often forgot that the AdPs were there and would ring a junior doctor instead if there was a problem. Another midwife believed that the role was working satisfactorily but the AdPs were not always around; *"they're valuable when they're here".* The orthopaedic AdP role was thought to be working very well but colleagues wondered if it could be used more fully. The other ESPs thought that the AdPs were more confident than they were because they had completed the MSc and had had a structured learning programme.

- **The training programme and mentorship**

Colleagues from both maternity services and orthopaedics highlighted some issues with the MSc course and the training of the AdPs in general. It was felt that the generic model of training was inappropriate because the trainees were developing their skills in very specific areas. Some thought that, at least in the early days, the course was geared towards nurses rather that AHP or midwifery AdPs.

> *"The non-clinical elements of the course were fine but the clinical teaching was not of the level that we required for our clinicians to practise – that's why we had to do add-ons...The people doing this course are already specialists – there is nothing generic about them."* [manager]

The AHP manager would have liked more involvement of professionals from outside nursing in the development of the MSc in Advanced Practice; it was thought that clinically, the course was set too low for professionals who were already autonomous practitioners. One manager was unhappy with the balance of theoretical teaching to WBL. She/he felt that there should have been much more WBL, resulting in less time out of the clinical environment, and that the academic teaching should keep up with the practical and not the other way round. One of the maternity service managers did not think there had been enough preparation for mentors initially or clarity about who would be suitable and what their commitment would be. Hence, some AdPs had had successful mentoring but others had had problems. It was important that AdPs had realistic expectations about the amount of support they would receive. That support needed to be sufficient but sometimes *"expectation wasn't matched by reality"* [manager].

- **Role clarity**

The trust Champion felt that there should have been more clarity about the roles from the outset, particularly those in maternity services. This clarity should have extended to better preparation for the rest of the service about the purpose of the role and what the longer term plans were for its implementation and development. Some staff midwives complained that the AdP role had never been explained to them, even at the very beginning. Midwifery staff still appeared to be uncertain about what the AdP role was for and were confused by the seemingly constant changes in what the AdPs were doing. They hoped, however, that it would become clearer when the AdPs were on the SHO rota full time. In orthopaedics, however, the reporting of the ESPs' activity was thought to have raised awareness of the role amongst managers and clinical staff alike.

The title of the role was seen as an ongoing problem. In orthopaedics, the AdPs were also known as ESPs but not all the ESPs were AdPs. In maternity, the AdPs were known as AMPs. It was thought that national clarification was needed in order that only professionals with certain qualifications could call themselves advanced practitioners.

- **Pay structure**

Some colleagues highlighted a need to be clearer about the pay structure related to the AdP role but it had been difficult because Agenda for Change[9] was just being implemented at the time when the AdP posts were introduced. The physiotherapy AdPs were in a *"schizophrenic"* situation with regard to their banding [trust Champion]. When they were working as ESPs in the orthopaedic clinic they were on an 8a banding but when they were working as normal physiotherapists they were on a band 7. Their manager was unhappy with this situation and felt that the AdPs/ESPs should be developed as a specific 'career grade' so that they would be paid the same whatever setting they were in. The ESPs thought that establishing the role as a career grade would be beneficial in that the service would not be overly reliant on particular individuals and their skills. They also believed that the higher level skills were not left behind when they were not working in the orthopaedic clinic and that they enhanced all their work, including what they did as physiotherapists. The trust Champion blamed the discrepancy in banding on funding problems.

- **Supernumerary status**

There was some debate about whether the trainee AdPs should have been supernumerary. Although it was agreed that this would be the ideal situation, some thought that it was never going to be realistic, whereas others believed it was possible and should have been built into the plan from the beginning. Senior medical and

[9] 'Agenda for Change: Final Agreement' (Department of Health, December 2004)

managerial staff in maternity services believed that the midwifery AdPs should never have been counted in the midwifery complement but should have been on a rota of their own. One of the obstetric consultants hoped that it would be better for future trainee AdPs because the lessons will have been learned:

> *"When you haven't done it before, you don't know what you're doing."* [consultant]

- **Critical mass**

The importance of AdPs not being isolated was emphasised as a requirement for long-term success of the role. It was thought that the AdPs in orthopaedics had *"a home"* there and they were well supported and integrated. If an AdP were on their own in a service, their need for support was more likely to be missed.

- **Sustainability and strategic plans**

The trust Champion, managers and clinicians were all keen to see the AdP role continue and believed that it was sustainable although finding sufficient, ongoing funding could prove to be a threat.

> *"They are part of the workforce – certainly here they are – can't see anyone getting rid of them."* [trust Champion]

The Champion indicated that there were longer-term strategic plans for the role but that they had to balance the role's obvious value against its cost. The Head of Midwifery would have liked full-time coverage of the AdP role but the financial pressures were too great. They were considering *"skilling up"* midwives to become AMPs without having to complete the MSc but were not sure if it would be possible. In orthopaedics, the possibility of having more ESPs who had not done the MSc was also still open. It was thought that the MSc in Advanced Practice should be developed so that it was more relevant to midwives and other professionals outside nursing. There were high hopes for when the midwifery AdPs went on the SHO rota:

> *"When they get the opportunity in August, I hope they really run with it."* [manager]

There were also other plans for developing the role in the maternity department. These included a triaging service and a 'Vaginal Birth after Caesarean Section' (VBaCS) service in which AdPs would take the lead. One of the obstetric consultants was very positive about the AdPs' role in training junior medical staff. There were problems with the way junior doctors were left out of hours without direct supervision but the AdPs were good teachers and always promoted normality. Some midwifery staff felt that everything was *"still a bit of a whirl"* but that it could all *"pan out very well"* [delivery suite co-ordinator]. A change in culture was needed, as was constant promotion of the role.

