

Analysis of the online workshop to consider the impact of COVID-19 upon and the implications for the future of advanced and consultant practice.

Enabling a more conscious response in the future.



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Executive Summary

In May 2020, Health Education England (HEE) conducted a two-week online workshop to investigate the challenges and opportunities experienced by Advanced Practitioners during the first wave of the COVID-19 pandemic.

The aim was to gain insight into the lived experiences of Advanced and Consultant Practitioners during unprecedented pressure and to understand the needs of the system.

HEE has undertaken a thematic analysis of the qualitative data collected from the online workshop, combined with the quantitative findings from an additional survey that ran in parallel.

There were six themes:

1. Where Advanced Practitioners skills and abilities were recognised and trusted, these were used to their full capability to embrace the challenge of COVID-19.
2. The combination of Advanced Practitioner experience, leadership, educational grounding and their ability to drive improvement has proven to be invaluable during the COVID-19 response.
3. Practitioners advanced capabilities are not understood or recognised across the board, limiting their opportunities during the response.
4. Some Advanced Practitioner professions raised significant concerns about feeling left behind or unfairly 'land-locked' by this lack of opportunity,
5. Enablers are needed to raise the profile of Advanced Practitioners, so the system understands their capabilities, broad knowledge base and the four pillars of practice.
6. There is a significant lack of equality and diversity within Advanced Practitioner roles; this has been highlighted and exacerbated by the lack of ESR data.



Next steps

Where their experience and skills are recognised, Advanced Practitioners were deployed effectively during the COVID-19 pandemic and with significant impact. But we need to continue to raise the profile of Advanced Practitioners and their offer to the workforce, to ensure:

- they can use the broad spectrum of their experience and knowledge to the benefit of the system
- they can respond flexibly and move to areas of increased service demand to provide consistency
- they contribute to patient safety and provide high-quality care where it is needed the most.

There is an immediate call to action for Advanced and Consultant Practitioners to educate and inform their colleagues around Advanced Practice, to unlock their full potential.



1. Introduction

1.1 Background

Delivering sustainable growth in the Advanced Practice workforce is a vital component in to addressing the ambitions of the NHS People Plan¹ to support the Long Term Plan².

'Advanced clinical practice: In 2020/21, HEE is funding a further 400 entrants to advanced clinical practice training, supported by the Centre for Advancing Practice – to build on the success already seen in using advanced clinical practitioners to greater effect in multidisciplinary teams, both in primary and secondary care'. Pg 42

Advanced level practice identifies experienced and appropriately trained clinicians as diagnostic decision makers, able to manage complexity, risk and significant multi-morbidity within their agreed broad scope of practice as part of a multi-professional team. The challenges and opportunities experienced by this workforce during COVID-19 was investigated to understand current and future workforce, organisational and system needs. Advanced practice is a level of practice, people trained to this level currently carry a number of titles i.e. Advanced Clinical Practitioners (ACP) or may hold a title encompassing their professional title e.g. Advanced Nurse Practitioner or speciality title, Advanced Ophthalmology Practitioner, the paper has utilised the more generic term advanced practitioner.

In May 2020 Health Education England (HEE) commissioned Clever Together to run a two-week crowdsourcing online workshop to generate insight into the lived experiences of advanced and consultant practitioners during the COVID-19 pandemic. Alongside the online workshop, participants were asked to share information about themselves and their experiences in a quantitative survey.

This paper incorporates the report provided by Clever Together and sets out a summary of the participation data and an overview of the conversation, the further analysis and qualitative feedback was undertaken by HEE utilising the anonymised qualitative data.

The current context for Advanced Clinical Practice: HEE carried out extensive research and engagement in 2018 to consider how best to develop the emerging advanced level of practice across professions. This research work, supported by Clever Together, looked at a range of emerging issues, but in particular:

- How to maximise the positive impact of advanced and consultant practitioners on patient outcomes;
- Understanding the workforce implications for advanced clinical practice; and
- Examining the effectiveness of current assurance mechanisms and the need for additional governance.

In the last 12 months there has been much progress informed by the initial research.

- Significant progress has been made in the development of effective and recognised pathways; and
- There is an emerging infrastructure for standards development; early work is in train by one regulator; and the centre for advancing practice is in development.

HEE has also been able to develop insight into the specific ACP workforce challenges within the NHS including issues around variation, emerging opportunities and trends in development.

1.2 The development of advanced practice

The development of advanced practice is at a critical juncture. HEE has three core workstreams for advanced and consultant practice:

1. Supporting the development of advanced level practice
2. Improving supply to meet service needs – expanding advanced practice training routes, advanced clinical practice roles and developing the levels prior to and beyond this level of practice
3. Creating the structure and governance for advanced clinical practice

COVID-19 has the potential to negatively impact on all three in the short term and longer term. While progress has been made, the impact of COVID-19 on this particular part of the NHS workforce is not fully understood. HEE commissioned Clever Together to carry out a rapid research and engagement exercise in order to understand better the following:

- The range of deployment or redeployment of advanced and consultant practitioners across the health system during COVID-19
- The experience of Advanced and consultant practitioners during COVID-19 including:
 - The extent to which advanced and consultant practitioner knowledge, skills and competence have been deployed effectively
 - The extent to which barriers continue to exist or have been removed (and reasons)
 - The impact on particular professional groups (e.g. physios, nurses, OTs etc)
- The insights and expectations of advanced and consultant practitioners and trainees about the impact of COVID-19

Clever Together was not commissioned to carry out a full analysis of the insight generated in the online workshop.



2. Online Workshop Participant Statistics

2.1 The advanced practice online workshop

The online workshop was live from Thursday 14 May – Thursday 28 May 2020 for all advanced and consultant practitioners to share their insight and to consider the impact of COVID-19 and the implications for the future of advanced practice.

In the two weeks the online workshop was live, 1,000 participants logged onto the platform. They shared over 1,375 contributions – a combination of ideas, comments and votes.

The workshop asked participants to share their views on four broad questions:

- Your COVID-19 story
- Your organisation's response to COVID-19
- Your knowledge, skills and competence
- Learning and looking to the future

Table 1 shows the distribution of contributions over the question areas.

Theme	Ideas	Comments	Votes
Your COVID-19 story	120	35	485
Your organisation's response to COVID-19	40	20	177
Your knowledge, skills and competence	23	24	166
Learning and looking to the future	28	32	225

Table 1: Contributions to each question

Analysis of the participants:

Before participants were able to join the discussion in the online workshop, they were asked to complete a short questionnaire to help establish their professional groups and their demographics, and to get a snapshot of their experiences prior to and during the COVID-19 response. The charts on the following pages reflect the responses to these questions. We have not, at this stage, carried out any detailed analysis of the qualitative feedback in the workshop by demographic group or mapped to responses about COVID-19 experiences.

1,000 people completed the gateway questionnaire.

The responses in Figure 1 show how the participants answered a series of questions related to their experiences of working as an advanced or consultant practitioner during the COVID 19 response.

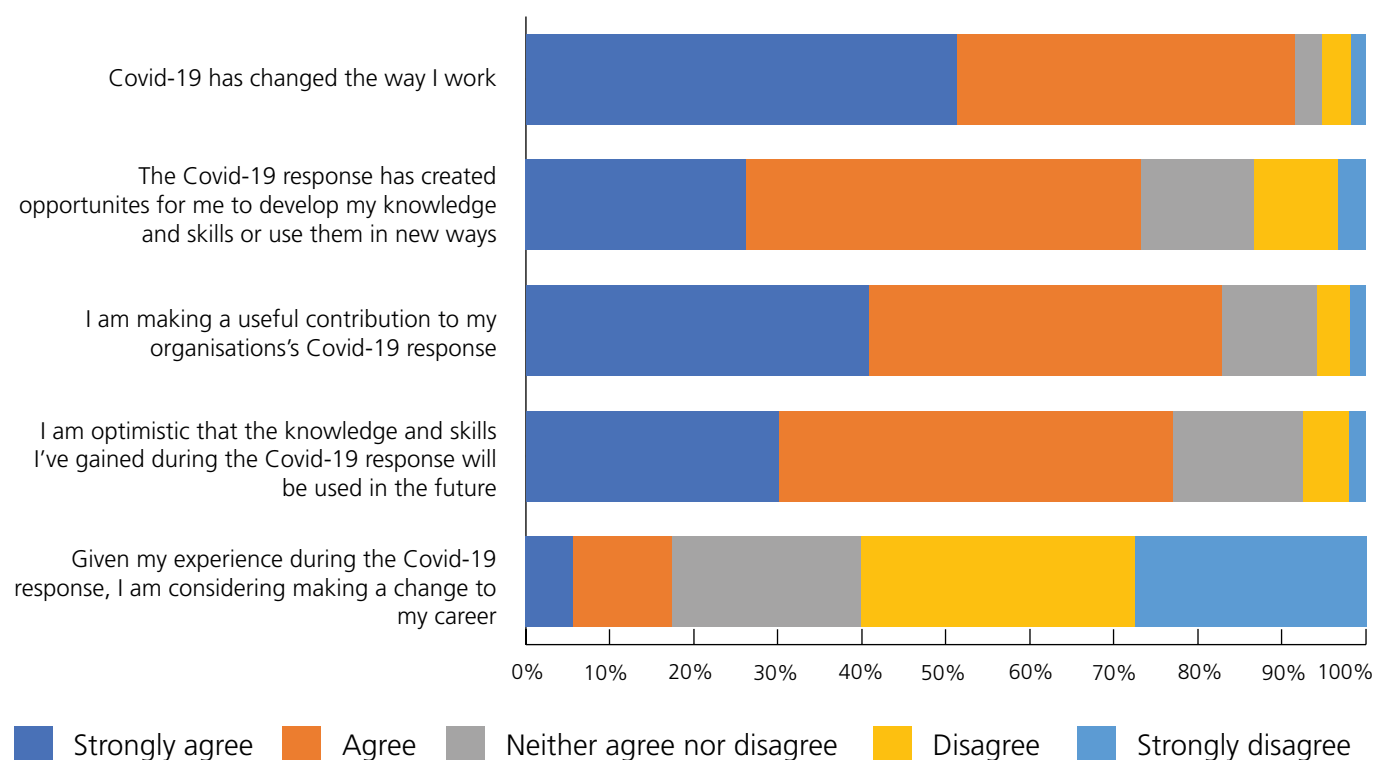


Figure 1: Experiences of working as an advanced or consultant practitioner during the COVID-19 response

The impact of COVID-19 on their working lives is stark with over 90% of participants stating that the COVID-19 response has changed the way they work to some extent. Although the impact on their working lives has been huge, over 70% felt that the response had created opportunities for them to develop their skills and knowledge. This positive message is echoed in the qualitative insight generated from the online workshop. 85% of participants felt that they had made a useful contribution to their organisation's response. Again, these figures are supported by the stories of the impact advanced and consultant practitioners have made in the online workshop.

We asked a question about whether participants were considering a career change as a result of COVID-19. 60% of participants felt that their experiences during the COVID-19 response would not lead them to consider a career change, with just over 20% neither agreeing nor disagreeing that the experiences had led them to consider a change of career. While this feedback is interesting, the data does not allow us to draw any conclusions on the impact of workforce supply, merely that there is likely to be some impact as a result of COVID-19.

Figure 2 shows that 87% of the participants were registered healthcare professionals with 7% having an academic or education role.

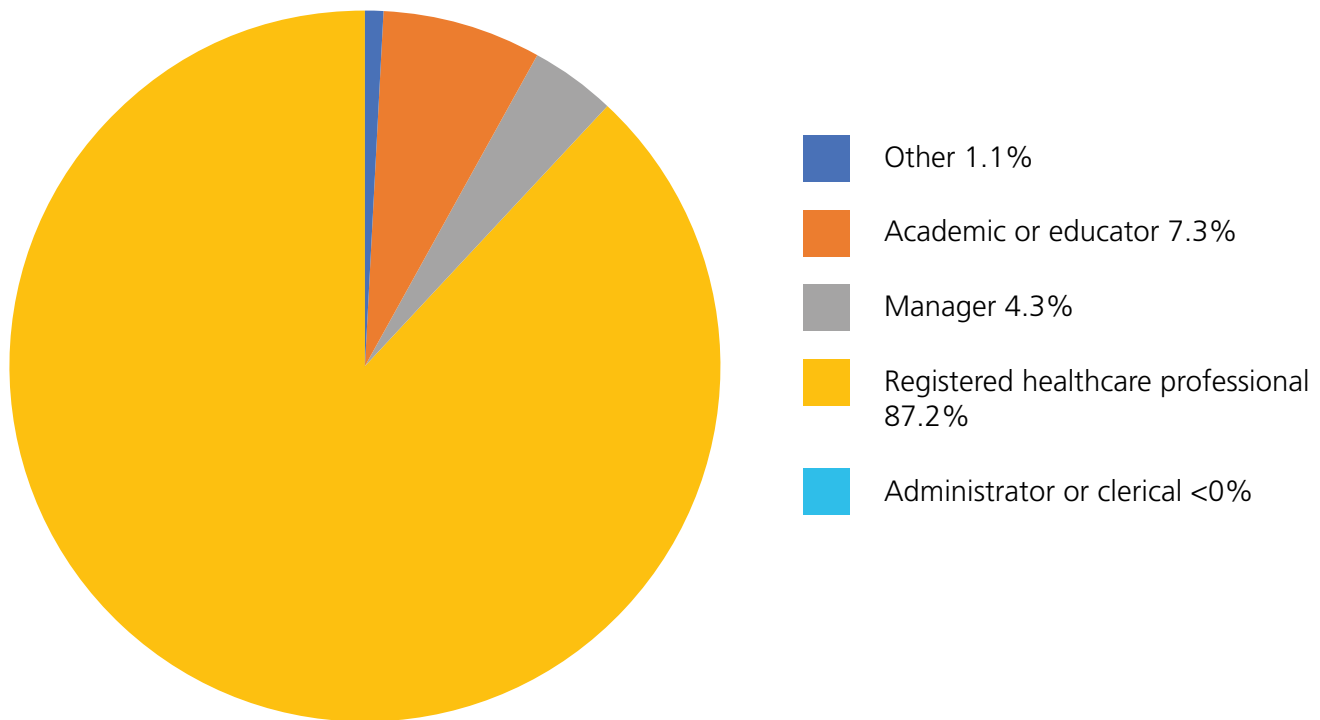


Figure 2: Primary role of participants in the online workshop

Over half of those who said they were registered healthcare professionals were advanced practitioners. (Figure 3). Over 20% of the participants were training to be advanced or consultant practitioners.

