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# Evaluation of the Advanced Practitioner Roles

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REPORT 465

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# Executive Summary

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In February 2008 Skills for Health, in partnership with NHS West Midlands, commissioned the Institute for Employment Studies to undertake a national evaluation of five Advanced Practitioner roles introduced under the New Practitioner Programme. The research involved a review to identify appropriate measures to use in the evaluation; a survey of sites at which Advanced Practitioners were employed and, for comparison, a similar survey of sites without these roles; and case studies of implementation sites. Although great care had been taken in designing the survey documents, there was a low response rate, therefore the data from the survey should be treated with caution. The report is based on a combination of evidence gained through the survey and richer qualitative data gathered during the four case study visits.

## Main findings

### The organisational impact

#### Impact on work practices

In the majority of trusts Advanced Practitioners were running separate or parallel sessions to consultants and in some they manage their own caseload. Where Advanced Practitioners were responsible for separate sessions these were either additional sessions to those run by medical staff or in some cases replaced medical personnel, enabling medical practitioners to undertake other activities or concentrate on more complex cases. In some sites however Advanced Practitioners were restricted in the tasks they could undertake through lack of support from consultants.

## Service benefits

The impact on work practices was widely believed to have brought improved service delivery. The benefits cited included reduced length of stay, improved patient care, reduced costs, a more efficient service and improved patient and staff satisfaction. However, because of the relative newness of the roles trusts had few data to support these claims.

## Junior doctors' hours

The single most common reason cited for introducing the Advanced Practitioner posts was to support the reduction in junior doctors' hours, and the survey responses and the case study interviews showed that the roles were having the desired effect. Two trusts provided data indicating that junior doctors' hours had reduced since the Advanced Practitioner posts had been introduced; however, without the comparison data from non-Advanced Practitioner sites it is not possible to draw conclusions from this, as it is likely that all trusts are seeking ways to reduce Junior Doctors' hours.

## Opting in to the Advanced Practitioner Programme

### Getting involved

The majority of the Advanced Practitioner sites had introduced the posts as a way of helping them meet the target of reducing junior doctors' hours. The other main reason cited for introducing the posts was to encourage inter-professional working. Survey respondents also mentioned specific service needs and service redesign to meet access and financial targets.

### Decision-making and leadership

The survey indicated that a senior individual – typically a clinical or nursing director or a consultant – had led the process in most places. The case studies confirmed that it was typically one inspired and committed individual who had spearheaded the development process, and where these individuals had left the project had often lost momentum.

At no site had an HR representative been involved in leading the process and where they were involved, it was typically in a specific advisory capacity. There was also little evidence of HR involvement in embedding the posts or in workforce planning to incorporate the posts.

## Consultation on and development of the AP role

At eight of the Advanced Practitioner sites there had been an internal consultation process. The people most often consulted were medical colleagues, senior managers and executive directors, senior nurses and other senior medical staff. Around half had consulted education and training providers.

Similar individuals were involved in the development programme. In only one case was there any HR involvement and that was restricted to advising on employment-related issues (eg contracts and terms and conditions).

## Business and commissioning plans

Only three of the twelve sites that responded had incorporated development and introduction of the Advanced Practitioner roles into their business plan. Just four had incorporated education and training for these roles into their commissioning plans, which has implications for sustainability.

## Communications

The majority of sites had not followed Department for Health (DH) Good Practice Guidance on communicating the new roles within trusts. A minority of the sites had a communications strategy for the Advanced Practitioner posts although most reported having used a range of communication methods to promote the new roles. In two-thirds of sites team meetings had been used to explain the roles. Only five of the twelve trusts reported having appointed a local champion to promote and coordinate introduction of the role.

## Identifying success criteria

Only four sites had identified criteria against which the success of the programme could be judged. Only two sites had planned any assessment and in one of these there was now little interest in auditing the project. In two of the case study sites Advanced Practitioners were becoming involved in auditing the impact of their work.

## Recruiting and developing Advanced Practitioners

### Recruitment

Nine of the sites had limited their recruitment to internal applicants, either through open internal advertising or targeted internal advertising, while three had advertised the posts externally.

A majority of trusts had specified minimum prior qualification levels for potential Advanced Practitioners, with most indicating they required degree-level – or equivalent – individuals. One scheme had tested the recruitment of science graduates (that is, personnel with no previous experience of providing direct healthcare). Although this had been an option for all of the development sites only one of the case study sites had tested this recruitment model, where it was found to have been very successful.

## **Training for the posts**

At the majority of sites the Advanced Practitioners had completed their training and no others were currently being trained. Only two sites reported trainees leaving before the end of the training period, and two sites had trainees still in training. Training was supplemented in most of the sites by mentoring provided in the main by senior clinicians or consultants.

## **Accessibility of the training**

Most Advanced Practitioners were trained through programmes developed as part of the pilot. In some cases this was inconvenient, with individuals having to undertake week-long block training far from their home and employment.

In one case, the training programme was delivered electronically, with supporting tutorials from clinicians. This had been very well received by the trainees, who had recommended the training modules to other staff members, such as SHOs.

## **Employment**

The majority of Advanced Practitioners remained in post at the sites that had provided their training. Some however had moved on since completing training, often to advance their careers. In some cases individuals had moved into Advanced Practitioner posts on higher pay grades at other organisations (one training site had lost both its Advanced Practitioners almost immediately following completion of their training), or had moved into more senior/managerial positions in the NHS. Others had taken up places at medical school.

## **Career options**

All the Advanced Practitioners were enthusiastic and positive about the roles. However, they noted that options for further career progression appear limited. Many were focusing on developing within the role to create a niche position for themselves. As the roles are relatively new there is no clear career pathway at present other than moving into management positions or, potentially, other types



of work such as academic or research posts, although no interviewees identified these as potential routes.

In addition, there are few opportunities for Advanced Practitioners to engage in Continuing Professional Development (CPD). Advanced Practitioners are not state registered posts and this means that there are currently no professional requirements regarding minimum levels of CPD as there are, for example, for nurses. In addition, the failure to incorporate the posts into the business and commissioning plans of trusts means that in many cases money had not been allocated for continuing professional development for this staff group.

## **Sustainability of the training**

The training for Advanced Practitioners had been costly during the pilot phase as it was specifically developed for relatively small numbers of trainees. There had been no attempt to identify areas of commonality, either between training for different groups of Advanced Practitioners or between training for Advanced Practitioners and for other staff groups. The case study interviews identified a number of areas of overlap that could be the basis for more economical delivery of future training for Advanced Practitioners. In addition, a distance learning programme delivered electronically had been extremely well received, and again constitutes a possible way of delivering training more cost-effectively in future.

## **Sustainability of the posts**

Most sites were not intending to commission further Advanced Practitioner posts, but at the two sites where more roles were planned, these were the same type of role already used. At one case study site a consultant wanted to begin training more Advanced Practitioners but was having difficulty gaining agreement at trust level.

## **The barriers**

### **Clarity of the role**

There continues to be a widespread lack of clarity about, and understanding of, the Advanced Practitioner roles. As a result, some colleagues feared the role would encroach on their areas of professional responsibility. The majority of trusts had had no real communication plan and only a minority had champions to promote the new roles. Individuals – Advanced Practitioners and consultants – were attempting to explain the new roles to colleagues and reassure them that there would be no displacement of existing staff.

## **The attitudes of colleagues**

On the whole colleagues' attitudes were positive. Where there was a lack of clarity about the role, hostility sometimes arose from fear of professional encroachment. Some junior doctors and consultants have refused to work with Advanced Practitioners but most have quickly been won round when they see the advantages both in terms of support for their own work and in terms of improved service for the patients.

## **Fitting new roles into existing organisational structures**

Projects had often focused on development of the new roles, often without considering how the Advanced Practitioners would fit into existing teams and organisational structures. In some cases the organisations only started to consider how they were going to use the new staff after the Advanced Practitioners had completed their training. Some sites were unsure if there was a job description for the posts. At one of the case study sites the tasks allocated to Advanced Practitioners changed from year to year according to the training needs of junior doctors.

## **The future**

Despite the positive response that Advanced Practitioners had received in the majority of sites, and the perceived benefits they brought, survey responses indicated that just three of the sites were considering commissioning more Advanced Practitioner posts. Six of the responding sites were not planning to commission any more and three did not know if they would commission any further posts.

## **The wider picture**

Because the survey had failed to provide the quantitative evidence required to demonstrate the impact of introduction of the Advanced Practitioner role, Skills for Health asked IES to undertake a further search through the literature, in particular focusing on those countries in which Advanced Practitioners had been in post for longer than in the UK.

The follow-up literature review revealed that, outside the UK, there is only restricted quantitative data available at present, even in countries where Advanced Practitioners were introduced some years earlier than in the UK.

A major factor influencing the extent to which cost savings are made is the model of service delivery in operating in the organisation within which the Advanced Practitioner works.

Furthermore, many existing data sets used in auditing health service performance currently do not reflect the role of Advanced Practitioners, which restricts the data available for analysis.

## **Summary of findings**

Significant investment in the training and development of Advanced Practitioners has taken place with centralised funding based on a bidding methodology that required bidders to provide assurances that, where positive outcomes are demonstrated, measures would be taken to embed the roles in the organisation and promote the roles to other organisations.

In almost all cases Advanced Practitioners have received a warm reception from their colleagues and provided positive benefits to patient care. In the majority of cases respondents and interviewees reported a range of ways in which the Advanced Practitioners had helped the team improve service outcomes and team productivity and increased team capacity.

Top-level commitment (at Executive level) was mostly seen only during the initial bid for development money. In most cases, professional advice from HR and finance departments was absent from both the initial phases of the role development and the continued promotion of the role as part of the organisational development process. There is little evidence that trusts have actively planned for the future incorporation of these roles within either their business/workforce planning or their education and training commissioning processes. Development work for the Advanced Practitioner roles had often been conducted with no real plan for how the roles would be incorporated within the team. In some cases the roles did not have job descriptions that reflected the new and enhanced competences acquired and how these had been put into practice.

The deployment of new or enhanced roles within an organisation will almost inevitably require some change to organisational structures and procedures. Focus on, and funding for, development of these roles led in many cases to organisations taking insufficient steps to consider the requirements for organisational development and change that would be needed to incorporate these roles successfully within team and organisational structures and future plans.

The Department of Health Good Practice Guidance emphasises the need for effective communications in successfully bringing about organisational changes of this nature. In the majority of cases, communication was left to the clinical champions who led the role development work or the individual practitioners themselves.

Local clinical champions and managerial advocates seeking to provide a clear argument in support of these posts have had difficulty obtaining clear data that demonstrate the cost-effectiveness and service benefits of these posts. Trusts have taken few steps to assess the impact of introducing the posts, as they would be routinely required to do, for example, if they asked for funding for additional consultants.

With only a few exceptions the costs for delivery of the training programmes are high because most of the roles are dependent upon extending the skills and competences of experienced practitioners through secondments. There appears to have been little attention to date to how costs could be reduced in the longer term, such as through defining common competences. This is surprising given the overlaps between the training of several of the Advanced Practitioner roles and between the Advanced Practitioner training programmes and other types of post-registration training for NHS professionals. Economies of scale will need to be considered if these training programmes are to continue to run.

## Recommendations

Given the above, we make the following recommendations:

- To ensure sustainability of new and enhanced roles, trusts need to establish robust planning arrangements, through their corporate governance systems, that include effective human resource and financial planning, as recommended in the Department of Health Good Practice Guidance.
- HR and finance personnel should move towards becoming 'routinely' involved in all role enhancement/new role development initiatives to ensure that the planning of such developments meets both current and future service requirements and that these initiatives are embedded in future business and workforce plans.
- Any future invitations to bid for development money should require evidence of significant senior level buy-in through presentation of the following:
  - A five-year workforce plan, showing how the trust plans to incorporate the new/enhanced role, including plans for rationalisation of other roles, where appropriate
  - Evidence of how the trust proposes to incorporate DH Good Practice recommendations into their development and implementation plan.
  - The funding body should require a report of the impact and longer-term investment plans to be presented at appropriate points within the implementation process/timeline.

- Approval of initial funding should be contingent upon receipt by the funding body of baseline data for the department or units in which the Advanced Practitioners will be based, along with a reporting plan for assessment of impact and reporting.
- Trusts need to explore how best to capture audit data to allow them to assess the impact of the introduction of new or expanded roles. A standard data-capture framework and procedure should be developed. The survey questionnaire on productivity reported here provides trusts with a basis for developing such an instrument. Since ideally the same audit information should be collected by all trusts, it may be appropriate for funding to be provided to enable an audit tool to be developed. Audit data could be reported through the same data-uploading procedure as is reported to the *Patient Journey Analyser* website.
- Alternative delivery options should be explored for training Advanced Practitioners. One distance learning (electronic delivery) programme has been extremely successful in allowing a large geographical spread of students whilst at the same time ensuring high educational standards are met. Some components of the Advanced Practitioner training programmes overlap with existing post-registration/postgraduate programme content (and some pre-registration education in the case of doctors). Training that maximises the use of existing modules where available, and offering electronic delivery as an option, would reduce costs and make future training more cost-effective, accessible and sustainable.

Direct or stepped entry into some programmes and the use of alternative funding streams to cover education costs should be maximised. Discussions should take place with funding bodies such as the Higher Education Funding Councils about the range of programmes that could be funded as part of the NHS Career Pathway to ensure the best value is gained from all the investment streams across healthcare programmes.

Given the current shortage of data, trusts might consider using the Skills for Health questionnaire as a basis for designing future procedures to capture the relevant information needed to assess cost-effectiveness.

The Advanced Practitioner roles have had distinctive benefits which, for various reasons, trusts have found difficult to document. The need to improve the evidence base on Advanced Practitioner role impact gives rise to two main challenges: securing resources to implement the roles to ensure that they are sustainable, and how best to diffuse innovation across the NHS.

Like many 'good ideas', Advanced Practitioner roles were not being systematically spread across NHS trusts or regions, so policy-makers may wish to consider

actions they can take to enable more effective intra- and inter-organisational learning. There may be a role for Skills for Health to play, together with the National Health Service Institute for Innovation and Improvement and the Department of Health, in fostering action learning projects to promote Advanced Practitioner roles and disseminate and embed other innovations.

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# 1 Introduction

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In February 2008 Skills for Health in partnership with NHS West Midlands ('the commissioners') issued an Invitation to Tender to undertake an evaluation of the Advanced Practitioner roles. The project aimed to obtain quantitative and qualitative information to demonstrate the benefits that have arisen out of introduction of the Advanced Practitioner roles that had been developed over the previous five years.

The commissioners were seeking this evaluation information in response to requests from service and education commissioners and providers. Although there have been some local evaluations of the impact of these roles, there had been no attempt to gather information nationally to determine the extent of any productivity gains arising from implementation of the Advanced Practitioner (AP) roles. This information is needed in order to inform service commissioners of the potential benefits arising from improvements to the skill-mix and the implications of this for future workforce planning.

The main objectives set out for the proposed programme of work were to:

- Undertake a comprehensive and comparative cost-benefit analysis that demonstrates the investment pathways for achieving Advanced Practitioner roles. The analysis aimed to examine the various routes to becoming an advanced non-medical practitioner and the indicative costs.
- Outline the future education and training pathways that will be required, and examine potential economies of scale and accelerated career pathways to create safe and effective non-medical Advanced Practitioners from a variety of recruitment sources.
- Submit a report that illustrates the actual high impact benefits gained from each of the core practitioner roles.

- Provide a process and continuing methodology to enable practitioners to contribute to ongoing information/data collection to demonstrate the continuing high impact service benefits of Advanced Practitioner roles.

In addition, a further outcome of the work was the development and delivery of a web-based management information system that would collect common data sets from NHS sites to indicate productivity analysis and inform workforce planning.

Therefore the final aim of the work was to:

- Provide a web-based data warehouse with the ability to collect and interpret common data sets and generate management information reports to produce productivity analysis.

In April 2008 the Institute for Employment Studies was awarded the contract to undertake this work. The programme of work agreed was to:

- review the ways in which productivity had been gauged in local evaluations of Advanced Practitioner projects and more widely in the NHS
- design questionnaires based on this information to capture appropriate productivity data and information about the background to implementation
- gather data both from sites that have introduced Advanced Practitioners and from a selection of sites that had not introduced these roles
- analyse the data to determine the extent of any impact and examine how that improvement is brought about; and to develop a web-based data collection and workforce modelling algorithm to assist NHS personnel in workforce planning.

In addition, four cases studies would be undertaken to explore issues in education, training and development and deployment of Advanced Practitioners.

There have been many previous innovative attempts to extend the roles of NHS staff, but until the NHS Career Framework was introduced (reinforced through the NHS pay system *Agenda for Change*), these attempts at job redesign had been neither systematic nor implemented at anything other than local level. The NHS Career Framework introduced a nine-tier framework for career progression within the NHS and set out a formal progression route that would allow the extended roles taken on by many staff groups in the NHS to be formally recognised and rewarded. Table 1.1, below, shows this progression framework.



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**Table 1.1: The nine level NHS Career Progression Framework**

Level	Grade
1	Entry level
2	Support workers
3	Senior healthcare workers, technicians
4	Assistant/Associate Practitioners
5	Practitioners
6	Senior/Specialist Practitioners
7	Advanced Practitioners
8	Consultant Practitioners
9	Senior Staff

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The purpose of the career framework is to enable skills escalation, aid development of new roles that meet patient need, assist development of competence-based workforce planning, give opportunities for individual career planning, enable easier recruitment and retention and improve transferability of roles and skills across healthcare organisations regardless of location. The career framework supports earlier developments in workforce redesign focused on the delivery of care to meet patients' preferences and expectations and pressures for efficient service delivery, and sets the context for development and introduction of the Advanced Practitioner roles.

This report sets out the programme of work undertaken for the evaluation:

- The rest of this chapter outlines the design adopted for the project, gives an overview of the method and lists the membership of the Steering Group.
- In Chapter 2, we report on the literature that was reviewed in order to inform development of the survey questionnaires.
- Chapter 3 describes the methods, materials and procedure.
- Chapters 4, 5, 6 and 7 report the main findings emerging from the work. Chapter 4 focuses on the background to organisations' decisions to become involved in the programme; Chapter 5 looks at the ways in which Advanced Practitioners have been recruited and trained to date; Chapter 6 explores the organisational impact of introduction of Advanced Practitioners; and Chapter 7 considers the barriers to implementation and further roll-out.
- Chapter 8 sets out our conclusions about the ways in which Advanced Practitioners have impacted on service delivery and productivity and makes recommendations to assist with future developments.

## 1.1 Design

When planning an evaluation of an initiative there are various options available regarding the design used in order to determine impact. The two main approaches are:

- a before-after comparison using data collected before and after implementation of the initiative at each site
- a comparison of a site at which the initiative has been implemented with a matched site at which the initiative has not been implemented.

While the first approach allows a comparison of outcomes before and after the initiative, it does not fully allow the evaluator to take into account the impact of any other changes that have taken place within the relevant environment (in this case, the health sector) in parallel with the changes of interest.

The second of these approaches allows for contemporaneous events to be dealt with within subsequent analyses, but the main danger to evaluation arises from the difficulty of ensuring an adequate match between sites (for instance, in this case, in terms of patient profile, socio-economic status and health economy of local area, any medical specialties offered, precise nature of staff skill-mix etc.).

Both of these approaches have their limitations. A more sophisticated evaluation approach includes both of these approaches; this is a 'mixed' model, which provides a before and after data set at implementation and comparison (non-implementation) sites. This allows the researcher to control for (at least within analyses) differences between sites and any broader changes occurring within the sector that could prove a threat to the evaluation. The data requirements are shown in the table below:

**Table 1.2: Evaluation data collection requirements**

Group	Before	After
Implementation site	Measures taken pre-implementation (T0)	Measures taken post-implementation (T1)
Non-implementation site	Measures taken at equivalent point in time to T0	Measures taken at equivalent point in time to T1

*Source: IES*

The research team therefore recommended that a range of comparison sites should be sought from whom comparative data would be requested (see Chapter 3 for further details on development of the data collection instruments).

## 1.2 Method

Five main components were planned for the research: establishment of a Steering Group to oversee and advise on the development of the project; a literature review to identify appropriate measures to include in the evaluation; a comparative survey of sites at which Advanced Practitioner roles had and had not been introduced, in order to gain productivity data; case studies to provide qualitative data on factors affecting implementation and to seek information on current arrangements for training; and lastly, analysis and modelling of the data, and reporting of the findings. In addition to identifying the routes through which Advanced Practitioners affect productivity, a subsidiary aim of this last phase of the work was to produce a model that could be used as a basis for future workforce planning.

### 1.2.1 The Steering Group

A 'virtual' Steering Group was established to guide and oversee development of the project. The Steering Group consisted of the following members:

**For Skills for Health:**

Kathryn Halford, Divisional Manager

Robert Standfield, Divisional Manager – Practice Development

**For Advanced Practitioner sites:**

Mr Colin Berry, Consultant Anaesthetist, Royal Devon and Exeter Hospital

Mr Jeff Crawshaw, Director of HR, Worcestershire Acute Hospitals NHS Trust

Mr Gareth Goodier, Chief Executive, Addenbrooke's Hospital, Cambridge University Hospitals NHS Foundation Trust

Dr Chris Streather, Medical Director and Director of Strategy, St Georges NHS Trust

**For education providers involved in delivery of Advanced Practitioner programmes:**

Anji Gardiner, Senior Lecturer and Programme Lead (Gastroenterology), Hull University

Mr Paul Power, Senior Lecturer (Paramedic Science), University of Hertfordshire

Dr Julia Williams, Principal Lecturer and Research Lead (Paramedic Science), University of Hertfordshire

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## 2 Scoping Review of Evaluation Literature

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The research commenced with a review of reports from earlier evaluations of Advanced Practitioner roles. In all cases these related to the introduction of one specific Advanced Practitioner group (eg, Surgical Care Practitioners, Endoscopists etc.) and in some cases the evaluation related to just one trust or Strategic Health Authority (SHA). The review of previous evaluations was then supplemented by a trawl of literature reporting other evaluations undertaken within the health sector, to determine what, if any, additional data should be sought. Much of the literature that had reported the context for, and process of, development of the Advanced Practitioner roles was also considered during this stage, including the Department of Health *New Ways of Working for Everyone: a best practice implementation guide* for trusts considering introducing Advanced Practitioner roles.

This chapter therefore begins by considering the development of Advanced Practitioner roles, and then moves on to previous work gauging cost-effectiveness of service delivery within the health sector. The primary intention in undertaking this review was to assist the development of an impact model of how skill-mix changes arising from the introduction of Advanced Practitioner roles affect productivity within the healthcare settings. The outcome of this stage of the work is a draft impact model which was used for two purposes: firstly, as a basis for the design of materials to evaluate the value of Advanced Practitioner roles; and secondly, as an initial hypothetical framework for the modelling analyses.

The first section of this chapter provides an overview of the background, context and rationale for the development and introduction of Advanced Practitioner roles. We then consider how these roles may contribute to improvements in productivity. In examining the potential ways in which Advanced Practitioners may improve service delivery and productivity we examine the factors assessed in local evaluations of roles. We then consider the various other definitions and measures of productivity and cost-efficiency that have been used within the health sector, along with the strengths and weaknesses of the different measures used in the evaluations.