The AHP manager said that they had no plans to establish further AdP roles in physiotherapy but that there was an occupational therapist AdP training to work in rehabilitation clinics. As with the physiotherapy AdPs, the aim of the role was to free up consultants' time to see more patients. Because the ESPs in orthopaedics have helped the trust to achieve the EWTD targets as well as the 18-week wait, they are viewed as very valuable.

3.4 Pennine Acute Hospitals Trust

The Pennine Acute Hospitals NHS Trust (PAHT) provides general and specialist hospital treatment to approximately 800,000 people who live in Bury, Oldham, Rochdale

and North Manchester. It was formed in 2002 as a result of a merger of four separate local trusts. There are four different sites: North Manchester General Hospital (NMGH), Royal Oldham Hospital (ROH), Rochdale Infirmary and Fairfield General Hospital.

3.4.1 Background to the advanced practitioner roles

There are 3 qualified AdPs working in PAHT at present but there are no trainee AdPs. Each of the AdPs work in different areas e.g. Accident and Emergency at NMGH, High Dependency Unit (HDU) at NMGH. There was also an AdP who was based in the HDU at ROH but he/she has left the post and has not been replaced. This case study focuses on the AdP based in HDU at NMGH.

Service drivers

Lack of resident medical teams – NMGH and ROH both had stand-alone HDUs whereas the other two hospitals had their HDUs and Intensive Care Units (ICUs) combined. There were no resident medical teams on the HDUs at NMGH or ROH so it was felt that there was a need for AdPs on these sites in order to improve the service. It was a way of *"stopping the gap"* [ICU consultant]. Originally it had been planned to have six AdPs across the two HDUs but the trust also wanted AdPs in other areas so it was decided to employ just one AdP in each HDU.

Clinical development and leadership – at NMGH the person who became the AdP was already employed in HDU as a senior nurse; the department valued his/her input and introducing the AdP role was seen as a good way of enhancing his/her skills and giving the incentive to remain in that particular clinical environment. There had also been a high sickness rate among staff and low morale on the unit for a number of years. It was felt that clinical leadership and support were needed from someone who did not have managerial responsibilities.

Bridging the gap – the role was intended to take some pressure off junior doctors based on ICU; there was an indication that they were being called to HDU to perform minor tasks that could be done by someone else who was suitably trained. However, the role was not simply meant to be a replacement for junior doctors in medicine but more akin to a mixture between the roles of a nurse and a doctor.

Gatekeeping – it was also hoped that the AdP would perform a gatekeeping role in HDU; there had been an identified need for a long time. Any consultant could say that they wanted a bed on HDU for a patient but without resident medical staff there was no one to assess the patient to see if they were suitable for HDU. Patients were often admitted to the unit without a plan of care. Patient flow through the department was *"inadequate"* and *"discharges weren't timely"* [senior nurse].

Intended benefits for patient care

The intended benefits for patients were therefore that they would be reviewed properly as soon as they were admitted to HDU and that they would have a management plan produced in a timely manner. Once in the unit, patients would then be reviewed on a daily basis by the AdP. This had not been happening previously because the 'parent' medical teams were too busy. The AdP would also be able to discharge patients without medical approval. It was hoped that delays in performing certain clinical tasks (for example, inserting central lines) would be reduced by the introduction of the AdP. In addition, they would have an extended role in forming links with speech therapists and physiotherapists.

3.4.2 Objectives of the advanced practitioner posts

PAHT's key objectives for their AdP posts in HDU were to:

- deliver efficient and high-quality care to patients in a timely manner
- improve management plans for HDU patients
- introduce and evaluate evidence-based practice
- support clinical teams
- enhance the role of the gatekeeper thereby preventing inappropriate admissions.

Most of the AdP's colleagues in HDU believed that the objectives for the role were being fulfilled. Management plans had improved and the AdP was able to help junior doctors plan care. He/she was able to support the clinical staff, initiate actions and provide a sound knowledge base. There was a feeling that things did not "*run as smoothly"* when the AdP was not there [ward sister]. It was thought that the AdP also noticed things that others did not, such as issues of poor practice, and had the clinical skills to give high-quality care. One staff nurse was concerned that objectives of the role were only partly being fulfilled because there were times when it was necessary for the AdP to be in the nursing 'numbers'; it was not possible to function as an AdP when he/she had to take patients.

One colleague commented:

> *"I don't know where we'd be without [AdP]".*

3.4.3 Impact

Key Achievements

- Fewer calls to the ICU medical team to attend HDU patients
- Better support and training for HDU nursing staff
- More consistent use of 'management plans' for patients and better coordination of care
- More timely and responsive interventions (e.g. swallowing assessment for patients following removal of a tracheotomy)
- Fewer inappropriate admissions to HDU
- Improved communication between HDU nursing staff and doctors in referring medical teams

A baseline audit of patient outcomes on HDU was performed in 2005 and there was a follow-up audit in 2006.[10] No recent audit data was available although they were planning to undertake another one in the near future. Existing service audits monitor bed occupancy, length of stay etc. The unit was hoping to see reduced length of stay and reduced inappropriate admissions as a result of the AdP role.

Impact on colleagues

The AdP in HDU had had a considerable impact on both medical and nursing colleagues within the department.

