AILLEURS

Development of advanced clinical practice in England: historical origins and future perspectives

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The aim of this article is to provide an overview of Advanced Clinical Practice (ACP) in England through looking at its historical developments, the education requirements and training provisions, practitioner's experiences and the challenges, present and futures faced by a diverse group of professionals.

Historical perspective/background

Early attempts to modernise nursing in England were initiated by Florence Nightingale, who sought to raise nursing standards by formulating the first school of nursing in 1860 at St Thomas's Hospital in London on her return from the Crimean War *[1, 2]*. Prior to formalised

Box

Nursing in England: some context[1]

- **Core qualification: 3-years degree: mix of academic modules at university and on-site clinical placements:**
  - **the academic modules are evaluated through formal exams, essay writing and simulated practice that are informed by research leading to a Bachelor of Science (BSc) in nursing;**
  - **placements require the completion of practice assessment documents leading to the professional registration with the Nursing and Midwifery Council (NMC).**
- **This training opens the way to further academic and clinical training at post-graduate levels (post-graduate diplomas, MSc, PhDs) to specialise, acquire deeper clinical and managerial skills and to progress to senior position such as specialist nurses or advanced clinical practitioners.**
- **A shorter 18-months training program exists at post-graduate level for applicants holding a prior BSc degree (in other disciplines) and therefore already considered academically proficient.**
- **Nurses specialise in their 3rd year of training in adult, paediatric, mental health or learning difficulties and are equipped with the knowledge and skills to care for these specific populations.**
- **Nurses and midwives are governed by the NMC to which yearly registration is compulsory and who holds an up-to-date register of professionals allowed to practice in the country. This register is available online and the public can access it at any time.**
- **Three yearly revalidation is required for nurses to remain on the register and evidence of continuous professional development combined with sufficient working hours are provided with critical reflection on their practice and on patients and colleagues' feedback.**
- **Allied healthcare professionals are organised through a structured hierarchy with banding and yearly reviews. Each increment is often attained through further education and training and is rewarded by more responsibility and an increase in pay. The strong connection between academic and theoretical knowledge combined with practical clinical training provides a firm foundation for advance practice to be built on.**

[1] Pre-registration and professional NMC standards governing nurses practices can be found: https://www.nmc.org.uk/standards/standards-for-nurses/

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training, nursing work consisted mainly of domestic duties that were increasingly delivered by working class women for monetary gain who did not require any qualifications *[2]*. Nursing schools applied an apprenticeship model and expanded in the United Kingdom and nursing became regulated in 1919 *[3]*. In the 1980s, a move to professionalise nursing required that nurse education became more theoretical based and that the level of training of nurses should be commensurate with other professional groups. Consequently, nurse education moved into Higher Education Institutions (HEIs) and all educational preparation is now at degree level and is underpinned by the Nursing and Midwifery Council (NMC) pre-registration educational standards *(box) [4]*.

The scope of nursing practice has expanded significantly over the years in response to service demands and medical staff shortages that has required enhanced knowledge and critical decision making skills when dealing with clinical complexities. There is a need for governance as currently there are more than 595 different nursing roles where the title 'Advanced' is used *[5]*. In addition, it is recognised that a wide range of healthcare professionals are working at an advanced level and there is need for better collaboration and a multi-professional approach towards the education and standardisation of ACP *(table I)*.

Table I. Multi-professional approach of advanced clinical practice.

Professionals entering advanced practice
• Nursing • Pharmacy • Therapeutic and diagnostic radiography • Physiotherapy • Paramedics • Speech and language therapy • Dietetics • Occupational health

Advanced Clinical Practice Education

Advanced clinical practitioners are a professional group that has emerged out of several different regulated healthcare professions such as nurses, physiotherapists, radiographers, pharmacists, speech and language therapists and other allied healthcare professionals. This workforce transformation in the National Health Service (NHS) in England allows new ways of working that enable experienced practitioners to optimise their skills to promote the well-being of communities and provide personalised care. In the interest of safety, quality and effectiveness, Health Education England (HEE) has produced a multi-professional ACP framework where educational programmes delivered by HEIs are designed to consistently reflect the 4 pillars of ACP: clinical, leadership and management, education and research. ACP is defined by HEE *[6]* as: '[…] delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence'.