The review ends by setting out the rationale for the measures included within the first draft of the questionnaires designed for the evaluation and presents the basic model used in designing the evaluation.

## 2.1 Background to the development of the Advanced Practitioner roles

Improving service delivery has been a key driver for initiatives to change work roles within the NHS. Most recently, policies such as '18 weeks' (the drive to reduce all referral to treatment waiting times for consultant-led services) have served to focus attention increasingly on cost-effective methods of delivering services. The work arising from these initiatives has been wide ranging and has included process mapping to determine the various routes and stages by which patients enter into and travel through the primary and secondary care stages, as well as considering the optimal treatment options available (Robinson et al., 2007; Baldwin et al., in progress).

One of the major initiatives undertaken in support of service delivery improvement was the development and introduction of Advanced Practitioner (and Assistant Practitioner) roles. These roles were designed to capitalise on the higher level skills possessed by many health practitioners such as nurses and members of the allied health professions (skills which in many cases exceeded those required by a strict interpretation of their job description) and their capability and enthusiasm for further development.

Even before these relatively recent changes to roles and service redesign took place, there had been increasing recognition of the potential for expanding roles within the health service. In particular, the previous 15 years had seen many changes to the pre-registration training of nurses and the various Allied Health Professions. These changes had recognised (albeit implicitly rather than explicitly) firstly, that individuals within these posts have the potential to contribute far more to a modern health service than was acknowledged by the older diploma and certificate programmes. Secondly, most of the newer degrees contain some component that recognises the increasing need for continuing professional development post-registration<sup>1</sup> and are therefore designed at encouraging

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<sup>1</sup> Indeed, legislation for some professional groups now makes CPD compulsory: eg for nurses, midwives and specialist community public health nurses the requirements for CPD are set out in the PREP - Post-registration education and practice - handbook available at [www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=1636](http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=1636), while for radiographers, compliance with the Health Professions Council's CPD requirements is now a condition of registration (see: [www.sor.org/public/educpd/faqs.htm](http://www.sor.org/public/educpd/faqs.htm)).

graduates to engage with self-directed learning strategies to support future lifelong learning.

Through these changes to pre-registration programmes universities and colleges began producing practitioners who expect to continue to develop their skills over the course of their career. Many of these institutions also introduced programmes to support CPD that would allow practitioners to develop further skills as well as remain up to date with changing health philosophies<sup>1</sup> and technologies.

However, to some extent the workplace in which these individuals are employed has lagged behind such developments. As the NHS itself has commented (NHS, 2007), the rather bureaucratic constraints on roles could lead to individuals using only a limited range of competences, and, often, undertaking less skilled work when they 'could be using their higher-level skills more effectively'. Professional boundaries and demarcation issues were not least amongst the constraints confronting those who sought to bring about changes in work practices to improve productivity (NHS, 2007).

However, the pressures arising from service improvement needs have increasingly focused the attention of policy-makers and practitioners on how best to utilise the considerable additional skills and potential of individuals working in the sector. Prior to the recent strategic decision to develop Advanced Practitioner posts there had been some (largely uncoordinated and ad hoc) attempts to extend the roles and responsibilities of some groups of practitioners (see, for example, Price et al., 2000; Price et al., 2002). However, it was not until the Changing Workforce Programme was initiated<sup>2</sup> that there was a national drive to redesign the roles of health service practitioners and provide a coherent approach to the integration of new roles within the service. We turn now to consider that programme of work.

### 2.1.1 The Modernisation Agency and Changing Workforce Programme

The need for work to undertake skills-mix experiments in a coherent fashion had been identified in *The NHS Plan* (2000) and *A Health Service of All the Talents* (1999). In 2001 the NHS Modernisation Agency was established, incorporating a team dedicated to developing New Ways of Working (the NWW team). The NWW team had a broad remit: it included both the revision of pay and staffing structures as well as the introduction of new and redesigned roles.

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<sup>1</sup> For example, the change in health philosophy (from reacting to ill-health to promoting the maintenance of good health) required by the White Papers *The Health of Our Nation* and *Our Healthier Nation*.

<sup>2</sup> And subsequently the National Practitioner Programme and the NHS Career Framework underpinned by Agenda for Change.

The Changing Workforce Programme (CWP) was established to design and trial such new ways of working and ran from 2001 to 2005 with 13 pilot sites (see Hyde et al., 2004 for a review). The work of the CWP subsequently developed into the National Practitioner Programme, which had responsibility for co-ordinating developments, bringing together stakeholders (including SHAs and professional bodies), leading on implementation and examining common issues such as regulation. A number of 'new ways of working' streams were established, each focused on a particular specialism and hosted by one SHA. These covered surgery, medical care, anaesthesia, critical care, endoscopy and assistant roles in theatre.

Development and introduction of the Advanced Practitioner roles was a major component of this work. Advanced Practitioner roles typically led to the introduction of more demanding and rewarding posts for practitioners to move into. Hyde et al. (2004) have summarised the four main ways in which roles were re-designed to offer practitioners more potential for development (see Box 1).

**Box 1: How roles are redesigned**

1. Skill-mix changes - moving tasks or roles up or down an existing professional hierarchy, eg through role substitution
2. Job widening - expanding or enlarging the content of a role, eg by bringing together functions which may previously have been done by others
3. Job deepening - enriching the content of a role, eg by giving it more significant and substantial responsibilities, greater autonomy or opportunity for development
4. Creation of wholly new jobs - by combining new and/or existing roles and functions in innovative ways

*Source: Hyde et al. (2004), A catalyst for change?*

The new roles were developed in partnership with relevant medical Royal Colleges, trade unions, professional organisations, the public and Skills for Health. In undertaking the role redesign/creation work the NHS Modernisation Agency analysed the contribution of the various professional staff groups to care pathway delivery and identified the potential for improving staff development opportunities, improving organisational performance and – not least – improving care for patients. The major goals for the development of new roles were:

- ensuring that necessary skills and competencies required by care pathways or interventions are present in the workforce
- providing opportunity to build additional skills in existing roles
- encouraging working across professional boundaries

- matching skill-mix to service delivery models
- improving recruitment and retention by opening up careers
- reducing workforce cost
- attracting a new workforce where shortages exist, and
- improving capacity and capability.

As indicated in Box 1 above, the Advanced Practitioner roles are characterised by the requirement to operate above qualified roles with increased breadth of function, under protocols for clinical practice. Often they require management of own caseloads with high levels of decision-making and diagnostic reasoning. Assistant Practitioners occupy an intermediate position just below the level of professionally qualified staff, and can provide a platform for entry in professional education as well as opportunities for task delegation from professionally qualified staff, enabling them to extend their scope or move into advanced roles.

These roles were developed on the basis of providing a national competence framework that would allow for transferability and a common understanding of the scope of practice, practice standards and educational requirements. Populating the new levels of this framework, therefore, would require professional development designed within the curriculum framework to allow practitioners to achieve the expected levels of competence required by the new work roles. Their development and implementation has therefore required substantial levels of investment, including the costs involved in:

- investment by trusts
- development monies from the Strategic Service Improvement Fund
- engaging in dialogue with education providers, and the investment of education providers in developing appropriate provision
- investment through support for new workers/for workers operating at new levels, including, in some Strategic Health Authorities, the provision of funding through their Workforce and Development Directorates.

Therefore, while many of the costs involved are accounted for in the development phase of work of this nature, ongoing expenditure arises from (in some cases) the recruitment and (in all cases) the development of individuals for Advanced Practitioner posts. Because there are ongoing costs involved in roll-out of these roles, further implementation therefore requires evidence that they add value in terms of service delivery and/or cost-efficiency. Such evidence of added value is also essential when considering workforce profiling for the longer-term needs of local health economies.



It is, therefore, essential to gauge the cost-benefits arising from introduction of these posts. In Section 2.2 we consider the ways in which the impact of these roles has been assessed in local evaluations of Advanced Practitioner roles to date. In Section 2.3 we consider the ways in which cost-benefits of other types of innovation within the health sector have been assessed, and issues around the assessment of cost-effectiveness within the health sector more generally. In addition to considering 'input' costs (that is, the development costs required for moving individuals into these posts) and measures of the 'outcomes' obtained (that is, the potential savings arising from increased local capacity leading to improvements in service delivery), there are a set of 'mediator' variables that can impact on the success with which those inputs feed through into positive outcomes. We explore these first, in Section 2.1.2.

### **2.1.2 The role of organisational factors in successful implementation of new ways of working and Advanced Practitioner roles**

There is evidence that, even where there is general support nationally within a profession for role development, implementation can remain patchy. Work by Price et al., (2002), revealed that the uptake of extended roles in radiography relied on local conditions and varied widely across the country; more recent work by Price and his colleagues (Price et al., forthcoming) reveals that while the four-tier structure for radiographers (Assistant Radiographer, Radiographer, Advanced Practitioner and Consultant), has been in place for four years, to date there are fewer than thirty diagnostic radiography consultants in post and fewer than ten therapeutic radiography consultants, lending weight to the view that implementation has been neither systematic nor widespread.

Hyde et al. (2004) have pointed to the particular challenges that can confront individuals or organisations when undertaking role re-design/creation. These challenges may be particularly acute when seeking to reassign role boundaries and responsibilities between different professional groups and it can be difficult to persuade the various professional groups of either the need for, or any benefits likely to arise from, any proposed changes. Professional rivalry may lead to resistance; however, even within professions there can be suspicion and resentment of those individuals who choose to move into extended roles.

To assist organisations with the task of introducing new ways of working, the Department of Health issued guidance in its document *New Ways of Working for Everyone: a best practice implementation guide*. This sets out a whole-system approach to local implementation, providing flow charts and an action-planning framework to guide local implementation. The document explains the need for the following components to maximise the chances of successful local implementation:

- 
- Board-level support and understanding of the work
  - involvement of other key stakeholders
  - links to be made between the NWW strategy and the organisation's business plan, workforce strategy and learning and development strategy
  - development of a clear communication strategy for the programme of developments
  - identification of local champions for NWW strands
  - engagement with staff, service users and carers to identify success criteria for the programme.

There is evidence that some of the Strategic Health Authorities and trusts are following at least some of the best practice implementation recommendations. For example, a report by Wherrett (2005) to the Norfolk, Suffolk and Cambridgeshire (NSC) Strategic Health Authority Workforce Stakeholders' Board indicated that the SHA had organised a series of events including:

- an NSC-wide event focusing on NWW
- a Surgical Practitioner Cluster group meeting, with speakers from Skills for Health and the Department for Health (DH)
- an NSC-wide scoping study of NWW.

In the report to the Board, Wherrett also set out a list of other activities they had undertaken and the costs of this work.

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**Table 2.1: Additional activities reported by the NSC SHA WSB**

**Activity 2003/04**

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Operating Theatres - HCA III Extended Role

**Activity 2004/05**

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Developing the Role of Day Surgery Surgical Technicians

Development of the Surgical Practitioner Role

New Ways of Working in Surgery Scoping Study

New Ways of Working in Surgery Event

**Activity 2003/04**

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Development of the Surgical Practitioner role

Development of the Anaesthesia Practitioner

**Commitments and proposed Activity 2004/05**

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Assistant Theatre Practitioner across 4 SHAs (NSC, E, B&H, LNR)

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*Source: Wherrett D (2005), Workforce Modernisation In Practice - New Ways of Working in Surgery*

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Where sites follow the DH guidance (and hence take actions such as those by the NSC SHA outlined above) this will help ensure that implementation of new ways of working is more likely to be successful. However, as indicated earlier in this section, research indicates that implementation decisions are often taken at a local level in response to local service delivery issues, with decisions to implement hinging upon the championing of extended or Advanced Practitioner roles by one or more key individuals; equally, though, certain key individuals can constitute barriers to implementation of extended roles. In the case of Advanced Practitioner and Consultant posts in radiography such key individuals include radiologists, Heads of Department and Chief Executives. A further factor affecting the success of such schemes is the availability of support workers to take on simpler tasks that Advanced Practitioners need to relinquish to enable them to focus on more complex work. Lack of support can lead to resentment amongst staff and the suspicion that well-intended initiatives have in fact been introduced simply to extend the volume, rather than the scope, of practice.

These workplace challenges can, therefore, have implications for the uptake and success of Advanced Practitioner roles and, thus, the possible costs and benefits. In considering impact on productivity it is important to analyse the implementation process adopted by individual organisations, as this may influence success or failure. Therefore, one of the issues to be addressed in the evaluation is the extent to which:

- the initiatives have been centrally co-ordinated
- the extent to which DH best practice guidance has been followed
- the supporting structures in place within workplaces introducing extended roles and advanced (and assistant) practitioners.

For this reason, a set of questions focusing on the leadership for implementing and championing of Advanced Practitioner roles at local level will be included within a questionnaire designed to gather information on the background to the initiative.

It is worth paying attention to such issues, for there are many potential benefits for organisations that do successfully introduce such posts. Not least among these is the increased skill-mix available to organisations facing increased demands on their services. As Hyde et al. (2004) note, in many cases environmental challenges and pressures drove changes to skill-mix requirements and the workforce composition needed to provide those skills. Influential factors included: skills shortages, the need for better management of labour costs and the desire to improve organisational effectiveness (Adams et al., 2000; Sibbald et al., 2002; Price et al., forthcoming). However, variations in the ways in which organisations introduce new roles, and their perceived objectives in so doing, may cause the

workforce to consider such initiatives more or less favourably, with potential implications for their success; for this reason we proposed gathering background information on the main reasons given by organisations for implementation.

We now move on to consider the outcomes that have been examined in previous evaluations of Advanced Practitioner roles.

## 2.2 Indicators used in local evaluations of Advanced Practitioner implementation

There is already a burgeoning body of literature that attempts to identify the benefits of introduction of the various new grades and types of worker. Evidence from the National Practitioner Programme (NHS National Practitioner Programme, 2007) of the benefits gained from introduction of Advanced Practitioner roles included: the freeing up of junior doctors' time for learning and the release of expert staff time to deal with more complex cases; improvements in staff retention; reduced waiting times for assessment and surgery for procedures such as varicose veins and hernia repair; and reduced length of stay for patients and efficiencies in throughput by, for example, being able to see more people in the same amount of clinic time or undertaking more operations in same amount of time. In addition, reduced theatre downtime, more efficient follow-ups post-surgery and reductions in the numbers of patients re-admitted and numbers of procedures cancelled were all cited as positive outcomes arising from introduction of these posts, which benefited both patients and NHS trusts. We now report some specific examples of such benefits.

A DH report on Diagnostics (NHS National Practitioner Programme, 2007) notes that introduction of Endoscopy Assistants, Co-ordinators, Practitioners and Nurse Endoscopists led to reductions in patient waiting times for examinations. In one hospital, Burnley General, introduction of these roles has apparently led to:

*'Timely discharge of patients [which] has reduced the backlog in recovery, preventing delays in patients moving from procedure rooms. The endoscopist can continue lists without leaving the room, which means less disruption and more privacy for patients. This has increased throughput enabling two additional slots to be added to every list and has contributed to a reduction in the waiting list. In addition the unit now has fully integrated day surgery and endoscopy teams with shared practice. This means an improved quality of service for patients has also increased staff morale.'*

Similarly, the Norfolk, Suffolk and Cambridgeshire SHA reported on the costs and benefits of the NWW in Surgery initiative. This involved the introduction of Surgical Care Practitioners (SCPs), Perioperative Specialist Practitioners (PSPs) and Assistant Theatre Practitioners among other roles. Box 2 shows some of the benefits identified by the SHA as arising from these changes.

**Box 2: Benefits arising from the New Ways of Working in Surgery**

- improved patient journey, better-informed patients and patient-focused care
- improvements in the continuity of patient care and in standards of service with a reduction in inappropriate admissions, cancellations, waiting lists and readmissions
- better theatre lists and case-mix management reducing over-running lists
- improved communications for patients and the multidisciplinary team
- assisting with the meeting of government targets for the reduction in junior doctor's hours in line with European Working Time Directive compliance
- increasing job satisfaction, assisting recruitment and retention and addressing the potential skills gap.

*Source: Norfolk, Suffolk and Cambridgeshire SHA*

In the evaluation of Perioperative assistants (NHS Practitioner Programme Perioperative Specialist Practitioners Summary Report 2005- 2006) the outcomes investigated included:

- the numbers of patients referred to ITU
- reductions in doctors' hours
- waiting list reductions for procedures in which the Perioperative assistants were involved
- increases in admissions on day of surgery (hence saving on the numbers of overnight stays required per procedure)
- reductions in locum costs
- reductions in numbers of procedures cancelled
- increased flexibility within the surgical team.

Therefore this earlier evaluation also suggested additional types of measures that needed to be included in the present work: before and after measures of locum costs, average numbers of overnights and numbers of day surgery admissions. However, flexibility is both difficult to put into operation and affected by the specific team composition; for this reason 'flexibility' was not included as a measure within the national evaluation.

Similar measures were suggested as intended outcomes during development of the Physician Assistant (Anaesthesia). The criteria used to assess success at local level were (Box 3):

**Box 3: Evaluation criteria used to assess impact of Advanced Practitioner (Anaesthesia) roles**

- Percentage of theatre utilisation and theatre downtime
- Number of joint operations per session before and after implementation
- Extra patients per list
- Number of theatres used
- Additional theatre lists
- Revenue generation
- Freeing up of consultant time
- Reduced locum costs.

The proportional cost-benefits derived from measures such as 'extra patients per list' will depend on the number of patients per list prior to the changes. Therefore, in order to obtain usable and nationally comparable data for such variables, numbers of patients on lists before and after will need to be collected, rather than any estimate of incremental gain.

Analyses of the introduction of the Endoscopy Practitioner role also indicated a wide range of potential benefits arising from the initiative, suggesting yet further variables that ideally should be included in an overall impact assessment. One anticipated benefit of introduction of Endoscopy Practitioners was reduction of the number of 'lost or missed' sessions, while reduction of waiting times for diagnostic tests was another. As with the 'extra patients per list' indicator, any national evaluation will need to collect information on length of waits before and after introduction of the practitioners, (rather than on percentage reductions in wait). This is because the value of any proportional reduction will depend on the initial length of wait at outset. In addition, the report suggested that, where responsibility for discharging patients was transferred away from consultants to endoscopy practitioners, this may release consultant time.

Together, the existing work examining the introduction of the endoscopist role suggested three measures that would need to be incorporated within the evaluation: a measure of consultant time available within relevant departments; before and after measures of lost or missed sessions; and before and after waiting times for diagnosis and intervention. However, the national evaluation was commissioned shortly after the deadline for 18 weeks had come into force (at the end of March 2008); given the impact this initiative had had on waiting times across the country the researchers believed the likelihood of detecting any

additional benefit accruing to presence of Advanced Practitioners would be slight. Therefore, although information on 'waiting times' (whether for diagnostic services or interventions) is in principle of interest, this data was not requested because of the strong possibility that these data would be contaminated by the large-scale improvements arising from attempts to directly address the 18 weeks deadline.

Most of the outcomes assessed in these local-level evaluations are of a sufficiently generic nature to make them appropriate for consideration in a national evaluation of Advanced Practitioner roles. However, other factors may be specific to a small number of sites or to specific practitioner roles. In some cases a role may have been introduced with a specific aim that is not viewed more widely as an intended (or indeed likely) outcome. One example is the aim of reducing junior doctors' hours. In piloting the measures for the current evaluation, one site reported that Advanced Practitioners had been introduced with the express intention of helping reduce junior doctors' hours, while another felt this was extremely unlikely to be either a goal or an outcome. This illustrates that beliefs about intended goals and priorities are unlikely to be consistent across all sites or for all Advanced Practitioner groups. Equally, though, it is possible that the introduction of Advanced Practitioners may have unanticipated as well as expected benefits. In addition to attempting to collect data relating to all of the potential contributing input and outcome measures we therefore also collected information on the intended goals within each of the participating Advanced Practitioner institutions.

## **2.3 Productivity studies within the health sector**

In the preceding section we have described the types of outcome used in evaluations of Advanced Practitioner roles to date. Often the types of measure used do allow for analysis of the cost-benefits and impact on productivity. Analysis of the cost-benefits and impact on 'workforce productivity' was to be a central part of this evaluation, and so, to ensure that appropriate measures were collected wherever possible, we explored the ways in which cost-benefits and productivity had been examined previously within the health sector. We therefore reviewed literature outside that relating to implementation and evaluation of Advanced Practitioners and the National Practitioner programme, and the findings from this part of the review are reported here.

However, one point quickly emerged from reviewing literature in this area: it became clear that many studies failed to consider potential improvements to productivity as possible outcomes when the impact of change was examined and, where they did, the results have not always been persuasive. One example of literature of this type came from Bloor and Maynard (2001), who reported that,

despite ‘increases in NHS funding and staffing, changes in technology and continuous reorganisation of structures’, evidence indicated little change in productivity. However, estimating productivity and efficiency benefits within the health sector is neither an easy nor an entirely straightforward task, especially where an attempt is made to draw conclusions across multiple sites and on a larger scale than purely local targets. The reasons for this are set out below.

### 2.3.1 Defining productivity and efficiency

It is important to consider the ways in which efficiency and productivity have been ‘operationalised’ or defined within the health sector. Dawson and her colleagues have provided definitions of efficiency, value for money, productivity and productivity growth within the NHS. They observe that such indices have ‘implications for both methods of measurement and policy relevance of the resulting indices’ (Dawson et al., 2005). They offer the following definitions (Box 4):

<b>Box 4: Measuring efficiency and productivity within the NHS</b>
<ul style="list-style-type: none"> <li>■ <b>Efficiency</b> is measured as the ratio of output produced with given inputs relative to the maximum feasible output.</li> <li>■ <b>‘Value for money’</b> reflects the value individuals/society place on output relative to the costs of production. This often corresponds to a cost-benefit analysis.</li> <li>■ <b>Productivity</b> is the ratio of a measure of total output to a measure of total inputs.</li> <li>■ <b>Productivity growth</b> is the change in output relative to the change in inputs. It is often interpreted as reflecting the effect of technical change on production.</li> </ul>

*Source: Dawson et al., (2005)*

Box 4 shows that, in gauging impact on outcomes, it is important to consider a range of derived variables<sup>1</sup> as well as raw scores (and changes to raw scores). In this evaluation we will be looking primarily at productivity measures derived from comparisons of ‘input’ measures such as total wage bill for a unit and outcome variables such as number of patients seen before and after implementation of Advanced Practitioner roles. However, the raw data amassed will potentially be of use should further exploration of efficiency and productivity growth be sought.

<sup>1</sup> That is, comparison of ratios rather than raw scores, such as numbers of patients or increase/decrease in patients.