[10] For further details of these audits, see the second year report of the evaluation 'Evaluating the Implementation and Impact of Advanced Practitioners across Greater Manchester – Progress and Challenges' September 2007

Medical staff – pressure had been taken off the ICU medical team; they were not called by HDU staff as much and they noticed when the AdP was not there. There had been some fear amongst consultants that learning opportunities would be taken away from junior doctors but those fears were unfounded. This may have been due to the AdP having formerly been in a teaching role. The AdP had actually been teaching the junior doctors at times which worked very well. Most of the junior doctors were thought to be enthusiastic about the role and willing to take it on board. It was a gradual process of change, however – it was thought that the effects would filter through slowly and eventually the junior doctors would start behaving differently even when the AdP was not around. In the early stages some colleagues believed that there was still a risk that having the AdP would lead to the junior doctors abdicating some of their responsibilities due to the support that the role offered; it was a "*double-edged sword"* [senior nurse]. Medical colleagues saw the AdP as part of the medical team, although registrars on ICU did not always understand the role because they moved around frequently. It was thought that they were sometimes challenged by the role and did not always have time to assimilate it. However, one of the ICU consultants believed that all doctors who had patients on HDU valued the role and could see the benefits.

Nursing staff – some nursing colleagues were described as being sceptical about the role at first and resentful of the interference of someone other than a doctor in their work, but over time they had begun to recognise the benefits for both patients and for themselves. They particularly benefited from the support and the AdP's role as a resource. Junior nursing staff benefited from teaching and the availability of the AdP. Previously, junior staff would have asked the senior nurses for assistance but they had not always been able to carry out what was required. The AdP, however, could often resolve problems without having to involve medical staff and was usually able to assist immediately. He/she gave *"peace of mind"* [ward sister]. The vast majority of nursing staff were thought to see the AdP as an asset; someone who could act as a negotiator with the medical teams. He/she was thought to *"carry a lot of sway with the doctors"* [staff nurse]. Nursing staff believed it was important that the AdP worked across the two daytime shifts; it was good for continuity and effective communication. One senior nurse believed that the presence of the AdP affected the quality of care provided by other staff; it made them *"scrub up"* and be *"more on the ball".* The presence of someone with high level skills raised other people's skills.

Impact on service delivery

It was thought that the AdP had had an impact on the delivery of care in HDU.

Management plans – these had been developed and were now in place (this had not been the case previously) and no time was wasted in waiting for medical teams to review patients.

> *"The admission process is much more streamlined."* [consultant nurse]

New policies and procedures – the AdP had developed a number of new sets of guidelines and care pathways for the department and some new policies had also been introduced. A nurse-led discharge policy had been put in place and the AdP had helped to develop a care pathway for liver patients. It was thought that the admissions and discharges policies were adhered to better since the introduction of the role as well as the bed closure policy. This adherence was being audited and appeared to be showing that the system was working better than previously. One of the ICU consultants was keen to see a policy introduced which legitimised the gatekeeping role of the AdP on HDU. It was felt that all referrals should go through the AdP but there had been some senior management opposition to the idea.

Marketing of the role – some presentations around the impact of the role had been made to groups within the wider organisation. These had taken place at the Critical Care Steering Group and also at a site-based clinical audit group. There was also in place an AdP steering group which fed back to the trust board.

Impact on patients

One senior member of the nursing staff described the AdP's impact as *"great, phenomenal."*

Quality of care – it was thought that this had improved for patients since the introduction of the role on HDU. Intervention was much more timely and practical procedures could be carried out more quickly.

> *"The big different is that the timeliness of medical interventions has improved."* [senior nurse]

One intervention which had been particularly affected was the swallowing assessment which had to be carried out after a patient had had a tracheostomy removed in order to allow them to eat and drink normally. Previously, a speech therapist had to perform this assessment but the AdP was now able to do it instead, potentially saving a patient a wait of several days.

Co-ordination of care – this was thought to have improved, as had medical planning for patients; the AdP was ensuring that medical teams were getting more involved in patients' care when they were on HDU. Since the introduction of the role, patients were visited on the ward by the AdP prior to their being admitted to HDU. The AdP was able to decide if admission to HDU would benefit the patient and also had the authority to accept or refuse the patient for care in the unit. Once patients were on the unit, the AdP knew who to speak to in order to get them reviewed. Previously, the nursing staff had experienced difficulties when trying to get doctors to come to HDU to see their patients; the AdP acted as a link between the medical teams and the nursing staff.

Prescribing – some colleagues thought that the role would be even more beneficial to patients when the AdP was able to prescribe (the non-medical prescribing course was being undertaken by the AdP at the time of the case study interviews).

How the role has improved care

A senior nurse gave an example of a situation in which the nursing staff on HDU were looking after a post-operative patient who they believed to have metabolic acidosis. The surgeons in charge of the patient believed the patient to be suffering from respiratory acidosis and did not think it necessary to discuss the case with the ICU medical team. The AdP was asked to review the patient and diagnosed metabolic acidosis. The surgical team were willing to accept this diagnosis and then liaised with the ICU doctors to make an appropriate plan of care for the patient. Another nurse highlighted the speed with which the AdP is able to assist in situations where HDU is very busy and there is an emergency. In one case, a very sick patient needed to be intubated very quickly but the unit was busy and there was no senior member of the nursing staff available to co-ordinate the intervention. The AdP, however, was able to be at the patient's bedside immediately and co-ordinate care (a consultant from ICU carried out the intubation).

"The result was a very rapid and safe intubation." [ward sister]

3.4.4 **Factors affecting impact**

There were a number of factors which it was thought had been important in achieving changes in relation to the introduction of the AdP role in HDU. These included:

- good support from medical mentors
- progressive thinking of the AdP
- existing good relationships which led to the AdP already being established within the team
- the support of the Critical Care Directorate
- supernumerary status whilst in training
- positive marketing of the role by the AdP and supervising consultant
- the AdP's
  - ability to negotiate with the medical teams
  - interpersonal skills
  - clinical knowledge and confidence in that knowledge
- the AdP not having his/her 'own patients' to look after (freed up time to support others).

It was felt that the strength of the AdP's personality was a facilitating factor in relation to the successful implementation of the role; he/she *"just drove it through"* [consultant]. The role of a nurse consultant who acted as a Champion for the role was also influential in its success. She helped to implement the role and liaised with the trust.