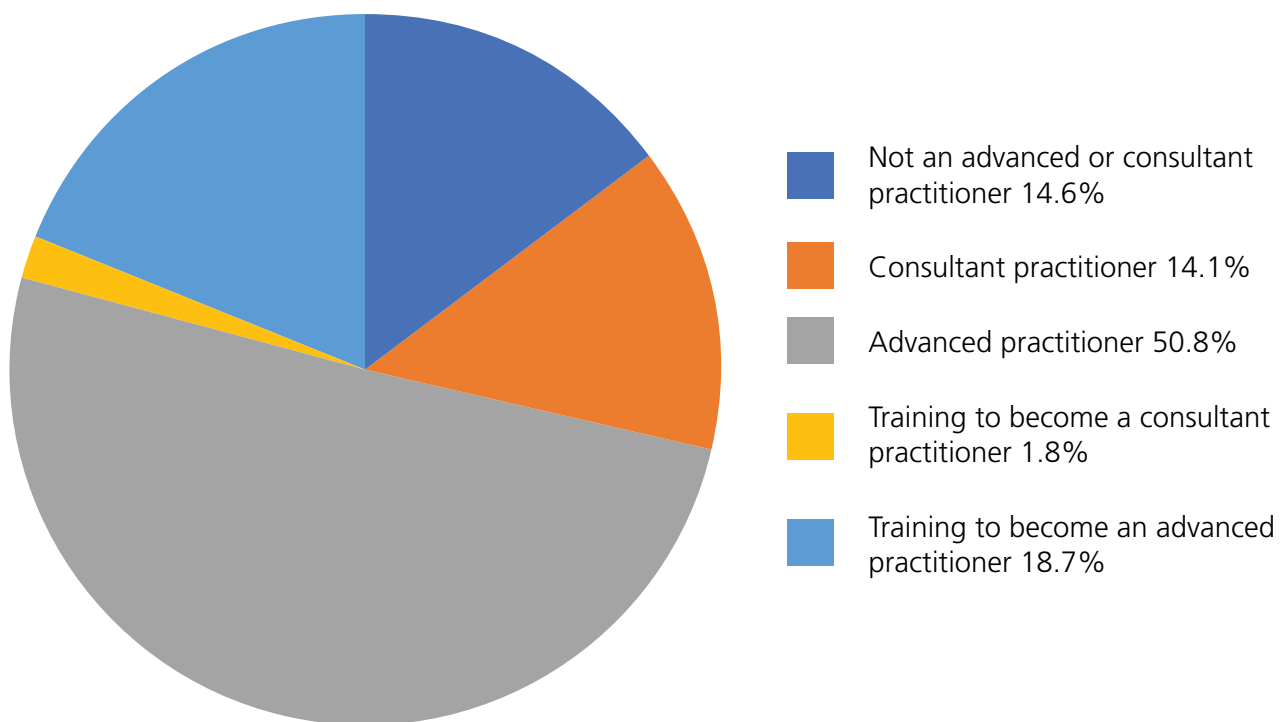


Figure 3: Advanced or consultant practitioner status

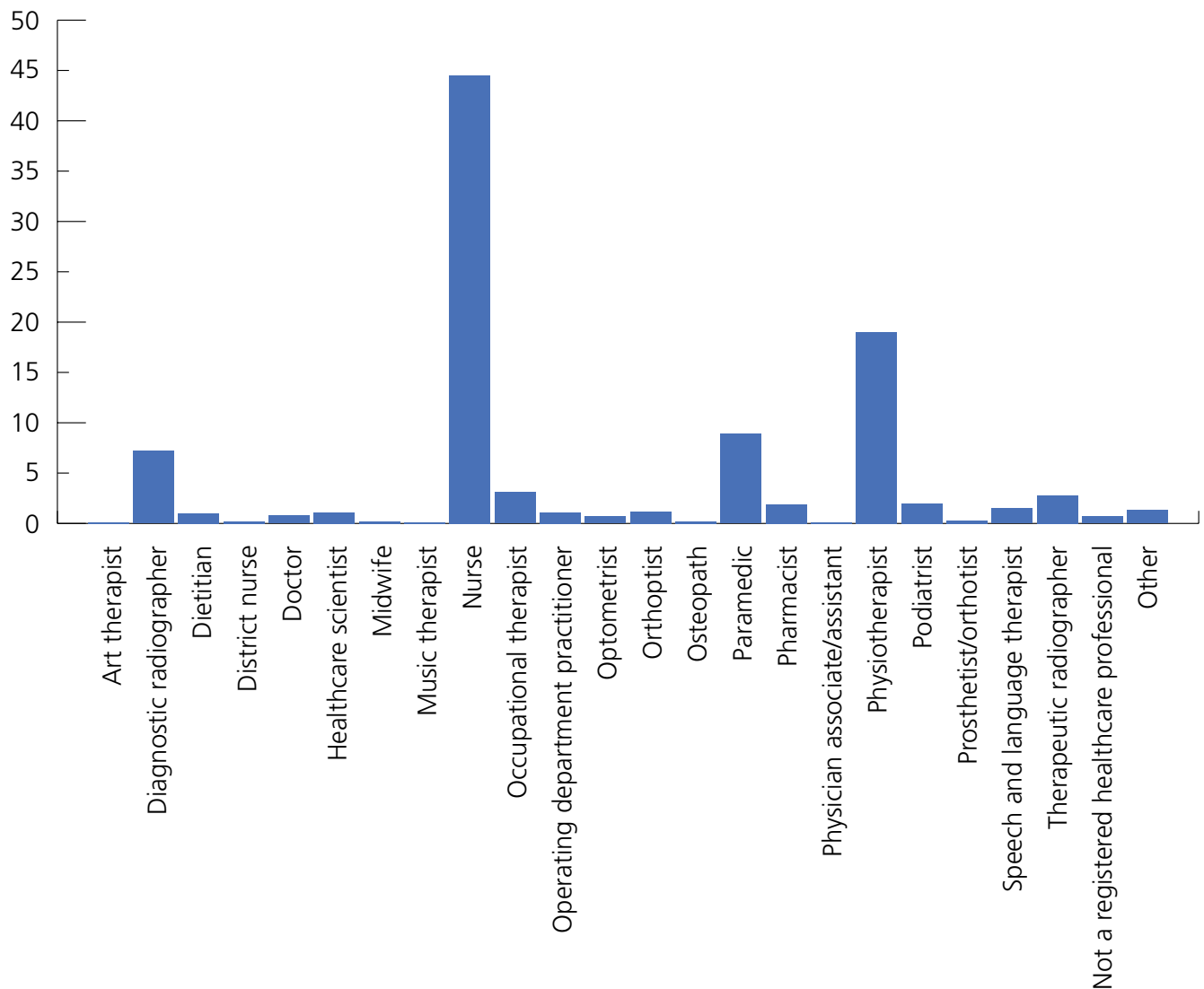


Figure 4: Participants by professional group (%)

Participants came from over 23 different clinical professions (Figure 4), with nurses and physiotherapists representing over 60% of all participants. The distribution of professions follows in part the relative size of the professions and access to training and understanding of advanced practice. Unsurprisingly, over half of the participants were from an acute setting (Figure 5). The workshop also saw representatives from a variety of types of NHS organisations as well as the independent sector and social enterprises.

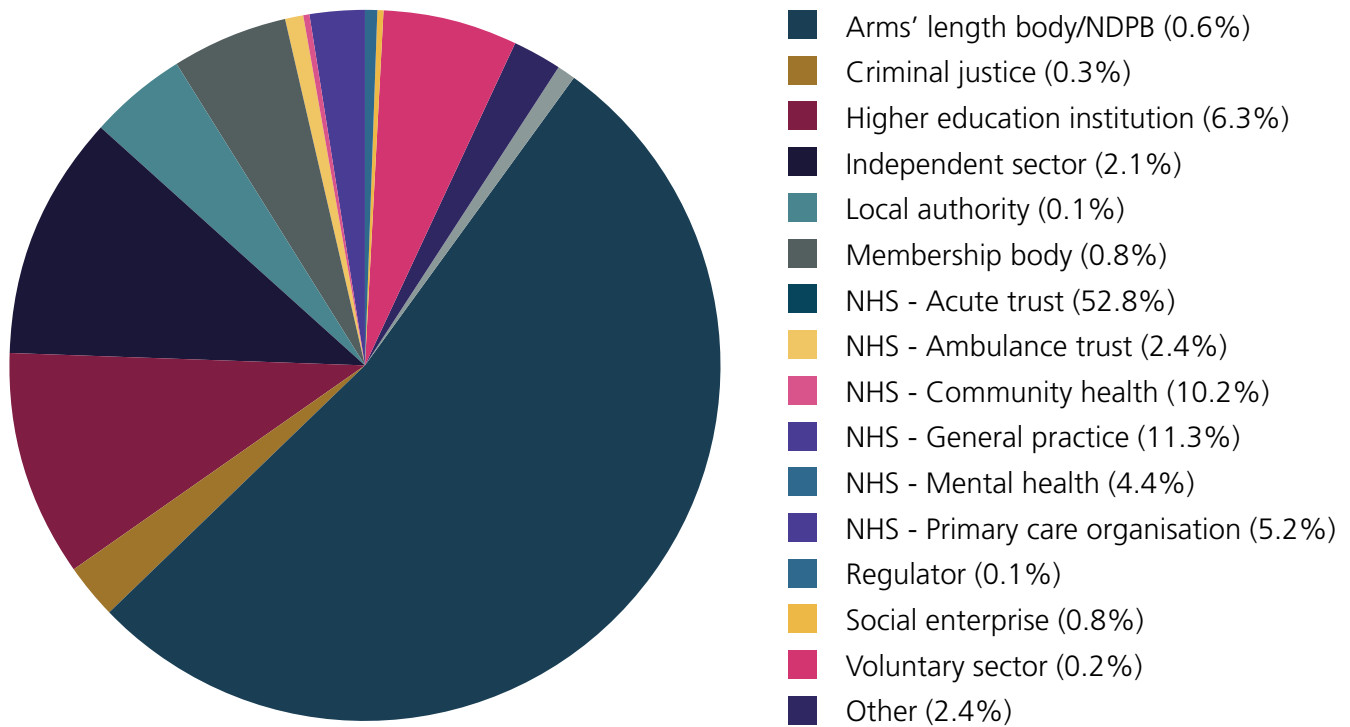


Figure 5: Types of organisations

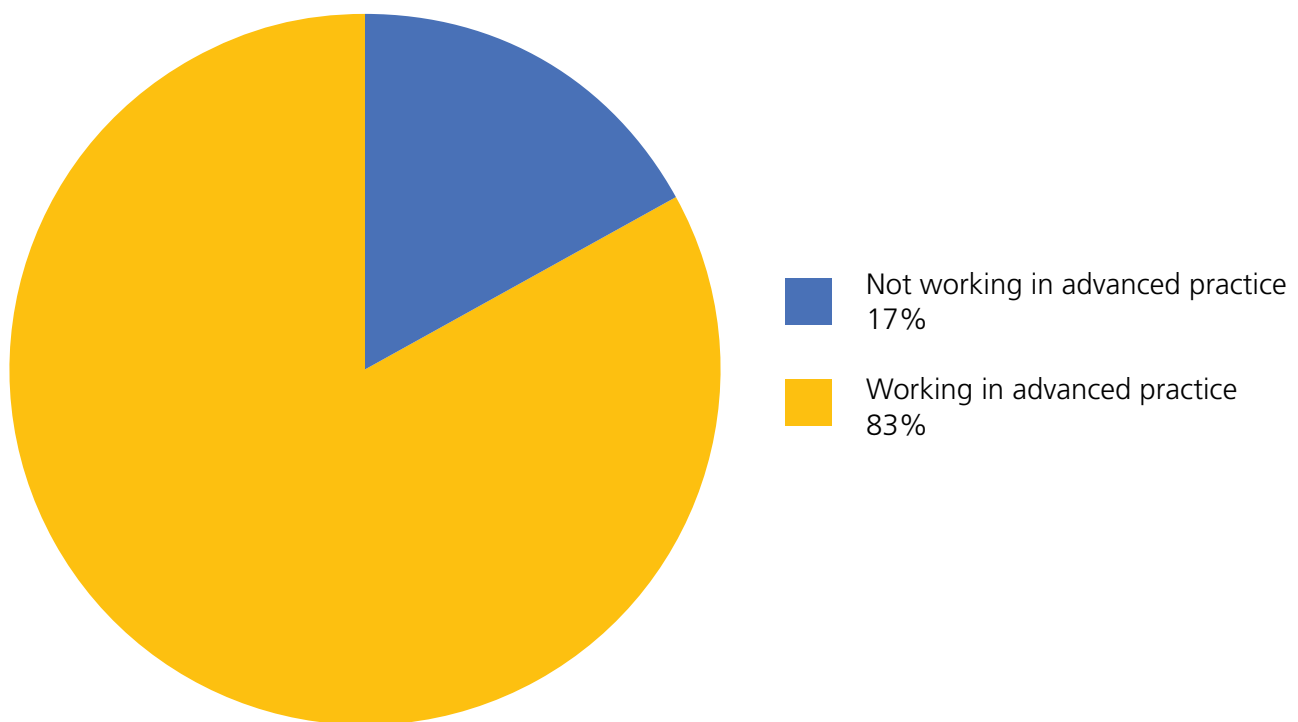


Figure 6: Role of advanced or consultant practitioners during the COVID-19 response

The participants who identified as being advanced or consultant practitioners were predominantly working in advanced or consultant practitioner roles during the COVID-19 response (Figure 6).

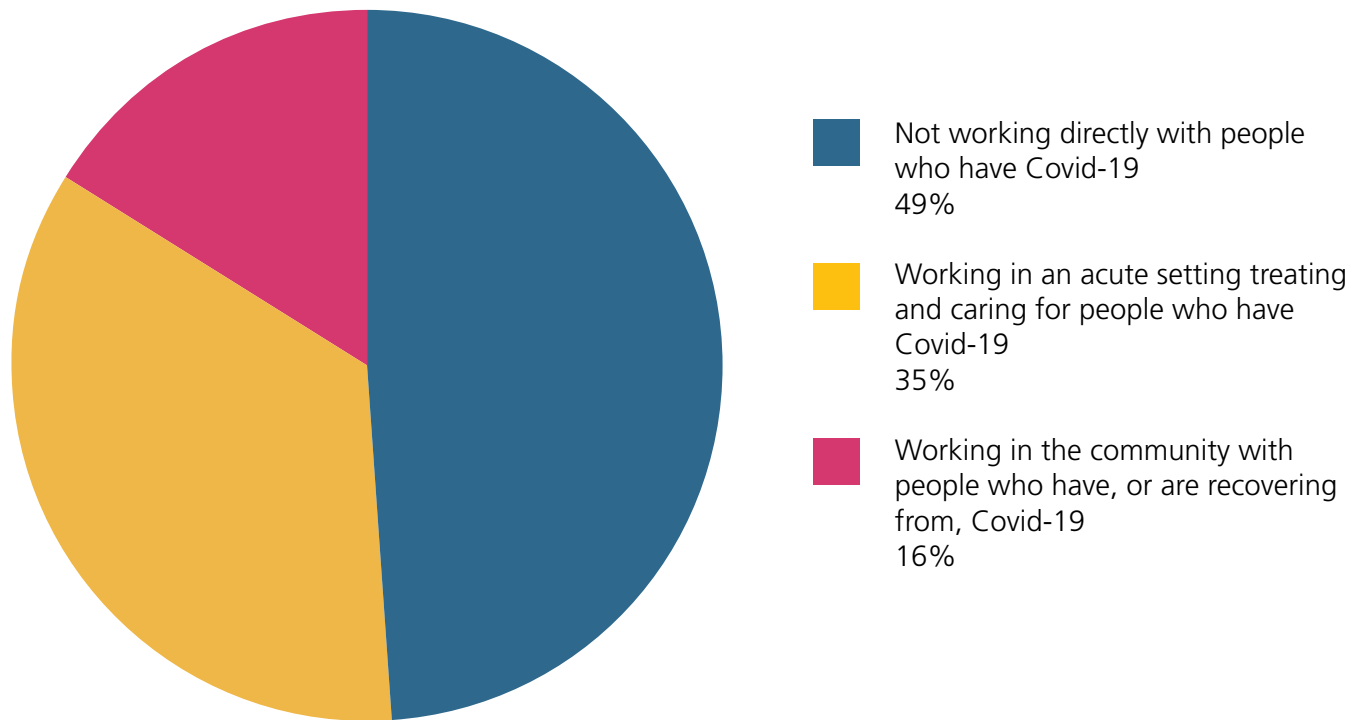


Figure 7: Role during COVID-19 response

Almost half of those working in an advanced or consultant practitioner role were not working directly with those who have COVID-19. (Figure 7).