However, before even raw scores can be considered there are other factors that need to be taken into account. Even defining output measures within the health sector can present a challenge. For example, Smith and Street (2007) at the Centre for Health Economics suggest there are problems with current Eurostat practice in this area, which recommends that the quantity of healthcare received by patients should be measured in terms of 'complete treatments' (Eurostat, 2001). They observe that:

*'Putting this definition into practice is not straightforward because it is a challenge to measure 'complete treatments' (Brathaug, 2006; Pritchard et al., 2006b). The majority of patients receive a range of interventions from different providers, in different settings, and, in the case of patients with chronic conditions, over a long period of time. It is not always possible to define when the treatment is complete and most countries lack the informational capability to track patients across different settings. This means that counting the number of patients who have completed their treatment is not currently possible. In view of these difficulties, it is common practice to define output in the health sector by counting the number of activities undertaken – for instance, the number of patients treated in hospital.'* (Smith and Street, 2007)

Furthermore, where studies do attempt to report on cost-benefits arising from initiatives, estimating the precise value of outputs can be a challenging task. For example, Dawson and Street (2000) have reported 'implausibly large variations' in the reported costs for many procedures, and attribute much of the variation to questionable data quality.

However, where differences are observed such findings may be more attributable to decisions made at regional level than to local management decisions. Hauck et al., (2003) examined 14 indicators of health authority performance taken from the NHS Performance Assessment Framework to estimate the extent to which variations in the performance of what they refer to as 'small health areas' (that is, areas with populations of fewer than 10,000 individuals) were attributable to the performance and actions of the health authority. While they found that some 80 per cent of variation in waiting times was attributable to the health authorities, only 10 per cent of the variation in mortality rates was attributable to the health authorities (in other words, 90 per cent of differences in mortality rates were attributable to local-level decisions). The fact that much more variation in waiting times than in mortality rates was attributable to health authority performance indicates that regional NHS managers have differential levels of influence over different aspects of performance.

Hauck and her colleagues suggest that such variances indicate that local managers are more able to influence some aspects of the health system than others. This emphasises the need for local comparators in any evaluation. Without local comparators there is the risk that changes occurring as a result of decisions taken

at health authority level could be attributed to the actions taken by individual trusts when in fact it may be due to overarching (regional) changes.

### 2.3.2 Input and outcome measures used in previous studies of productivity

Perhaps unsurprisingly, one of the main outcomes of interest in evaluations of impact in the health sector has been waiting lists. Several previous studies have considered the impact of changes in funding regimes on specific sub-groups within waiting lists. Street et al. (2007) report on the outcomes of a change in funding implemented in hospitals in Australia. Within a year of introduction of the funding reforms the overall waiting list had fallen by 16 per cent of the pre-funding reform total. However, looking at this single overarching figure gives only part of the picture. Street et al. report that the most dramatic fall was seen in the principal target population of category 1 patients waiting more than 30 days. This was not a short-lived effect ... by February 1996, nobody fell into this category, a situation that persisted until (at least) August 1996, more than three years after the reform was introduced.' (Street et al., 2007). They also report that there was

*'... a decline in the number of category 2 patients waiting longer than clinically acceptable. The number waiting more than 90 days fell substantially in the immediate aftermath of the reform .... [However] the size of this reduction was not maintained, although the number of patients in this category never returned to pre-reform levels.'* (Street et al., 2007)

The Street et al. report therefore confirms the need to look carefully at the detailed outcomes rather than taking a broad overview of the situation.

### 2.3.3 Mediating the relationship between inputs and outcomes

Other analyses reported by the Centre for Health Economics at York have indicated that relationships between input and outcomes can vary depending on the particular health condition involved. Martin et al., (2007) report that for both cancer and circulation problems it was possible to develop 'robust and well-specified statistical models' that demonstrated a strong positive link between expenditure and better health outcomes (in terms of lower mortality rate). In addition, they were also able to calculate 'satisfactory regression analyses' to demonstrate the link between expenditure and outcomes for some other programmes: neurological, respiratory, gastro-intestinal, trauma, burns and injuries, and diabetes. However, for many illnesses mortality rates or 'years of life lost' are not appropriate measures, because some conditions tend not to be fatal.

In addition to the mediating effect of type of illness or ill-health condition on the relationship between expenditure and outcomes, the activities on which staff

spend their time can also affect the ultimate value of any changes implemented. A recent review by the BMA (2006) reports the Department of Health's (DH) commitment to achieving annual efficiency benefits in England of at least £6.5 billion by 2007/08, with up to £2.9 billion of these gains being expected to come from making better use of staff time. This particular initiative was known as Productive Time (PT) with PT gains being seen as arising through a combination of the modernisation strategies for people (Pay and Workforce Reform), processes (10 High Impact Changes) and technology (Connecting for Health) in order to maximise service improvement. Therefore, any evaluation should ideally examine the types of activities undertaken by staff, as well as hours spent in employment per week. This is especially the case where an aim of implementation of Advanced Practitioner posts is to free up the time of more highly paid staff groups, such as consultants. However, it may be difficult to establish how staff use extra time gained or saved by these changes, particularly for those with more discretion over their work, such as consultants. Therefore, it was decided to seek information on potential freeing-up of consultant time, but not to seek further information on the types of activities on which that saved time was spent.

## 2.4 Conclusions and implications

This review of literature has described the context and rationale for introduction of the Advanced Practitioner roles, considered the definitions and measures of productivity used within the health sector, the strengths and weaknesses of various different measures and considered what factors have been included within local evaluations of the impact of the Advanced Practitioner roles.

The evidence certainly suggests that the NWW initiatives are yielding the types of benefit anticipated, but variations in how different regions and organisations gauge levels of impact means that, at present, no overall assessment of cost-benefit can be presented. We also do not know whether differences in the types of data collected reflect local priorities, local preferences for certain measures borne out of history, or different local management information system capabilities.

In some cases, where evaluations had been undertaken in a single trust they would sometimes report variables such as 'percentage change' in theatre utilisation or waiting list reductions rather than primary data (ie theatre utilisation rates before and after). While such 'derived' variables can be useful in a local context, they are less meaningful when attempting to compare across sites. In such instances the team took the view that it would be more useful to gain raw data rather than to request such derived data. Therefore, the survey questionnaire would need to be designed to collect information on numbers and costs before and after implementation rather than 'reductions'. Flexibility, mentioned in the local

evaluation of the Perioperative Assistant, is difficult to operationalise and, since it will be affected by the specific team composition, was not included as a factor.

The studies reviewed demonstrate that a range of measures should be used to avoid the risk of drawing the wrong conclusion, which can arise from using single measures. The measures collected should also permit a range of comparisons to be made to give the best chance of capturing improvements. Furthermore, a range of derived or second-order measures (that is, measures derived from manipulating or combining primary data) are likely to be needed to help unpack where and how initiatives have their impact. In addition, as the evidence shows, different derived measures can demonstrate impact in different circumstances, and the variations are not always predictable. This is particularly important for this project where productivity impacts are being studied across sites in which a variety of Advanced Practitioner roles have been introduced with different objectives. It was therefore important to ensure that a sufficiently wide range of primary data was collected and, additionally, that these data were appropriate to support the development of a range of secondary variables in any subsequent analysis.

There is still little information available about data collection capabilities nationwide for the current evaluation. It was therefore necessary to be sensitive to the difficulties that some sites might face in providing optimal levels of data of the type necessary to inform a full evaluation. The project was, therefore, also of use in informing Skills for Health about any development and/or support needs that some sites might require in order to enable them to contribute fully to a national evaluation of these initiatives, together with information on any barriers they encounter to providing data sought by Skills for Health.

## **2.5 Implications for design of the survey instruments**

The previous local evaluations of NWW initiatives have identified many potential input variables and outcome measures that might be explored within the evaluation. These variables were supplemented by information taken from the literature on productivity in the health sector.

In the earlier sections we noted the need for the evaluation to collect primary data that can be used directly within calculations of productivity and also to enable the calculation of derived variables (such as percentage reduction in waiting lists). For this reason, we recommended collection of the following data to inform the evaluation:

- The population of staff on the various grades of interest, and their supporting grades.

- Numbers on education programmes, per cent retained, per cent qualifying and per cent expected to enter local workforce.
- Patient throughput numbers prior to implementation and post-implementation.
- Patient waiting list length pre- and post-implementation.
- Reductions in theatre downtime/increased theatre utilisation.

In addition, in order to conduct a cost-benefit analysis it would also be necessary to collect information relating to the costs of educating and training staff, and the staffing costs for the particular skill-mix employed pre- and post-implementation.

It is quite possible that, when analysed, these data may not necessarily be relevant for all of the Advanced Practitioner roles; for example, while introduction of certain of the Advanced Practitioner roles may impact on junior doctors' hours, others may not. Nonetheless, all of these data needed to be collected at this exploratory stage of the research in order for the team to be able to assess (through the modelling process) which of the variables were related to each other, and whether this differed for the various Advanced Practitioner roles.

Many of the local evaluations we cited above referred to qualitative factors such as improved quality of service and staff morale. While these are important (for example, see Miller et al. (2007) for a summary of psychological factors affecting organisational performance), Skills for Health did not believe it was feasible to include such measures in the evaluation. The emphasis in this exercise, therefore, was primarily on cost-benefit analysis of impact of the roles. The initial hypothetical impact model is shown in Appendix 1.

It is likely that outcomes of implementing Advanced Practitioner roles will vary between the specialties. We therefore see an important role for the evaluation in contributing towards our understanding of such variations. In broad terms, collection of the above measures should enable a calculation of productivity resulting from the introduction of new roles. It will also help clarify which data will need to be collected in future to support evaluations and workforce planning exercises. As such, the potential benefits of this work could go far beyond the shorter-term benefits of gauging the impact of the Advanced Practitioner roles.

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## 3 Method, Materials and Procedure

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In this chapter we give details on design of the survey and case study materials, the distribution arrangements for the survey and the case study interviewees.

### 3.1 Survey

#### Design and piloting of the questionnaires

Two survey tools were developed for the survey: a background questionnaire which requested information on the rationale and process for introducing the role(s), and a productivity data questionnaire which sought data that would allow calculation of the economic benefits arising from introduction of the roles.

The process adopted for developing the questionnaires was as follows:

- Collation and review of documents reporting local evaluations of Advanced Practitioner roles.
- Team meeting to discuss measures used in evaluations to date and any limitations (eg percentage improvements rather than absolute numbers).
- Further literature review of published materials to consider any additional measures that should be included.
- First draft of evaluation questionnaires.
- Meeting with Skills for Health.
- First revision of questionnaires.
- Circulation of questionnaires to Steering Group members for comment; meetings with or telephone discussions with relevant personnel to discuss any revisions needed.
- Second revision of questionnaires.
- Finalisation of the two questionnaires.

## 3.2 Developing the questionnaire content

The questionnaires sought information on two different topic areas. First, they sought information on the circumstances surrounding introduction of the Advanced Practitioner roles. This was because the way in which an initiative is introduced can affect its subsequent success. It is also likely that this will affect the extent to which any productivity gains are subsequently made.

Second, data was sought relating to the productivity of the various practices, units or wards in which the Advanced Practitioners were employed, dating from before introduction of the initiative and for the current year.

### 3.2.1 Background questionnaire

The Department of Health *New Ways of Working for Everyone: a best practice implementation guide* was used to inform development of this questionnaire. The document provides guidance for trusts considering introducing Advanced Practitioner roles, and it was important to determine the extent to which trusts had adhered to these principles in introducing the new roles. The background questionnaire therefore sought information on the following topics:

- Reasons for developing and introducing the Advanced Practitioner role.
- Leadership of the implementation programme.
- Consultation and communication processes.
- Planning education and training provision.
- Recruitment procedures and numbers recruited to posts/completed training.
- Local assessment of impact.
- Utilisation of Advanced Practitioner roles.
- Staff reaction to new roles.

### 3.2.2 Productivity data questionnaire

The previous chapter set out the range of variables considered in various previous evaluations. The items for the productivity questionnaire were compiled using that information.

Depending on the type of post that was being evaluated, reports had included measures such as changes in bed occupancy, waiting lists and freed-up consultant time. The productivity data questionnaire requested data relating to the unit, ward or directorate within which the Advanced Practitioners were employed, and

included details such as the composition of the team in which the Advanced Practitioners worked, details of the working arrangements for the Advanced Practitioners and their team, waiting list length, theatre occupancy and data on numbers of procedures.

Respondents were asked to provide these data for the most recent year and for three years previously. The rationale for asking for data for three years previously was that this was a time when the majority of sites either did not have NPP Advanced Practitioners in post, or they were still in training or had only just completed their training.

In particular, an evaluation of Emergency Care Practitioners undertaken by the Emergency Care Practitioner Team (2007) had shown that the benefits realised through introduction of this role were mainly seen in out of hours services. For this reason, we sought information on the shift patterns worked by practitioners.

Some of the previous evaluations had commented on the benefits arising from the release of consultant time which could then be used for more profitable ends. For this reason we included questions relating to the way in which Advanced Practitioners worked with consultants – in direct collaboration with them or in parallel, and whether Advanced Practitioners dealt with any particular types of activity (for example, minor surgical procedures), thus releasing consultant time to concentrate on more complex cases.

In addition, Skills for Health was interested in determining whether the introduction of Advanced Practitioners had affected junior doctors' working time. This was a question of particular interest to the health sector given the impending impact of the European Working Time Directive (2009).

Overall, the productivity questionnaire requested data on the following:

- The type of organisation in which the Advanced Practitioners were employed, typical shift patterns and staffing levels in the unit or department.
- Working arrangements between Advanced Practitioners and consultants and additional capacity generated through change to working arrangements post-implementation.
- Training and education provided for Advanced Practitioners.
- Staffing levels pre- and post-implementation, including use of locums.
- Junior doctors' hours pre- and post-implementation.
- Numbers of planned patient sessions, theatre utilisation, average lengths of patient stay pre- and post-operative.



- Waiting list details.
- Numbers of cancellations.
- Discharge arrangements.
- Numbers of readmissions
- Numbers of patient complaints.

### 3.3 Feedback on questionnaires

Feedback was received through visits and through telephone discussions with Steering Group members. In addition, one SHA, contacted during our attempts to identify non-Advanced Practitioner trusts, kindly gave helpful feedback on the questionnaires and on the background to developments of Advanced Practitioner posts.

#### 3.3.1 Background questionnaire

Most of the Steering Group members believed that the background questionnaire was fairly straightforward to fill out. One person believed that, for the sites that had had Advanced Practitioners in post for some years, it might be difficult for respondents to recall the details of the development and implementation process, particularly those who led the initiative. On discussing this issue with the team, it was felt to be important at least to attempt to gain information about the development process, and therefore these questions were retained.

Some advisors suggested additional reasons why sites had decided to implement Advanced Practitioner roles, which were added as response options to items within the questionnaire. This was the main revision to the background questionnaire.

#### 3.3.2 Productivity questionnaire

The productivity data questionnaire elicited a much wider range of responses. Two members of the Steering Group believed that sites would be unable to provide any of the information requested. Contrasted with this, others said:

*'It is easy to use and all very relevant without being too cumbersome or complicated.'*

*'It is the most developed framework I have seen, but most trusts should be able to provide this information; it is what is required for audit purposes.'*

As part of the piloting the most appropriate target respondents for the questionnaires were identified (that is, which role within a hospital would be most

likely to be able to provide this information). Most of those consulted felt that the Director of Nursing would be most likely to have this information available, with some also suggesting the Director of Patient Services.

### 3.4 Revision of the questionnaires

The questionnaires were revised in line with the (largely very positive) feedback received and then submitted to Skills for Health for final approval. Following approval being received from Skills for Health, distribution to named individuals at sites commenced.

Copies of both questionnaires are shown in Appendix 3. A modified version of the productivity data questionnaire was designed for use with the 'non-Advanced Practitioner' comparison sites. This is shown in Appendix 4.

#### Identification of sites and central contact details

It was agreed that Skills for Health would provide the project team with a list of contact details at each of the Advanced Practitioner sites. A list was provided based upon those sites and individuals involved in the initial piloting of the roles. The list indicated that, at the majority of sites (54), just one of the Advanced Practitioner roles of focal interest in this project had been introduced; six sites had two and just one site had three roles in place<sup>1</sup>.

Using this information IES produced a master list that identified a senior contact for each Advanced Practitioner role at each site. Each of these individuals was contacted and asked if the trust still had Advanced Practitioners in post. Those still employing Advanced Practitioners were invited to identify the most appropriate person to complete the questionnaire. Where named individuals were no longer in post, their replacement was contacted and asked either to complete the questionnaires or to provide the name of an individual or individuals who could complete them.

Where the list did not provide a contact name for a hospital (where, for example, a hospital was a member of a cluster group but there was no senior contact identified for the site) *Binley's Directory of NHS Management, Spring 2008 Edition* was consulted and individuals were contacted and asked the same questions until a senior person who worked with the Advanced Practitioners and could complete the questionnaires was identified.

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<sup>1</sup> It should be noted that some sites also had advanced critical care practitioners and assistant theatre practitioners and critical care practitioners, but the survey did not ask sites about these roles as they were not a focus of this study.

During these telephone calls trusts were also asked to identify hospitals in the region which (as far as they were aware) did not employ NPP Advanced Practitioners and which therefore might be appropriate to serve as part of the comparison group. However, few contacts were able to provide this information. Therefore, Strategic Health Authorities were contacted and asked if they could provide contact details for hospitals within their area that did not (as far as they were aware) employ Advanced Practitioners in relevant professional groups. Four SHAs subsequently provided the information requested.

### **Distribution**

Once an appropriate senior person at each trust had been identified the two questionnaires were sent, with a covering letter printed on Skills for Health letter-headed paper and signed by Kathryn Halford (see Appendix 2). The questionnaires were customised to identify the appropriate Advanced Practitioner group at each site. A reply-paid envelope was provided for return of the questionnaires. Where the initial telephone call had revealed that Advanced Practitioners were employed at different hospitals within a trust, multiple sets of questionnaires were sent, customised as appropriate for the different Advanced Practitioner groups.

### **Follow-up**

Distribution was followed up by phone calls to the main contacts to request return of the completed questionnaires.

## **3.5 Response rate**

After the questionnaires were distributed it soon became clear that the concerns expressed by some of the Steering Group regarding the ability of trusts to provide productivity data were justified. After the follow-up phone calls just thirteen sets of questionnaires were received from Advanced Practitioner sites and three from non-Advanced Practitioner sites. Trusts with Advanced Practitioners in post had clearly found it easier to provide information on background to the initiatives than they did to provide productivity data, for while they had completed most of the questions in the background questionnaire, they had struggled to provide any data on productivity.

## **3.6 Changes to procedure**

Once the survey was distributed it became evident that, contrary to expectations, many trusts were unable to provide the data requested. At that point IES offered to undertake case studies instead of the survey, but Skills for Health decided to

continue with the survey, as they believed it would be useful to gain information regarding the extent of data (non-) availability in general.

As indicated above, trusts were slow to return the questionnaires. Mindful of the need to complete the work in a relatively short length of time, Skills for Health agreed that the case studies could be arranged in parallel with the survey, rather than following analysis of the survey data, as had first been intended. Selection of the case study sites was limited to those who could facilitate visits by the end of August 2008.

### **Response profile**

The majority of survey respondents were responding from acute secondary care institutions. Three were foundation trusts and three were teaching trusts. One was a non-teaching hospital. The other respondents did not give this information.

At most of the responding sites the Advanced Practitioners worked standard hours, with those at one site working from 8-5 and another site at which they worked one evening a week. They tended to work in teams in which a wider mix of working hours was found.

#### **3.6.1 Case studies**

Case studies were undertaken at four sites employing Advanced Practitioners. These sites were selected to provide a range of Advanced Practitioners: surgical care (two); perioperative specialist practitioners; and physician's assistant (anaesthesia). The anaesthesia case study trust provided interviews with consultants and Advanced Practitioners at two hospitals.

To be included within the case study component of this investigation, sites needed to have had Advanced Practitioners in post for some time, so that interviewees could comment on where and how they were utilised within the hospital, and any impact seen. The sites were also chosen to provide a reasonable geographical spread. Originally it had been intended that two sites with just one Advanced Practitioner group (role) in place and two sites with more than one Advanced Practitioner group (role) would be selected. Given the time constraints for the work, however, this was not possible.

The purpose of the case studies was to gain in-depth data regarding the ways in which the Advanced Practitioner posts had been developed and introduced at each site, the training that Advanced Practitioners had undergone and the way in which the posts were being utilised. Discussion guides were designed for interviews with human resource leads, consultants/clinical supervisors, with

medical or non-medical colleagues and with the Advanced Practitioners themselves. The discussion guides are shown in Appendix 5.

At each case study site an interview was requested with the HR lead involved in the initiative (where there had been HR involvement), consultant/clinical supervisors, medical or non-medical colleagues who worked with the Advanced Practitioner(s) and with the Advanced Practitioners themselves. At one trust the education lead was interviewed.

Once the case study visit arrangements had been confirmed it became clear that there had been little HR involvement at these sites. Therefore, interviews with HR consultants were not booked. Four case studies were undertaken, which involved interviews with a total of fourteen individuals: five consultants, six Advanced Practitioners, one deputy divisional manager, one specialist registrar, one head of nursing, one assistant director of therapy services, one education lead and one practitioner lecturer.

### **3.7 Reporting the data**

Given the low response rate to the survey, we have combined the findings from the survey data and the case studies. The combined findings from the survey and case studies are reported in the following four chapters.

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## 4 Opting in to the Advanced Practitioner programme

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### Key findings

- The main reason cited for involvement in development of the Advanced Practitioner roles was to reduce junior doctors' hours. After this, service re-design/service improvement was most often cited.
- Clinical directors or consultants had most often led the developments; at a majority of sites executive directors had not been engaged with the project after the initial bid for funding.
- Typically, one inspired and committed individual had led the development process; when these people leave, development projects can struggle and lose direction.
- At no site had an HR representative led the project. There was also little evidence of HR or Finance involvement in embedding the posts, or of workforce planning to incorporate the posts. Nor had the posts been included within business plans or education and training commissioning plans.
- Most sites had not drawn up a plan for communicating Advanced Practitioner developments to staff in the trust.
- A minority of sites had identified criteria against which to judge the success of the programme.

### 4.1 Getting involved

Each institution cited several reasons that had motivated their decision to become involved in developing, or introducing, the Advanced Practitioner role:

- The reason for becoming involved that was cited by the largest group of respondents was as part of an attempt to reduce junior doctors' hours; seven indicated that this had been a motivation for involvement.
- Six said it had been part of an attempt to increase service capacity.
- Six said that encouraging working across interprofessional boundaries had been a motivating factor.

Other reasons cited included there being a specific service need, cited by three respondents. In one case the service need had been to provide continuity of care given the reduction in junior doctors' hours, in another it had been the demand for surgical assistance and support. Service re-design was also cited by three sites, three said that introduction of the Advanced Practitioner posts had been a response to government targets and two had been seeking to reduce workforce costs.

At one site there had been interest within the relevant departments in the novel training programmes; this was because, at the time when the Advanced Practitioner posts were being introduced in that organisation (2004) there were particular political and economic factors that had driven developments and made departments keen to be involved. However, this respondent felt that the political and economic climate had now changed.

The questionnaire responses indicate that while a range of factors had informed the decisions of trusts to become involved in developing and introducing Advanced Practitioner posts, the factor that was identified by the largest number of respondents was the impending impact of the Working Time Directive on junior doctors' hours. The importance of this factor in motivating introduction of the Advanced Practitioner posts was confirmed in the subsequent case study interviews.