There were certain key factors which were thought to have delayed the impact of the post. These were:

- the issue of the AdP not always being able to work in the role and being pulled into the 'nursing numbers' to cover for staff shortages (which in turn led to a delay in the AdP commencing the non-medical prescribing course)
- the isolation of the AdP in the unit (more than one could provide support and accelerate impact)
- the lack of a resident medical team in HDU which meant that the AdP had to work with many different teams and doctors

- the lack of certainty concerning funding (both whether there was any funding and if so, whether it should come from the medical or HDU budget)
- the dearth of support from those high up in the trust
- lack of understanding of the role on the part of some members of the nursing and medical staff.

3.4.5 Learning lessons and looking to the future

- **Making the most of the role**

It was generally thought that the AdP role was working well in HDU at NMGH but only when the AdP was able to work properly as an advanced practitioner and was not pulled into the nursing numbers.

> *"It is unfortunate that the impact is diluted by factors beyond [the AdP's] control."* [nurse consultant]

Some junior nursing staff in particular felt that it was unfortunate that the AdP was not in the role all the time. They felt that the AdP was less available when having to look after his/her own patients and the impact of the role could not be maximised. The department was not getting to see the real benefits.

- **Demonstrating the value of the role**

The role was highly valued but it was seen as difficult to demonstrate that worth in terms of hard data. It was viewed as a role that was still developing – *"a work in progress"* [ICU consultant]. Those in the unit would have liked to develop it more but there was a need not to *"ask for too much in too short a time"* [senior nurse]. The role was seen as having many advantages but it was fortunate that the AdP not only has the clinical skills but also the ability to get other people on board.

- **Critical mass**

Only having one AdP each in each department was not thought to be a satisfactory arrangement. Some colleagues believed that the trust should have focused on having a team of AdPs in one area; in that way the impact would have been maximised and the AdPs would have provided a more comprehensive service and been able to support one another. The 'piecemeal' nature of implementation had led to a number of AdPs in other areas leaving their posts (at least three out of the original six); they were *"too spread out"* [nurse consultant]. A formal strategic plan, which looked at where AdPs were really needed would have possibly avoided this problem. The importance of support should not be underestimated.

- **Funding**

Some colleagues believed that the funding had not been planned satisfactorily and that a separate funding stream for AdPs should have been in place from the start. The AdP in HDU was initially funded from the nursing budget but the role was partly intended to relieve the medical teams of some of their workload. At the time of the case study interviews, this issue had been partially resolved and there was a separate budget for funding the AdP post.

- **Pay structure**

Agenda for Change banding was thought to be a problem in relation to retaining AdPs in Critical Care. These AdPs were banded at 7 but others in the trust were banded at 8a; this was seen to be an unfair situation and one that needed remedying.

- **Risk assessment**

Although no formal risk assessments were undertaken for the AdP roles in HDU, the development of competences was agreed by a divisional advanced practitioner group

which then fed into the trust's advanced practitioner steering group. In addition, any new tasks that the AdP performs as a qualified practitioner have to be risk assessed in order to ensure safety and appropriate training.

- **Mixed views about the future of the role**

There was a mixture of optimism and pessimism among senior colleagues in relation to the role's future. One ICU consultant felt *"more positive now than...six months ago"* because at that time there was no management support for the role. That situation had changed and it was believed that there was a divisional objective to support the AdP role. A senior nursing colleague, however, thought that owing to the position of the trust, it was unlikely that they would be investing more in the role in the near future. There were no longer-term strategic plans regarding AdPs within the trust and no more AdP roles were being pursued.

One of the senior nurses was hopeful that the AdP on HDU at NMGH may lead one of the new HDUs in the trust in the future, although it was seen as important that the role did not turn into a managerial one rather than a clinical one. The present post on HDU was thought to be sustainable as long as the funding was there. In order for the role to continue to be successful, some believed it was necessary to extend the service so that the department had AdP cover over a longer day, say from 7am to 8 pm. This would inevitably involve the appointment of more AdPs on the unit. It was also thought it would be more successful if the AdP was able to work in partnership with a dedicated medical consultant for HDU.

3.5 Bolton Hospitals NHS Trust

The Bolton Hospitals NHS Trust (BHT) is based at the Royal Bolton Hospital (RBH) in Farnworth. The trust was formed in April 1994 and serves a population of approximately 265,000 people. In 2007/08, there were 32,396 emergency admissions. One of the trust's strategic aims is to provide *"excellent and accessible emergency care".*[11]

3.5.1 Background to the advanced practitioner roles

There are 10 qualified AdPs and nine trainee AdPs working in BHT at present. There is one qualified AdP (Cohort 1) and one trainee AdP in the main Accident and Emergency department (A&E) at RBH and there is also a qualified AdP in the paediatric A&E department. Of the remaining qualified AdPs, four are in Women's and Children's Services, two are in the Surgical and Anaesthetics division and two are based on the Acute Medical Referral Unit (AMRU). The other AdPs that are still in training are based in Women's and Children's Services (two trainees), the Surgical and Anaesthetics division (two trainees), AMRU (one trainee) and the Medical division (three trainee nurse practitioners). This case study focuses on the AdPs based in A&E at RBH.

Service drivers

The trust Champion was involved in the proposals for the AdP posts from the outset. It was decided that the trust would target emergency services in order to reduce emergency admissions and also provide an opportunity for nurses to upscale and lead the workforce transition needed due to the introduction of the EWTD. At the time of the case study interviews there were nine consultants in the A&E department at RBH (5.5 whole time equivalents). This was more than it had been previously and was partly as a result of a reduction in junior doctors' hours. There was now a consultant in the

[11] From the trust website at www.boltonhospitals.nhs.uk/about/default.html

department at all times. The qualified AdP in A&E put his/her name forward for advanced practitioner training even though it was not certain what form the job would take after qualification.