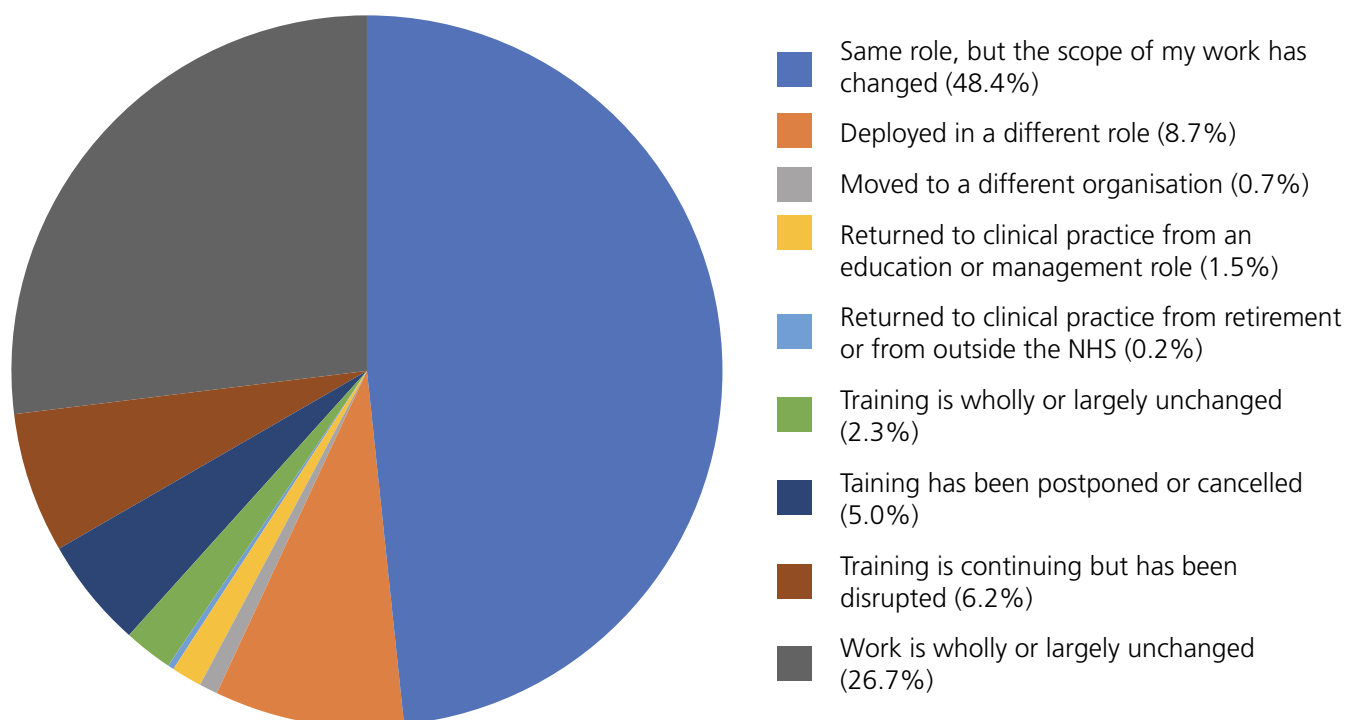


Figure 8: Impact of COVID-19 response on normal role or training

Almost half (48.4%) of participants told us that they were in the same role, but the scope of their work had changed. While 26.7% reported that their work was wholly or largely unchanged due to the COVID-19 response. (Figure 8).

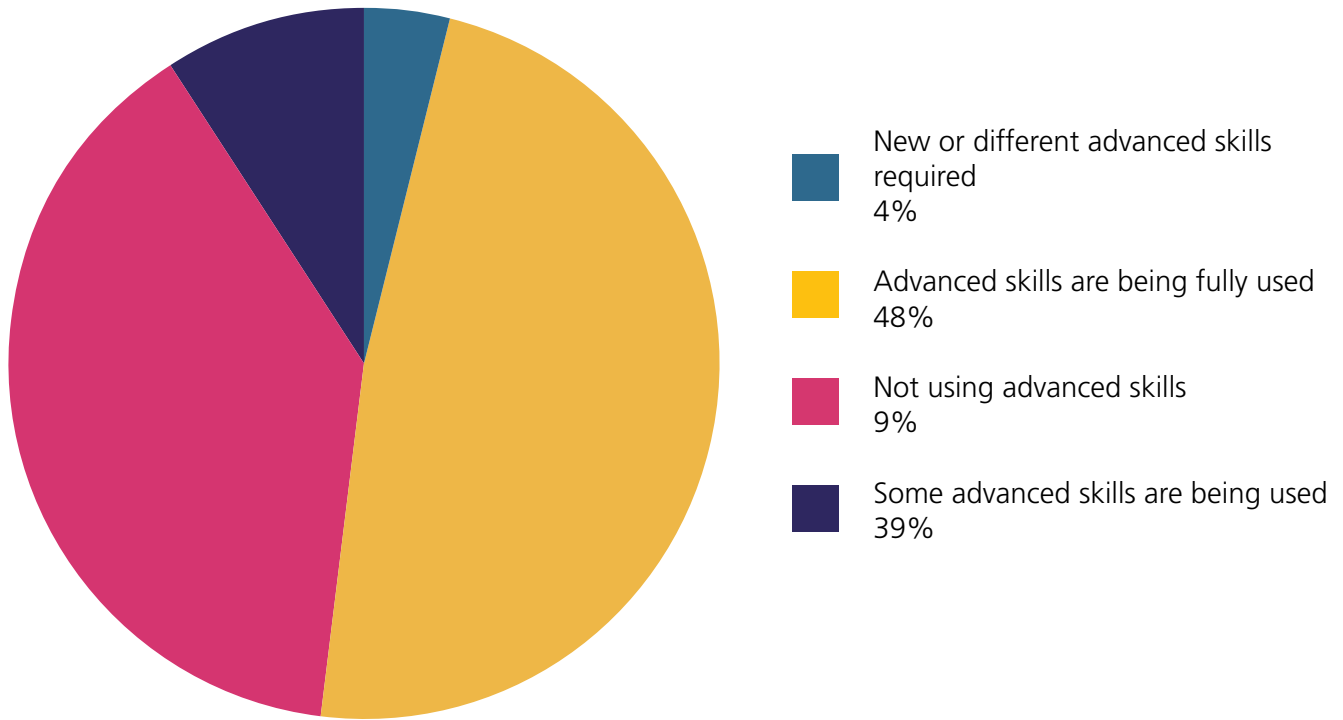


Figure 9: Use of advanced skills during the COVID-19 response

Only 9% of the participants felt that their advanced skills were not being used, with almost half (48%) reporting their skills were fully used (Figure 9).



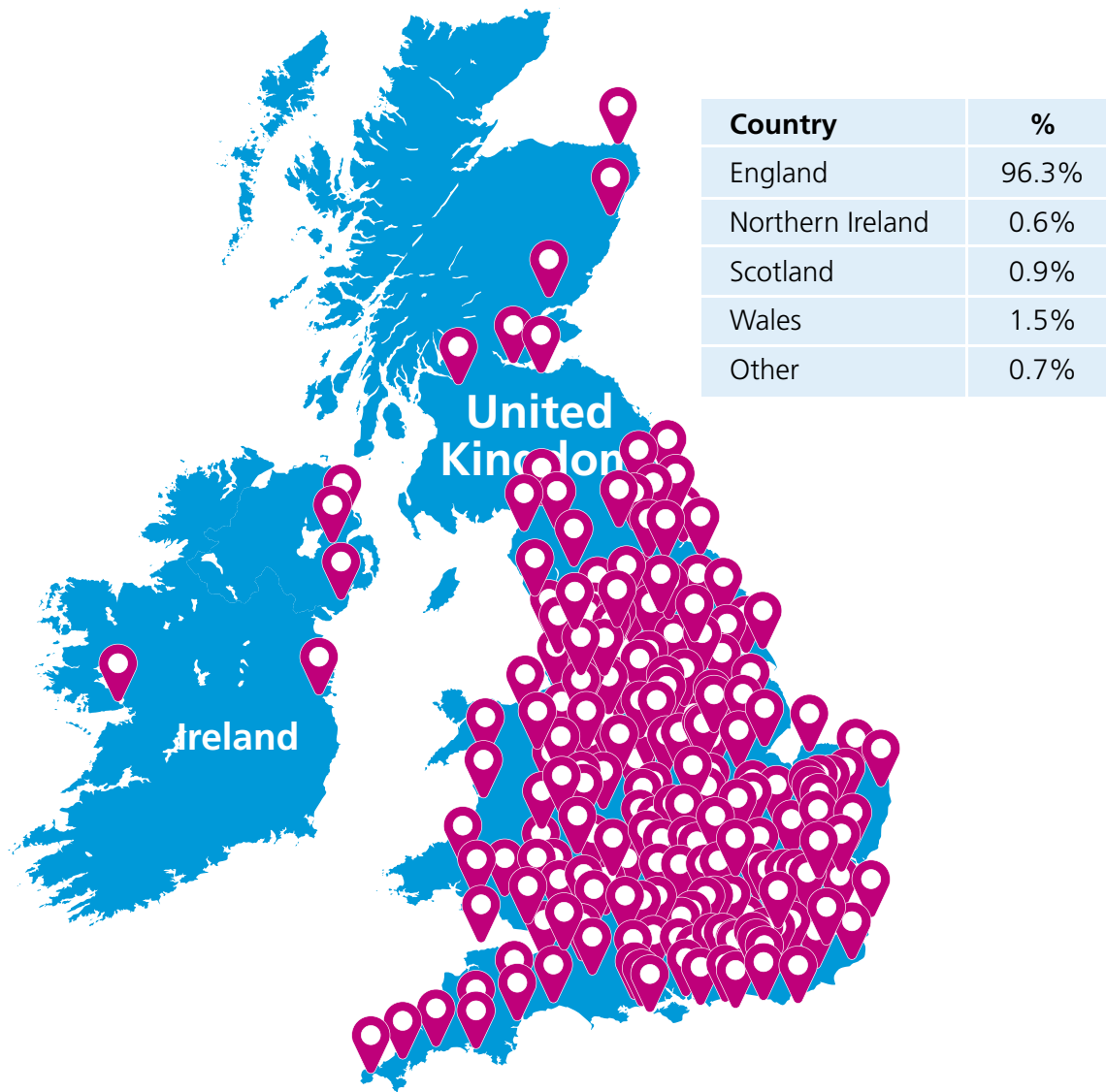


Figure 10: Geographical location of the participants

This online workshop was hosted by HEE, therefore the vast majority of participants were from England. It is encouraging to see experiences were shared from across the UK, and beyond.

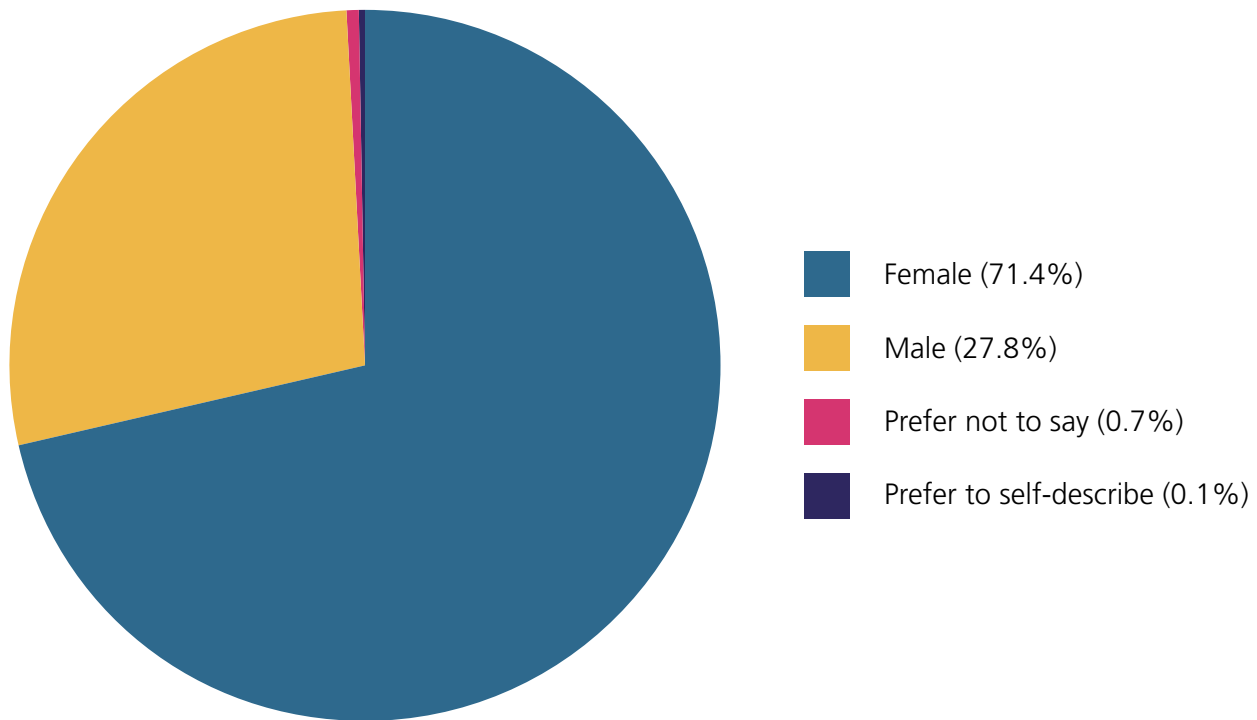


Figure 11: Gender of participants

Over 70% of the participants identified as female with just over a quarter being male. We have no comparative data to make a judgement about the representativeness of participants. The participants in this online workshop, in common with most workshops of this nature, was self-selecting. (Figure 11) Participants came from a broad age range, with almost two thirds of participants being aged between 31 and 51.