*'There were two issues: initially, they started as posts to help get the waiting lists down, but my view is the impending [need to reduce] junior doctors' hours and reduction in the workforce was the main aim to the developments.'* (Case study interview)

*'At the time the role was brought in there was a projected decrease in the numbers of consultants and they were having problems recruiting. And especially the need to reduce the hours of junior [doctors]. But [the focus] has evolved from the projected shortfall in consultants to a reduction in junior [doctors'] hours.'* (Case study interview)

## 4.2 Decision-making and leadership

At six sites the decision to become involved had been taken by a director (a clinical or nursing director) or associate director (in one case, associate director of surgery, in another, of nursing). In two other sites consultants or surgeons had led the

work to introduce the posts. In eight cases there had been board-level support for the initiative. In two cases this meant that funding was made available for the project.

*'Agreement to continue funding of post.'* (Survey respondent)

*'There was some funding available for the training post. There was an assumption we needed to cover a third of the costs from the centre, the rest would come from the SHA.'*  
(Survey respondent)

The case studies revealed that, in common with many new role redesign and service development initiatives<sup>1</sup>, it is one inspired and committed individual who pushes through the development, finding funding and assembling a team of like-minded enthusiastic individuals. Although in some cases the Chief Executive or other senior staff were responsible for initiating the project, there was typically little involvement of senior management after the very early days of inception of the project. There was also little evidence of planning or leadership from the HR department. Indeed in most cases, no HR staff were involved.

*'The CE and Clinical Director had responded to the invitation to express interest. The Expression of Interest was precisely that, I think. I talked to the clinical director who had been involved in the bid to the DH. We tried to interest trusts at senior level, sign off at executive level but we found it difficult to engage senior people.'* (Case study interview)

*'There was no process – it was just, "Here's some money from the departmental budget, go away and do it".'* (Interview with survey respondent)

*'We did have an HR person ... their key role was looking at employment issues not the role. Our trainees were employed, not bursaried or on grants, therefore there were employment issues ... the project group held a seminar for HR and service managers that got zero response ... There is little HR involvement in education and training. There is a tendency for HR to be involved only in employment-related issues rather than workforce development in general.'* (Case study interview)

Subsequently, once the posts are introduced there also seems to be little involvement of HR in embedding the posts or in learning from the experience. Where the initiative has been the brainchild of a particular individual this can mean that there is no subsequent consolidation of organisational learning from (or about) the development. This, combined with the relatively high levels of staff turnover in the NHS, can lead to loss of the knowledge gained and organisations failing to build on previous developments. One such situation had led to a complete loss of momentum at one case study site:

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<sup>1</sup> See, for example, Hyde et al. (2004), *A Catalyst for Change? The National Evaluation of the Changing Workforce Programme*, Department of Health



*'The trust lost money, the Director of Nursing left, and the person who replaced her knew nothing [about the developments], so they did not appoint the additional [Advanced Practitioners].'* (Case study interview)

## 4.3 Consultation on the roles and involvement of stakeholder groups in development

### 4.3.1 Consultation

Respondents were asked about the consultation process that had preceded development of these posts. The intention in asking this was to explore whether, at those sites that consulted more widely, there was more successful implementation of the posts.

While only eight of the twelve respondents said that there had been internal consultation regarding the need for the Advanced Practitioner role, when asked if various groups had been consulted more responded, and it emerged that there had been some amount of consultation at all sites.

- All thirteen survey respondents reported that medical colleagues in the team who would work with the Advanced Practitioners had been consulted.
- At ten sites senior managers or executive directors had been consulted.
- Nine sites had consulted senior nursing staff.
- At six sites other senior medical staff had been consulted and six sites reported consulting non-medical colleagues in the immediate team.

While just one had consulted trade unions, three had consulted education and training practitioners and four had consulted non-medical colleagues. Additionally, nine sites had consulted externally: six of these had consulted their SHA and five had consulted relevant professional bodies.

### 4.3.2 Development

Respondents were also asked about the various groups that had been involved in developing the roles:

- At eleven of these sites medical colleagues had been involved in developments.
- Eight had also involved senior managers and executive directors.
- Eight had involved senior nurses and six had consulted other senior medical staff.

- Six had consulted non-medical colleagues and five had involved education and training providers.
- At four sites professional bodies had been consulted and four had consulted their SHA.

Individual sites also recorded having consulted local staff management committees, trade unions, patients and the New Practitioners Programme Group.

### 4.3.3 Business plan

In only three of the sites had development and introduction of these roles been part of the business plan. In each case the context was service provision: one said it was service need; another said it had been to improve service capacity; another said it had been part of service re-design. At one site introduction of the roles had subsequently become part of the business plan and another respondent said that, while the initiative had not formally been part of the business plan, all four trusts in that particular development cluster had suggested becoming involved with a view to determining, as the project was rolled out, whether there was a valid business case for bringing Physician Assistants (PAs) into their departments. This individual also commented:

*'It was difficult to get [this idea] across to colleagues in New Ways of Working in [this area] – they had a simplistic view that a need could be identified and you could then train them up, but that just isn't valid.'* (Survey respondent )

Just four sites reported that education and training for these roles had been incorporated into their commissioning plan.

### 4.3.4 Communicating information about the Advanced Practitioner initiative

Six sites reported that they had had a communications strategy for introducing the posts to the organisation. The main route through which the developments had been communicated was in team meetings (nine sites) with sites otherwise using a mix of emails, face-to-face discussions, flyers, working groups and features in the trust magazine to promote the roles.

Six sites had appointed a local champion. In one case this was the consultant, who acted as clinical supervisor. At other sites the person fulfilling this role appears to have had a wider remit that was closer to the role of a project manager: at one site the respondent reported that the champion had been responsible for leading the development and training, while at another the champion's responsibilities had included:

*'Implementing and publicising the training programme and introducing the trainees, ensuring that the training was conducted in a satisfactory manner and ensuring the process of induction/ interfacing with the team went smoothly for the Advanced Practitioners.'* (Survey respondent)

## 4.4 Identifying success criteria

Only four sites had identified success criteria against which success of the programme could be judged. One of these sites said that measures had been developed 'specific to the hospital role with the Modernisation Agency'. These sites reported that senior medical staff, senior nursing staff, non-medical staff, senior managers and executive directors had been involved in the process of identifying 'success criteria'. Just one site said that the national competency framework had been used.

The criteria had not really been used after development. One survey respondent said that criteria had been developed 'only in theory' and that the Advanced Practitioners had 'been assessed against these once'. Another said that:

*'[We had] planned audit to assess effectiveness in organisation. Not really working – now lack of interest.'* (Survey respondent)

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## 5 Recruiting and Developing Advanced Practitioners

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### Key findings

- The majority of Advanced Practitioners had been recruited internally. Just one explicitly tested the potential for recruiting people from outside the health sector.
- The training for Advanced Practitioners had in some cases involved a great deal of travel and time spent away from home. However, a distance learning programme developed for training Advanced Practitioners had been very well received.
- While the majority of sites surveyed and visited during the case studies still had Advanced Practitioners in post, some had moved on to advance their careers. Some Advanced Practitioners had been lured by offers of higher band jobs. Some had moved into medical training.
- All of the Advanced Practitioners were enthusiastic about the career options provided by the posts. However, at present little thought has been given to the future career paths available to people in these posts, and there is little provision of or funding for CPD.
- The training had been costly. Interviews revealed some capacity for more cost-effective delivery of training in future.
- Few sites were considering commissioning further Advanced Practitioner posts.

In this chapter we report the ways in which individuals had been recruited to and developed for the Advanced Practitioner posts.

## 5.1 Recruitment to the roles

At six of the sites recruitment had been by open internal advertising. Five sites had advertised externally. Three said they had used targeted internal recruitment (that is, they had targeted specific staff groups in recruiting to these posts) and three sites reported that certain individuals had been nominated by a manager. One person had been seconded to the post.

### 5.1.1 Job descriptions for Advanced Practitioners

Ten sites reported that their trust had produced job descriptions and nine had produced person specifications for the Advanced Practitioner roles. The remaining three sites were unsure if these had been produced. At one of the case study sites the Advanced Practitioners confirmed this point:

*Interviewer: Do you have a job description?*

*Advanced Practitioner: Not a job description, a brief outline .... a person spec., but we have moulded it and we adapt to what is needed locally.*

### 5.1.2 Minimum qualifications

Six of the responding sites reported that minimum qualifications had been specified for potential applicants for the Advanced Practitioner posts, with most indicating that a degree-level person or equivalent (eg 'post-experience registered nurse or similar') was specified. One person commented that, where applicants had been accepted who only just met the minimum specification, the trust had had to work hard 'in order to bring those people up to the required standard'.

### 5.1.3 The recruitment pool

One site had opened the posts to external recruitment, so that anyone with the appropriate qualifications and experience could apply. Most of the other sites had used some form of internal recruitment process. Sites participating in the original pilot projects had been given the option of selecting from existing healthcare practitioners or from science graduates. In the event only one site decided to try the option of recruiting science graduates, although this one cluster had involved four trusts. In both recruitment routes the individuals selected were viewed as competent and successful recruits. However, interviewees from the trusts that had recruited science graduates made the following apposite comments:

*'We felt strongly that it was the beginning of the period when there were large numbers of graduates coming out of the universities, they were bright and we felt we should tap into that pool. If we took healthcare professionals we would be 'robbing Peter to pay Paul' – we*

*would be taking the best people, and ultimately it is not in the best interests of the NHS – it just causes more recruitment difficulties further down the line.’ (Case study interview)*

*‘I felt strongly that science graduates were the right group to look at – this was the Atlanta Georgia model – they need to have a proven academic history. Plus there is a need to increase the workforce, not take from shortage areas. And it is cheaper than training existing staff. And it has proven to be very successful.’ (Case study interview)*

However, it should be noted that trusts will probably need to be careful in wording advertisements as limiting intake to external graduate applicants is likely to run up against equality legislation. A further point is that any selection procedure will need to incorporate some practical experience to allow potential trainees to discover whether they are able to cope with working in theatres and other health settings.

#### 5.1.4 Training for the posts

Training programmes had been developed specifically for the Advanced Practitioner roles early on in the development of the programme. At ten of the responding institutions all of the trainee Advanced Practitioners had finished their training. Two sites had Advanced Practitioners who were still undergoing training. Three sites had had trainees leave before completion of the course.

None of the sites reported that individuals had trained in more than one Advanced Practitioner practice area, although an account was given while piloting the questionnaires of this having happened at one site.

At eight of the sites the Advanced Practitioner trainees had received ongoing clinical supervision, but no respondents had reported the provision of peer mentoring (most likely because of the absence of peers in these areas due to the initiative being relatively new). However, nine of the sites did report that Advanced Practitioners had had mentors during their training, but these tended to be senior clinicians or consultants.

#### 5.1.5 Retention

At one site a delay in funding had led one Advanced Practitioner to leave before the trust could make a formal job offer. Advanced Practitioners remained in post at most of the sites; however, in one trust the majority of the Advanced Practitioners had left and the one individual who remained at the trust was no longer in the Advanced Practitioner post. Another site had had their Advanced Practitioners poached by another trust almost immediately after they had completed their training. As a result they had no Advanced Practitioners in post and at the time of the survey were not training any replacements or planning to recruit.

## Accessibility of the training

The case studies provided information on how the training programmes had been received. Two of the case study trusts were located in the Midlands. In both of these, the trainees had been required to travel to London for one-week block training sessions at London-based universities once a month, which necessitated the trainees staying in London for the duration of those sessions. This had not been easy for them.

*'It was nine months, with one week in four being spent in London, the rest on site .... When you come back to base though there's nothing connecting it to your situation .... They need to look at improving home support. I hung out with the SHO, but that's no substitute for a mentor who is from the same group as you and knows the sorts of problems you will face.'* (Case study interview)

*'At first it was in blocks of one week a month. It was horrendous, a 5 am start.'* (Case study interview)

In a third case study however, based in the south west of England, the theoretical input had been delivered via e-lectures and so trainees had not had to travel to attend lectures. The trainees were extremely enthusiastic about these, and indeed had even shown the lectures to other staff.

*'The e-lectures were fantastic ... brilliant, and you could just keep on watching them until you got it. You can just dip in and out of them. And I let the new SHOs watch it and they used it too.'* (Case study interview)

## 5.2 Improved career options

All of the Advanced Practitioners interviewed were very enthusiastic and positive about the career opportunities that had been provided by these posts.

*'[The Advanced Practitioner role has] opened doors. I feel privileged. I would never have done this without going to medical school. Options for people with science degrees are quite limited. It's opened up a whole new avenue. I feel privileged, really privileged.'* (Case study interview)

*'It was absolutely the right decision. I have the autonomy, I love being able to get on with it.'* (Case study interview)

For one interviewee the Advanced Practitioner role had provided the opportunity she was looking for. Asked what her career options in the NHS had been before the post was introduced she simply said: *'Leaving.'*

However, at present there are few further routes for career advancement for Advanced Practitioners, which is a concern for some of the people who work with them:

*'We don't know. It's a new career and there is not a career path laid out as such. Where do they go from here? Into management? Medical school? I hope we can retain them. They may move to other trusts or other parts of the country. It is a concern that this could happen.'* (Case study interview)

*'I don't think there are any [career routes] at present. It won't become clear until the roles are more developed. Perhaps like ODPs they will go into management. There is a need to develop the role to keep it interesting. Any career development is within the role at the moment.'* (Case study interview)

Although the Advanced Practitioners acknowledged the fact that career options may be limited, at present they appear quite content to remain within these roles:

*'Career development? I haven't really thought about developing the role until I have really found my feet and gained more experience—I just want to settle in and do the job well. There is quite a lot to do promoting the role. There will be a limit to what we can do. But you could have quite a nice niche and expand your own role. You can mould it into what you want to do and get involved in more extended roles.'* (Case study interview)

## 5.3 Sustainability

Although the roles were proving popular with the individuals recruited, and with consultants too (see Chapter 6), there were fears for the future sustainability of the training and, as a consequence of this, for the roles themselves.

### 5.3.1 Sustainability of the training

Given the very small numbers of individuals going through Advanced Practitioner programmes at present it would seem sensible to fund a small number of universities to develop exemplar distance learning e-modules that could be used by practitioners to reduce the amount of travelling required by trainees and, at the same time, to reduce delivery costs for these programmes.

In addition, at present learning programmes for the various Advanced Practitioner roles are being delivered as entirely separate and discrete programmes. In part this is because programmes for single practitioner roles have been developed by separate universities. However, many of the interviewees felt that there were common areas which could be taught with mixed groups of practitioners – for example, it was felt that there were some areas of overlap in the knowledge required by surgical care and perioperative specialist care practitioners. Although interviewees felt they knew too little about the requirements of the other programmes to comment in any depth on the likely common areas, interviewees were able to identify some areas likely to be common not just across groups of Advanced Practitioners but other healthcare professions too:



*'Some, applied physiology, patient care.'* (Case study interview)

*'Aseptic Technique, manual handling, perhaps.'* (Case study interview)

*'Possibly it would be useful and probably nothing would be lost if topics such as basic suturing were taught jointly .... actually, you probably could say that there is around a 30-40 per cent overlap on clinical knowledge and you could put us in the same class for areas such as heart, lungs, general systems.'* (Case study interview)

*'There are few common areas. We probably lack the medical side that is in the Physician's Assistant training but it would be nice to incorporate that, if that happened then there would be grounds for some common areas. The First Aid course was done with the theatres aspect of the First Assistant people.'* (Case study interview)

*'The components of the [Perioperative] course are largely advanced assessment and prescribing. A large part of the postgraduate diploma covered physical assessment and for many nurses that was the main hurdle. There is a big overlap between the PG [Nursing] Diploma and the Perioperative qualification. It probably would be possible to organise joint sessions with other groups of trainees – [for] the core components – things like interpretation of investigations.'* (Case study interview)

Unless more economical ways of delivering the training are found, it is unlikely there will be much further progress in rolling out the roles:

*'It would be prohibitively expensive to utilise the training structure used on the pilot as part of the normal education for Advanced Practitioners. You are talking about academic teaching for a very small number, so training costs are very expensive.'*

(Case study interview)

Furthermore, there had been little planning regarding the future development needs (CPD) that would be required by these practitioners once in post. While some were being supported to expand their skills in further areas of extended practice, others were not receiving any development.

*'We don't seem to get any funding for anything. And there are not that many courses for us to progress onto and maintain our knowledge – it's all in-house, there is no national structure to help us keep our knowledge up to date. You can pick out modules from the MSc but there is nothing for [these Advanced Practitioners] as a body. Lots of SHOs and registrars go on courses that would be appropriate for [us] but we can't go and we do not get the opportunities. This is what we need to move on and it isn't there and we don't get invited. And funding. Doctors get a funding allowance for courses, we don't.'*

(Case study interview)

In the next section we consider the sustainability of the Advanced Practitioner posts themselves. It can be seen that respondents' views on the sustainability of the posts was closely linked to sustainability of the training. Without available training (and funds for training) respondents saw little chance that these posts would continue.

### 5.3.2 Sustainability of the posts

Interviewees had fears regarding the future sustainability of these posts. This was for two main reasons: firstly, the fact that in many sites no more Advanced Practitioners were being trained or appointed; and secondly, because of problems with incorporating these posts into trusts' planning for future staffing levels and training budgets.

As indicated above, the training during the pilots had, of necessity, been costly, as universities had to develop and deliver programmes for relatively small groups of learners. In addition, the employment costs of the trainees had been borne through the project funding. Therefore quite large sums of money<sup>1</sup> had been made available for the development work, but in some cases once the funding ended the trusts had started to reconsider whether they could fund the positions. This is exacerbated by the fact that there is, at present, little evidence of the economic benefits of introduction of the posts (the primary reason for commissioning this work). This was also evident in the difficulties experienced in collecting survey data because in some cases, Advanced Practitioners were no longer in post due to termination of funding.

*'I still don't really know if the training programme will remain. The political drivers have disappeared, workforce planning was the main thing. I think it is too early and there are too few PAs to detect the impact at present.'* (Interview with survey respondent)

*'The role has not been rolled out as much as we had expected. The original idea was to 'pilot' with one, then introduce perhaps four or five more, but this has not happened due to money problems.'* (Case study interview)

*'I would like to train a new cohort. Only having one set limits what we can do ... but the issue of funding for future training is a problem. There is no real precedent for trusts to fund this type of two-year course themselves. There has to be some sort of assistance and recognition within the national training budget that money for training for these posts needs to continue to be allocated.'* (Case study interview)

*'No one is going through [the programme] at the moment. We have said we would be interested in training more but that requires will on the part of the trust to make that investment, and we need to demonstrate the benefits first.'* (Case study interview)

*'In many cases these initiatives appear to have become mired once the first or second cohorts had completed training; this appeared largely to be due to lack of central leadership or agreement within the health service as a whole regarding how these posts are paid for, especially the funding for training.'* (Case study interview)

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<sup>1</sup> One case study interviewee cited a sum of £40,000 being made available for training for each Advanced Practitioner, while another site spoke of having been allocated nearly £600,000 for employing Advanced Practitioners (as trainees) and training them.

*'Still uncertain as to whether we need large numbers of APs. Many unemployed medical anaesthetists about who can work independently, unlike APs. Many new starters in medical anaesthesia, makes providing space in theatres for training APs an issue in our trust.'* (Survey respondent)

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## 6 The Organisational Impact

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### Key findings

- In many of the trusts Advanced Practitioners were running separate or parallel sessions to consultants.
- The extra capacity provided by Advanced Practitioners in some cases enabled medical practitioners to take on more complex cases or undertake other activities.
- The impact on work practices was widely believed to have brought improved service delivery.
- Trusts believed that introduction of the Advanced Practitioners had helped them to reduce junior doctors' hours; however, few trusts had data to demonstrate this benefit.

In this chapter the impact of Advanced Practitioners on work practices and service quality is explored.

### 6.1 Impact on work practices

Survey respondents were asked to describe how the Advanced Practitioners worked within their team or department. In answering this question they were given four response options ('works alongside the consultant and medical/team with a specific role within the team'; 'has responsibility for own discrete set of separate tasks that they perform with close supervision'; 'manages their own caseload with remote supervision'; 'runs separate sessions from those run by consultant and/or medical/nursing team'), and they were also able to write in their own description of work responsibilities if they wished. Eight hospitals provided data on working arrangements for Advanced Practitioners.

- In eight of the hospitals the Advanced Practitioners work alongside the consultant/medical team but have their own specific role.
- In five they run separate sessions.
- In six sites they have their own set of discrete tasks to undertake.
- In four sites the Advanced Practitioners managed their own caseload.
- At six sites respondents indicated that a mix of three or more of the above arrangements applied to the Advanced Practitioners working at their site.

Survey respondents provided further descriptions of the work undertaken by Advanced Practitioners. These were:

*'Also run GP direct access lists.'*

*'Has own injection clinics.'*

*'Used as follow up, some following more investigations required, some straight-forward post op.'*

*'Pre assessment clinic.'*

Those who indicated that their Advanced Practitioners ran separate sessions were asked whether these were additional sessions, or replaced a medical practitioner in existing sessions. At one site they ran additional sessions, at two sites the Advanced Practitioner replaced a medical practitioner, and at two sites Advanced Practitioners were used both to run additional sessions and to replace a medical practitioner.

Respondents were asked how the additional capacity created through use of Advanced Practitioners was used. Three respondents said that this freed up senior medical staff to see more complex cases; one also said that it allowed the hospital to run more clinics and see more patients. Another commented that it allowed physicians to take up other duties.

There is also evidence that working practices are changing so that hospital facilities and teams are being utilised more cost-effectively. Two extracts from case study interviews follow. In the first, a consultant gives a detailed description of the ways in which the introduction of Advanced Practitioners had brought cost savings. In particular the interviewee described how Advanced Practitioners had enabled far more efficient use of theatres. In the second, the interviewee describes how introduction of the Advanced Practitioner role helped improve theatre efficiency and led to improved working conditions more widely.

*'One [Advanced Practitioner] is trained for [a specialist area] so is working semi-independently in [that] theatre. We would normally have to pay a doctor to do that, so the*

*savings are quite clear there. But that is not part of the standard [Advanced Practitioner] role. We have developed roles by having one Advanced Practitioner in each of two adjoining theatres and one consultant supervising the two. We do this, but not as often as I would like, just one day a week. The cost savings are difficult to tease out for this situation but if there is a staffing crisis then it is good. That was the idea at the start. The second way [of gaining cost-efficiency] is to improve theatre turnaround times. Sometimes we have a 30 minute turnaround, while the whole team is standing idle ... with Advanced Practitioners, you can [work in parallel so that] you can get four joints done on a list rather than three. It all saves money. We did an audit project when the Advanced Practitioners were training: it demonstrated seven minutes savings, but we were not sending for the patients early enough. In the best cases you can save 15 minutes turnaround. If you can get your systems to work properly it is possible to save money. But that relies on adequate numbers of porters, operating tables, trolleys. It needs the theatre staff to be on board. There is the whole ethos that needs to be worked on to get people working together properly.'*

(Case study interview)

*'They [the Advanced Practitioners] have facilitated same day admissions. We now get people seen before they come into theatre. One consultant is now asking for [an Advanced Practitioner] to help so that he can see more people and it means he can now get a tea break! [The Advanced Practitioner] working in parallel with the consultant releases consultant time. Incidentally, we are now working whole-day lists and with the European Working Time Directive it is very helpful to have an Advanced Practitioner there to assist.'*

(Case study interview)

*'APs have been appointed in addition to consultants. No consultant sessions have been dropped. Funding for APs was secured on basis of other revenue [being] generated by extra cases being done in theatres due to AP presence.'*

(Survey respondent)

### 6.1.1 Using Advanced Practitioners' skills

Sites were asked whether the qualified Advanced Practitioners had been able to utilise their full range of skills. The majority (nine respondents) agreed that Advanced Practitioners had been able to use their skills.