Intended benefits for patient care
The intended benefits of the AdP role for patient care in A&E were to:

- provide a safe, quality service to patients despite the EWTD
- improve continuity
- reduce the number of 'hand offs'
- increase the number of people who could see and make decisions about patients; there were not enough junior doctors *"out there"* to cover for their reducing hours [A&E consultant].

3.5.2 Objectives of the advanced practitioner posts

BHT's objectives for their AdP posts in A&E were to:

- improve the patient experience around unscheduled care
- enhance out of hours service provision
- comply with the EWTD
- reduce emergency admissions
- reduce length of hospital stay.

Improvement in patient experience and enhancement of OOH provision – it was generally thought by colleagues that the AdP was improving the patient experience around unscheduled care and was also enhancing service provision in the A&E department.

Bridging the gap – there had been an impact on waiting time for patients because the AdP worked in the same way as an SHO.

> *"[The AdP] performs like a dedicated, intelligent, hard-working doctor."*
> [A&E consultant]

The A&E consultants, however, also felt that the AdP's work went beyond that of a junior doctor. The AdP had the skills of the junior doctor but also many years of nursing experience and so had a different approach. The AdP was thought to give holistic care which did not focus on pathology and came from a nursing perspective. The patient experience was also improved through better continuity of care; the AdP was able to see patients from start to finish and often did not have to involve a doctor at all.

Reduction in emergency admissions – the trust Champion believed that there had been a reduction in emergency admissions but had no data to support this assertion. It was thought that junior medical staff without advanced skills would sometimes admit patients *"just to be on the safe side."*

Length of hospital stay – senior medical staff did not think that the role was having an impact on length of hospital stay but it was thought that length of time in A&E was possibly being affected because the AdP functioned like a junior doctor in many ways. The trust Champion, however, said that audit figures relating to the four hour target[12] were not, at present, showing a reduction in time spent in the A&E department but the figures did not separate out the AdP's activity from those of the other members of staff.

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[12] See footnote 7 above.

3.5.3 Impact

Key Achievements

- A much improved patient journey through A&E with better continuity of care/fewer 'hand-offs', earlier treatment and a short 'length of stay'
- More holistic assessment of A&E patients and more appropriate investigations
- Perceived reduction in emergency admissions
- Reduced pressure on A&E doctors time in a department where recruitment of middle grade doctors was difficult
- An important source of expert advice for nursing staff

There were no separate audits being carried out to measure the impact of the AdP roles. The trust Champion felt that any benefits were *"difficult to quantify"* and the trust were trying to develop some key performance indicators for the AdP roles. It was acknowledged that some work still needed to be done on collecting measurable data to demonstrate the impact of the roles.

Impact on colleagues

In general, the trust Champion considered that the AdPs had had a positive impact on their medical, nursing and allied health professional (AHP) colleagues and most of them had welcomed the posts.

Medical staff – for doctors in A&E, it was thought that the AdP shared *"the burden a little bit"* [A&E consultant] – he/she could be left in charge of both the 'majors' and 'minors' areas and was able to *"just crack on and do it"*. At the time of the case study interviews, the medical team was short of 15 middle grade doctors; the AdP was able to work alongside the junior doctors to make up some of this shortfall. It was felt that the relationship between the doctors and the AdP was different to that between the doctors and nurses; the expectations were different because the AdP was "*'practitioning' not nursing"* [A&E consultant]. The benefit was that the AdP was *"doing a medical role from a nursing perspective"* [A&E consultant]. The AdP's value to the medical team was also evidenced by the permanency of the post, unlike many transient doctors who were only in the department for a few months. The AdP was more involved in how the department worked and had more invested in it. There was an indication that some medical colleagues outside A&E were sceptical about the role and were not prepared to accept referrals from the AdP; the medical teams were seen to be more accepting than the surgical teams in this respect.

Nursing staff – funding issues had caused some anxiety amongst nursing staff because the AdPs were funded from the nursing budgets. Once the AdPs qualified, the nursing numbers were reduced which caused some tension. This had continued to be a problem because the nursing and medical budgets were looked at entirely separately and the Champion was not aware of any plans to bring AdPs into medical budgets. The trust was aware of the problem when the roles were implemented but no satisfactory solution could be found due to the separate nature of the funding streams. The nursing staff valued the AdP as a resource; a source of advice and expert knowledge. They benefited from the assistance the AdP provided and the access they had to him/her. One staff nurse was keen to see more AdPs; having more people who could see, treat

and discharge would be very valuable. It was felt it would be a *"sad waste"* if the AdP role was not continued in A&E – a *"step backwards"* [staff nurse].

Impact on service delivery

Skill mix – the trust Champion felt that the skill mix in A&E had been more flexible since the introduction of the AdP role but it was also thought that the impact would be more considerable if there were a greater number of AdPs in the department.

Patient pathway – the AdP had developed a new initiative in A&E called 'Pit Stop' which was designed to reduce patients' waiting times and speed up their journey through the department. The AdP was able to review people and refer them directly on to other teams or units e.g. stroke unit; this was intended to improve the patient pathway. It was thought that the quality of 'Pit Stop' depended on the AdP being there. It was *"nothing measurable, it just works better when [the AdP] is there"* [A&E consultant].

The AdP as a 'link' – some colleagues commented on the AdP's 'linking' role. The AdP was doing both what doctors did and what nurses did – *"bridging the gap"* [staff nurse].

New policies and procedures – some new procedures had been introduced in relation to the AdP role. The AdP in A&E could refer directly to consultants, admit and discharge patients and request radiology investigations such as x-rays and scans. The AdP had instigated the latter but it had taken a long time to set up; some colleagues in radiology had had problems accepting the role. In addition to these changes, some prescribing practices had also been amended.