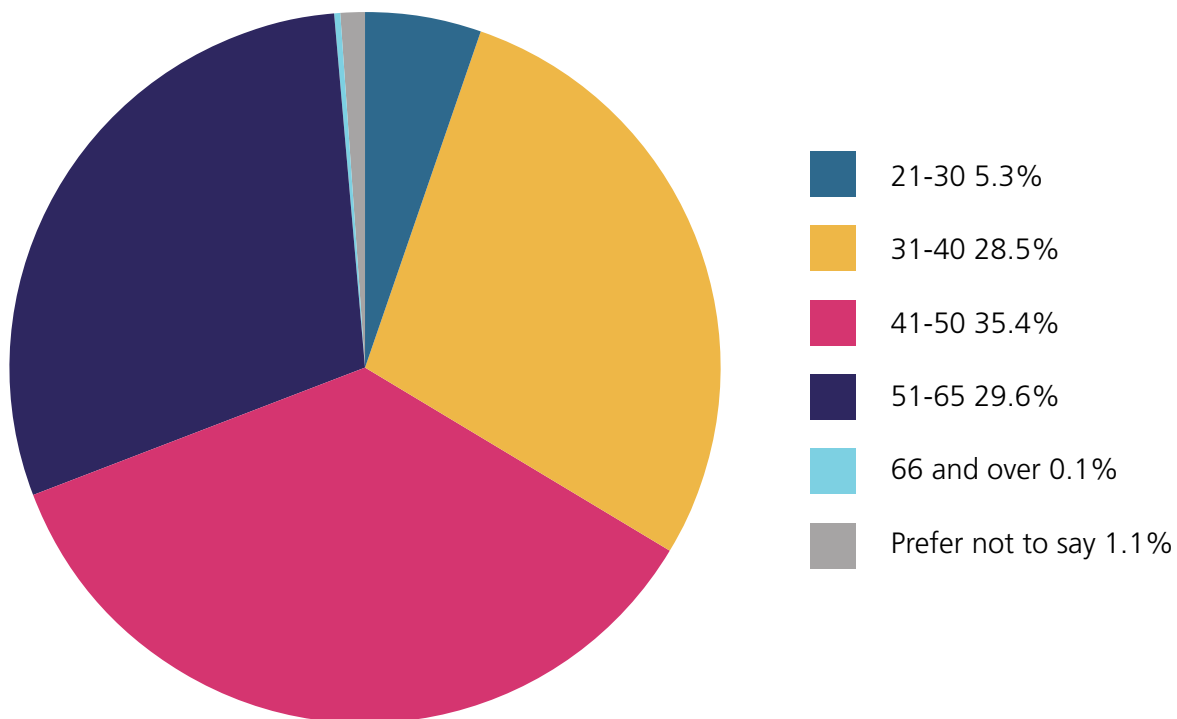


Figure 12: Age of participants

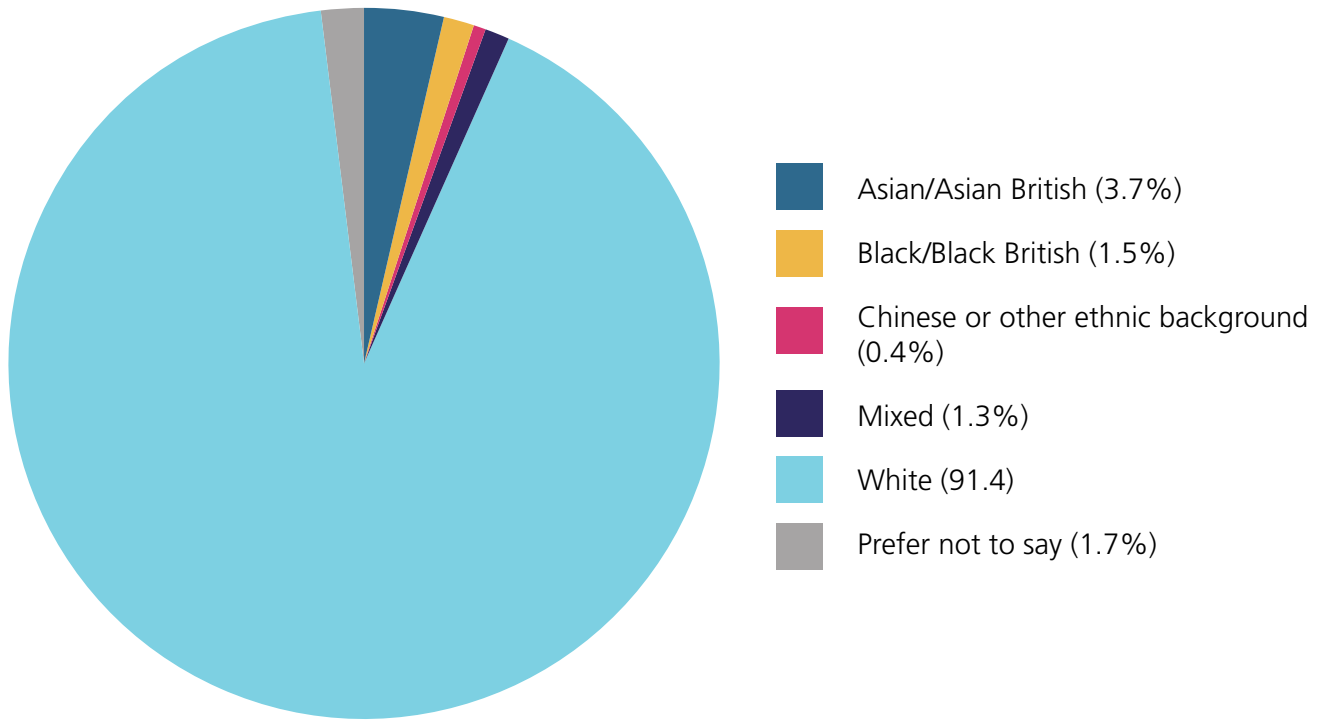


Figure 13: Ethnicity of participants

Due to the current lack of data for this workforce it is not possible to undertake comparative analysis to assess how representative the ethnicity of participants was, compared to the population group. (Figure 13).



3. Overview Of The Conversation

3.1 Your COVID 19 Story

Tell us your personal experiences of working as an advanced or consultant practitioner during the COVID-19 response. How has your work or training been affected? Are you working in a different role? Are you working to your full potential? How has your clinical specialism been used during the COVID-19 response? Have you experienced any challenges? And what impact is COVID-19 having on your physical and mental health and wellbeing?

This section was intended to provide a repository of learning and best practice case studies rather than a broader conversation. This offered insight into the breadth of advanced roles in service and the value added over this time, these examples are included in their original presentation in Appendix 1. The most popular idea was discussing the value of the four pillars of ACP (clinical practice, education, leadership and research) as part of everyday delivery of care.

This was illustrated by the following quotes in other parts of the conversation:

“When speaking with [an advanced practitioner in training] and observing her practice I noted how she was clearly pulling on all 4 pillars of ACP (clinical practice, education, leadership and research) in her role during this time:

She became an excellent educator to redeployed staff working in that area- something she would never have thought she would need to do so extensively.

When on shift staff frequently looked to her to provide leadership in unfamiliar, unprecedented and scary times, and she expertly provided this with clear and supportive instructions and decisions.

In coffee room debates about ‘what’s new about COVID-19’ she often was able to refer to an evidence base to support what she was saying, to dispel myths and propose areas that still were uncertain, and would likely feature in future research or evidence to come out of this time....she was brilliantly demonstrating what it means to be the true embodiment of an ACP!”

“I am also very encouraged by the huge number of postings...which attest to practitioners valuing all four ACP pillars, and many examples of people using their non clinical pillars more fully at this time. I think the descriptions of how people have evolved their practice really attest to the considerable agility of advanced and consultant practitioners in being able to work differently, think creatively and engage in higher level problem solving and decision making. All things we hope ACP education achieves – but this data base is strongly suggestive that we are achieving those goals – and that advanced and consultant practitioners have a huge part to play in the future NHS workforce.”

The role of clinical leadership in primary care was also a strongly supported topic. The following quotes reflect the conversation:

“Clinically I am not having the patient contact that I use to have and now undertaking a managerial role. I provide advice and direction to GP’s and advanced practitioners in regards to local COVID19 responses and support the implementation of new ways of working. I have discussed with the chair of the LMC about the fact that I feel I should be using my clinical skills more however he has dismissed this and stated that him and his colleagues need the direction I give to enable them to deal with more patients than just those I can see in person.”

3.2 Your organisation's response to COVID-19

How is your employer responding to the additional workforce challenges caused by COVID-19? Do you feel your experience as an advanced or consultant practitioner is being effectively used by your organisation or elsewhere? Have you had a role in managing your organisation's COVID-19 response, or supporting services to recover or restart?

The most popular ideas in this section discussed the use of remote appointments and digital innovation as well as remote working. Quotes from the conversation around these themes included:

"We decided to see people referred urgently, remotely. As ACP I was asked to lead this work. This was very hard at first but we got training and learnt, we are now flying, the patients love it and we are getting better we don't want to go back to how we were – we are evaluating the work, it looks good...."

We now have students joining these sessions and we are learning, supervision and bringing on the next generation – This will drive our outpatient redesign!"

"We have provided remote consultations within our practices, PCN and beyond in supporting other practices. Due to the capacity of working across multiple patient populations I have been able to maximise the use of my skillset and experience. In some regards it has furthered my clinical development. Video consultations have been key to improving our approach to patient care and feel much more personal than telephone appointments."



3.3 Your knowledge, skills and competencies

How are your knowledge, skills and competence as an advanced or consultant practitioner being used (or not used) to respond to COVID-19? Are you able to use your advanced skills at this time, and are you learning new skills? Are there any skills you think you may need to develop for a second wave of COVID-19 or another future pandemic?

Popular themes in this section included advanced clinical practitioners and prescribing. Quotes from the conversation around this theme included:

“The outbreak has... required.. practitioners to utilise their skills to the full extend within their scope of practice. Limitations arise and frustrations when differences appear e.g. paramedics not being able to prescribe controlled drugs, physios can prescribe fentanyl but not co-codamol! and vague recommendations to the extent of their prescribing practice”

“There needs to be full equality, whereby an independent prescribing qualification entitles prescription of the same ranges of drugs with the same restrictions for all, regardless of underlying profession. Until then, paramedics and physios in particular will be held back in advanced practice roles compared to nurses.”

Another popular contribution was around using skills to the maximum. Quotes from the conversation included:

“My skills have developed significantly and I have definitely been working to my potential – my leadership and management skills have benefitted enormously, significant research skills have been used to assess and determine a response to the massive volumes of clinical and non-clinical information we have been deluged with. My clinical skills have developed in terms of my confidence and ability to manage conditions remotely. The paramedic background has been very helpful as managing uncertainty and working in unfamiliar conditions is very natural to us, where others from other professional backgrounds have struggled more at times. Paramedics I have spoken to have also said our training in major incident management has been invaluable – we know how to approach these situations and it is clear there is a certain mindset shared across all professional groups who have had that training.”

New skills and new care pathways were also developed during the COVID surge for both COVID and non-COVID patients. Examples include:

As an ACCP my skills have been used to the max, I have developed new techniques (lung US) and a newfound ‘flexibility’ in clinical examination in full PPE.

“The pandemic has broken down a lot of barriers, for example as a consultant practitioner I have taken the lead for the department in negotiating new pathways for PTS (Post Traumatic Stress) with various specialties which has meant a safer and better patient experience”

and

‘We weren’t really needed for COVID-19 response, but we had patients who were non-urgent we might be able to help. In a week we agreed national guidelines for virtual assessment based on a lot of the work we were already doing we have had more compliments and thanks by working virtually and differently than we normally get. In fact, we are slightly overwhelmed by our patient’s gratitude. It’s inspiring.

3.4 Learning and looking to the future

In what ways (if any) has the COVID-19 response created opportunities for you as an advanced or consultant practitioner? Are there positive examples of your involvement in the response that you can share? And are there changes happening now that can be secured for the future?

Popular ideas in this section discussed issuing of fit notes. Quotes from the conversation included:

“As autonomous ANP , I can prescribe to the equivalent level of my GP colleagues, I have admission rights equivalent to my GP colleagues, I have the autonomy of assessing my patient to the same level. However, a requirement of a significant number of patients within primary care require a Fit Note – this is not currently available for any advanced or consultant practitioner.”

Another popular idea was around the need to show the value of advanced and consultant practitioners, build skills and confidence. Quotes from the conversation included:

“My portfolio shows clearly what I can do and my level of practice means I was classed as a senior decision maker in the team, we all pulled our weight each shift and we delivered for our patients – I need to be far prouder of what I have achieved and share with people the full potential of my role to build on this and help embed the roles and support the trainees to show their value and build skills and confidence. We need to show people what these roles can do, back them up with training that means the same wherever you go and a big badge of honour that says I am an Advanced Practitioner



4. Themes

HEE undertook a simple thematic analysis of the anonymised qualitative data and cross checked these with high level outcomes from Clever Together. The notable themes that have emerged from the conversation are documented below: A total of six major themes were found across the discussion. Selected quotes from the crowdsource have been included in each theme to illustrate themes identified within the conversation.

- Where Advanced Practitioners skills and clinical decision making ability were recognised, identifiable and trusted, they were utilised to their full capability. This enabled advanced and consultant practitioners to embrace the challenge of COVID-19 and used their skills and knowledge to deliver high quality care for patients. This was through a combination of hands on clinical activity, education or designing and leading the introduction of new services e.g. remote consultation, community outreach.
- The importance of the synthesis of experienced leadership, educational skill and the ability to drive change and improvement alongside clinical practice has proven to be invaluable and has been powerfully deployed during the COVID-19 response. Advanced Practitioners have driven innovative care pathways for those with COVID-19 and those with other conditions.
- Where opportunity was not optimised, roles were limited by imagination, there is much potential yet to be realised. There is a lack of understanding in some organisations about the role and potential skills advanced and consultant practitioners can provide to both patients and the wider organisation. This led to frustration that the ACP roles were not being fully utilised.
- Frustrations about the apparent inequality across the professions and sectors was amplified and a cause of significant frustration. Significant concerns were raised about some professions or sectors feeling left behind or unfairly 'land locked' were raised. This was specifically in relation to non-medical prescribing, primary care support to train and supervise advanced roles and those without statutory regulation.
- A number of enablers are needed to maximise productivity such as – better understanding of scope of practice, clinical decision making and the four pillars of practice, alongside specific activities such as fit notes, death certificate, ESR identification and skills/skills passport recording.
- Equality and Diversity – the importance of this agenda has been highlighted and is exacerbated by the lack of ESR data.

4.1 Full utilisation – Where Advanced Practitioners skills and clinical decision-making ability were recognised, identifiable and trusted, they were utilised to their full capability. This enabled advanced and consultant practitioners to embrace the challenge of COVID-19 and use their skills and knowledge to deliver high quality care for patients. This was through a combination of hands of hands on clinical activity, education or designing and leading the introduction of new services e.g. remote consultation, community outreach.

“ACPs have stepped up and shown courage and commitment to work in any way possible to ensure that patients continue to receive high quality care safely. All 4 pillars have been shown in their work as they have led on Trust wide C-19 projects, led on C-19 education, moved specialties, altered their working patterns, joined different rotas etc”

The stability offered by this workforce came through strongly, their knowledge of the environment, their established skills and ability to support, educate and supervise multi-professional colleagues.

“The ACP team in ED has really come into its own over this period. We have established ourselves as a valued, stable workforce able to cover all aspects of the department. We have all brought different skills which we can continue to develop and strengthen within emergency medicine.”

This theme was driven by the different levels of understanding of roles, scope of practice and level of decision making within teams. The stress of the fast emerging pandemic exposed the levels of organisational understanding and trust of these less familiar roles. Ranging from:

- one example of a Trust deploying its senior advanced and consultant practitioners into leadership roles to ensure the full utilisation of all ACP skills across the Trust, fully liberating the skills of advanced and consultant practitioner and trainees both within their core professional and ACP roles
- through to a consultant nurse being deployed into ITU into a band 5 nursing role.

The fact that 48% of staff reported that they had been trusted to fully utilise or translate their skills, with only 9% reporting that their skills were not used, still means that there is still opportunity for 52% of advanced and consultant practitioners to be better utilised.

“We have been left to create our own roles during the crisis. I don’t think this is unreasonable as we are highly experienced senior members of staff and can see where our skills are best used. It has given me the opportunity to revise and renew my ED/trauma skills and knowledge and develop a role for surgical care practitioners in ED or on an acute assessment unit. I have remained flexible and willing to be redeployed, but we have been lucky, and not been hit so hard as other parts of the country.”