At the sites where Advanced Practitioners had been able to fully utilise their additional skills the respondents gave examples of the types of activity in which Advanced Practitioners had been and were involved. The list of activities included:

*Anaesthetic pre-assessment, assisting in theatre and ward work (PA Anaesthesia)*

*Assisting in theatre and on wards. Pre-clerical and pre-assessment of patients (Surgical care)*

*Cardiopulmonary exercise testing; eye blocks for cataract surgery, indirectly supervised (PA Anaesthesia)*

*Pre-admission, outpatients; surgical assisting, consulting and prescribing (Surgical care)*

*Wound closure, first assistant at surgery, joint infections (Surgical care)*

However, one survey respondent observed that it takes time and opportunities to practice skills in order for an Advanced Practitioner's skills to be fully deployed, while another commented that those opportunities could be restricted by the teams in which they worked:

*'The skills they acquired are very fresh, they are neophytes. All have been able to use those skills appropriately that they have developed, but it requires both experience on the part of the trainees to develop new ways of working further, and it requires the practitioners to use their skills more through gaining more experience in order to use them effectively. It is not all immediate.'* (Survey respondent)

*'Restricted by lack of support from some of the consultants.'* (Survey respondent)

However, at some sites Advanced Practitioners were limited in the tasks they could undertake. At one site the jobs that Advanced Practitioners were able to do varied with the training needs of the junior doctors. This had led to a situation in which the work contracts for the Advanced Practitioners changed from year to year:

*'Our job plans have changed each year according to the needs of the service. We did more work in clinics last year because the junior doctors wanted more theatre work.'*  
(Case study interview)

In another, an individual had found their skills underused to the extent that, for a while, they had been faced with losing their job (although in the end the situation was resolved):

*'One Advanced Practitioner was faced with redundancy. That was because [their] consultant was using [them] as a dogsbody.'* (Case study interview)

## 6.1.2 Impact on junior doctors' hours

The survey data had revealed that in many trusts the main objective in introducing the Advanced Practitioner posts had been to achieve a reduction in junior doctors' hours. As reported in Section 6.1 above, survey respondents and case study interviewees had linked introduction of the Advanced Practitioner roles with their ability to meet the requirements of the European Working Time Directive.

However, just three of the sites that responded to the survey could provide data on junior doctors' hours in the departments in which Advanced Practitioners were employed. In one case, they had gone from having no junior doctors to having nine hours per week, presumably indicating that they had no junior doctors until

relatively recently. However, both the other two departments had seen a drop in junior doctors' hours: in one case from 24 to 12 hours a week, and in the other from 56 to 50 hours a week.

Given the fact that none of the comparison (non-Advanced Practitioner) sites could provide data for junior doctors' hours (and given the very low number of responses in general) it is not realistic to take these numbers as firm evidence for the impact of Advanced Practitioner posts on junior doctors' hours. However, the subsequent case study interviews tended to confirm the impression that Advanced Practitioners are contributing to the reduction in junior doctors' hours. In one case this was perceived as having helped the trust to achieve its aim and at the same time helped junior doctors to pursue their training needs, although elsewhere people continued to have concerns about the impact of Advanced Practitioners on training opportunities for junior doctors.

*'It has freed up junior doctors from the 'donkey work' and allowed them to concentrate on their training.'* (Case study interview)

*'I believe that we [should] make use of them [in such a way that] the junior doctors' training is not compromised.'* (Case study interview)

*'I think we should not have [Surgical Care Advanced Practitioners] here as it is a teaching hospital and I do not feel it is appropriate for SCPs to do tasks an SHO would cut their teeth on. But they are fine in a District General hospital.'* (Case study interview)

However, the evidence suggests that, with the right level of planning, by people of an appropriate level, such difficulties can be avoided:

*'One problem for me was about theatre capacity to train them. All hospitals have junior [doctors] you are training up, paramedics in for training, police in for training, and we had to accommodate the [Advanced Practitioners] as well, so that could be tricky on occasions, but I put a lot of time in myself to make it work. But in [another site] it was delegated to a secretary and that's part of the reason it didn't work there.'* (Case study interview)

The emerging evidence suggests that the introduction of Advanced Practitioners is helping to reduce demands on junior doctors' time. However, training for both groups needs to be planned with care to ensure neither doctors nor Advanced Practitioners miss out on essential training or work opportunities. Stronger data on junior doctors' hours will be needed before any firm conclusions can be drawn.

### 6.1.3 The service benefits

There is evidence from the survey returns and the case studies that the patient experience is improved by the presence of Advanced Practitioners. There is also emerging evidence that improvements to patient services can be cost-effective.

*'Reduced length of stay, improved quality of care.'* (Survey response)



*'It is early days, but I do feel it's been of benefit. The wards have a contact point now.'*  
(Case study interview)

We saw in Section 6.1, above, that the Advanced Practitioners were helping increase capacity and free up consultant time. Survey respondents were asked to give examples of the ways in which the introduction of Advanced Practitioners had benefited the service. The observations of survey respondents included:

*'Help with service provision, reduced costs.'*

*'Help with what would otherwise be single-handed practitioners with busy lists; improved theatre turnover.'*

*'Improved patient care.'*

*'Increased activity, continuity of care.'*

*'Reduced length of stay, improved quality of care.'*

*'Efficiency, patient satisfaction, staff satisfaction.'*

*'Smooth running of the teams, and team cohesion and communication.'*

However, interviewees at the case study sites themselves commented on difficulties they had experienced in getting hold of the data that is needed in order to prove the case for the cost-effectiveness of introducing Advanced Practitioners.

*'The other main problem for the development of the role is financial – I don't feel we've hugely demonstrated the cost savings of Advanced Practitioners and it is hugely difficult to show them. We have got the opportunity to do this but pressures of other things means we have not done this. But we do need to be able to demonstrate the cost savings.'*

(Case study interview)

In some cases the Advanced Practitioners themselves were getting involved in seeking out the relevant data:

*'Yes, it has impacted on lots of things: reductions in waiting times, reduced bed length of stay ... length of stay will be audited in April. Myself and the audit office will do that.'*

(Case study interview)

In another of the case study trusts one of the Advanced Practitioners had conducted an audit of 100 cases which had demonstrated a small but significant time saving. The same trust had engaged a research consultancy to estimate the potential for savings based on parallel working sessions in theatres which had suggested potential savings of between £46,286 a year (assuming one Advanced Practitioner in post and using the most conservative assessment of potential benefit) and (£709,714) assuming three Advanced Practitioners in post and using the most optimistic calculation. Assuming it costs approximately £40,000 to employ an Advanced Practitioner (on Band 7, and including on-costs), the costs in

each of these two scenarios would be £40,000 and £120,000, leading to a profit somewhere in the range between £6,000 and £589,000<sup>1</sup>. Another trust had audited their APs' work in the trauma theatre and demonstrated that they could work on one extra person a day due to presence of the APs.

However, other organisational changes may be needed in order to allow the potential benefits of Advanced Practitioner roles to be fully realised. As one interviewee who was quoted earlier in this chapter (p.48) pointed out, while it is possible to save money, this relies on other supporting parts of the system being in place: adequate numbers of porters, operating tables, trolleys, etc., and, in addition it needs all staff to work together to bring about the potential benefits.

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<sup>1</sup> Analysis by Newton Consultants

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## 7 The Barriers

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### Key points

- There remains a lack of clarity about, and understanding of, the Advanced Practitioner roles.
- In the absence of a communications plan it had often been left to Consultants and Advanced Practitioners to inform other staff about the role.
- On the whole, colleagues' attitudes were positive. Where this was not the case, it most often arose through fear of professional encroachment or lack of clarity about the role.
- Trusts had often failed to consider the changes that would need to be made to organisational structures and processes to enable the Advanced Practitioners to fully utilise their skills.
- Some sites had not developed job descriptions for the posts.
- Despite the enthusiasm for the service improvements brought about by introduction of the new roles, few sites planned to recruit and train more Advanced Practitioners.

Several barriers to introduction and further roll-out of these roles were identified, mainly during the case study and other interviews. The main barriers were: confusion over the role, and, related to this, the attitudes of colleagues; fitting new roles into existing organisational structures and working arrangements; accessibility of training; and the longer term sustainability of the posts. As issues concerning the accessibility of training and sustainability were reported in earlier sections (Chapter 5) they are not re-visited in this chapter.

### 7.1.1 Clarity of the role

One of the issues that emerged from the case studies was that there is a lack of clarity about the new roles. Respondents reported that other colleagues – nurses and consultants in the main – did not understand what the role entailed. Patients too did not really understand where the role fitted into the hospital ‘hierarchy’.

*‘It has not been easy. In the first stage they were [perceived] as glorified nurses. No fixed rota, [it] was very sketchy, “You fit in where you are needed”. Then in the second stage we sat down to define and organise the rota, clinics, theatres, wards, but we did not really work on a day-to-day basis. Now we are in the third phase, it just started in early August this month, we lost a lot of the workforce and defined the role so it covers more of the SHO role, particularly in the ward. SCPs are more happy in that role, they are trained for it – prescription writing, patient discharge, they are trained to do these things.’*

(Case study interview)

*‘Patients don’t really understand the role. One issue is what uniform they wear. They could wear civilian clothes, like other professions. They decided they would not wear nurse uniforms as they would be seen as nurses.’* (Case study interview)

One respondent had taken some time during implementation to try to address this issue and allay fears, and interviewees at the case study sites also said they had taken similar actions as individuals:

*‘Myself and a manager from the SHA did a lot of work going into trusts to explain the new role and reassuring them that the new role would not displace any existing people.’*

(Interview with survey respondent)

*‘Often people were not that interested. My anaesthetic department was very supportive but in one a significant number of people in the department did not support it and they do not have any Advanced Practitioners now. It was essential to have the support of the department and the wider staff – nurses, ODPs in theatre. I talked to them about it, there was some resistance, it is human nature to have fears, but generally speaking we were very positive.’* (Case study interview)

One of the points within the Department of Health Good Practice Guidance concerns the need for a communication plan for communicating with existing staff about the new roles. As has been seen in the earlier sections, in many sites there was little buy-in at senior level and communications were left to the project team to organise. Typically it was through the effort of just a few dedicated individuals such as those above, who took it upon themselves to speak to their team or department, that word was spread about the new roles.

### 7.1.2 The attitudes of colleagues

As indicated above, sometimes colleagues may resist introduction of the posts because they do not understand how the new roles will work or may view these

posts as a threat to their own profession. However, in the main, the survey revealed that other staff had reacted generally positively to the new roles. Eight of the respondents reported that reactions had been positive, one thought that reactions had been negative and one was neutral. The person who reported negative reactions said that this was because the role was perceived as clashing with nurse roles. One person said there had been a mixed reaction to the role from consultants:

*'Some consultants positive, some negative.'* (Survey response)

Given that few of the sites appeared to have had a comprehensive communication plan it is perhaps unsurprising that some sites reported negative attitudes amongst colleagues. Although in some cases working relationships have not improved, in the majority of sites, once the Advanced Practitioners began working with their team any fears that colleagues may have held were quickly allayed. In many cases even those who were initially antagonistic towards the role have become more positive, especially once the benefits for their personal working arrangements started to emerge:

*'The role is not yet seen by hospital doctors as part of a solution to a problem. We need to sell it better using positive role models and remembering how resistant to change doctors are in general and how particularly so they are at the moment. The roles oddly are seen as a threat not an opportunity to share out some of the generalist tasks and free up time for more complex or specialty work. This is a big PR task.'* (Survey respondent)

*'There was some slight resistance from breast care nurses – they see themselves as more experienced, [the Advanced Practitioner] is doing the things they might want to do.'* (Case study interview)

*'Nurse practitioners are traditionally very territorial and, whilst the doctors looked at my post and gave it a fair go, nurses thought I would tread on their toes, or saw my role as junior to theirs. So there was friction.'* (Case study interview)

*'The biggest challenge was resistance from some of the junior doctors. [Some of them] liked her because she could be used as a source of knowledge and continuity, she is very knowledgeable. Some took that on and used it to their own advantage, and now there is increasing familiarity with the idea so there is less concern. Others, though, took the attitude of, "I'm a doctor, you're a nurse", and some consultants said, "Why are we employing nurse practitioners<sup>1</sup>? We should be employing junior doctors". But they are becoming more enlightened now.'* (Case study interview)

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<sup>1</sup> Although it should be noted that this was an Advanced Practitioner position, not a nurse practitioner.

*'One or two people remain antagonistic. About four consultants asked not to be involved, but all are now quite happy and like to have the Advanced Practitioners with them as it does make a difference to a busy list.'* (Case study interview)

The constraints that some Advanced Practitioners faced in using their full range of skills in the workplace were touched on in the previous chapter and so are not repeated here.

## 7.2 Fitting the new roles into the organisation

Many people we spoke to recognised that, with hindsight, while organisations had been keen to introduce the roles, they had not considered how the roles would fit into the existing organisational structure.

*'They developed the people but did not develop the role or the organisation.'*  
(Interview with SHA Workforce Planning specialist)

*'It is not just about training these people, you then have to integrate them into the trusts they will be working in.'* (Interview with survey respondent)

*'Really we did it the wrong way round – we appointed and trained [the Advanced Practitioner] and then started to think about how we would use her.'*  
(Case study interview)

*'The main problem was that we initially introduced the role without a clear idea of the role and what they [the Advanced Practitioners] would be doing.'* (Case study interview)

Future projects to develop new or enhanced roles should bear in mind the fact that hospital structures may also need redesigning in order for those roles to be used to maximum effectiveness.

## 7.3 Planning for the future

Earlier sections revealed that most sites had not incorporated the Advanced Practitioner roles into either their Business Plan or their Education and Training Commissioning Plan. The surveys revealed that only two sites were considering commissioning more Advanced Practitioner posts. Six sites said they were not considering commissioning more posts while three did not know.

Since responsibility for development of these posts was devolved and central funding ended trusts have struggled to understand how to take forward the roles. In some cases Advanced Practitioner posts were removed when trusts ran into financial difficulties. Some trusts have started to recruit Advanced Practitioners trained by other trusts. Thus the current stock of qualified practitioners is being diluted across the country, with very little thought at present to how these posts will be continued – and filled – in the future.

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## 8 Conclusions

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Despite the barriers encountered by those involved in developing the posts and by the post incumbents themselves, all interviewees were convinced of the value of the posts, both for the trusts and the individuals who had been offered these opportunities. Sites were enthusiastic and believed that there should be further expansion of the posts. However, few trusts had plans to recruit more Advanced Practitioners and those who were keen to recruit more were unsure where funding for the posts would come from.

Significant investment in Advanced Practitioners has taken place with centralised funding based on a bidding methodology that included an assurance that measures would be taken to embed the roles in the organisation. Top-level commitment was mostly seen only during the initial bid for development money. In most cases, professional advice from HR and finance departments was completely absent from the development process. There is little evidence that trusts actively planned for the future incorporation of these roles within either their business and workforce planning or their education and training commissioning processes. Development work for the Advanced Practitioner roles had often been conducted with no real plan for how the roles would be incorporated within the team. In some cases the roles did not have job descriptions.

As a result, in some cases individuals had faced barriers in attempting to deploy their skills within the trust. The deployment of new or enhanced roles within an organisation will almost inevitably require some change to organisational structures and procedures. Focus on, and funding for, development of these roles had led in many cases to organisations taking insufficient steps to consider the requirements for organisational development and change that would be needed to incorporate these roles successfully within organisational structures and future plans.

The Department of Health Good Practice Guidance emphasises the need for effective communications in successfully bringing about organisational changes of this nature. There is guidance freely available for NHS managers attempting to bring about organisational change and service improvement, including suggestions for how best to communicate with teams to ensure that staff understand the nature of and reasons for changes. In many cases, however, communication was left to the individuals spearheading the development work, or the Advanced Practitioners themselves.

Most Advanced Practitioners have received a warm reception from their colleagues. The majority of respondents and interviewees reported a range of ways in which the Advanced Practitioners had helped improve service and capacity. However, local champions and advocates seeking to provide a clear argument in support of these posts have had difficulty obtaining clear data that demonstrate the cost-effectiveness and service benefits of these posts. Trusts have taken few steps to assess the impact of introducing the posts, as they would be routinely required to do, for example, if they asked for funding for additional consultants.

Provision of future training clearly needs to be considered. The pilot arrangements in some cases were very costly and inconvenient. There appears to have been little attention to date to how costs could be reduced in the longer term. This is surprising, firstly given that there were relatively small and geographically-dispersed groups of trainees for the posts; and secondly given the overlaps between the training of several of the Advanced Practitioner roles and between components of the Advanced Practitioner training programmes and other types of post-registration training for NHS professionals. Clearly economies of scale will need to be considered if these programmes are to continue to run. Cost-effective ways of delivering programmes to a geographically-dispersed group of trainees will also need to be found.

Continuing professional development options for these groups of staff are currently not widely available and funding depends on local decisions. The way in which CPD for these practitioner groups is funded needs to be considered at a national level.

## 8.1 Recommendations

Given the above, we make the following recommendations to Skills for Health:

- To ensure sustainability of new and enhanced roles, trusts need to establish robust planning arrangements through their corporate governance systems that include effective Human Resource and Financial planning, as recommended in DH Good Practice Guidance.



- HR and finance personnel should move towards becoming 'routinely' involved in all role enhancement/new role development initiatives to ensure that the planning of such developments meets both current and future service requirements and that they are embedded in future business and workforce plans.
- Any future invitations to bid for development money should require evidence of significant senior-level buy-in through presentation of the following:
  - A five-year workforce plan, showing how the trust plans to incorporate the new/enhanced role, including plans for rationalisation of other roles, where appropriate.
  - Evidence of how the trust proposes to incorporate DH Good Practice recommendations into their development and implementation plan.
  - The funding body should require a report of impact and longer-term investment plans to be presented at appropriate points within the implementation process/timeline.
  - Approval of initial funding should be contingent upon receipt by the funding body of baseline data for the department or units in which the Advanced Practitioners will be based, along with a reporting plan for assessment of impact and reporting.
- Trusts need to explore how best to capture audit data to allow them to assess the impact of introduction of new or expanded roles. A standard data-capture framework and procedure should be developed. A *Workforce Productivity Evaluation Tool* currently being developed may be of use (see [www.healthcareworkforce.nhs.uk/resources/latest\\_resources/workforce\\_productivity\\_evaluation\\_tool\\_interest.html](http://www.healthcareworkforce.nhs.uk/resources/latest_resources/workforce_productivity_evaluation_tool_interest.html)). Alternately, the survey questionnaire on productivity reported here could provide trusts with a basis for developing their own instrument. Since ideally the same audit information should be collected by all trusts, it may be appropriate for funding to be provided to enable an audit tool to be developed. Audit data could be reported through the same data uploading procedure as is reported to the *Patient Journey Analyser* website.
- Alternative delivery options should be explored for training Advanced Practitioners. One distance learning (electronic delivery) programme has been extremely successful. Some components of the Advanced Practitioner training programmes overlap with existing post-registration/postgraduate programme content. Training maximising the use of existing modules where available, and offering electronic delivery as an option, would reduce costs and make future training more cost-effective, accessible and sustainable.

- It would be useful if money could be found to develop further distance learning modules for other programmes.
- The extent of overlap across programme content (not just between different groups of Advanced Practitioners, but between Advanced Practitioners and other healthcare groups, including SHOs) should be examined further to see if there is potential for the development of common modules for use by a wider range of trainee practitioners.

## **8.2 Evaluating impact**

We have noted the difficulty that trusts experienced in providing the types of evaluation data that are needed in order to provide a broader assessment of the impact of introduction of the Advanced Practitioner roles. Because the survey had failed to produce the types of data required, following conclusion of the survey and case studies Skills for Health asked IES to undertake a further review of international reports evaluating the impact of Advanced Practitioner posts. The outcomes of this follow-up review are reported in the final chapter, Chapter 9.

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## 9 The Wider Picture

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### Key points

- There is restricted quantitative data available at present, even in countries where Advanced Practitioners were introduced some years earlier than in the UK.
- A major factor influencing the extent to which cost savings are made is the model of service delivery within which the Advanced Practitioner works.
- Many existing data sets used in auditing health service performance currently do not reflect the role of Advanced Practitioners, which restricts the data available for analysis.

The intention had been to obtain data from the Advanced Practitioner implementation sites that could be used to demonstrate the cost-effectiveness of introducing Advanced Practitioners into the healthcare team. Unfortunately, by and large, respondents were unable to provide the types of data we had hoped to collect.

The various consultants and managers we spoke to during the case study visits were convinced of the value of the Advanced Practitioner roles. They believed that introduction of these roles had led to greater quality of care for patients and increased patient satisfaction. The Advanced Practitioners themselves felt that these new roles had provided them with valuable career development opportunities that would not have otherwise been available to them.

However, while such outcomes are welcome, such benefits alone are unlikely to be sufficient in persuading trusts to introduce these posts more widely. We therefore sought information about the impact to date on service delivery. Consultants spoke of increased turn-around times in surgery and greater throughput of patients in clinics arising from Advanced Practitioners running parallel sessions. The Advanced Practitioners too spoke of the ways in which they felt that they had

contributed to service improvements, and indeed some were involved in starting to seek audit data of the type that we had hoped to obtain during this work.

The research revealed that there is currently little in the way of hard evidence within the UK to support the claims for the cost-effectiveness of introduction of the roles. Much of the evaluation has been qualitative (see, for example, Kneebone et al., 2006). We therefore next searched for evidence from overseas (primarily the USA and Australia) where Advanced Practitioners have been in post for longer, as well as for any further information we could find relating to the situation in the UK.