Marketing the role – the trust had a programme of communication in place in order to disseminate information about the AdP roles. There were presentations to the trust board initially and subsequently there had been updates and information sharing for staff in the wider organisation. The trust Champion felt that the dissemination had had a positive impact and was an important part of the process when developing new roles and initiatives.

Impact on patients

Continuity of care – the main impact of the AdP role on patients was thought to be better continuity of care. The AdP could see patients through from start to finish which meant that their care was not disjointed or delayed by having to wait for medical staff to review them.

Holistic care and improved patient pathway – the trust Champion believed that the AdPs were providing improved assessment *"at the front line"* and that these assessments were more holistic. The A&E AdP's extra experience meant that he/she was more decisive about what to do with patients; junior medical staff could often *"stall"* when they were uncertain [A&E consultant]. The patients were getting appropriate investigations and were getting earlier treatment. Because patients' journeys through the department were quicker, there was less likelihood of A&E becoming too busy and overcrowded. This was seen as a particular advantage because it was thought that the department was physically too small for the number of patients seen.

Prescribing – the AdP's ability to prescribe was seen as helpful – it was better that the patient was not delayed by having to wait for a doctor to prescribe their medication.

Lack of critical mass – despite the difference in patient care effected by the AdP, it was felt that this was still limited due to there only being one qualified AdP on A&E; a greater number would have a greater impact.

How the role has improved care

A staff nurse gave an example of how the AdP was improving care. A patient was in the A&E department suffering from shortness of breath. There were no doctors available but the AdP was able to assess the patient and prescribe nebulizers. The staff nurse administered the nebulizers and when the problem had eased the AdP returned and finished assessing the patient and planned the next stage of their care. The staff nurse felt that the AdP did not look at things in the same way as a doctor. He/she was able to decide on a course of action and then carry out that action, rather than always passing it on to a member of the nursing staff. The AdP would often decide that nebulizers needed giving but instead of seeking out a nurse to give them, the AdP would give them him/herself.

3.5.4 **Factors affecting impact**

A number of factors were of importance in relation to achieving positive changes through the introduction of the AdP role. These were thought to be:

- leadership and promotion of the role at a strategic level
- good, ongoing communication throughout the trust
- good support for AdPs in training from management, Champion etc
- the experience and skills of the AdPs
- the personality and drive of the AdP in A&E
- the 'bridging' nature of the role; combining the skills of the doctor and the nurse.

The trust Champion believed that the mentoring/supervising system had worked well for the AdPs in BHT; this was mainly provided by medical consultants. An open opinion amongst the medical staff was also thought to have facilitated the introduction of the role in A&E. The allowed the AdP to pursue the role in the way that he/she thought fit. It was thought, however, that boundaries in A&E between medical and nursing staff had always been relatively *"blurred"*; doctors had worked very closely with nurses anyway [A&E consultant].

A number of factors were thought to have delayed the impact of the posts:

- the absence of forward-looking workforce planning at a strategic level
- the lack of a clear direction for the role
- financial pressures
- the lack of sufficient numbers of AdPs to have a significant impact
- the A&E AdP having to be in the nursing numbers due to staff shortages
- the inability of the A&E department to 'compartmentalise' the job
- lack of authority to order all necessary investigations e.g. radiology.

3.5.5 **Learning lessons and looking to the future**

Most of the AdPs' colleagues believed that the role was working well. The trust Champion praised the AdPs for their commitment to the role and believed them to be very focused on their objectives. The Champion felt that the AdPs in BHT were at the forefront of developing the nursing element of advanced practice. There were some issues which it was thought needed to be addressed, however, in relation to the future success of the role.

- **Clarity of role**

Some colleagues were still not entirely clear about the role, although they did feel that it was having an impact. The AdP was seen as not exactly the same as a junior doctor but not a nurse either. The role was still developing but there was some discomfort around the idea that the AdP gets the responsibility of a doctor but not the rewards – *"a cheap pair of hands"* [A&E consultant].

- **Clinical accountability**

The AdPs worked within a framework and had leadership and mentorship in their areas. They also had regular meetings with their line managers and Champions. The consultant who was the A&E AdP's clinical supervisor while in training was continuing to act in that capacity. There was some uncertainty, however, about to whom the A&E AdP's was clinically accountable (the role was being funded from the nursing budget).

- **Strategic planning**

In retrospect, it was felt that workforce planning should have been done by the trust at an earlier stage; they were only really starting to look at it properly at the time of the case study interviews. A *"robust framework"* for monitoring impact should also have been set up before the introduction of the posts [trust Champion]. There was a need to ensure that all those who would be involved with the AdPs were 'signed up' to it right from the start. Although it was felt that medical staff were, not all nurse managers were enthusiastic or committed to the role. Having a specific role for the AdP to go into when the training was finished would also have maximised the impact; it had been difficult to get the AdP into a role at that time. The A&E AdP's supervisor felt that there had been some problems with work-based learning (WBL) but some of this had been related to the supervisor being part-time.

- **Planning for the future**

Colleagues in A&E were all keen to see the continuation of the AdP role and its development within the department. The trust Champion indicated that they would be commissioning more AdPs but that financial constraints were slowing the process down. There was also a need to become clearer about what the roles were for and what exactly they should do. Strategic discussions were taking place within the trust at the time of the case study interviews. One of the key challenges was to obtain measurable outcome data; without this, making the case for future role development would be difficult. Consultants in A&E were looking to employ more AdPs and believed the role to be sustainable but were uncertain about where the funding should come from. They indicated that the shortfall in medical staff would not be made up by employing more doctors because the availability was not there. In addition, the junior doctors who were employed in the department were working fewer hours and had less experience than previously. Hence, it was seen as essential that the AdP role should develop. One of the consultants believed that AdPs would be more suitable than specialist practitioners. Although 24-hour cover from AdPs was seen as desirable by medical colleagues, the source of funding was seen as an issue, as was the need for suitable candidates for the role – they needed to be capable of independent practice.