A number of examples stated that people were frustrated and felt devalued when their roles were not understood, they were under-utilised or sub-optimally deployed. Some professions felt that as they were not nurses, people did not know how to use them.

‘The barrier was lack of understanding of roles but also highlights the risks of not having a critical mass of ACPs to create a community of practice’.

‘I think it comes back to the fundamental need to have clear organisational buy in to the ACP/ consultant practitioner role’.



A recurrent theme was the need for standardised, nationally recognisable training pathways similar to those for emergency department and intensive care facing advanced practitioners. It was felt that this was transformational and staff in those roles reported consistent optimal deployment and utilisation.

Governance also was clearly stated as a key issue and enabler for optimal utilisation: A Directors view:

“There has been a huge amount of work to ensure that ACPs have had the tools and permissions to provide the clinical care that they needed to during this pandemic. This has meant having to rapidly agree to changes in policies at Board level and agreeing to new ways of working that have enabled ACPs and other staff to work effectively across a rapidly changing healthcare environment. There have been some great positives such as the way we have been able to work with partner organisations to meet patient’s needs. Particularly with discharge planning. There have also been some challenges with redeployment and reallocation of slightly different roles for ACPs. We hope to learn from discussions with staff”.

Many respondents illustrated the feeling of liberation about being able to step into their roles, trusted to get on with the work:

“My experience of providing seamless healthcare without perceived barriers of red tape was my biggest enjoyment. The masks and gowns took away the perception of who you are in a hierarchy, which was a blessing in disguise and gave me more courage to question and learn and listen and talk to the bigger teams.”

The ability for some roles to be liberated, to work across traditional boundaries of professions, services and/or sectors to meet people’s needs was reported to be motivational and refreshing. There was a shared concern by many that this will now go back to as it was before COVID. The ability to “step into full role, allowed to get on” ... “without the normal politics at play” was a consistent comment within this theme. Many respondents talked in terms of teams working better together, respecting each other’s contribution, learning together and appreciating each other’s skillset.

A common post was the need to utilise existing recognised skills and adapt roles e.g. change hours, join clinical rotas or swiftly develop out of hour or 24 hour, 7 day services. Which was embraced and delivered substantial benefit and was felt likely to continue into recovery.

4.2 All 4 pillars – The importance of the synthesis of experienced leadership, educational skill and the ability to drive change and improvement alongside clinical practice has proven to be invaluable and has been powerfully used during the COVID-19 response.

Advanced practice is characterised by four pillars of practice – clinical expertise, leadership, education and research/improvement consultants have the additional skills of systems leadership. Historically organisations have prioritised clinical skills, however the synthesis of the four pillars of advanced level practice has shown clearly the enabling and supportive benefit of the four pillars.

“My ACP role was fully used in every way – people say it is because they could understand what I could do and then what I could do more of. This will be really interesting to see how this has broken down the last few remaining barriers as we all got along together with a single focus – it was very levelling.”

“Leadership has been core to my role throughout the pandemic and as part of the senior leadership team of the department, problem solving, crisis averting and managing change has been key to our daily work, identifying, exploring and analysing different solutions, ways of working and pathways has been a core part of the job for the last 3 months”

“How can you do the job without the ability to evaluate, teach and assess/use the evidence in a better way, I worry people see these as an add on it should be a spiralled synthesis of all 4 that we deploy seamlessly over the day – clinical care is enhanced.”

Within this very busy theme the pillars were discussed as a synthesis of skills required by the senior, experienced staff in these roles to maximise care delivery, transformation and team productivity.

The sub theme of the education pillar in practice to drive service change or support redeployment was a repeated post from supporting the Nightingale units to establish through to supporting large scale upskilling in critical care. Support to the redeployment and care of staff to areas and new environments /roles was common place.

There were a number of comments from advanced practice educators and students about the impact of the pandemic upon their studies for education programme delivery.

“I believe the longer term outcomes of the ‘COVID-catalyst’ will include some positive changes to HEIs, where we use technology more effectively and pedagogically.”

A small sub theme emerged of supporting and driving the recovery of pre-registration clinical learning and students once this had been enabled, with examples of advanced practitioners establishing novel mechanisms to build resilient virtual training models.

The theme also displayed a strong sub-theme of research and improvement being vital additional skills that enabled a holistic response within teams and at times an aspect of the role that has been less visible.

“Additionally as a consultant practitioner I have also been involved in COVID research within the trust, the co-ordinated approach and ability to fast track studies in clinical practice has meant an immense amount has been achieved and I am a PI in a COVID observational trial as part of my role.”

“The crisis ‘pump primed’ some service improvement ideas we had already been developing such as virtual clinics and telemedicine (home BP and pulse oximetry monitoring in heart failure) that we will be continuing. Especially within cardiology, our ACP workforce has proved invaluable in helping us ensure that we continued to provide a patient focussed, high quality and cost efficacious service”.

The sub theme of leadership was the strongest. The optimal utilisation of advanced and consultant practitioners as experienced leaders required to drive service response e.g. virtual set up and triage, or safe service suspension and high risk monitoring.

Leadership for restart and recovery emerged over the duration of the questionnaire as this topic was beginning to be amplified in service and again advanced and consultant practitioners reported being requested to lead restart and recovery planning and delivery.

“Now that COVID has passed the peak, the challenge is identifying those patients who may have adverse outcomes as they have failed to seek urgent care or have refused to attend an urgent appointment for fear of contracting COVID-19. The other challenge is to prevent the return to ‘old ways of working”.

“as much positive change has occurred and instead we need to harness this catalyst for change in an environment that traditionally can seem to take an age to progress even minor change. As consultant nurse in the service I have been able to advocate and argue for changes in practice and influence future service changes in how we manage our patient base going forward whilst providing healthy challenge to my surgical consultant colleagues. It has truly demonstrated the use of all key components to the consultant role and how all 4 areas came to the fore in times of crisis and across multiple boundaries””.

“Leadership has been core to my role throughout the pandemic and as part of the senior leadership team of the department, problem solving, crisis averting and managing change has been key to our daily work, identifying, exploring and analysing different solutions, ways of working and pathways has been a core part of the job for the last 3 months.”

Clearly again where these roles were not understood by service none of this added value was realised, staff were redeployed to low banded clinical roles out of specialty, they reported feeling demoralised.

The ability to develop, evidence, drive, evaluate and undertake significant service transformation and now to drive service restart was reported to be invaluable, whilst role modelling the new post COVID learning and behaviours e.g. embedding discharge to assess and outpatient redesign.

The leadership of advanced practitioners across services was visible, supporting the emerging need for risk assessment and ensuring safe services and deployment.

“On reflection, before COVID 19, I did not considered my BAME background was a factor and needs specific risk assessment. During my ACP training I have gained leadership skills which have helped me to improve my confidence. I have now taken leadership role and represented my trust – BAME group in conversations with NHS England. I have liaised with equality and diversity lead of the trust and worked to provide more guidance to support the implementation of risk stratification to BAME colleagues.”

4.3 Lack of understanding Where opportunity was not optimised, roles were limited by imagination, there is much potential yet to be realised. There is a lack of understanding in some organisations about the role and potential skills advanced and consultant practitioners can provide to both patients and the wider organisation. This led to frustration that the advanced practitioner roles were not being fully utilised.

‘The lack of an ACP registration meant that the organisation’s natural panic response was to pull everyone back to their base registration basic role i.e all nurses will nurse, all physios will physio etc. This created a surplus of staff in the wrong areas, not utilising their skills well. We have an ACP lead and overall the ACP workforce was maintained where it needed to be but not without some fight’

“I am a consultant practitioner working with acute medicine so my role hasn’t changed during COVID and has enabled me to utilise my skills/experiences as a senior decision maker. However, I have been redeployed back to critical care where I felt my skills were not full time utilised. My background is critical care but going from working as an 8b to that of a band 5 wasn’t the most effective use of my skills.

This is the challenge that I feel ACP’s and consultant practitioners face when compared to medical colleagues and highlights the lack of understanding by organisations regarding the role of the ACP.”

“I have now (after 6 weeks) been taken out of Hot ED and just working in Cold SDEC/ACU. The numbers of patients are low as they get stopped in Hot ED due to SOB or temperature and I feel like a secretary, following up patients via the telephone and following up outstanding results. I do not feel I am working to the best of my ability and have lost any respect as an ANP that I previously had.”

There was, for a few, a reported theme of sadness and lack of value in that a number of people felt that roles were often “limited by imagination”, and that some professions were unfairly “land locked.”

A theme of the building of the opportunity for consultant roles to influence and lead across systems and advanced roles to work across systems to the benefit of the population emerged over the conversation.

“I have been working for 2 shifts a week with the metropolitan police and fire brigade on the Pandemic Multi Agency Response teams. These teams were a London wide initiative to manage the elevated number of deceased patients as a result of COVID-19. The role was extremely varied and offered an opportunity to work alongside the police and fire brigade in a mutually appreciative manner. The work involved was quite challenging and I was able to offer a senior pastoral role to support the other disciplines. They were witnessing scenes they did not see on a regular basis and this could be difficult. Offering advice and support for debriefs and reducing fears was interesting work.”

4.4 Equality of opportunity – Frustrations about the apparent inequality across the professions and sectors was amplified and a cause of significant frustration. Significant concerns were raised about some professions or sectors feeling left behind or unfairly ‘land locked’ were raised. This was specifically in relation to non-medical prescribing, primary care support to train and supervise advanced roles and those without statutory regulation.

There was significant distress highlighted by professions with regards to a perceived widening inequality of opportunity. The key area where this was most obvious was with non-medical independent prescribing, many professions e.g. ODP and OT stated this significantly limited their ability to optimally respond and that their career opportunities were unfairly limited where prescribing ability was mandated for certain roles and/or training pathways, not always some considered appropriately.

“However, I do have to stress that my role was made far more complex due to the fact that I was unable to independently prescribe during critical situations, and moving forward in advance clinical practice, this will hinder my development because I will be unable to prescribe once qualified at this time therefore, delaying patient care and treatment. During these times I had to look for a medical practitioner or a nursing advanced clinical practitioner to prescribe for me so that I could administer essential drugs. I feel if the ODP were permitted to become an independent prescriber, it would empower my role tenfold and allow me to provide better care for my patients during these difficult times when staffing is stretched to an absolute maximum.”

‘A full formulary should be granted to all health professionals who are registered prescribers with the appropriate qualifications. Practitioners should only prescribe medicines that are within their proven competencies... It should be a matter of competence not a matter of background profession. This will ensure that patients are treated efficiently, safely and by the person most appropriate to provide them’

This then also led to several career routes being closed to them, for instance, many advanced practice roles and ACP training pathways e.g. those credentialed by the Faculty of Intensive Care Medicine and the Royal College of Emergency Medicine.

There was an emerging theme present in a number of the primary care posts that the roles were valued, deemed highly useful but because of that they were not given time out to train and were fearful they were being left behind. They felt they needed a more flexible and equitable training option.

“I seem to have slipped through the net, so as to speak with no degree and not an advanced practitioner, I am feeling inferior to my colleagues who have completed the NMP course or advanced practitioner courses. My practice is happy with my skill set and the work I am doing and although I have suggested doing the NMP or an advanced practitioner course at this time, this is not what they are able to support. We now have such a varying degree of educated professionals all striving to do a masters etc.”



4.5 Required enablers – A number of enablers are needed to maximise productivity such as – better understanding of scope of practice, clinical decision making and the four pillars of practice, alongside specific activities such as fit notes, death certificate, ESR identification and skills/skills passport recording.

“Sadly despite all that has been achieved, it’s the small things that still form a massive barrier to practice such as not being able to sign a fit note for a patient I have examined, diagnosed and managed, and having to ask a junior doctor who hasn’t seen the patient to sign a fit note. My doctoral thesis examined why pts sought unplanned follow up after visiting an ED, the most common cause was for a fit note!”

A number of enablers are needed to maximise productivity, these are shown in the table below:

Digital skills:	Technology was a major enabler in the form of virtual consultations, remote reporting, virtual rehabilitation, teaching, supervision – issues were highlighted in access to equipment, digital skills and the need to learn effective assessment, treatment and supervision skills in the online/virtual environment. “I think telephone triage and consultations are challenging and are testing my advanced practice skills, using far more critical thinking and reasoning that face to face, when often we utilise non verbal clues and that “end of bed” assessment with an element of intuition.”
Access to ordering radiological investigations:	“I work within oncology in an acute trust where unless you are a Doctor you cannot request imaging. This was a highly debated issue within my trust pre COVID and was not moving forwards but when COVID hit it became a real clinical issue.” This was a very frequent issue raised, although many others gave examples of how they had sorted the issues locally.
Fit notes:	The inability to complete fit notes was the most commonly occurring frustration with Advanced and consultant practitioners needing to seek medical support to complete.
Death certification:	Inability to complete was a repeated theme especially at the peak of the pandemic
Prescribing shortfall for many professions:	There were two thematic issues: <ul style="list-style-type: none"> • Some professions with existing prescribing rights had limitations to their practice which limited productivity and patient care e.g. physiotherapy, paramedics and podiatry. • Some professions have no access to prescribing rights, and this was seen to be a significant challenge to new roles and role extension e.g. operating department practitioners, orthoptists, occupational therapy There was a repeated call for equality of access at the advanced practice level as all undertake the same training. It was felt that this needed significant modernisation. The respondents were unswerving that independent prescribing rights needed to be accessible for all healthcare professionals working at advanced levels who have completed their training / competencies.
Primary care IT functionality to support AP prescribing etc	For instance, some primary care IT systems still do not enable all advanced and consultant practitioners to undertake certain activities eg prescribing, fit notes.

ESR and skills recording	The accurate recording of advanced and consultant practitioners on ESR and the recording of trained skills is essential for timely, accurate and optimised deployment. ESR has no reliable data on advanced practice roles and as such was not able to support the identification of this staff group. The lack of transferable qualification also makes links to e-rostering challenging.
Portfolio evidenced skills	Accumulated portfolios of skills enables clinical confidence in clinical skills and the acquisition of new skills like ITU to be recorded. There was a strong theme that staff were not deployed well as there was 'no understanding about what people could do'. There was a common thread that it was easy to become niche quite quickly and that although these roles are not generic, a need for a broad base was essential and emphasised during redeployment.
Clinical supervision	Supervision: the ability to deal with and manage ambiguity and complexity, requires supervision in a crisis perhaps even more so than in periods of calm. Thus, many staff used technical solutions to optimise outcomes within the technology available as an online opportunity. HEE has sponsored a number of virtual communities of practice which were well reported. There was a consistent ask for remote specialty specific communities of practice to network emerging specialty facing ACP roles.
Scope of practice /Professional indemnity	There remains a need for clarity on scope of practice for professions that move a significant distance from their core professional training and traditional scope of practice. The lack of recognisable training has not helped this challenge. "As an acute ward ACP from a Podiatrist background I cannot get private malpractice insurance. My doctor colleagues working at a similar level can but as I am an AHP ACP there currently isn't anyone who will cover me. It is fine saying that Trust indemnity will cover you, but having your legal fees covered and someone having your back, should something go wrong is essential!"
Strategic workforce and educational planning	Strategic workforce and educational planning is essential to grow advanced practice roles across the different clinical areas and to ensure ongoing development to maximise the potential workforce and retention.

Well being and resilience initiatives remain essential for staff both in work and shielding.

4.6 Equality and Diversity – Equality, Diversity and wider health and carer issues – the importance of the EDI agenda has been highlighted and is exacerbated by the lack of ESR data.