This second search for relevant literature revealed that the difficulties encountered in seeking appropriate data are by no means restricted to the UK. There have been repeated calls for adequate evidence to allow the assessment of the cost-efficiency of service developments for many years. One factor influencing the extent to which cost savings are made is the model of service delivery within which the Advanced Practitioner works. Where studies have been conducted it is often assumed that savings will be made from Advanced Practitioners undertaking some of the tasks traditionally undertaken by doctors or consultants. Scheffler et al. (1996) alerted evaluators to the dangers of making assumptions about the mode of deployment early on in the history of development of these roles:

*'Studies show significant opportunities for increased physician substitution and even conservative assumptions about physician task delegation imply a large increase in the number of PAs and NP[nursing practitioner]s that can be effectively deployed. However, the current literature has certain limitations that make it difficult to quantify the future impact of PAs and NPs ... the vast majority of PA and NP productivity studies have viewed PAs and NPs as physician substitutes rather than as members of interdisciplinary healthcare teams.'*

(Scheffler et al., 1996)

Two years later Richardson et al. (1998) published an extensive literature review of studies in which doctors had been replaced by other health professions. While their review demonstrated considerable scope for alterations in skill mix, Richardson et al. found that the studies often had design deficiencies. They commented that, rather than other staff groups being used in the place of doctors:

*'... increased roles for non-physician personnel may result in service development/enhancement rather than labour substitution. Further study of skill-mix changes and whether non-physician personnel are being used as substitutes or complements for doctors is required urgently.'* (Richardson et al., 1998)

It is because we wanted to determine the extent to which Advanced Practitioners were working alongside doctors and consultants to increase capacity or improve

service quality that we asked in our survey about team composition and arrangements for running clinics and theatre sessions.

In an article published the following year, Richardson (1999) commented that, while changes in the combination of the various professional staff groups has in many cases been effective:

*'The (opportunity) cost implications of such changes in the skill-mix are rarely evaluated adequately. The impact of releasing professionals' time has not been estimated and therefore determining whether changes are cost-effective is difficult; these difficulties have often been increased by poor study design.'*

(Richardson, 1999)

He concluded that economic evaluation has been under-utilised in studies of skill-mix and argued for the value of including such evaluations in future assessments of the impact of changes to skill-mix, stating:

*'[Where] skill-mix changes reduce cost and improve or maintain patient outcomes, this is strong evidence that these changes should be implemented.'*

(Richardson, 1999)

Unfortunately, one of the few attempts made to quantify the impact of introduction of these roles was flawed by making precisely the mistake identified by Scheffler et al. (1996) and by Richardson et al. (1998). In their evaluation of the impact of advanced nursing roles in the USA Schroder et al. (2000) based their conclusions largely on the fact that much lower salaries are paid to nurses than to physicians, and they assumed that the advanced practice nurses were undertaking activities that would otherwise be undertaken by more costly physicians. Based on this assumption Schroder et al. concluded that the benefits arising from the introduction of these advanced roles over time outweighed any initial organisational costs arising from introduction. In addition, but apparently uncosted by the researchers, was their finding that preventive measures taken by nurses appeared to be more successful than those undertaken by physicians, thus reducing readmissions. This is precisely the sort of data that needs to be collected and considered within the overall calculation of benefits gained from introduction of new roles and/or changes to skill-mix. It was for this reason that readmissions had been one of the categories of data that we had hoped to collect in the present study.

Some of the most recent attempts at assessing the contribution made by physician assistants and nurse practitioners to care have been undertaken by Perri Morgan and her colleagues conducted in the USA. Morgan et al. (2007) analysed a series of national data sets to determine the extent to which the data reported could illuminate the impact of these roles on patient care. They discovered that existing national healthcare surveys did not fully reflect the roles of physician assistants and nurse practitioners, and they recommended that, if the impact of these roles

was to be assessed in future, the data required in national surveys would need to be revised. They also comment that such analyses are critical if informed decisions are to be made about the numbers and mix of practitioners needed:

*'Our analysis of existing national healthcare surveys shows that research based on several widely used surveys may inadequately account for the contributions of PAs and NPs and create a distorted picture of the actual healthcare provided. Without modifications to existing surveys or new surveys designed to fully reflect the activities of PAs and NPs, policy-makers may underestimate their current and potential contributions and their influence on numbers of physicians needed.'*  
(Morgan et al., 2007)

In a more recent study, Morgan et al. (2008) attempted to examine patterns of 'resource use' when patients visited their physicians. They found that, currently, the existence of Physician Assistants does not significantly affect overall patterns of 'resource use' when patients visit; in other words, patients tend not to be seen by a physician and a Physician Assistant, but by just one or the other. Morgan et al. (2008) say that their data suggest that the current situation tends more to:

*'... extend physician services to patients than to play a complementary role that leads to increased healthcare resource use.'* (Morgan et al., 2008)

They conclude that if predictions of a physician shortage are borne out, and the numbers recruited to the Physician Assistant role increase in line with expectations, then Physician Assistants would be predicted to account for an increasing proportion of patient care in the US in future. Under those circumstances, Morgan argues,

*'Because labour costs for PAs are lower than of physicians ... the use of PAs may increase efficiency in healthcare delivery.'* (Morgan et al., 2008).

A recent press release by HealthForce Ontario (2008) reports that evaluation findings from Phase 1 of an initiative that introduced new PAs, NPs and Acute Care Nurse Specialists had had a positive impact on the delivery of healthcare services, which, the press release states, included:

*'... shorter wait times, shorter stays in EDs, and fewer patients who left without being seen.'* (HealthForce Ontario, 2008)

In the latest round of work, which was about to commence as this study concluded, HealthForce Ontario announced that a new round of evaluation of the demonstration projects:

*'... will examine the Physician Assistants' impact on quality and quantity of care (wait times/access), team and patient satisfaction and team recruitment and retention.'* (HealthForce Ontario, 2008)

Hopefully the Ontario evaluation may finally provide the data that will allow an estimate of the economic value of these roles. Such data are required in order for a persuasive case to be made for further roll-out of these posts. In the meantime, in the UK at least, trusts might wish to consider using the categories of information requested in the Skills for Health questionnaires as a basis for designing future procedures to capture the relevant information needed to assess cost-effectiveness.

The positive outcomes of Advanced Practitioner roles have often been asserted by stakeholders involved in their design and implementation. The roles have had distinctive benefits which, for various reasons, trusts have found difficult to document. The need to improve the evidence base on AP role impact also gives rise to two main challenges which NHS organisations face in embedding these roles. The first is securing resources to implement the roles, to ensure that they are sustainable. The second is related to the persistent problem of how best to diffuse innovation across the NHS. Like many 'good ideas', AP roles were not being systematically spread across NHS trusts or regions, so policy-makers may wish to consider actions they can take to enable more effective intra and inter-organisational learning. It may be worth considering whether there is a role for Skills for Health to play, together with the National Health Service Institute for Innovation and Improvement and the Department of Health, in fostering action learning projects to promote AP roles and disseminate and embed other innovations.

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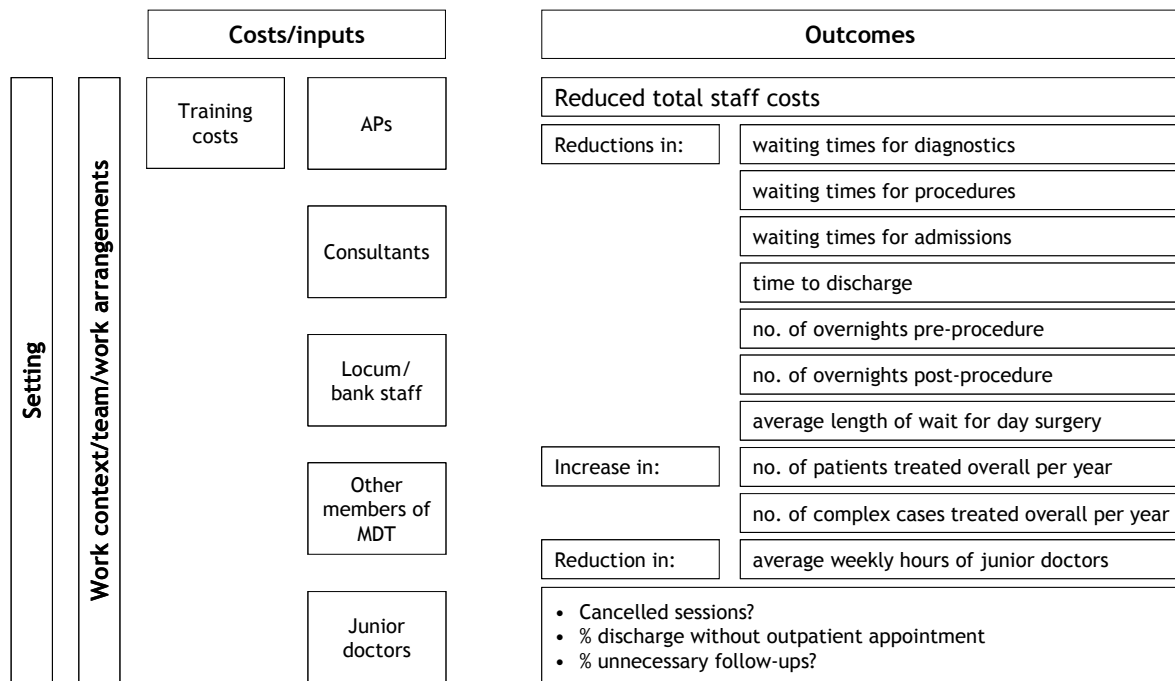
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# Appendix 1: Impact model

Figure 1



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## Appendix 2: Introductory Letter

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Re: National evaluation of Advanced Practitioner roles

Dear

I am writing to request your participation in a research project that has been commissioned by Skills for Health in partnership with NHS West Midlands. The research is evaluating the impact of the introduction of the Advanced Practitioner roles and their implications for future workforce development. The evaluation is being conducted on our behalf by the Institute for Employment Studies (IES), an independent, apolitical, research organisation.

I would very much appreciate your assistance with this work. Enclosed with this letter are two questionnaires that I would like to ask you to complete and return to IES. A reply-paid envelope is included for your use. I can give you our assurance that no organisation or individual will be identified in the report of the work and the data you provide will remain confidential to the research team.

If you are unable to provide all of the data and other information requested we would still appreciate your submitting whatever information you are able to provide. Indeed, it would be very valuable if you could indicate where any aspects of the data present you with particular difficulties in reporting.

We envisage the final report being made available via Skills for Health's website following the project's conclusion in September this year. May I thank you in advance for your help with this research by filling in and returning the questionnaires to IES. If you have any queries, please do not hesitate to contact the lead researcher, whose contact details are given below.

Yours sincerely

Kathryn Halford  
Divisional Manager  
New Ways of Working

Lead researcher:

Dr Linda Miller – email: [linda.miller@employment-studies.co.uk](mailto:linda.miller@employment-studies.co.uk), tel: 01273 873114

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## Appendix 3: Survey Questionnaires

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Examples of:

- Surgical Care Practitioner – Background survey
- Advanced Practitioner Anaesthesia – Productivity survey



# SKILLS FOR HEALTH SURVEY PART 1: BACKGROUND TO INTRODUCTION OF ADVANCED PRACTITIONER ROLES WITHIN YOUR ORGANISATION

**Confidential to the Institute for Employment Studies**

The Institute for Employment Studies has been commissioned by Skills for Health and NHS West Midlands to evaluate the impact of introducing the NHS Changing Workforce Programme Advanced Practitioner roles in the NHS across England. We are seeking some background information on how these roles were introduced in your organisation. We would be grateful if you would complete this questionnaire and return it with your copy of the data collection form.

This work is evaluating the impact of the following Advanced Practitioner roles: Surgical Care Practitioner; Perioperative Specialist Practitioner; Physician Assistant Anaesthesia (previously Anaesthesia Practitioner); Endoscopy Practitioner; and Physician Assistant. This questionnaire relates to introduction of the Surgical Care Practitioner role. If your organisation has introduced more than one role you will receive a second questionnaire pack for the other role.

Please note that all information you provide will be confidential to the research team and your organisation will be anonymous. No organisations will be identified within the final report.

If you have any questions about completing this questionnaire, please contact Dr Linda Miller at the Institute for Employment Studies: linda.miller@employment-studies.co.uk or telephone 01273 873114.

Would you be willing to be contacted if we had any further questions?    Yes        No   

If yes, please provide contact details

Name: ..... Organisation: .....

Address: .....

Phone no: ..... Email: .....

**These details will not be used to identify your response to the questionnaire and will be stored separately from survey responses.**

**PART 1: BACKGROUND TO INTRODUCTION OF ADVANCED PRACTITIONER ROLES WITHIN YOUR ORGANISATION**

**NAME OF HOSPITAL**

**SURGICAL CARE PRACTITIONER ROLE**

Is there a particular team or specialty within which the Surgical Care Practitioners work in your organisation eg operating theatre, emergency department?

Yes  No  *If yes, please specify* .....

**Section A**

In this first section, we would like to ask you some questions about the factors that prompted development of the Surgical Care Practitioner role in your organisation and the people who were involved in its development

A1. What was/were the main factor(s) that motivated the development of the Surgical Care Practitioner role? (*tick as many boxes as appropriate*)

- The Surgical Care Practitioner post was developed in response to a service need identified by the organisation  
If yes, what was this service need? .....
- As part of a service redesign initiative to bring about service improvement. If part of a service redesign initiative, what other components of the service were re-designed (if any)?  
.....
- To extend the skill mix available in certain areas of our activity. If yes, please indicate the main area(s) of activity identified for skill mix development  
.....
- To reduce workforce costs
- We were co-opted to the development programme
- To attract new employees to areas where skills shortages existed
- The Surgical Care Practitioner post was developed in response to a government target
- The Surgical Care Practitioner post was developed to help us meet the 18 week wait target
- To encourage working across interprofessional boundaries
- Not known
- To increase service capacity
- To improve recruitment and retention by opening up career pathways
- The Surgical Care Practitioner post was developed in response to local targets
- The Surgical Care Practitioner post was developed to help us meet the 4 hour wait Accident and Emergency target
- The Surgical Care Practitioner post was developed to help us address junior doctors' hours
- Other (please state) .....

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A2. What was the job title of the person (or team or committee name if a group was involved) who first led the work to introduce the Surgical Care Practitioner posts in your organisation? *(Please write DK if not known)*

.....

A3. Were you aware of board-level support for the development of these posts?

Yes  No  Don't know

If yes, what form did this support take? .....

A4. What is the job title of the person (or team or committee name if a group was involved) who first led the development process to introduce the Surgical Care Practitioner posts in your organisation? *(Please write DK if not known)*

Who led the development process .....

A5. Were any of the following key stakeholders actively involved in the development process for the Surgical Care Practitioner role? *(tick as many options as applied in your organisation; if none, please go to Q A6)*

- |   |   |
|---|---|
| <input type="checkbox"/> Immediate colleagues (medical) who would work with the new APs | <input type="checkbox"/> Immediate colleagues (non-medical) who would work with the new APs |
| <input type="checkbox"/> Senior managers and executive directors                        | <input type="checkbox"/> Non-executive directors  |
| <input type="checkbox"/> Senior nursing staff   | <input type="checkbox"/> Senior medical staff   |
| <input type="checkbox"/> Trade unions   | <input type="checkbox"/> Local staff/management committees                                  |
| <input type="checkbox"/> Other internal group <i>(please specify)</i> .....             | <input type="checkbox"/> SHA  |
| <input type="checkbox"/> Patients   | <input type="checkbox"/> Carers   |
| <input type="checkbox"/> Professional bodies  | <input type="checkbox"/> Education/training providers                                       |
| <input type="checkbox"/> Skills for Health  | <input type="checkbox"/> New Practitioners Programme group                                  |
| <input type="checkbox"/> Other external group <i>(please specify)</i> .....             |   |



A6. Was there any *internal* consultation process regarding the need for this role? Yes  No  Don't know

If yes what groups were consulted? *Please tick as many boxes as appropriate:*

- |   |   |
|---|---|
| <input type="checkbox"/> Immediate colleagues (medical) who would work with the new APs | <input type="checkbox"/> Immediate colleagues (non-medical) who would work with the new APs |
| <input type="checkbox"/> Senior managers and executive directors                        | <input type="checkbox"/> Non-executive directors  |
| <input type="checkbox"/> Senior nursing staff   | <input type="checkbox"/> Senior medical staff   |
| <input type="checkbox"/> Trade Unions   | <input type="checkbox"/> Local staff/management committees                                  |
| <input type="checkbox"/> HR networks (i.e. HR and OD managers)                          | <input type="checkbox"/> In house trainers/educators  |
| <input type="checkbox"/> Other (please specify) .....                                   |   |

A7. Was there any consultation process regarding the need for this role *external* to the trust? Yes  No  Don't know

If yes, which groups were consulted? Please tick as many as appropriate

- |   |  |
|---|--|
| <input type="checkbox"/> SHA                          | <input type="checkbox"/> Deanery                           |
| <input type="checkbox"/> Local Management Committee   | <input type="checkbox"/> Patients/carers                   |
| <input type="checkbox"/> Professional bodies          | <input type="checkbox"/> Education/training providers      |
| <input type="checkbox"/> Skills for Health            | <input type="checkbox"/> New Practitioners Programme group |
| <input type="checkbox"/> Other (please specify) ..... |  |

A8. Was development of the Surgical Care Practitioner role part of the organisation's business plan? .....

Yes  No  Don't know

If yes, what element of the organisation's business plan did this role support? (please specify) .....

A9. Was learning and development provision for this role incorporated into the organisation's education and training plan?

Yes  No  Don't know

A10. Was provision of this role indicated in the education and training commissioning plan submitted to the SHA workforce directorate?

Yes  No  Don't know

If no or don't know, how was learning and development for the APs commissioned?

**Section B**

In this section we would like to ask you about the process of communication, introduction and evaluation of the AP role.

B1a. Was there a communication strategy telling employees and managers about the development of this role?

Yes  No  Don't know

B1b. How was the introduction of the new role communicated?

- team meetings
- email
- other (please specify) .....
- flyers
- working groups

B2. Did your organisation identify any local champions for the Surgical Care Practitioner role?

Yes  No  Don't know

If yes, what was the role of these champions within the organisation in implementing/publicising the AP role? .....

B3. Were any explicit success criteria identified for assessing the local impact of the new AP role?

Yes  No  Don't know

*If no or don't know, please go straight to question B6*

If yes, what criteria were identified? .....

B4. Who identified these criteria? (please tick as many boxes as appropriate)

- Immediate colleagues (medical) who would work with the new APs
- Senior managers and executive directors
- Senior nursing staff
- Trade Unions
- HR networks (ie HR and OD managers)
- Other (please specify) .....
- Immediate colleagues (non-medical) who would work with the new APs
- Non-executive directors
- Senior medical staff
- Local staff/management committees
- Service users and carers

If service users and carers were involved, what process was used to seek their views? .....

B5. Have you assessed the introduction of the new roles against these criteria? .....

Yes  No

*If yes, could you please provide a copy of the evaluation, or a link to any report arising from it. Thank you.*

**Section C**

**This section asks you about the education and development process for the AP role and the process you adopted to recruit individuals to this role.**

C1. Is there a job description for the Surgical Care Practitioner role?

Yes  No  Don't know

*If yes, could you please provide a copy. Thank you.*

How was this/were these developed? .....

C2. Is there a person specification for the Surgical Care Practitioner role?

Yes  No  Don't know

*If yes, could you please provide a copy. Thank you.*

C3. What was the agreed minimum qualification and level of experience for individuals wanting to apply for these posts? .....

.....

C4. Have all the individuals in Surgical Care Practitioner posts successfully completed the formal training?

Yes  No  Don't know

C5. Were all of the individuals who completed the formal training offered posts as Surgical Care Practitioners afterwards?

Yes  No  Don't know

If no, why was this? .....

C6. Of those who were offered and took up Surgical Care Practitioner posts, are they all still in post?

Yes  No  Don't know

If no, why was this? .....

C7. Are any individuals currently progressing through the formal training programme for the Surgical Care Practitioner role?

Yes  No  Don't know

If yes, how many? .....

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C8. Did any individuals train for more than one Advanced Practitioner role?

Yes  No  Don't know

If yes, please give details.....

C9. Have any individuals dropped out of Surgical Care Practitioner training (not completed the programme)?

Yes  No  Don't know

If yes, why was this? .....

C10. Did all Surgical Care Practitioners have mentors when they took up AP positions?

Yes  No  Don't know

What was/were the job title(s) of those who mentored the Surgical Care Practitioners? .....

C11. How were staff recruited to the Surgical Care Practitioner positions? (*Please tick all that apply*)

- Nomination by manager or clinician of specific individuals identified as having the potential to meet the academic and practice requirements
- Targeted internal recruitment - any member of specific staff groups with minimum qualifications and experience could apply
- Open internal recruitment - any member of staff with minimum qualifications and experience could apply
- Open external recruitment - any applicants with the required minimum qualifications and experience could apply
- Individuals were seconded to the posts by Trusts
- Other (*please describe*) .....

C12. After the formal training and initial period of mentoring, was there any form of ongoing support for the Surgical Care Practitioners? If yes, what form did this support take?

- Clinical supervision  Performance review
- Peer mentoring  Mentor/Preceptor
- Other - (*please specify*) .....

C13. Have the Surgical Care Practitioners been able to utilise the full range of skills they acquired during the training?

Yes  No

If no, why is this? .....

C14. If not already identified within the Job Description please outline the range of tasks that the Surgical Care Practitioners currently undertake.

.....

C15. How have other staff in the teams in which Surgical Care Practitioners work generally reacted to introduction of these posts?

Very positive 1 ----- 2----- 3----- 4 ----- 5----- 6 ----- 7 very negative

If they have reacted positively, what are the perceived benefits? .....

If they have reacted negatively, what has been the nature of the difficulties? .....

C16. Are you considering commissioning any further Advanced Practitioner posts?

Yes  No  Don't know

If yes, are these

More individuals within the same type of AP post, or  New (different) AP posts

C17. Do you have any other comments on the AP posts or the background/process of developing/introducing new AP roles, organisational context? *(please specify)*

.....

.....

.....

**Thank you for completing this questionnaire**

Please return this questionnaire to: The Institute for Employment Studies, Mantell Building, University of Sussex Campus, Brighton BN1 9RF



## SKILLS FOR HEALTH SURVEY PART 2 - PRODUCTIVITY DATA

**Confidential to the Institute for Employment Studies**

The Institute for Employment Studies has been commissioned to evaluate the impact of introducing Advanced Practitioner roles in the NHS across England for Skills for Health and NHS West Midlands. In this second questionnaire we ask you to report management information relating to the teams, units or departments in which Physician Assistant Anaesthesia Practitioners are working. We would be grateful if you would complete this questionnaire and return it in the enclosed pre-paid envelope along with your copy of the background information survey.

**We realise that some of this information may prove challenging to provide. If you are unable to provide any of the information it would be very helpful if you would show that it is unavailable by writing U/A at appropriate points in the questionnaire. We will be very grateful for whatever data you are able to provide us with, even if it is only partial data.**

All information you provide will be **confidential** to the research team and your organisation will be **anonymous**. The information will be used to assess the costs and benefits of introducing AP posts. The analysis (and the model used as the basis for the analysis) will be made publicly available at conclusion of the project for use by NHS managers to assist in future workforce planning.

If you have any questions about completing this questionnaire, please contact Dr Linda Miller at the Institute for Employment Studies: linda.miller@employment-studies.co.uk or telephone 01273 873114

### NAME OF HOSPITAL

This questionnaire relates to the Physician Assistant Anaesthesia role. Please indicate how many of these Practitioners you have in post: .....

Contact name in case of query: ..... Phone no: .....