Chapter 4
Findings and Recommendations

Three Key Findings

- Advanced Practitioner roles are having a positive impact on patient care and service delivery in their trusts and the majority to appear to be achieving some or all of the objectives originally set out for them
- The AdPs' capacity to work beyond their base profession (i.e. being 'advanced' practitioners as opposed to highly skilled nurses, midwives or AHPs) is significant in achieving that impact
- The SHA's original vision that the development of AdP roles should be service driven, and as such a 'critical mass' of AdPs would be needed for these roles to have maximum impact on service delivery, has proved to be correct

The case studies presented in this report, and the wider work on impact which has run through the evaluation, clearly show that the Advanced Practitioner roles are having a positive impact on patient care and service delivery in their trusts and particularly in relation to the five main reasons for creating the AdP posts mentioned in the introduction to this report.

- In relation to **ensuring better access to services**, there is evidence that the AdP role has led to:
  - better engagement with hard to reach groups
  - reduced waiting times (e.g. in A&E)
  - improved access to primary health care services both in and out of hours.
- The AdP roles are shown to be **improving activity and service delivery** through greater continuity of care, fewer hand offs and a smoother care pathway for patients. This has been made possible because AdPs are able to:
  - assess patients who would previously have had to see a doctor
  - undertake a wider range of clinical tasks than colleagues in their 'base profession'
  - prescribe drugs and dressings
  - order investigations.
- The evaluation indicates that the roles are **addressing governance and compliance issues** by contributing to trusts' efforts to meet major local and national service targets/ objectives, including:
  - reducing the number of unplanned admissions to hospital
  - meeting the 18 week target
  - achieving the Gold Standard for end of life care
  - reducing avoidable A&E attendances.

  The roles have also enabled trusts to address medical staffing issues notably by:
  - meeting the EWTD (e.g. by AdPs joining the junior doctor rota)
  - easing pressure on senior medical staff (e.g. by replacing them in clinics or reducing calls for consultants to see patients)

  - reducing GP call outs and GP workload by seeing patients who would previously have been seen by a GP.

- The AdP role is contributing to **increasing workforce productivity** by improving training and support for other staff, including junior medical staff and staff from partner organisations (e.g. nursing homes).
- There is evidence that the AdPs are **enhancing patient experience** by giving patients greater choice in their care, for example through:
  - enabling patients to die at home or in their care home rather than in hospital
  - offering patients the choice of seeing an AdP rather than a GP.

4.1 Maximising Impact

Linking AdP roles to service development - From the outset, the SHA has emphasised that *"the driver for the* [AdP] *role is service need",* and one of the primary reasons for developing new 'generalist' Advanced Practitioners was to support the development of new services, alongside modernising and increasing the workforce. The evaluation clearly shows that these roles work best where their creation has indeed been service driven. This increases acceptance of the role because colleagues and referring professionals are more likely to understand why it has been created, and can see the benefits of having the role in service terms. It also helps to ensure that the AdPs are able to work effectively because they are integral to the service rather than a 'bolt on' extra.

Ensuring 'critical mass' – The SHA also envisaged that because AdP roles were service driven, it was very likely that trusts would need a number of AdPs doing the same or very similar roles if the hoped-for impact on services was to be achieved. Again the evaluation reinforces this point. While 'lone' AdPs can clearly make a difference and are often highly valued by colleagues and patients, the impact of the role would be much greater (especially in 24/7 services such as A&E and HDU/ICU) if there was a cadre of AdPs within the service. Having a number of AdPs in one department or service also gives them more visibility, and perhaps a greater sense of permanence. Conversely a 'lone' AdP post can be perceived as vulnerable if the post holder decides to move on or finances are tight.

Being clear about the purpose of the AdP roles – The importance of trusts being clear about the purpose of the AdP roles they have established has been a constant theme throughout the evaluation. Clarity about the purpose of the role has so many 'knock on' consequences – for shaping the AdPs' work based learning, for the morale and effectiveness of individual AdPs and for acceptance and understanding of the role by colleagues, patients and referrers – that it cannot be overemphasised as a factor in maximising the impact of AdP roles. However, as the case study in Bolton PCT showed, it is possible to establish AdP roles without the exact purpose of the roles being clear, as long as:

- there is clarity about the service they will work within
- the broad objectives they are aiming to achieve have been set out
- the trust as a whole and service managers strongly value the roles
- the trust has a well thought out process/structure for finalising the purpose of the roles when the time is right
- the AdPs themselves are fully engaged in agreeing the final purpose for the role.

Promoting AdP roles in the wider organisation – The quicker the AdP roles are accepted/understood within the organisation and amongst key partners externally, the sooner they can begin to have an impact on service delivery and patient care. It is therefore essential that trusts make a real commitment to actively promoting their AdP posts. There is much that the AdPs can do themselves, and the evaluation showed that most were active in promoting and explaining their role through formal and informal means (e.g. attending meetings, talking to key referrers etc), but the trusts must also promote and publicise the roles systemically.

Securing support from senior management and senior clinicians – Whilst promoting the AdP role generally within the organisation is important, it is also essential to secure the support of senior managers and clinicians. They play a vital role in ensuring that the systems and processes needed for AdPs to work effectively are in place, but also in ensuring that the roles are accepted and supported. The support of consultants and GPs is particularly critical, as AdP roles frequently span nursing/AHPs and medicine.