Advanced clinical practice programme at City, University of London

City, University of London's MSc Advanced Clinical Practice is a multi-disciplinary course delivered through the apprenticeship and non-apprenticeship funded route. Our innovative programme prepares students to become competent ACPs by developing their core capabilities and speciality-specific competencies across the 4 pillars in HEE *[6]* multi-professional framework. Our programme has been designed in consultation with ACPs, academics, employers and patients, and the modules are taught collaboratively by expert clinicians and academics with a strong presence of public involvement. The core modules (Professional portfolio, Professional Leadership, Advanced Clinical Assessment & Diagnostic Reasoning Across the Lifespan, Research methods, Leading and Evaluating Learning in Healthcare Practice, and Dissertation) are taken over 3 years. In addition, students can choose independent prescribing or elective modules to contextualise their learning in accordance with their service needs and speciality. The end point assessment is required by the apprenticeship route. An example of how the programme is structured is demonstrated in *table II*.

The university has a long history of direct, positive impact on healthcare services in England and has

equipped healthcare practitioners with the knowledge and skills at an advanced level who deliver a high standard of care in settings such as urgent treatment centres, accident and emergency departments, general practice, rapid response services and rehabilitation units.

Two advanced clinical practitioners reflect on their journey

Dr Gemma Hurley, ACP in general practice

"I have worked in primary care as an Advanced Nurse Practitioner (ANP) (a kind of ACP) across the country for the past 22 years serving diverse population groups and I continue to maintain my clinical capabilities working in general practice. For example, I have worked in Edinburgh and the East End of London providing health care needs for individuals who are socially deprived and experience complex health care problems. My advanced clinical skills in diagnostics and health assessment combined with my critical stance to advanced clinical reasoning mean I work autonomously to provide patient-centred care using sound professional judgement that is underpinned by evidence based practice. I am an independent nurse prescriber that has added benefits for patients in providing a holistic and comprehensive care management plan. My clinical responsibilities include patient's history taking, advanced physical health assessment skills and its interpretation, ordering of relevant investigative tests, referring to various clinical pathways such as cardiology, musculoskeletal units and mental health services and providing patient reviews through collaborative multi-disciplinary working. I have maintained my registration with the NMC and my knowledge, skills and behaviour are underpinned by the NMC's standards for practice and professional Code. As the associate professor in ACP at City, the leadership and management, education and research capabilities are integrated in my role and responsibilities."

Dr Enrique Castro-Sánchez, a 20-year arc in human immunodeficiency virus (HIV) care

"Advanced clinical practice in the UK has experienced a dramatic progress in the last 2 decades, in alignment with the advances seen worldwide. In 2004, I was appointed as a trainee specialist HIV nurse, a precursor role to ACPs in HIV, at a large central London NHS clinic, aiming to translate models of care present in the United States and Canada *[7]*. There was a need to care for an increasing cohort of patients which, thanks to emerging treatments, had a life expectancy close to those without HIV. Such increased survival, whilst a terrific success, challenged HIV services which forecasted a doubling and tripling in patient demand for appointments. Additionally, patients' needs were also more predictable, with the focus of attention shifting towards therapy and psychosocial support, promotion of self-care behaviours, and management of treatment side effects.

As a very niche post compared to more established ACP roles, the foundational work was tailored to the needs of the patients seen at the centre, the human resources and expertise available, and the structures already in place. Paired with a medical consultant as clinical supervisor, we defined the characteristics of patients suitable for ACP management (i.e. those well and stable, on or off therapy, etc.), the focus of the consultation (the whole person, although we did not use any theoretical model), and the consultation struc-

Table II. Structure of advanced clinical practice programme at City, University of London.

Phase 1	Credits	Award	
APM Professional Leadership	15		
APM Period 2 Advanced Clinical Assessment & Diagnostic Reasoning Across the Lifespan	30		
HRM020 - PRD1 15 (Research methods) pillar	15		15 credits
Total credits end year 1	*60*		Professional portfolio
Phase 2			To complete portfolio by year 2
Independent and Supplementary Non-Medical Prescribing (v300)(30 credits) or Electives	30		
APM058 Leading and Evaluating Learning in Healthcare Pratice (15 credits)	15		
Total credits end year 2	*45*		
Final Phase			
Dissertation APM056	45	MSc Advanced Clinical Pratice Apprenticephip route (185 credits)	
End Point Assessment APM057	20		

ture as a 'One Stop Shop' model, where as many if not all needs, both acute and routine, were addressed *[8]*. Therefore, in a typical appointment, serologies were taken, treatment adherence evaluated, head-to-toe physical assessment and diagnosis of carried out, sexually transmitted infections screened, and managed, primary care interventions implemented (for example: smoking cessation, recreational drug use, weight and exercise, etc.), HIV and other medicines prescribed, and referrals and communication to other professionals made.