**Type of Organisation:**

- |                                 |                          |                    |                          |
|---------------------------------|--------------------------|--------------------|--------------------------|
| Primary care                    | <input type="checkbox"/> | If hospital is it? |                          |
| Acute care - Secondary          | <input type="checkbox"/> | Foundation         | <input type="checkbox"/> |
| Acute care - Tertiary           | <input type="checkbox"/> | Teaching           | <input type="checkbox"/> |
| Acute care - Quaternary         | <input type="checkbox"/> | Non-teaching       | <input type="checkbox"/> |
| Mental health - Acute/inpatient | <input type="checkbox"/> |                    |                          |
| Mental health - Community       | <input type="checkbox"/> |                    |                          |

**Section A**

**Staff work patterns in unit/dept**

A1. Please indicate the work pattern that the Physician Assistant Anaesthesia Practitioners normally work:

- |   |   |
|---|---|
| <input type="checkbox"/> Standard hours (9 - 5) | <input type="checkbox"/> Out of hours               |
| <input type="checkbox"/> Shift                  | <input type="checkbox"/> Other (please state) ..... |

A2. Please indicate the work pattern of the majority of other staff in the unit/department:

- |   |   |
|---|---|
| <input type="checkbox"/> Standard hours (9 - 5) | <input type="checkbox"/> Out of hours               |
| <input type="checkbox"/> Shift                  | <input type="checkbox"/> Other (please state) ..... |

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A3. In the table below, for each of your APs please indicate the unit/departments in which the Physician Assistant Anaesthesia Practitioners work, any particular team or specialty in which the APs work and how many APs work in each area. Please also indicate the proportion of time the AP spends in that team, unit or department (or write FT if full time)

AP Role	Unit/department/area	Team or specialty	WTE/Proportion of time
Example one Physician Assistant Anaesthesia Practitioner	e.g. Theatres	e.g. Surgical team	e.g. FT
Example two Physician Assistant Anaesthesia Practitioner	e.g. Orthopaedics	e.g. Work across Operating Theatres/ In-patient wards / Out-patients	e.g. 0.4 WTE / 0.4 / 0.2

A4. Please describe how Physician Assistant Anaesthesia Practitioners work within the existing team, unit, department or specialism (*tick as many as apply*):

- Works alongside consultant and medical/nursing team with specific role within team eg in theatre
- Has responsibility for own discrete set of separate tasks that they perform with close supervision eg pre-op. assessment
- Manages own caseload with remote supervision
- Runs separate (parallel or supplementary) sessions from those run by consultant and/or medical/nursing team
- Other (please specify) .....

A5. If the APs run separate sessions, are these **additional** to those that are run by the medical and/or nursing staff (ie more sessions are now run), or do they replace a medical practitioner in some or all of them (ie same number of sessions is run, but fewer patients are seen by medical practitioner)? *If APs do not run separate sessions, please go to Part B.*

Additional sessions  Replaces medical practitioner in existing sessions



A6. If the APs run their own sessions and/or their own caseload eg out-patient clinics, how is this additional capacity used?

- More clinics are now delivered/more patients seen
- More complex cases are seen by senior medical staff
- More time is allocated to each patient
- Other (please specify .....

**Section B**

**Education and training for PHYSICIAN ASSISTANT ANAESTHESIA PRACTITIONERS**

- B1. Where do your Physician Assistant Anaesthesia Practitioners undertake their formal accredited education/training programme? .....
- B2. Was the training you commissioned for the Physician Assistant Anaesthesia Practitioners role full-time or part-time? Full-time  Part-time   
*Go to Q B3 Go to QB4*  
 Some full-time and some part-time   
*Please answer both Q B3 and Q B4*
- B3. If full-time, what is the length of secondment of your Physician Assistant Anaesthesia Practitioners to the training? .....
- B4. If part-time, how many days a week did your Physician Assistant Anaesthesia Practitioners attend training? ..... For how long? .....
- B5. Please give the cost of training provision (ie course fee or equivalent) per Physician Assistant Anaesthesia Practitioner trained .....
- B6. If possible, please give the costs of other training support, eg supervisory time, mentoring, etc.....
- B7. How many Physician Assistant Anaesthesia Practitioners in total have you enrolled on the training to date?.....
- B8. Of these, how many completed the course and gained accreditation?.....
- B9. Have any Physician Assistant Anaesthesia Practitioners been appointed on the basis of their acquired knowledge and skills rather than following the approved training programme (this does not mean that they do not meet the AP standards but rather they have achieved them through accreditation of prior learning (APEL))  
 Yes  No  *If no, go to question B10* If yes, how many? .....
- B10. How many of the Physician Assistant Anaesthesia Practitioners appointed by your organisation are still in post? .....
- B11. Please indicate the year in which the Physician Assistant Anaesthesia Practitioner post was introduced in your organisation (*please circle appropriate year*)  
 2000      2001      2002      2003      2004      2005      2006      2007      2008

B12. What is the year for which you have the most recent complete MI information (*please circle appropriate year*)?

2000      2001      2002      2003      2004      2005      2006      2007      2008

## Section C

### BEFORE AND AFTER IMPLEMENTING THE AP ROLES IN YOUR ORGANISATION

This section asks you for ‘before and after’ data relating to the unit or department in which Physician Assistant Anaesthesia Practitioners work. **The information requested is largely data that you would already provide for audit purposes, but we realise that accessing data prior to the last financial year may be difficult. We will be very grateful for whatever data you are able to give. If you are unable to provide data for any categories, please write in U/A, as that will help us to understand types of data that are more or less readily available within NHS Trusts.** Where you are asked for data relating to ‘before’ introduction of the Physician Assistant Anaesthesia Practitioner role, please provide data for the year before the one you have ringed above (one year prior to introduction). For the ‘after’ data, please provide data for the *most recent* complete financial year. In each case, please provide data only for the team(s), unit(s) or department(s) in which Physician Assistant Anaesthesia Practitioner staff are employed. Thank you.

### SECTION C1 STAFFING LEVELS PRE- AND POST-IMPLEMENTATION

Starting with medical consultants, please provide the following information for each medical consultant in the team/unit/department (*if data is unavailable please write U/A; fill in a new row for each consultant in the team/unit/department*):

	Department/unit/clinic	Before AP introduction		After AP introduction	
		Number of contracted planned activities (PAs) spent in team/unit/ department by medical consultants	Medical consultant whole employment costs (salary + oncosts)	Number of contracted planned activities (PAs) spent in team/unit/ department by medical consultants	Medical consultant whole employment costs (salary + oncosts)
Consultant 1					
Consultant 2					
Consultant 3					
Consultant 4					
Consultant 5					
Consultant 6					

Next, please provide the number of medical locum or bank days used by this team, unit or department and the standard payment rate for these posts in the team/unit/department (*if data not available please write U/A*)

	Team/unit/department	Before AP introduction	After AP introduction
Number of locum/bank days			
Medical locum/bank staff salary (if standard rate please write here; otherwise write number of locum staff and rate at which employed in separate rows below)			

For the relevant team, unit or department, please provide the number of other medically-trained staff working as part of this medical team, unit or department (*if none, leave blank*).

Number of members of other medical practitioners in the relevant team/unit/department:	Team/unit/department	Before AP introduction			After AP introduction		
		Number of staff in this grade	Number of contracted planned activities (PAs) spent in team/unit/ department	Whole employment costs (salary + oncosts)	Number of staff in this grade	Number of contracted planned activities (PAs) spent in team/unit/department	Whole employment costs (salary + oncosts)
Junior doctors							
Staff/associate grade doctors							
Others (please give details							

In the next table, please enter the **average hours worked by junior doctors** per week for the year **prior to** introduction of Physician Assistant Anaesthesia Practitioners and the most recent year for which you have information available. This is because, in some organisations, reduction of junior doctors' hours was one of the objectives in introducing these roles. **Please note, we are interested in your data even if this was not the intended outcome in your organisation, as this data will enable us to gain a fuller picture of impact across the country. (If data not available please write U/A).**

	Before AP introduction	After AP introduction
Average hours worked by Junior Doctors in the relevant team/unit/department		

For the relevant team, unit or department, please provide the number of non-medical staff working as part of this medical team, unit or department (*if none, write 'none'*).

Team/unit/ department	Number of members of other staff/ professional groups in team/unit/department:	AfC banding(s)	Before AP introduction		After AP introduction	
			Number of staff in this grade	WTEs	Number of staff in this grade	WTEs
	Nurses AfC	3/ 4				
	Nurses AfC	5				
	Nurses AfC	6				
	Nurses AfC	7				
	Nurses AfC	8				
	Nurses AfC	9				
	Allied Health Professions - please specify job title(s) below and give AfC bandings					
	Other staff in clinical team? Please specify and give AfC bandings					

**C2 SERVICE CAPACITY PRE- AND POST-IMPLEMENTATION OF AP ROLES**

The next section asks you for information about the numbers of planned procedures undertaken and service capacity. **Again, we realise that this data might be challenging to provide and will be very grateful for whatever data you give. If you are unable to provide data for any categories, please write in U/A, as that will help us to understand types of data that are more or less readily available within NHS Trusts.** Please provide data only for those units and procedures which are undertaken by teams in which [AP]s work and complete only those sections that relate to your situation. Please leave any sections that do not apply to your situation blank (ie, if Physician Assistant Anaesthesia Practitioners only involved in out patient procedures, leave 'in-patient' section blank). **NOTE: PRIMARY CARE SECTION (C.2.3) FOLLOWS ELECTIVE SURGICAL (C.2.1) AND NON-ELECTIVE SECONDARY CARE (C.2.2) SECTIONS. PLEASE GO TO FINAL SECTION (C.2.3) IF YOU DO NOT OFFER SECONDARY CARE SERVICES.**

**C2.1 ELECTIVE SURGICAL SERVICES DURING NORMAL OPERATING HOURS, INCLUDING ANAESTHETICS (if data not available, please write U/A).**

	Before AP introduction	After AP introduction
<b>In-patient procedures:</b>		
Number of theatres available to relevant team		
Number of planned patient sessions/week for relevant team		
Number of potential patient procedures, if theatres working at maximum capacity, per year		
Theatre percentage utilisation (ie, achieved compared to planned utilisation) per year		
Average length of stay (number of nights accommodation) for patients, pre-procedure		
Average length of stay (number of nights accommodation) for patients, post-procedure		
Average waiting time in days from referral by GP to first contact with team		
Average waiting time in days between referral from GP to treatment		
Number of patients treated overall/year by relevant team		
Number of theatre sessions cancelled on day of surgery		
Number of procedures cancelled on day of surgery		
Percentage of patients discharged without need for follow-up		
Percentage of patients discharged with telephone follow-up		
Percentage of patients discharged with follow-up outpatient appointment		
Number of re-admissions		
Number of complaints per annum		

	Before AP introduction	After AP introduction
<b>For day procedures:</b>		
Number of potential patient procedures per year if day case centres/clinics functioned at maximum capacity		
Number of patients seen in day case unit per year by relevant team		
Number of complex cases treated per year by relevant team		
Average waiting time in days from referral by GP to first contact with team		
Average waiting time in days from referral by GP to treatment		
Average length of wait in hours from registration on day of appointment to treatment/procedure		
Number of theatre sessions cancelled on day of surgery		
Number of procedures cancelled on day of surgery		
Percentage of patients discharged without need for follow-up		
Percentage of patients discharged with telephone follow-up		
Percentage of patients discharged with follow-up outpatient appointment		
Number of re-admissions		
Number of complaints per annum		

### C.2.2 NON-ELECTIVE SECONDARY CARE

	Before AP introduction	After AP introduction
Average patients seen in department per day		
Average wait (in hours)		
Number of complaints per year		
Number of junior doctors in department		
Average number of cases seen by each Consultant		
Average number of complex cases seen by each Consultant		

**C.2.3 PRIMARY CARE**

	<b>Before AP introduction</b>	<b>After AP introduction</b>
List size (number of patients)		
Number of patients seen per week		
Number of GPs in practice		
Number of Practice Nurses in practice		
Number of complaints per annum		
Number of Junior doctors in practice		
Number of patients referred on to secondary care		
Average number of cases seen by each GP		
Average number of complex cases seen by each GP		
Number of cancelled clinics per week		

**Thank you for completing this questionnaire**

Please return this questionnaire to: The Institute for Employment Studies, Mantell Building, University of Sussex Campus, Brighton BN1 9RF



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## Appendix 4: Comparison Sites

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Questionnaire sent to sites without Advanced Practitioners in place

## SKILLS FOR HEALTH SURVEY PRODUCTIVITY DATA - NON AP SITES

Confidential to the Institute for Employment Studies

We would very much appreciate your providing as much of the information requested below as possible. We realise that some of this information may prove challenging to provide. Where you are unable to provide any of the information it would be very helpful if you would write U/A at appropriate points in the questionnaire. We will be very grateful for whatever data you are able to provide us with, even if it is only partial data.

We need comparison data from similar clinical areas to where the National Practitioner project roles were developed. We are looking in particular at Advanced Practitioner roles in the following areas: Surgical Care Practitioner; Perioperative Specialist Practitioner; Physician Assistant Anaesthesia (previously Anaesthesia Practitioner); Endoscopy Practitioner; and Physician Assistant. This information is needed to assist us in gauging the impact of Advanced Practitioner roles nationally. All information you provide will be **confidential** to the research team and your organisation will be **anonymous**. The information will only be used to assess the costs and benefits of introducing Advanced Practitioner posts. The outcomes of the analysis (and the workforce planning model produced as part of that work) will be made publicly available at conclusion of the project for use by NHS managers to assist in future workforce planning exercises.

We would be grateful if you would complete this questionnaire and return it in the enclosed pre-paid envelope.

If you have any questions about completing this questionnaire, please contact Dr Linda Miller at the Institute for Employment Studies: linda.miller@employment-studies.co.uk or telephone 01273 873114

### NAME OF HOSPITAL

Would you please confirm that you have no none of the above NPP Advanced Practitioner roles in place at your trust?

- There are no NPP Advanced Practitioner roles in place at this trust, *OR*
- We do have some NPP Advanced Practitioner roles at this trust. **If you tick this box, please do not complete the questionnaire - return it in the prepaid envelope now. Thank you.**

Contact name in case of query: .....

Phone no: .....

**Type of Organisation:**

- |                                 |                          |                    |                          |
|---------------------------------|--------------------------|--------------------|--------------------------|
| Primary care                    | <input type="checkbox"/> | If hospital is it? |                          |
| Acute care - Secondary          | <input type="checkbox"/> | Foundation         | <input type="checkbox"/> |
| Acute care - Tertiary           | <input type="checkbox"/> | Teaching           | <input type="checkbox"/> |
| Acute care - Quaternary         | <input type="checkbox"/> | Non-teaching       | <input type="checkbox"/> |
| Mental health - Acute/inpatient | <input type="checkbox"/> |                    |                          |
| Mental health - Community       | <input type="checkbox"/> |                    |                          |

**Section A****Staff work patterns in Theatres/Surgical Department**

Please indicate the work pattern worked by the majority of staff within unit/department:

- |   |   |
|---|---|
| <input type="checkbox"/> Normal hours (9 - 5) | <input type="checkbox"/> Out of hours               |
| <input type="checkbox"/> Shift                | <input type="checkbox"/> Other (please state) ..... |

**Section B****Staffing levels within Theatres/Surgical Department**

We would like to ask you for staffing and performance data relating to the unit/department. In this first section we would like you to provide 'before and after' data for your unit or department for the current year and for 2005-06. This information is requested in order to allow us to make broad comparisons of costs before and after the introduction of AP roles across the country. **The information requested is largely data that you would usually provide for audit purposes, but we realise that accessing data prior to the last financial year may be difficult. We will be very grateful for whatever data you are able to give. If you are unable to provide data for any categories, please write in U/A, as that will help us to understand types of data that are more or less readily available within NHS Trusts.** In each case, please provide data only for the department(s) requested. Thank you.

**Section B1 Staffing Levels**

Starting with medical consultants, please provide the following information for each medical consultant in the team/unit/department (*if data not available please write U/A; fill in a new row for each consultant in the team/unit/department:*

	Department/unit/clinic	2005-06		Most Recent Financial Year	
		Number of contracted planned activities (PAs) spent in team/unit/department by medical consultants	Medical consultant whole employment costs (salary + oncosts)	Number of contracted planned activities (PAs) spent in team/unit/department by medical consultants	Medical consultant whole employment costs (salary + oncosts)
Consultant 1					
Consultant 2					
Consultant 3					
Consultant 4					
Consultant 5					
Consultant 6					

Next, please provide the number of medical locum or bank days attached to or relating to this department and the standard payment rate for these posts in the team/unit/department (*if data not available please write U/A*)

	2005-06	Most recent financial year
Number of locum/bank days		
Medical locum/bank staff salary (if standard rate please write here; otherwise write number of locum staff and rate at which employed in separate rows below)		

For the department, please provide the number of other medically-trained staff working as part of this medical team, unit or department (*if none, write 'none'*).

	2005-06			Most recent financial year		
Number of members of other medical practitioners in the relevant team/unit/ department:	Number of staff in this grade	Number of contracted planned activities (PAs) spent in team/unit/ department	Whole employment costs (salary + oncosts)	Number of staff in this grade	Number of contracted planned activities (PAs) spent in team/unit/department	Whole employment costs (salary + oncosts)
Junior doctors						
Staff/associate grade doctors						
Others (please give details)						

In the next table, please enter the average hours worked by junior doctors in the department per week during these years (*if data not available please write U/A*).

	2005-06	Most recent financial year
Average hours worked by Junior Doctors in the relevant team/unit/department		

For the relevant department, please provide the number of non-medical staff working as part of this medical team (*if none, write 'none'*).

Number of members of other staff/ professional groups in team/unit/department:	AfC banding(s)	2005-06		Most recent financial year	
		Number of staff in this grade	WTEs	Number of staff in this grade	WTEs
Nurses AfC	3/ 4				
Nurses AfC	5				
Nurses AfC	6				
Nurses AfC	7				
Nurses AfC	8				
Nurses AfC	9				
Allied Health Professions - please specify job title(s) below and give AfC bandings					
Other staff in clinical team? Please specify and give AfC bandings					

## B2 Service Capacity

The next section asks you for information about the numbers of planned procedures undertaken and service capacity. **Again, we realise that this data might be challenging to provide and will be very grateful for whatever data you give. If you are unable to provide data for any categories, please write in U/A, as that will help us to understand types of data that are more or less readily available within NHS Trusts.** Please provide data only for those units and procedures requested and complete only those sections that relate to your situation. Please leave blank any sections that do not apply to your situation. *NOTE: PRIMARY CARE SECTION (B.2.3) FOLLOWS ELECTIVE SURGICAL (B.2.1) AND NON-ELECTIVE SECONDARY CARE (B.2.2) SECTIONS. PLEASE GO TO FINAL SECTION (C.2.3) IF YOU DO NOT OFFER SECONDARY CARE SERVICES.*

### B.2.1 Elective Surgical Services During Normal Operating Hours, Including Anaesthetics (if data not available, please write U/A)

	2005-06	Most recent financial year
<b>In-patient procedures:</b>		
Number of theatres available to relevant team		
Number of planned patient sessions/week for relevant team		
Number of potential patient procedures, if theatres working at maximum capacity, per year		
Theatre percentage utilisation (ie, achieved compared to planned utilisation) per year		
Average length of stay (number of nights accommodation) for patients, pre-procedure		
Average length of stay (number of nights accommodation) for patients, post-procedure		
Average waiting time in days from referral by GP to first contact with team		
Average waiting time in days referral from GP to treatment		
Number of patients treated overall/year by relevant team		
Number of theatre sessions cancelled on day of surgery		
Number of procedures cancelled on day of surgery		
Percentage of patients discharged without need for follow-up		
Percentage of patients discharged with telephone follow-up		
Percentage of patients discharged with follow-up outpatient appointment		
Number of re-admissions		
Number of complaints per annum		

	2005-06	Most recent financial year
<b>For day procedures:</b>		
Number of potential patient procedures, if day case centres/clinics functioned at maximum capacity, per year		
Number of patients seen in day case unit, per year by relevant team		
Number of complex cases treated per year by relevant team		
Average waiting time in days from referral by GP to first contact with team		
Average waiting time in days from referral by GP to treatment		
Average length of wait in hours from registration on day of appointment to treatment/procedure		
Number of theatre sessions cancelled on day of surgery		
Number of procedures cancelled on day of surgery		
Percentage of patients discharged without need for follow-up		
Percentage of patients discharged with telephone follow-up		
Percentage of patients discharged with follow-up outpatient appointment		
Number of re-admissions		
Number of complaints per annum		

### B.2.2 Non-Elective Secondary Care

	2005-06	Most recent financial year
Average patients seen in department per day		
Average wait (in hours)		
Number of complaints per annum		
Number of junior doctors in department		
Average number of cases seen by each Consultant		
Average number of complex cases seen by each Consultant		



**B.2.3 Primary Care**

	2005-06	Most recent financial year
List size (number of patients)		
Number of patients seen per week		
Number of GPs in practice		
Number of Practice Nurses in practice		
Number of complaints per annum		
Number of junior doctors in practice		
Number of patients referred on to secondary care		
Average number of cases seen by each GP		
Average number of complex cases seen by each GP		
Number of cancelled clinics per week		

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## Appendix 5: Discussion Guides

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- Interviews with HR/OD personnel
- Interviews with (non-supervisory) colleagues
- Interviews with AP managers or supervisors
- Interviews with APs

## Interviews with HR/OD personnel

- Thank you for agreeing to be interviewed.
- Introduce self and IES: IES is an independent, not for profit research organisation and has been a leading centre for applied research in learning and skills and human resource management for over 30 years.
- Purpose of research: Skills for Health has commissioned an evaluation of the impact of introduction of Advanced Practitioner roles. We are exploring the impact of the roles nationally and factors supporting their implementation; there is no intention to evaluate or assess any individual AP or any individual's performance.
- Check availability of interviewee (ie how long they have for discussion), but stress that this interview should last no longer than one hour.
- Assure interviewee of confidentiality and anonymity. No one from SfH will have access to the detailed interview notes or tapes at any time. The purpose of the study is NOT to judge individuals and there are no right or wrong answers to the questions you will be asked.
- Ask for agreement to tape the interview as this saves time in having to take notes and enables thorough analysis. If meet with objections, take notes instead – ensure interviewee is comfortable with tape recording (ie informed consent is given), rather than assuming this will be the case.
- Any questions?

Trust:

Core AP roles at site:

Interviewee:

*Interviewer – check which AP roles in place across the board (other than core roles). These should be the main focus of the interview. If more than one AP role, please ensure you are clear on whether interviewee is talking about introduction of one or both roles.*

**I'd like to start by asking you some questions about how the trust came to be involved in developing the AP role and your involvement in those developments**

1. Brief history – what is interviewee's role; what is their connection with the AP project? If not a member of the original team involved with implementation, what happened to the original instigators of the project/roles?
2. Prior to becoming involved in introducing the AP role(s), had the trust done any work locally on role extension for any groups?

3. Are there any staff groups for which you've decided to work on role extension rather than develop a new post such as the AP positions? If yes, could you please describe this work? Why did you opt for role extension rather than development of new posts?