Throughout the pandemic issues of risk assessment, shielding and the wider needs of the workforce were very clear. Respondents reported feeling that they had 'let down' colleagues as they were required to shield and felt useless and guilty.

The diversity across sectors, professions, is also interesting in this agenda. The ethnicity data presented above showed 91.4% of the respondents reported themselves as white British. As part of the wider EDI work a small group convened to agree next steps on widening our representation – a colleague in this conversation made the following representation, stating that he felt that he had everything stacked against him, and although he had won through others should not have to feel so peripheral 'as an Asian, male, physiotherapist working in learning disabilities it took me 5 years to make the case to be trained as an advanced practitioner.'

5. Beyond The Conversation – Next Steps

5.1 Full utilisation

The workshop illustrated that 85% of advanced practitioners reported feeling that they had made a useful contribution to the response to COVID 19, 48% felt that their skills had been fully utilised, with only 9% feeling that their skills had not been used. This does however mean that 52% could have been enabled to offer more of their skills to the response.

A future wave of the pandemic will enable services to offer a more concious response. Advanced and consultant practitioners are urged to plan with line managers and operational leaders how to optimise utilisation of their skills ahead of any future escalation. This may be into deployed roles, wider service clinical leadership, supporting the maintenance of clinical education (including students) or focussed support to services working to restart and recover.

5.2 The synthesis of the 4 pillars of practice

The value attributed to the broad skills of the advanced practitioners across clinical care, leadership, education and research/improvement was significant and came as a surprise to many .

The lived experience case studies and quotes through this work evidence the varied utilisation of the sythesised skills of the advanced and consultant practitioner. It is suggested that individuals share the multi-dimensional aspects of their practice to support a wider understanding of the synthesised knowledge and skills and to allay anxiety that these are silo'd skill sets, in order to illustrate the wider contribution of these roles to the things that matter to patients and services.

5.3 Lack of understanding of the role

The advanced roles that appeared to be more fully utilised during the pandemic were the well established and standardised roles – where people knew what they could expect of the workforce and where capability and confidence were high. The emerging Centre for Advancing Practice will support standardised core training in the major pathways to help establish, liberate the roles e.g.mental health, learning disabilities and support the recognition for more bespoke advanced level roles.

With the emerging Centre for Advancing Practice a series of communications campaigns are in development. The development of the Regional Faculties of Advancing Practice within HEE will enable better local understanding and support. The national and regional teams are commencing a series of webinars, the annual conference and wider communications to support the wider messaging of advanced and consultant practice. The teams will work with employers to suupport greater optimisation of the opportunity. Clear organisational and leadership understanding is essential to optimise the opportunities of the level of practice, the roles and the governance of these roles.

There is an immediate call to action to all in this work, to encourage advanced and consultant practitioners to support people to 'know how to optimally utilise their skills' to enable them to offer their best value to their employers and the populations that they serve. The lived experienced case studies show a small insight into the wide breadth of advanced roles.

5.4 Equality of opportunity across professions

The HEE programme has set out to be fully inclusive. Work has been undertaken with some of the less represented professions and specialities to understand the oportunites available e.g. radiography, operating department practitioners, ophthalmology. This work has enabled the illustration of roles and opportunities.

Prescribing – discussions are ongoing to understand the current challenges, needs and opportunities across the professions. A case of need is in development for a number of professions, whilst a number of other pieces of work are in train to support expansion of wider medicines mechanisms for some professions. This will take a number of years to enact. This will add value in the medium term. Some professional bodies e.g. Royal College of Occupational Therapy issue publish advice on how to optimally utilise the existing medicines mechanisms available to the profession.

Primary care – The shared responsibility for the development and retention of experienced workforce is a very important partnership across systems, the current advent of Primary Care Networks and Training Hubs will offer a new opportunity to coordinate and develop training.

The HEE Multi-professional Framework for Advanced Practice focussed upon the statutory regulated professions, there are a number of established and new professions who are able to advance their practice yet have voluntary registration e.g. many healthcare science and psychology professions. Work is being undertaken to support the full understanding of the opportunities, challenges and potential next steps.



5.5 Required enablers

Digital skills:	Significant learning has been made available through the https://www.e-lfh.org.uk/ website. HEE has piloted remote supervision and the development of communities of practice in both primary care and mental health pre-pandemic – this work will be expanded into the future.
Access to ordering radiological investigations:	Many Trusts have very effective negotiated arrangements with their Radiology Teams to enable timely and efficient requesting. This should be achievable in all Trusts for advanced and consultant practitioner recognised and trained in their Trust to the required capabilities.
Fit notes:	Work is ongoing with the Department of Work and Pensions to support fit notes to be extended to the wider advanced practice workforce.
Death certification:	This is currently being investigated.
Prescribing shortfall for many professions:	Please see section 5.4.
Primary care IT functionality to support AP prescribing etc	Lack of local IT functionality in primary care is frustrating and needs to be escalated through the practices and primary care networks to optimise productivity.
ESR and skills recording	ESR data cleansing information will be shared with teams to support teams to improve their ESR data for advanced and consultant practitioners. As the credentials start to be delivered staff will be issues with electronic badges and recorded on a central list to evidence their skills. This will support deployment.
Portfolio evidenced skills	Advanced and consultant practitioners will have access to a portfolio through the Centre for Advancing Practice.
Supervision	Supervision is essential to support learners and optimise skills acquisition, education and training, developing role and embracing professional identity. HEE is reviewing the funding support to learners. Access to well being and resilience support is essential for staff.
Scope of practice	It is essential that scope of practice is clearly understood, shared with the team and agreed to support the workforce and team to operate safely.
Strategic workforce and educational planning	Regions will continue to work to develop longer term strategic workforce and educational planning. Advanced role development will however remain dependent upon funding.

5.6 Equality and Diversity

Regional faculty teams will support the wider equality and diversity agenda and the challenges of access across professions, sectors and specialties.

Shielding: It is recommended that any advanced or consultant practitioners that may need to actively shield, works with employers ahead of a future surge to understand the opportunities for remote supervision, student support, education and training that will support shielding senior staff to undertake a rewarding and fulfilling part of the pandemic response and maximise their contribution.

Final Comment From The Crowd

“I think I’ll be better prepared for a 2nd wave. We’re going to have to get used to working in different ways. COVID-19 isn’t going anywhere anytime soon”

‘Unfortunately, as advanced practitioners, I think we are often undervalued, but I hope that COVID will change the way we work and our value to the rest of the team/hospital’

‘I am very optimistic with the skills that I have gained during this challenging time will help me to improve our services and provide person centered care as qualified advanced care practitioner.’

This project was commissioned to generate insight via a crowdsourcing platform into the realities advanced and consultant practitioners were experiencing as a result of COVID-19 and to analyse the data about the participants.

The qualitative feedback shared with HEE gives a rich picture of the experiences of advanced and consultant practitioners. The data is a snapshot in time, but also provides useful indicators both about the ongoing management of COVID-19, but also critical insight for policy makers wishing to ensure this key professional group continues to grow as a key component of multi-disciplinary teams of today, and of the future.

Grateful thanks to Clever Together, Hugh and Fiona.



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Advanced Practice responses to Covid-19 across different Health and Care settings.



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Responses to Covid-19 across different departments

The following Health and Care departments gave their viewpoint with how they responded to the Covid-19 pandemic:

- ACCP
- ACP
- Advanced Dietitian
- Advanced Nurse Practitioner, Mental Health and Primary Care
- AHP Consultant in Community Neurological Rehabilitation
- Healthcare scientists
- Clinical and academic learning
- Community Rehabilitation Team
- Consultant Nurse
- Consultant Podiatrist and Podiatric surgeon
- Advanced Practitioner within Primary Care
- Learning Disability Trainee Advanced Clinical Practitioner and Physiotherapist
- Nearly qualified ACP

In May/June 2020 Health Education England (HEE) commissioned Clever Together to run an online workshop to support the sharing of learning of Advanced Clinical Practitioners and Consultant Practitioners during the COVID-19 Pandemic.

The following report summarizes a suite of examples shared during the workshop and should be read in conjunction with the Clever Together data report and the HEE project report.



Skills utilised during Covid-19 pandemic

ACCP – ITU

“I am an Advanced Critical Care Practitioner (ACCP) working in a major trauma and neurosurgical centre. As a unit we had excellent leadership and preparation before the pandemic affected us. The ACCP team have been used to their full potential, playing an important part of the medical rota. We have experienced a high volume of Covid admissions and expanded beyond the walls of our current footprint. As a whole clinical team, we shared our skills and knowledge with non-ICU trained nurses and also received a massive amount of help from ex-ICU nurses who were happy to return. We also did an immense amount of training to develop a dedicated poisonings team, which consisted of Physio’s and speech and language therapists. They were a fantastic help during our busiest period.

As an ACCP my skills have been used to the max, I have developed new techniques (lung USS) and a newfound ‘flexibility’ in clinical examination in full PPE. Working as a team and ‘looking out’ for each other as been imperative.”

ACP – Leading across pathways

“As an ACP, I spent a lot of time working at an operational level with partner organisations. This has been key already – coordinating support for young people with special education needs & disability, ensuring we reach out to families as much as possible. We are now starting to consider how we will support young people returning to school. There is a huge amount of information available to support this – organisations across the country (and around the world) have created materials and resources which are accessible to individuals with a learning disability and/or autism.”

Advanced Nurse Practitioner – Mental Health

“My usual job role is within liaison psychiatry however following the outbreak I was redeployed to work as ANP (Advanced Nurse Practitioner) within an older persons inpatient setting. The ward purpose was redesigned to support discharges from our acute trust to provide assessment of future care needs for patient living with or suspected to be living with dementia.

My scope of practice has changed in the way I have utilised my physical health skills on par with my mental health ones. Patient admitted to our ward usually have physical co-morbidities which at time are not at their optimum. I have been required to monitor both physical and mental health which is a stark difference from my previous role of assessing and signposting patients experiencing mental health problems within an acute physical health setting. I am lucky I have been supported by a great medical team who have allowed my skills to develop outside of my usual scope of practice. During this time, I have been required to engage with carers and families and engage in difficult conversations regarding DNAR and ceilings of care.

Despite the pandemic being devastating. I feel the opportunity for me to expand my practice has been invaluable.”

AHP Consultant in Community Neurological Rehabilitation

"I have mostly had the opportunity to use my strategic leadership & hands-on therapeutic skills during Covid-19 period. As part of the Covid-19 response a skill set analysis saw community neuro-rehabilitation staff re-deployed to a regional in-patient neuro-rehab unit within the patch with the primary purpose of providing intensive (twice daily or more) interventions for those individuals who could cope with this to expedite discharge & improve flow for neuro-rehab patients from the acute wards.

The outcome has been better than expected in that the intensity has reduced the average Length of Stay from 106 days to 49 days – the cost savings will support further investment in in-patient (& community services in that patients who were seen not to be manageable in the community previously were found to be so).

The hybrid model of in-patient neuro-rehab expertise & focus with community neuro-rehab expertise & focus has enabled development of:

- Comprehensive management packs on discharge for each patient (with a digital copy going to their local CNRT) with detailed community info & contacts for the local area & subsequent sharing of resources on posture/spasticity management/exercises etc across the locality & region through a network portal.
- Integration of different models of care so the patient benefits & are better ready for discharge & managing on discharge.
- Better risk management & safer outcomes for discharge, particularly for cognitive & behavioral patients.
- Sharing of equipment, tools & kits (community teams brought their kit into the unit) for greater knowledge & experience.
- Setting up rapid access to suitable wheelchair & seating as the combined knowledge & perspectives facilitated better robust risk assessments.
- Sharing of knowledge & skills e.g. splinting, orthotic management & treatment
- Recognition that future rotational opportunities between community & in-patients would benefit patients, the organisation & wider neuro-rehabilitation pathway.
- Data collection to share with the regional agenda for transforming neuro-rehabilitation services that has paused during Covid-19, with the opportunity to influence this further.
- Identification of Covid-19 related neurological consequences/sequelae that would otherwise not be picked up.
- Video/telephone joint AHP/Consultant clinics for management of complex pain & spasticity, via access to community technology not otherwise available to acute physicians.
- Reduced patient transfer between hospital sites meant the criteria was relaxed to enable stroke patients to access the unit, making more appropriate use of the staff skills & improving the flow from the acute wards.
- Greater staff & patient satisfaction.

The remainder of the community neuro-rehabilitation team engaged with a project with the self-management service for coaching conversations & engagement with appropriate Apps with coaching support, referring patients to them after completing a comprehensive telephone or video triage to ensure the appropriateness of the referral & continuing to see patients (video/face to face) who were at risk of losing their potential for recovery if intervention was delayed. The outcome has been that all high-risk referrals have been dealt with & the waiting list has remained manageable with no-one (at this point!) having lost their potential for recovery."

Cardiac Clinical Scientist

“As a cardiac clinical scientist, my main roles are split between advanced clinical practice and teaching echocardiography to an advanced level of competency.”

Clinical and academic learning

“But now we are experienced in this sort of response and we have the experience of having to deliver the education elements in more flexible and often remote ways. It will be important to review with employers, team leaders, learners and educators to identify which aspects of the education response might be sustained for service and learner benefit; more curriculum available remotely/flexibly, reduced travel time to HEIs, more time to engage in workplace learning/contextualising academic learning in practice but also whether there are ways in which the learning experience is diminished. So, to have consensus about what still needs to be delivered in an HEI setting and what learning, teaching and supervision skills development may be required in the practice-based workforce to support this rebalancing between workplace learning and more traditional classroom-based learning.”

Clinical Scientist

“Advanced Clinical Scientist/Cardiac Physiologist I have been trained in the Scientist-led Valvular Heart Disease Clinic for surveillance of valve disease ranging from mild to severe. I am also an experienced echocardiographer.”

Community Rehabilitation Team

“I lead the community rehabilitation team, the diverse skills we have across our professions are vital for recovery and an integrated physical and mental health offer.”

Consultant Nurse

“I have been working as a consultant nurse for a number of years within intermediate care and older people’s care. The current Covid-19 pandemic created a need for my community NHS trust wto have consultant cover for all community hospitals (physical and mental health) and we do not have many medical consultants.

Therefore, I joined the consultant rota alongside my medical colleagues to provide 7-day 8-8 medical cover for the whole of Dorset community services. In addition, I was asked to provide the consultant geriatrician input to 2 additional community hospitals Monday to Friday. I am an advocate for the need for advanced practitioners to demonstrate the level of ‘expert’ in the majority of what we do and that ACPs and Consultant practitioners should be stretched. This was certainly the case for me and I experienced the feeling of being ‘stretched’ on a few occasions. Despite this I did not feel out of my depth and feel that I have grown as a consultant from my experience. I believe I have also offered a different model of consultant practice as a geriatrician to my medical colleagues and have received comments about this.”

Consultant Podiatric Surgeon redeployed to Plastic Surgery and ICU

“Our elective foot and ankle surgery service based in theatres in community hospitals was mothballed due to the pandemic. We were asked to make contact with colleagues in the acute sector to find redeployment. Numerous opportunities were offered by other teams including using our ultrasound and cannulation skills to be upskilled by anesthetic colleagues to place central lines. However, my own redeployment took two concurrent avenues: 1) assisting in plastic surgery and 2) working for (rather than in) ICU.