In addition to the clinical work, as we gained experience, HIV ACPs also engaged, in what clearly were the other pillars of advanced practice, in research and service evaluation aiming at developing services and roles *[9]*. We were presenting at national and international conferences, as well as starting to write academic peer reviewed manuscripts. In terms of postgraduate education, whilst there were university modules for nurses in HIV, there was however no programme aimed at the emerging ACP nurses, so we fostered relations with relevant higher education institutions, developing and delivering teaching materials. Finally, as clinical leaders, we contributed to internal and external committees as well as collaborated and influenced scientific societies, providing a visibility about what the role could be, if the right conditions and mindsets were afforded and encouraged. If must be said, the support provided by medical colleagues, other nurses and health and social care professionals was exceptional, and patients were understanding towards the role's benefits and limitations.

> **The university has a long history of direct, positive impact on healthcare services in England**

Almost 20 years later, due to a gap at a research-intensive institution, I returned to lecture at an ACP programme at City University. The maturity and consolidation of the ACP structures at national level, and at the university, were undoubted. I was responsible for the leadership module and the end point assessment for apprentice ACPs and was delighted to see the range of fields in which ACPs were based, together with the scope of their research ideas and their vision of where the role could get to. It was fantastic to see how natural the ACP role fitted into the views of many undergraduate and postgraduate nurses as a possible step in their careers. And both locally and nationally, advanced practice was supported by national networks of advanced practice educators, a newly launched national centre for advanced practice, and the very essence of advanced practice had been strengthened by the inclusion of other professionals such as pharmacists, or paramedics."

Growing opportunities, emerging and remaining challenges

However, leading some communities of practice for ACPs in London, we could still see some of the unmet needs and gaps which remained, together with structural challenges and sources of frustration for some of the attendees. The very fact that some organisations were interested in funding communities of practice highlighted that need for support in addition to (or perhaps, away from) clinical supervision *[10]*. For example, the focus of the role is firmly placed on the 'clinical' elements, and there could be little discussion about the clinical pillar as the main remit for these professionals. However, there is uncertainty about where, and how, to progress other pillars. In terms of research and quality improvement, the emergence in the UK of 'clinical academic' posts which combine clinical and research time in a substantive manner demand that ACPs consider their fit in view of their need to demonstrate practice in all 4 pillars *[11]*.

Further, there are challenges regarding the 'on the ground' training and education of ACPs. Even if ACPs may perform certain tasks, assume certain decisions, or provide care which is equivalent to that provided by other professionals, they are not however these other professionals, and they are bound by other codes of practice, education traditions and paradigms. Whilst long ago nurse practitioners were defined as 'not minimedics, but maxinurses', they are often seen

as a replacement for medical practitioners *[12]*. The differences between professional groups are telling, particularly in management of uncertainty or complexity, the essence of advanced practice *[6]*. At this point in the ACP journey, it may be pertinent to reflect about who should be providing support to ACPs in their development, i.e. other ACPs (clearly, if available), or medical professionals as typically seen now. It may also be appropriate to reflect upon any evidence on the best way to manage, if not individual ACPs, the emerging teams composed solely of advanced clinical practitioners. Would it be enough, or appropriate, for them to continue being managed or supervised by 'non-ACPs'?

Finally, ACPs need to lead the way regarding the production of evidence about the impact of their role, if not on clinical processes and outcomes, on the health service and systems at large. Again, limiting any evaluation of ACP roles to the clinical domain seems wasteful. However, the challenges around understanding what 'impact' may have ACPs, and for whom (i.e. patients, other professionals, ACPs themselves, policymakers, the wider society) demand further reflection about the role itself, and particularly the views of those funding, and conducting, the posts.

Conclusion

ACP in England has developed greatly in the past 2 decades with each professional tailoring their training to the need of the population(s) they care for. As it developed its presence in the healthcare environment and broaden its scope of practice, guidelines and frameworks have been published to harmonize the training required and ground a vast array of practices and professionals into a common framework. These common values and the regulations being put in place, might give grounds to the title "ACP" being registered and protected in the future. This 'modern era' of ACP in the England suggests a brilliant and successful experience and future. There is still a need however to recognize that the burgeoning of opportunities and formal structures, together with support mechanisms, are experienced by the practitioners' side by side with challenges about how the role is developed or progressed. Such recognition could prove to be vital for other countries and health care systems intending or starting to consider advanced clinical roles. ■

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