4. What were the main reason(s) for introducing the AP role(s)?

*(Allow interviewee to identify main reasons. Depending on how readily they are able to identify reasons, prompt with: service improvements (improving patient care/experience; increasing capacity); reducing costs ; links between improved career options and ability to retain staff; need to remedy skill shortages; meeting working time directives; trust was asked to participate)*

5. *If multiple objectives given, Were any of these more/most important?*

6. Who first raised the idea of introducing the AP role(s) here?

*(Explore whether initiated within the trust, via university partners, championed from within, prompted by news of funding availability etc.)*

7. Who decided that the trust should go ahead and create the new role(s)?

8. Who was involved in developing/implementing the new role(s) within the trust? *(Check for: staff side reps, the clinical teams in which the roles were introduced, HR/OD staff, others? etc)*

9. Did you encounter any local challenges with job design or re-design for these posts?

*(Probe around senior management support, conflicting goals/ensuring integration with local priorities, funding availability, staff turnover, clinical governance and patient safety issues, resistance from teams and/or patients/service users, service redesign around new roles, changing organisational priorities)*

10. How easy was it to introduce the roles, once you decided to go ahead with them?

11. What process was used to develop/implement the role? *(Check for project champion/service mgr operating alone, a steering group etc?)*

12. How long did it take to get from considering the idea to a) enrolling the first recruits on their training, b) the qualified APs moving into post?

13. Was that about the length of time you had expected, or longer, or shorter? *If longer/shorter, Why is that?*

**I'd now like to ask you some questions about recruiting to the AP role**

14. Were any particular staff groups (eg nurses, receptionists etc.) targeted for recruitment to these posts?  
*If no, How did you decide on who should be targeted for recruitment?*  
*If yes, How did you decide on which staff groups to recruit to the AP roles?*
15. How did you recruit individuals to the AP roles? (*Probe on: was the opportunity offered to all staff in the groups targeted who had appropriate experience and qualifications? To just a few who were felt to be appropriate for development? Were individuals nominated by managers?*)
16. What sorts of recruitment methods did you use? (*adverts/notice board/website/staff newsletter/email etc.*)
17. How many people volunteered/were selected/applied? Was there a selection process? If so, what form did it take and who was involved in managing/running it?
18. Did you get the expected number of applications? (*too many/too few?*)  
*If too few, Why was this?*
19. Do you have any figures for the costs involved in recruitment to these posts? If yes, can you tell me how much recruitment/the various recruitment routes cost?
20. (*If different recruitment routes were used*) How effective were the various recruitment routes you tried? Did you find that any one recruitment route/method was more effective than the others?
21. Did everyone who was offered the opportunity to train for these posts take up the offer? If not, why was this? (*Probe on support within organisation; quality, appropriateness and accessibility of external training; enthusiasm or otherwise of staff groups seen as filling these posts; clinical support etc.*)
22. *Depending on reasons given, probe further using selected questions from 22a to d:*
  - 22a. Why do you think there was particular enthusiasm/no particular enthusiasm for these posts?
  - 22b. Was there a reason for clinical support/opposition?
  - 22c. Why do you think organisational support was high/lacking for this initiative?
  - 23d. What format did the training take? (*who provided it, how selected, whether in-house/external/mixed model? Use of mentors/clinical supervision etc?*). What

were the strengths and weaknesses of the training? (*Note: more questions follow on training issues*)

23. Looking back, was this/were these the right staff group(s) to recruit?

How did they respond to the training programme?

(*Probe on recruits finding it too difficult/ too easy/too slow and reasons why.*)

Would it be possible to recruit individuals with lower qualifications and/or less experience to the programme?

*If yes*, What kind of groups can you envisage recruiting from? Would the training programme need to be modified in any way?

24. Were the recruits able to use APEL to satisfy the requirements of any parts of the training?

*If yes*, What parts of the training did they tend to have existing experience and knowledge of?

Were they able to 'fast-track' their progress through/attainment of those parts of the programme?

*If no*, Why was that?

In your opinion, would it be useful if individuals could be fast-tracked on the basis of previous experience and knowledge?

*If yes*, How might this work?

*If no*, Why is that?

*If no*, Was this because they did not have any relevant prior knowledge or experience, or because the training provider would not recognise/use it?

*If programme did not allow this*, In your opinion, would it be useful if individuals could be fast-tracked on the basis of previous experience and knowledge?

25. As far as you are aware, is there any overlap in the training provided for the [NAME OF AP GROUP THAT IS SUBJECT OF THIS INTERVIEW] and that provided for [DELETE RELEVANT ROLE FROM THIS LIST: Anaesthesia Practitioner, Endoscopy Practitioner, Surgical Care Practitioner, Perioperative Specialist Practitioner and Physician Assistant]? Or with any other similar positions (eg other Advanced Practitioner groups or Allied Health Professions)?

*If yes,* Does the training programme for [NAME OF AP GROUP THAT IS SUBJECT OF THIS INTERVIEW] involve any joint sessions with trainees for other Advanced Practitioner roles? Or with any other groups of Advanced Practitioners or other Allied Health Professions?

*If yes,* Could you tell me what is involved?

*If no,* Do you think it would be possible for joint sessions to be organised? Would there be any advantages to that, do you think? (*Probe on potential for cost reductions; larger learner groups leading to more peer support; larger learner groups making it easier/providing more incentives for universities to run programmes; more viable for commissioners*)

**I'd now like to ask you about the impact of the AP role and what you think the benefits have been for your department and the trust, and things that helped or hindered introducing the role.**

26. How have the APs been received by a) patients b) medics/consultants c) nurses d) other team members e) other APs f) anyone else they work with?

27. Do you feel that, overall, the introduction of APs has been a success? Why/why not?

28. What would you say has been the main impact of the new roles? Have you gathered data on any measures to evaluate this?

*(Check main objectives identified at beginning of interview then probe on whether they have achieved the objectives they set out to achieve.)*

29. Do you believe this (the main objective(s) the trust identified, (eg improved skill-mix, improved career pathways and retention etc.) was/were achieved?

30. Has it/these objectives been the main outcome(s)?

31. *If yes,* Why do you think that is? Did anything in particular help with implementation?

32. *If no,* Why do you think that was? Did anything in particular prove to be a barrier to implementation?

33. Do you have any further, longer-term plans for implementation/AP extension here? *If yes,* What are they? *If not,* Why is that?

34. What do you think are the main costs and benefits associated with the recruitment and training routes available for these practitioner roles? Are there any ways in which recruitment/training could be improved?

35. Do you believe any benefits you have obtained have been worthwhile?

36. Has it been cost-effective? Is there evidence of savings as well as (the main benefits identified in [q. X above])? Have you collected any data on this?

37. What do you feel are the main career path options available to APs now?

38. Do you have any other comments or observations you would like to make?

Thank you. Should you wish to make any further comments, you can contact me [give card]. If you have any queries after the project has concluded, you can contact Kathryn Halford or Robert Standfield at Skills for Health.



## Interviews with (non-supervisory) colleagues

### Introduction

- Thank you for agreeing to be interviewed.
- Introduce self and IES: IES is an independent, not for profit research organisation and has been a leading centre for applied research in learning and skills and human resource management for over 30 years.
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- Ask for agreement to tape the interview as this saves time in having to take notes and enables thorough analysis. If meet with objections, take notes instead – ensure interviewee is comfortable with tape recording (ie informed consent is given), rather than assuming this will be the case.
- Any questions?

Trust:

Core AP roles at site:

Interviewee:

Interviewee's role:

Brief description of current job role, what it involves, how long they've been doing it, how long they've worked at the trust, whether they're full-time/part-time etc.

1. Did you work in this team prior to introduction of the AP role(s)?
2. Were you involved in development of the AP roles in this trust?
3. Can you describe the sorts of activities the AP is involved with in your team?  
How much does your job require you to work closely with them? What sort of involvement do you personally have with APs?
4. Are any of those activities also undertaken by other team members, or is the AP role fairly distinct (does the role have clear boundaries)?

5. Were you offered the chance to train for the AP role when it was introduced?

*If no, Was that because [their staff group] was not invited/eligible to train/AP is a more junior role?*

*If yes, Why did you chose not to take up the offer? Would you consider it if it were to be offered to you again now? Why is that?*

6. Do you think that introduction of the AP role has had much impact on the functioning of your team/department?

*If yes, How has introduction of the AP role affected the team?*

*If no, Why do you think that is?*

7. Do you think that introduction of the AP role has had any impact on your job?  
*(probe on whether they have been able to give up certain activities; were these activities they were happy to give up?)*

8. What do you think the career options are like for people who have gone into the AP role?

9. How do the career options for APs compare to the compare options for [your job title]?

10. Is there any other AP role (other than the one we've been discussing today) that you might consider moving into in the future?

Why is that?

11. Are there any other comments you would like to make about how the AP roles were introduced and how it has worked out?

Thank you. Should you wish to make any further comments, you can contact me [give card]. If you have any queries after the project has concluded, you can contact Kathryn Halford or Robert Standfield at Skills for Health.

## Interviews with AP managers or supervisors

*Interviewer – This interview guide for use with supervisors/managers of in-scope APs.*

### Introduction

- Thank you for agreeing to be interviewed.
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- Ask for agreement to tape the interview as this saves time in having to take notes and enables thorough analysis. If meet with objections, take notes instead – ensure interviewee is comfortable with tape recording (ie informed consent is given), rather than assuming this will be the case.
- Any questions?

Trust:

AP roles in interviewee dept:

Interviewee:

Brief description of current job role, what it involves, how long they've been doing it, how long they've worked at the trust, whether they're full-time/part-time etc.

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**I'd like to start by asking you some questions about how the AP roles came to be developed and introduced within this trust.**

1. Were you a member of the original team involved with implementation? If not, how did you become involved with introduction of/supervision of APs?
2. Prior to becoming involved in introducing the AP role(s), had you been involved in any work locally on role extension for any staff groups?
3. Were you involved in the decision to introduce the AP role in your department?
4. What in your view were the main reason(s) for introducing the AP role(s)?

*(Allow interviewee to identify main reasons. Depending on how readily they are able to identify reasons, prompt with: service improvements (improving patient care/experience; increasing capacity); reducing costs; links between improved career options and ability to retain staff; need to remedy skill shortages; meeting working time directives; were asked to participate)*

5. If multiple objectives given, were any of these more/most important?

*(Explore whether initiated within the trust, via university partners, championed from within, prompted by news of funding availability etc.)*

6. Who (else) was involved in developing/implementing the new role(s) within the trust? *(Check for: staff side reps, the clinical teams in which the roles were introduced, HR/OD staff, others etc?)*

7. Did you encounter any local challenges with job design or re-design for these posts?

*(Probe around senior management support, conflicting goals/ensuring integration with local priorities, funding availability, staff turnover, clinical governance and patient safety issues, resistance from teams and/or patients/service users, service redesign around new roles, changing organisational priorities)*

8. *(If involved with development process)* What process was used to develop/implement the role? *(Check for project champion/service manager operating alone, a steering group, the team affected by the role?)*

9. How easy was it to implement the roles, once you decided to go ahead with them?

10. How did you feel about the introduction of the new role(s)?

11. How did other members of the team in which the APs work feel about introduction of the new role(s)?

12. How long did it take to get from considering the idea to a) enrolling the first recruits on their training, b) the qualified APs moving into post?
13. Was that about the length of time you had expected, or longer, or shorter?  
*If longer/shorter Why is that?*

**I'd now like to ask you some questions about recruiting to the AP role.**

14. Were you involved in deciding which staff groups to recruit to the AP roles?  
How did you decide that?
15. Which staff groups (ie, staff groups, eg nurses, receptionists etc.) were targeted for recruitment to these posts?
16. Were you involved in the recruitment process? How did you recruit these individuals to the AP roles? (*Probe on: was the opportunity offered to all staff with appropriate experience and qualifications? To just a few who were felt to be appropriate for development? Were individuals nominated by managers? Recruitment methods used – website/staff newsletter/email etc.*)
17. How many people volunteered/were selected/applied? Was there a selection process? *If so*, What form did it take and who was involved in managing/running it?
18. Did you get the expected number of applications? (too many/too few?) *If too few*, Why was that?
19. Do you have any figures for the costs involved in recruitment to these posts?  
*If yes*, Can you tell me how much recruitment/the various recruitment routes cost?
20. (*If different recruitment routes were used*) How effective were the various recruitment routes you tried? Did you find that any one recruitment route/method was more effective than the others?
21. Did you get the calibre of applicants you expected applying for these posts?
22. Did everyone who was offered the opportunity to train for these posts take up the offer? *If not*, Why was this? (*Probe on support within organisation; quality, appropriateness and accessibility of external training; enthusiasm or otherwise of staff groups seen as filling these posts; (lack of) clinical support etc.*)
23. Depending on reasons given, probe further using selected questions:
  - 23a. Why do you think there was particular enthusiasm/no particular enthusiasm for these posts?

23b. Was there a reason for clinical support/opposition?

23c. Why do you think organisational support was high/lacking for this initiative?

23d. What format did the training take? (*Who provided it, how selected, whether in-house/external/mixed model? Use of mentors/clinical supervision etc?*)

23e. What were the strengths and weaknesses of the training?

24. Looking back, was this/were these the right staff group(s) to recruit?

How did they respond to the training programme?

*(Probe on recruits finding it too difficult/ too easy/too slow and reasons why.)*

Would it be possible to recruit individuals with lower qualifications and/or less experience to the programme?

*If yes,* What kind of groups can you envisage recruiting from? Would the training programme need to be modified in any way?

25. Were the recruits able to use APEL to satisfy the requirements of any parts of the training?

*If yes,* What parts of the training did they tend to have existing experience and knowledge of?

Were they able to 'fast-track' their progress through/attainment of those parts of the programme?

*If no,* Why was that?

In your opinion, would it be useful if individuals could be fast-tracked on the basis of previous experience and knowledge?

*If yes,* How might this work?

*If no,* Why is that?

*If no,* (APEL use) Was this because they did not have any relevant prior knowledge or experience, or because the training provider would not recognise/use it?

*If programme did not allow this,* In your opinion, would it be useful if individuals could be fast-tracked on the basis of previous experience and knowledge?

26. As far as you are aware, is there any overlap in the training provided for the [NAME OF AP GROUP THAT IS SUBJECT OF THIS INTERVIEW] and that provided for [DELETE RELEVANT ROLE FROM THIS LIST: Anaesthesia

Practitioner, Endoscopy Practitioner, Surgical Care Practitioner, Perioperative Specialist Practitioner and Physician Assistant]? Or with any other similar positions (eg other Advanced Practitioner groups or Allied Health Professions)?

If yes, Does the training programme for [NAME OF AP GROUP THAT IS SUBJECT OF THIS INTERVIEW] involve any joint sessions with trainees for other Advanced Practitioner roles? Or with any other groups of Advanced Practitioners or other Allied Health Professions?

*If yes, Could you tell me what is involved?*

*If no, do you think it be possible for joint sessions to be organised?*

*Would there be any advantages to that, do you think? (Probe on potential for cost reductions; larger learner groups leading to more peer support; larger learner groups making it easier/providing more incentives for universities to run programmes; more viable for commissioners)*

**I'd now like to ask you about the impact of the AP role and what you think the benefits have been for your department and the trust, and things that helped or hindered introducing the role.**

27. How have the APs been received by a) patients b) medics/consultants c) nurses d) team members e) other AP groups f) anyone else they work with?
28. Have the APs encountered any challenges in undertaking the roles?
29. Have you found any particular difficulties or issues in managing/supervising the new APs?
30. Have any of the APs moved on since the role was introduced? *If yes, Why was that?*
31. Do you feel that, overall, the introduction of APs has been a success? Why/why not?
32. What would you say has been the main impact of the new roles? Have you gathered data on any measures to evaluate this?
33. *(Check main objectives identified at beginning of interview then probe on whether they have achieved the objectives they set out to achieve.)* Do you believe this (ie the main objective(s) identified by the trust, (eg improved skill-mix, improved career pathways and retention etc.) was/were achieved?
34. Has it/these objectives been the main outcome(s)?

*If yes, Why do you think that is? Did anything in particular help with implementation?*

*If no, Why do you think that was? Did anything in particular prove to be a barrier to implementation?*

35. *If skill-mix or retention not mentioned, ask, Have the new roles had any impact on your ability to retain staff? If yes, Has this had any impact on the overall level and mix of skills within your department?*
36. Has having the AP(s) in the department inspired any other members of staff to consider undertaking further development to move into the same or a similar role?
37. Do you have any further, longer-term plans for implementation/AP extension here?  
*If yes, What are they? If not, Why is that?*
38. What do you see as the main career path options available for those in AP posts?
39. What do you think are the main costs and benefits associated with the recruitment and training routes available for these practitioner roles? Are there any ways in which recruitment/training could be improved?
40. Do you believe any benefits you have obtained have been worthwhile?
41. Has it been cost-effective? Is there evidence of savings as well as (the main benefits identified in [q. 29/30 above])? Have you collected any data on this?
42. Do you have any other comments or observations you would like to make?

Thank you. Should you wish to make any further comments, you can contact me [give card]. If you have any queries after the project has concluded, you can contact Kathryn Halford or Robert Standfield at Skills for Health.



## Interviews with APs

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- Ask for agreement to tape the interview as this saves time in having to take notes and enables thorough analysis. If meet with objections, take notes instead – ensure interviewee is comfortable with tape recording (ie informed consent is given), rather than assuming this will be the case.
- Any questions?

Trust:

Core AP roles at site:

Interviewee:

Interviewee's role:

Brief description of current job role, what it involves, how long they've been doing it, how long they've worked at the trust, whether they're full-time/part-time etc.

**I'd now like to ask you some questions about how you came to be doing the AP role and how you were recruited to it.**

1. What were you doing before you moved into the AP role ?

1a. Had you received any training while in that post? What was that? (*probe new skills? New ways of doing existing tasks? On/off the job? Formal/informal? Any qualification received?*)

1b. Had you received any promotion while you were a [name of job]?

1c. What were your career options before you heard about the AP roles?

2. How did you find out about the AP positions?

3. What were your thoughts when you heard about the AP position? Were you immediately attracted to the post?

*(Whether yes or no) Why was that?*

4. *If were not immediately attracted to the post, What persuaded you to apply for the position?*

5. *(Use appropriate version of this question depending on how they heard about the AP position – whether found out and applied, or were informed about scheme and then nominated) Did any of your colleagues decide to apply for/Were any of your colleagues nominated for the AP role too?*

How many?

Was that all of your colleagues in the same post as you at the time?

*If not, How many did not apply/were not nominated? Do you know why this was? (Probe on reasons for some not applying or for only a sub-set being nominated.)*

6. Looking back, do you think this was/these were the right staff group(s) to recruit?

Do you think it would be possible to recruit individuals with any lower qualifications and/or less experience to the programme?

*If yes, What sort of people do you think would be good at/able to do this role?*

*What sort of training would they need? Would it be any different from yours?*

7. What do you think was the trust's main intention in introducing the AP roles these posts? (service improvements/increasing capacity; cost-benefits; links between improved career options and ability to retain staff; skill shortages; were asked to participate etc. )

8. *(Select version according to whether touched on in earlier points or not) Were you involved in the original development work for the posts? Or, Can I confirm, you were involved in the original development work for these posts?*

*If yes, Were there any particular challenges with designing these posts?*

**Now I'd like to ask you about the training you received for the AP role and your experience of moving into the AP role.**

9. What did the training for the AP role involve?
10. How did you and the other trainees find the training? (*Probe on: was it of an appropriate standard? Provided the right level of information and skills? Made sense in context of the role you would be performing? Timing/location? Probe on recruits finding it too difficult/ too easy/too slow and reasons why.*)
11. Were you or the other recruits able to use APEL to satisfy the requirements of any parts of the training?
- If yes, What parts of the training did you have existing experience and knowledge of?*
- If not, But you had relevant experience/qualification, why was APEL not available?*
- In your opinion, would it be useful if individuals could be fast-tracked on the basis of previous experience and knowledge?
- If no, Why is that?*
12. As far as you are aware, is there any overlap in the training provided for you and your fellow trainees and that provided for [DELETE RELEVANT ROLE FROM THIS LIST: Anaesthesia Practitioner, Endoscopy Practitioner, Surgical Care Practitioner, Perioperative Specialist Practitioner and Physician Assistant]? Or with any other similar position (other Advanced Practitioner groups or Allied Health Professions)?
- If yes, Did the training programme for you involve any joint sessions with trainees for other Advanced Practitioner roles? Or with any other groups of Advanced Practitioners or other Allied Health Professions?*
- If yes, Could you tell me what is involved?*
- If no, Do you think it be possible for joint sessions to be organised? Would there be any advantages for trainees? (Probe on potential for larger learner groups leading to more peer support; access to range of different tutors; insights from other specialisms; better inter-professional working)*
13. How have you found the new role? (Likes/dislikes, difficulties/challenges and how overcome?)
14. How have you found working with colleagues in your new role? (*Probe on colleagues' responses to the new role? Pleased/enthusiastic? Cynical/discouraging?*) Why do you think colleagues responded in this way?

**I'd now like to ask you about the background to introduction of the AP role and what you think the benefits have been for you and the trust, and things that helped or hindered introducing the role.**

15. What do you think was the trust's main intention in introducing AP roles?  
(service improvements/increasing capacity; cost-benefits; links between improved career options and ability to retain staff; skill shortages; were asked to participate etc. )
16. Do you think the trust has achieved its objectives in introducing the new post?  
*If no, Why not?*
17. What benefits do you think the trust has gained as a result of the new post?  
*(Probe on cost savings, recruitment/retention/patient care etc.)*
18. From your point of view, do you think that anything in particular helped with introduction of the AP roles?  
  
*If yes, What was that?*  
  
*(Probe on support within organisation; quality, appropriateness and accessibility of external training; enthusiasm or otherwise of other staff groups; enthusiasm or otherwise of colleagues; clinical support etc.)*
19. Did any issues in particular prove to be a barrier to implementation?  
  
*(Probe on (lack of) support within organisation; (lack of) quality, appropriateness and accessibility of external training; (lack of) enthusiasm or otherwise of other staff groups; enthusiasm or otherwise of colleagues; (lack of) clinical support etc.)*  
  
*Depending on reasons given, probe further eg, Why do you think there was particular enthusiasm/no particular enthusiasm (etc.) for these posts?*  
  
*Why do you think clinicians supported/opposed the introduction of the role?*  
  
*Why do you think organisational support was high/lacking for this initiative?*  
  
*If not already mentioned previously Do you feel that, personally, the AP post has benefited you?*  
*If yes, How?*  
  
*If no, Why is that?*
20. What are your own career plans now?
21. Do you feel that, overall, introduction of the [name of AP role] has been a success? *If yes, How? If no, Why not?*

22. Can you think of any additional types of support which might help the national implementation of AP roles in other trusts?
23. Are there any other comments you would like to make or any other important issues you think we have left out?

Thank you. Should you wish to make any further comments, you can contact me [give card]. If you have any queries after the project has concluded, you can contact Kathryn Halford or Robert Standfield Skills for Health.