Plastics role has been to assist in theatres on patients with skin cancers requiring excision and reconstructions via extensive flaps and grafts. With our own experience from podiatric surgery in wound care/debridement, incision and drainage, prescribing, delivering local anesthetics, primary wound closure, ORIF, we have been able to assist the plastics fellows and ST grades to complete lists more efficiently. Role currently ongoing.

ICU role: I was included in the recruitment of 30 consultants (medical and AHP) to take on the daily phone calls to the relatives of those in ICU who were Covid-positive and were vented. This included a daily email briefing via email of all the patients in ICU and allocation of which families are on your list to call. ICU at the peak were overwhelmed with work and the delegation of the daily family update which can often be challenging, difficult and emotional, was designed to reduce the burden on ICU. Glad to have been a part of it. Role was no longer required 1/52 ago.”

Consultant Podiatrist

“I work as a Consultant Podiatrist, managing both a team of podiatrists and a MPTT with GPSI’s ESP Physios and Podiatrists. My podiatry team have been partly seconded into District nursing teams and have taken over the foot and lower leg ulcerations. They have also been doing Insulin and clexane injections when required. We have maintained critical care and as an independent prescriber; I am very busy with keeping the foot ulcerations covered for infections. We work across community, acute, mental health and ambulance and the new teams have given me excellent input into the Crisis response team also. I am fortunate to work alongside a very supportive Consultant in Diabetes and I have taken over his foot clinic with some support for the last hour of the clinic. I have also managed to have the same support from the visiting vascular consultant (we have no vascular service as we are on an island).”



Consultant Practitioner – Redeployed but not fully used

“I am a Consultant Practitioner working with acute medicine, so my role hasn’t changed during Covid and has enabled me to utilise my skills/experiences as a senior decision maker. However, I have been redeployed back to critical care where I felt my skills were not full time utilised. My background is critical care but going from working as an 8b to that of a band 5 wasn’t the most effective use of my skills.

This is the challenge that I feel ACP’s and consultant practitioners face when compared to medical colleagues and highlights the lack of understanding by organisations regarding the role of the ACP.

I think it comes back to the fundamental need to have clear organisational buy in to the ACP/consultant practitioner role. As to going to critical care that’s more complicated due to the need for experienced ICU staff. The issue was that there were staff that had left ICU more recently that were not mobilised. It just felt my role was devalued.

The barrier was lack of understanding of roles but also highlights the risks of not having a critical mass of ACPs to create a community of practice. Perhaps if we sat under medicine and not nursing this may have prevented it? I don’t think that there was anything else that I could have done differently.”

Consultant Practitioner – Broken down barriers

“The pandemic has broken down a lot of barriers, for example as a consultant practitioner I have taken the lead for the department in negotiating new pathways for PTS (Post Traumatic Stress) with various specialties which has meant a safer and better patient experience, additionally, normal barriers and challenges to expanding radiology protocols have been eased in order to provide safe efficient and clear diagnostic pathways for pts, and these have been treated as a pilot and been really effective.”



Covid roles in a large team of ACPs

- “One of our ACPs has been leading the trust resilience team for the COVID response, he had this role in his job plan but has now undertaken the role full time during the pandemic.
- ACPs have developed Covid pathways across the trust from admission to discharge.
- ACPs in cardiac surgery have been supporting critical care and have taken all non-Covid patients.
- We have moved a number of our senior ACPs into tier 2 rotas to support Covid areas and to support the hospital at night medical rota.
- Our inter-professional ACP educators have developed multiple learning resources for the trust.
- An ACP has led on the recruitment of calls to arms nurses.
- ACPs have led on the upskilling/delivery piece in critical care/ED.
- An ACP undertook scoping of the entire trust nursing workforce identifying nurses who have/could be upskilled to work in different areas.
- Setting up minor injury units off site.
- We have a number of ACPs leading on the PPE piece in their clinical areas.
- An ED ACP has been seconded into a deputy head of service role to do a rapid improvement project on team working as well as lead on the ED Covid response.
- We are grateful for the support we have had in becoming advanced practitioners, which has allowed us to develop many of the skills needed to meet the challenges of Covid-19. The overlap between expertise, education of others, and leadership would seem to place advanced practice at the heart of continuity and recovery of clinical services throughout the NHS.

We are lucky to have a Trust lead ACP who sits within corporate services and this has allowed ACPs as a group to be supported. Yes, all training is on hold (academic included), yes some trainee ACPs have been redeployed (for example where their base role was left unsupported due to medical redesign) and there is anxiety about how we are going to resume ‘normal’ ACP activity. There is, however, a sense that everyone has been looked after (physically and mentally) and patient safety has been optimised.

As qualified practitioners, my colleagues and I were moved to take a more senior lead in our neighboring department, and it was nice we were trusted to step up to do so. Other ACP colleagues have been moved to night or weekend work (where this was not their norm) to ensure services were safely covered.”

Intensive Therapy Unit (ITU)

“We supported with ICU (Intense Care Unit) consultants, two anaesthetic teams and at its height – over 12 intubations a shift on the wards. Gate keepers to HFNT / CPAP (Continuous positive airway pressure machine) / NIV to ensure, diagnose and recommend as part of an MDT (Multiply disciplinary team) approach the correct modality of support. Working with the patient and supporting the development of new ways of communicating via IT. Frequently explaining to loved ones and the patient the need for intubation and if the situation, which was often, was terminal. This was heart breaking, soul destroying. To see the fear in people’s eyes. To smile with our eyes.”

“I volunteered to go back to practice where I trained as an ICU Nurse many years ago. As course leader for our MSc ACP course I was privileged to work closely with students on the MSc ACP program. It was incredible to see ACCPs doing the work of senior clinicians at a time of crisis. They took up the challenge with enthusiasm and made it obvious to see how important the role of ACCPs are in Critical Care. How important is was to have these advanced practitioners adapting quickly to the Covid-19 conditions imposed on Critical Care. Their willingness to learn e.g. new ventilation strategies and then teach these to others was fantastic to see. The support that ACCPs provided to all professions on ICU was incredible as redeployment meant a whole range of professions needed support and ACCPs felt very at home in this new environment.”

Learning Disability Trainee Advanced Clinical Practitioner and Physiotherapist

“I am a trainee advanced clinical practitioner (ACP) and physiotherapist working in learning disabilities. Covid-19 has been challenging along with providing lots of opportunities to use the skills and knowledge gained during ACP training included in all 4 pillars: Clinical, education, leadership and research. I have not been able to use all my ACP skills however I am amazed to see the flexibility and courage of all the staff in providing the outstanding care to all service users.

We have:

- Changed to 7-day service from 5-day service in matter of few days.
- Started using technology and video consultations to do triage, assessment and reviews. It is challenging to review patients via virtual platform and not able to assess hands on. However, this has provided with an opportunity to look at the case load and review some patients and do triaging virtually. This would help in providing more person centered, effective and efficient care.
- Started virtual postural care reviews and positioning plans to manage patients safely at home.
- Started liaising with service users and their families regarding dementia care. The challenge was to discuss about advanced care planning without being face-to-face however after building a rapport it was easier.

I have completed my non-medical prescribing. I am now planning to set up virtual dementia review clinics as a quality improvement project and start using my NMP skills and knowledge to help people with dementia.

- Supported a physio student and provided an opportunity to learn during challenging times. She has now successfully completed her degree and going to start her new job to help NHS.
- Completed psychiatry audit on behalf of Prescribing Observatory for Mental Health (POMH-UK).
- Gained insight in the medications used for mental health and physical management for the people with learning disabilities.

I am very optimistic with the skills that I have gained during this challenging time will help me to improve our services and provide person centered care as qualified advanced care practitioner.”

Mental Health

“8 weeks on I find I am using many of my advanced skills. The ability to land in a new team and pick up the reins; leadership using key values in the absence of protocols/ clarity in a new and rapidly changing situation; coaching to support staff in decision making when my clinical expertise is not immediately applicable; Quality Improvement to ensure staff are engaged in monitoring for unintended consequences of changes made; networks and research skills to identify relevant information to bring to the service; courage to try new things & role model – early adopter of virtual mediums to undertake Dialectical Behavior Therapy. And – probably irritating for all around me – questioning how we are evaluating, capturing learning, considering how the future might look and who and how we work inclusively to engage the right people to determine this.”

Pharmacist Trainee – Use core skills

“Pharmacist trainee Covid-19 has certainly provided opportunities to utilise my clinical specialist background. With my pharmacist hat on, I have been able to support the team in the development of a second A&E once capacity had been met and provide advice around the safety of medicines in terms of storage and capability. I have enjoyed allowing my pharmacist role grow within in the department and has shown the potential there could be for permanent pharmacist support within the ED as there are many things that are developing within the department in which pharmacy or a pharmacist should be supporting. One such intervention is pathway for anticoagulation for our AF patients and ensuring they receive the counselling that is required.”

Podiatry prescribing

“As a Podiatrist, we qualify with the ability to buy, sell and administer medication on the POM-S and POM-A list and we undergo rigorous pharmacology training to do so. We do the same prescribing qualification as our nursing colleagues. In fact, I did mine at level 7 to ensure my practice was as robust as is possible. Despite this we have limitations imposed on our prescribing practice that our nursing colleagues do not. A full formulary should be granted to all health professionals who are registered prescribers with the appropriate qualifications. Practitioners should only prescribe medicines that are within their proven competencies. This is a professional matter, either we trust our practitioners to operate within their scope of practice and within the legal framework or we do not. It should be a matter of competence not a matter of background profession. This will ensure that patients are treated efficiently, safely and by the person most appropriate to provide them their Well put – “competence not professional background” really sums up the frustration regarding legislative barriers to a true multiprotection level of ACP.”

Primary care

“ACP paramedic primary care leadership asked by CCG and backed by LMC to drive system hot hub response areas. The ECP service mainly manage calls from residential and nursing homes however in the last week they have taken on in hours death verification. To assist in this, I am involved in an education program to upskill nurses to verify death in their nursing homes.”

Radiography

“During this crisis I have found that as consultant practitioners we have been left to deliver essential services to allow my radiology colleague to be better utilised elsewhere. The two of us have run all of the 2 week wait breast cancer clinics and the associate imaging work-up (with the exception of MRI).”

“Work in paediatric tertiary referral hospital in Interventional Radiology undertaking procedures such as vascular access. We have had a few paediatric patients with COVID but largely, our workload has remained similar. However, we had large amount of staff sickness at the beginning, leaving only 1 consultant (out of 5) still able to come to work and run lists. I became invaluable to her for a few weeks as I could independently run lists and carry out procedures whilst she fielded phone calls and zoom meetings. Unfortunately, as advanced practitioners, I think we are often undervalued, but I hope that Covid will change the way we work and our value to the rest of the team/hospital.”

“Our team of 3 reporting radiographers (2 consultant practitioners and one advanced practitioner), have been hot-reporting our ED chest X-rays, Monday to Friday 8am – 6pm, for a while now so we had no real change to our practice. However, have implemented a reduced service over the weekend to ensure minimal delay in report turnaround. We also implemented using the British Society of Thoracic Imaging’s report proforma to provide uniformity across our reports and clear classification of findings to aid referring clinicians. These reports were often available before the RT-PCR swab result so we are guiding clinicians primary diagnosis in the early stages. A recent audit of practice has been undertaken which is now being written up for publication.”

Radiology

“Our Advanced and Consultant practitioners played an integral part in triaging patient referrals currently in the system making clinical decisions. This helped with validating waiting lists. They also took on more clinical duties to free up our Radiologist workforce.”

Support and education

“Our ACP forum. I decide to plough my efforts into the forum and I have sourced a knowledge hub to facilitate our online learning. We have organised to provide webinars and meetings for our members (for free as no money from the training hub). We believe this contact is invaluable for our members (we have around 150).”

Surgical Care Practitioners – Surgery

“As lead for ANP’s and SCP’s (surgical care practitioners) required a review of their working patterns to allow extended shifts and 7 day working to support inpatient workload and POD working on other sites to support other areas. This meant reduced ANP support at spoke sites for vascular inpatient work – this has allowed consultant level review and opinions for any referrals ensuring robust transfer, investigation, treatment or discharge plans. Significant level of support was implemented as staff also required to support critical care when admissions to DCC increased. SCP’s joined together to form a 7-day rota with on call to support out of hours emergency surgery across three surgical specialties.

Again, robust communication channels established to ensure wellbeing of staff and appropriate deployment as required. Reduced junior doctor availability during Covid has allowed my ANP’s have demonstrated their worth by supporting other specialties and this has generated discussion as to how they can implement different ways of working for their own teams. There has been specific feedback from junior medical staff on the value of this ANP team during Covid-19 peak and the impact of their advanced skills and knowledge in the management of urgent and deteriorating patients in the absence of regular junior medical support.”

“The impact on surgery has perhaps been the greatest for us and has proven challenging but not surprisingly the ACPs have been amazing. The team divided and supported ICU, hospital out of hours and ED helping with RN shifts when struggling trying to staff 2 separate EDs. like every challenge its provided opportunity though for us to support the surgical trainees accessing a variety of alternatives such as time in elderly care or shadowing the med reg to facilitate confidence in dealing with medical emergencies and help build relationships. The trainee in ED has fully embraced opportunity to continue learning and hasn’t felt it negatively impacting on her training. One of the great things for the trust has been the ability to make a transition to embed ACP’s in Hospital out of hours now which is something we had been reviewing. Some of the ACPs have supported and really found it rewarding whereas previously there was a skepticism and anxiety about it.”

Trainee ACP – Training others

“I currently work as a trainee advanced clinical practitioner in acute medicine and emergency care. I was redeployed to the emergency department in my previous role as head of resuscitation for my advanced life support skills and as part of my ODP role for airway management support. I supported the emergency department team with advanced life support in Covid cardiac arrest.

It was fantastic that as practitioners we were able to support the emergency department during this unprecedented time and I learnt skills from the nursing team which I can take with me back to my Advanced Practice role which was fantastic.”

Trainee ACP

“She became an excellent educator to redeployed staff working in that area- something she would never have thought she would need to do so extensively.

When on shift staff frequently looked to her to provide leadership in unfamiliar, unprecedented and scary times, and she expertly provided this with clear and supportive instructions and decisions.

In coffee room debates about ‘what’s new about Covid-19’ she often was able to refer to an evidence base to support what she was saying, to dispel myths and propose areas that still were uncertain, and would likely feature in future research or evidence to come out of this time.

So it struck me that she was so focused on the clinical competencies and so nervous about getting these right, worried about missing out on opportunities to practice and be assessed in them under ‘normal’ circumstances she was perhaps missing how she was brilliantly demonstrating what it means to be the true embodiment of an ACP!”



Challenges faced due to Covid-19

Advanced Nurse Practitioner – Primary Care

“We were asked to work weekends which I feel has helped both with the management of the patients avoiding unnecessary escalation back to the acute hospital and the leadership with the nursing team. During the three week period of not having a GP and dealing with very sick patients has really helped develop my confidence as an Advanced Nurse Practitioner and has made me really think about what nurses offer in these roles and how community hospitals could be nurse lead with input and support from a consultant. The only issues that have been faced is with requesting radiology, I am allowed to request x-ray’s but not ultrasounds and when I questioned this, I was told this was due to it being a more in-depth test. I have since asked and challenged whether this could be looked at for the future.