Allowing/enabling AdPs to work at an advanced level – One of the most common reasons given for AdPs and their colleagues feeling that their roles were not achieving maximum impact was that they were either not allowed or not enabled to work consistently at an advanced level. Sometimes this was because systems or protocols had not been changed to recognise the existence of AdP posts (e.g. AdPs not being allowed to request investigations or make/accept referrals); at other times, AdPs were being pulled back into their old role or into the routine work of the ward or team (i.e. being part of the 'nursing numbers') at busy times, or were having to work some sessions as an AdP and some in their base profession because of financial constraints. In a few cases there appeared to be some reluctance or anxiety about letting AdPs 'fly solo', but with sound clinical governance arrangements and good support this should not be a concern.

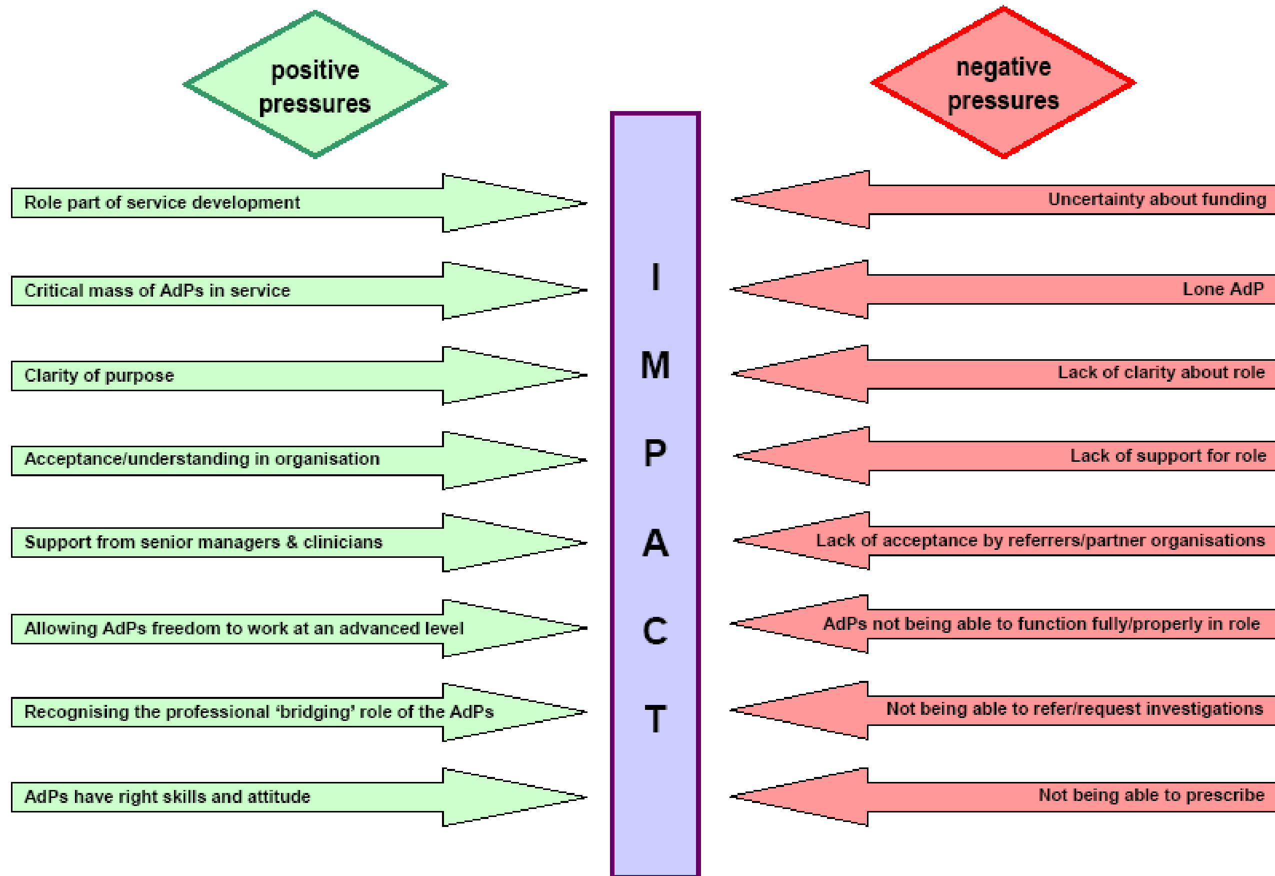
Clinical governance and Continuing Professional Development – The evaluation revealed that in some areas there was uncertainty in relation to who the AdPs were clinically accountable to. It is inherent in the AdP role that they take on new clinical responsibilities and there is a need for trusts to be clear about the governance arrangements for the posts prior to their implementation. As mentioned above, this is necessary to allow AdPs to function fully in their roles. The means by which AdPs ensure their continuing professional development was also raised as an issue. New professional support arrangements, which recognise the nature of the role and the responsibilities involved in it, are required; existing professional support mechanisms may not be sufficient. The importance of peer support was highlighted on a number of occasions and the existence of the North West AdP Forum has a significant part to play in this respect.

Recognising the 'bridging' role of AdPs – Although addressing medical staffing issues was from the outset an important reason for establishing many AdP roles, the evaluation revealed that they are also performing an important 'bridging' role that needs to be recognised and supported. The bridge was most often between their base profession and medical staff, but sometimes between non-medical professions (e.g. nursing and AHPs). This appeared to not only enhance the impact of the role, it also had spin-off benefits such as better communication between professions, improving working relationships and better support for junior staff.

A diagram showing the main positive and negative pressures at play in relation to the impact of the AdP role can be seen in Figure 1.

There is no doubt that Advanced Practitioner roles can have a significant impact on service delivery and patient care. They also have an important place in initiatives to reshape services and the wider workforce. However, the impact of these roles depends on trusts recognising they do not exist in isolation. For them to be effective they have to be understood and accepted by colleagues and partner organisations, systems and processes have to change to enable them to function, but above all they must be embedded in the needs of the service.

Figure 1 - Pressures at play in relation to the impact of the AdP role



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