From an organisation perspective because we were having Covid positive patients we were told that we were not allowed to go various places in the hospital, not allowed to request x-rays as they were a clean site but from a mental and physical wellbeing view; I felt that we were infected ourselves even though we were the ones treating the patients. Line managers never came to the ward to support the staff we just got on and did it. Now having some time to reflect I’m not sure if the ward was the end of life ward how different my mental health would have been affected. I really please that most of the patients have come through there diagnoses of Covid and gone home, business as usual for the ward just under very different circumstances. The biggest challenged which I feel has not had a good outcome for the patients is the continuous moving of them into different bays due to who is infected etc. This could not of been helped as we were learning as we were going along and this has now slowed down but it seemed every day patients were in a different bed which is not great for the patients with dementia.

I definitely feel that my knowledge as skills has been used to the max during this period and I have learnt so much more about the management of different conditions and the management of older people. For my own development it has identified that I would like to go and spend some time in the acute hospitals developing my acute skills of my role as I have never worked in an acute hospital setting. It has also highlight further how advanced practice has developed and can develop further if allowed and what a great job we do as clinicians at keeping vulnerable patients safe during a very difficult time.”

Lost opportunity

“Initially there was a lot of anxiety as the situation evolved. We were not involved in any prior strategic/ educational needs planning for this and in my opinion, it was a real opportunity lost to prepare and when needed support to our junior colleagues. As a result, when we were confronted with Covid we were totally unprepared, and this only added to the stress. I had to feel my way through things at the beginning and lacked clear direction. Much of the decisions were made remotely and dissemination of plans was done in a scatter gun manner. From poor PPE guidance, how to cohort and whom, swabbing and transport of specimens. I never seem to have a clear handle on this planning.

I quickly became exhausted as for a period alone due to illness. As I was autonomous and able to do DNACPR and prescribe was good for the patient. However, I feel pigeon holed as a junior doctor of sorts when instead I could have been used more resourcefully to help with planning and staff training.”

Prescribing

“From a profession specific perspective, the inability to prescribe controlled drugs as a paramedic has added complexity and limited my efficacy in providing complete and timely care, particularly to my palliative patients.

Not pin it down too far whilst I feel that we, as AHPs, need to ultimately move to standardise our nomenclature, scopes of practice and means of working, from a short term perspective I think the variety of service provision displayed within this thread shows the true nature of the ACP role and its ability to be used flexibly to drive progression and innovation.”

“There needs to be full equality, whereby an independent prescribing qualification entitles prescription of the same ranges of drugs with the same restrictions for all, regardless of underlying profession. Until then, paramedics and physios in particular will be held back in advanced practice roles compared to nurses.

Therefore, promoting a code of conduct and standards of practice, promoting and “protecting” the title of the advanced clinical practitioner, recognises that standard of professional under that multidisciplinary body is registered and entitled to independently Prescribe under the protected title.”



Improvements on reflection, due to Covid-19

ACP – New Roles

“The decision was then made to move myself and fellow ACPs from our medical assessment unit (where we had been for almost 3 years) to our ambulatory care department to support the presence of senior decision makers. This role was entirely new to us as a group as we found ourselves working without direct consultant or registrar support which, whilst scary at first, has really challenged us to fully utilise the skills we have developed over the last 5 years. I personally feel I have stepped up to provide a service in this critical time. I feel we have potentially changed the way in which we work once we de-escalate the COVID response. I think a lot will change and we will have a key part within our service. I think we have demonstrated the use of ACPs in our service and the wider organisation.”

Advanced Dietitian

“Only just stepping into the realms of advance clinical practice pre-Covid, my development has all taken a bit of a sidestep. However, this experience has offered me personal and professional growth that I did not foresee. As an advanced dietitian I have stepped back into my critical care clinical role but focused on training others and facilitating learning of acute care but very much nutritional rehabilitation. I have had the opportunity to use the post-ICU nutrition research I did to network on rehabilitation aspects within my profession nationally, but also regionally and locally within AHP/MDT forums. This is also currently informing possible further work in collaboration with a higher education institution on nutritional recovery. In my current interim leadership role, I have had to forecast with little guidance to hand, look at adapting working to much more proactive ways, adjusting work patterns, working through supply problems, and using technology clinically and operationally. It has been a fast pace of change and adapt but leading a team that embraced this as an opportunity has been a great experience through which everyone has grown to feel confident and equipped for any future pandemic.”

Advanced Practice Orthotist – Not needed on the front line

“As an Advanced Practice Orthotist, I was not needed on the front line.

Frustrated and really really concerned for our patients my team and I got our thinking caps on. We weren't really needed for covid-19 response, but we had patients who were non-urgent we might be able to help.

Could we work smarter and help non-urgent orthotic patients?

The short version is my team and I challenged each other and came up with a plan. Telephone reviews etc are easy. As a team we believed we might be able to virtually assess and treat some new patients. We bounced ideas around, looked at evidence and drew up some protocols.

After testing the idea, I approached my professional body and formed a working group. In a week we agreed national guidelines for virtual assessment based on a lot of the work we were already doing, we have had more compliments and thanks by working virtually and differently than we normally get. In fact, we are slightly overwhelmed by our patient's gratitude. Its inspiring.’

In the face of Covid-19, we couldn't help Acute Covid -19 patients, but we figured out how to work safely and smarter. Our waiting lists are reducing, and we are only seeing extremely urgent face to face patients

Why didn't we do this before?”

Advanced Practitioner – Mental Health

“This was a service which previously had two psychiatrists, in early May 2020 one psychiatrist left the Trust, a planned departure to find work elsewhere. In my role of advanced practitioner, I have been supporting the team with initial assessments, diagnosis, prescribing, medication reviews, embedding research and policy into working practices, teaching and education amongst the team, leadership, and support for senior colleagues. Additionally, the findings of this trial have been incredibly successful, excellent patient satisfaction, increased access to medication, decreased waiting times, positive feedback from psychiatrist colleague about support to the team, positive feedback from managers within the Trust, positive feedback from clinicians within the team. A very safe, effective, means of working with high satisfaction and increased leadership with considerable financial savings using flexibility to redistribute the workload, empower staff and embed new ways of working into the service. I strongly hope that aspects of this model can remain moving forwards and can be used to shape future workforce plans to meet the predicted increase in demand for mental health services.”

Move to logistics

“Advanced Practitioner in emergency care I have seen my role change considerably, moving from one that was mainly clinical to a role that was far more managerial, and logistics based. Also, a large portion of my time was used to teach junior staff both nursing and medical in readiness for Covid. This has gradually rebalanced but has allow me to develop my role and consider all 4 pillars.”

Advanced Practitioner Virtual Fracture Clinic – Increased efficiency

“I work as an AP (Assistant Practitioner) in virtual fracture clinic and fracture clinic in a well-established service which is generally very open to different ways of working and has integrated AP roles fully. We are very used to successfully reducing new patient face to face contacts by offered telephone appointments for 25% of referrals. We currently provide a service on a block contract, so any efficiencies benefit the provider.

The barriers to video calls (which we have been working towards) have been magically broken down by Covid as our Trust attempts to prioritise resources to minimise face to face contacts.

Since Covid our AP team have also been screening patients due follow up fracture clinic appointments and delivering telephone consultations. This has resulted in 25-50% patients having a telephone consultation with half of those telephone consultations resulting in patients being discharged and happy with their outcomes. It has made us really question our care pathways and why we review certain patient groups at certain time frames.

Even in a forward-thinking service there is an element of paternalistic care. In addition, having trainee medics working in clinic inevitably results in some patients being followed up unnecessarily.

We ask ourselves going forward, should APs schedule telephone follow-up clinics as well as face to face fracture clinic follow up clinics. And should we screen more clinics to identify patients who might prefer and benefit from a telephone consultation. There are great socioeconomic benefits to patients and referrers to reduce face to face contacts even without Covid as a driver but tariffs often act as a deterrent to services developing along these lines as there is generally a lower tariff for a telephone appointment than a face to face appointment. An additional consideration is work satisfaction and training opportunities. As clinicians we like face to face contacts and prefer this interface that makes therapeutic communication easier and offers better teaching opportunities. Essentially, we need to provide a patient centered service without making our working lives less satisfying or restricting training for future APs. These areas need deep reflection and research. My experience is once changes are made and there is a cost benefit it is hard to unmake them.”

Diversification of workload in primary care

“We focused on wellbeing, especially around LTC such as rheumatology patients and frailty. Wellbeing calls have been routinely made to the mentioned groups and have been successful in picking up on stoical patients who have had the need to have a consultation but were afraid to ‘bother’ general practice but sit out the pandemic first. Was able to make sure that they had the relevant virtual rehabilitation tools and able to signpost where relevant to services needed, especially around frailty which will have prevented falls. Many mental health issues – anxiety and depression were identified and managed appropriately with signposting.

Working more closely with the MDT, improved communication case managing patients multi-professionally to ensure that they were seen when appropriate and to put together a package of care and get it right first time preventing multiple phone call/unnecessary visits/preventing future problems.”

Emergency Department

“Clinically, the focus has shifted enormously but it is heartwarming to see that advanced practice has been pivotal in this change in our ED, we have been consulted and our opinion valued as we progress through this pandemic. It is refreshing to see that the NHS can still function and function well with the loss of some of the red tape that usually makes change very difficult to manage.”

“The ACP team in ED has really come into its own over this period. We have established ourselves as a valued, stable workforce able to cover all aspects of the department. We have all brought different skills which we can continue to develop and strengthen within emergency medicine.”

End of life care

“Clinically this role pushed the boundaries further for me in terms of symptom control management at the end of life, where within frailty I am often more involved in making and putting together the patient personal advanced care plan.

My time in palliative care have meant that both frailty and palliative care teams are now going to look at how we can work more jointly going into the future.”

Need formal recognition of roles

“The lack of an ACP registration meant that the organisation’s natural panic response was to pull everyone back to their base registration basic role i.e all nurses will nurse, all physios will physio etc. This created a surplus of staff in the wrong areas, not utilising their skills well. We have an ACP lead and overall the ACP workforce was maintained where it needed to be but not without some fight.”

Newly qualified ACP – Inequity

“I am a newly qualified ACP and therefore my practice continues to be supervised by a member of the medical team in which I work. I do ward rounds with the consultant and the rest of the team on a daily basis. I have used the ACP training to assess, diagnose and manage numerous respiratory conditions e.g. Covid-19, hospital/community acquired pneumonias, aspirational pneumonia, pulmonary embolisms etc. I’ve also used the ACP training to assess, diagnose and/or manage multiple abdominal and neurological presentations from pseudo obstruction to neuro syphilis. My Previous Podiatry experience reinforced with the holistic understanding brought about by the ACP training, meant that I also was able to diagnose staph bacteremia, erythroderma, acute limb ischemia with mesenteric ischemia – requiring urgent thrombectomy, advancing osteomyelitis – requiring urgent amputation, an NSTEMI and an episode of undiagnosed paroxysmal AF. I have provided multiple A-E assessments of deteriorating patients and initiated immediate treatment or investigation. I have cannulated, performed venipuncture, done arterial blood gasses, catheterised, washed and cleaned patients, reviewed diabetic meds and CBGs, managed hypo/hyperglycemia and even hung IVs or given out meds in order to help the overstretched nursing staff. I’ve had tracheostomy management and NG tube insertion training. I am able to request x-rays, CTs and ultrasound scans meaning that I have been able to facilitate appropriate investigations for our patients in a timely manner. I’ve utilised my wound care skills to manage pressure sores, ischemic wounds and diabetic ulceration. I’ve used my MSK knowledge to help position, prone and mobilise patients. I’ve also helped run the lower limb MDT outpatient clinic once a week. As a newly qualified ACP I feel that this has been a baptism of fire which, has catapulted my skills in a way that was supervised and safe. I have worked within my new scope of practice but at a highly advanced level.

The main challenge has been the rapid deterioration seen in these patients which, has been mentally exhausting. It also brought about one of the great privileges that being a health care professional can afford and that is providing comfort and reassurance to those in the last days, hours or minutes of their life. I have helped assess and manage agitation in the end of life patient, advocating for them and ensuring a dignified passing. The sheer number of patients who died was overwhelming at times, but we ensured that as a team we checked in on each other, supported each other and the professional relationships we’ve developed as a result are incredible.

Another challenge is that ACPs from AHP backgrounds still aren’t ubiquitously accepted as being able to do the ACP role in general or acute medicine. Despite the multiple key transferable skills, we possess there continues to be resistance, skepticism and apprehension. I have been a prescriber for about 5 years and there remains contention as to what I can and cannot have on my p-formulary. There remain restrictions on my prescribing with regards to being able to prescribe controlled drugs, despite being competent in the assessment and management of the conditions requiring the emergency administration of these. I feel that an annotation to the HCPC register or a separate accreditation would help support understanding and improve public confidence. The limitations around prescribing need addressing and parity with our nursing colleagues is essential.”

Lack of understanding of the full breadth of skills

“It certainly felt that the trust did not understand the breadth of skills and experience they had in their ACP workforce.

Most of our ACP were redeployed to work in a band 5 role as they were ‘manpower’. All the training and experience, breaking down barriers we have achieved went out the window, a lot of ACP felt degraded by recognition, facilitation and empowerment of your role within your organisation. Having a clear job description, line of supervision and leadership to support you and the autonomy to work as an ACP would be a far more effective way of overcoming these barriers.”

Radiography

“Work in pediatric tertiary referral hospital in Interventional Radiology undertaking procedures such as vascular access. We have had a few pediatric patients with COVID but largely, our workload has remained similar. However, we had large amount of staff sickness at the beginning, leaving only 1 consultant (out of 5) still able to come to work and run lists. I became invaluable to her for a few weeks as I could independently run lists and carry out procedures whilst she fielded phone calls and zoom meetings. Unfortunately, as advanced practitioners, I think we are often undervalued, but I hope that Covid will change the way we work and our value to the rest of the team/hospital.”

Shielding

“I feel cared for by my department; however, I personally feel like I have failed my team. They have invested time on helping me develop my advanced clinical skills many of which are transferable and would be used in this crisis and I’m at home.”

“Since Covid-19 I was designated home working as I had to medically shield, so I was transitioned into active telephone and queue triage for new and f/up in my specialty, as well as being linked to the acute eye casualty triage to triage A&E and in patient referrals to correct specialty. Allowed me to use my advanced practice skills and knowledge in different manner, and also work alongside my medical colleagues to priorities those px in f/up queue. Big change for a clinical orthoptist who normally works on wards and in acute clinic seeing px with neuro disorders as well as specialty paed.”

Support to staff

“The use of electronic devices to facilitate communication between our patients and their loved ones have also been utilised regularly, this has been especially demanding and distressing at times but an essential part of our role. We have been lucky enough to have access to psychological support, if required. A service which is probably not replicated everywhere, we are definitely privileged to have access to this team.

The first wave has been a massive learning curve for myself and all members of our team. We are having regular debriefs in order to use our experiences to celebrate our success and make improvements where required.

I am trying to look upon this global pandemic as a massive opportunity, I hope to become a better practitioner, a better communicator and a better teammate. My resilience, resolve and psychological strength is being tested everyday, but I am surrounded by an amazing family and team who provide me with love and support.”

Trainee ACP – Worry that I’ll lose momentum

Trainee ACP, year 3 in an acute surgical specialty.

“I’ve been redeployed back to my previous work place in ICU as a staff nurse and the plans for me to stay there until the end of July will mean I will have been out of my trainee environment for 5 months with no opportunity for training or supervision in advanced practice.

Study time is cancelled and with 3 children at home, coupled with the exhaustion from working full time hours in full PPE, finishing my dissertation or completing any home study to complete competencies is impossible. Various logistical problems will mean that qualifying will now be 1 year later. I’m worried that I lose momentum and the will to finish the training altogether.”