

# Advanced clinical practice education in England

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of Deans of Health/Health Education  
England advanced clinical practice  
education conference

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## Foreword



This report is one part of the Council of Deans of Health's ongoing collaboration with Health Education England on advanced clinical practice. This is a complex and rapidly moving policy space. Over the past six months we have elicited universities' views on advanced clinical practice, in particular exploring perceptions, expectations, pressures and obstacles to implementation of the national framework and the apprenticeship. We have sought here to summarise that feedback and identify next steps.

I am grateful to our steering group members for their contribution to this work and value, in particular, the contribution made by external stakeholder organisations.

I look forward to continuing to lead the Council's engagement in this area.

### **Professor Ruth Taylor**

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The Council of Deans of Health represents the UK's university faculties engaged in education and research for nurses, midwives and allied health professionals. At any one time our members will be educating in the region of 120,000 future registered health professionals. Operating as a multi-professional organisation at the heart of policy and political debate, the Council aims to lead policy at national and UK level, promoting the essential contribution of our members to health and social care.

# 1 Introduction

On 14 September, the Council of Deans of Health (the Council) hosted a conference, with the support of Health Education England (HEE), to bring universities/higher education institutions (HEIs) in England together with HEE and other stakeholders to discuss the future of advanced clinical practice (ACP)<sup>1</sup> education in England. Most delegates had institutional responsibility in universities for advanced practice programmes. This was followed by a smaller workshop on 11 October, which gave Council members – deans and heads of school – an opportunity to discuss the topics covered at the conference.

This report is a product of those events and of the Council's wider involvement in the development of advanced clinical practice in England. It includes recommendations for next steps.

Advanced practice policy differs across the four nations. The Council, as a UK-wide organisation, is involved in advanced practice policy across the UK but this report relates only to ACP education in England.

## 2 Executive Summary

- There was commitment from all parties at the main conference on 14 September to work together to optimise outcomes for service users and providers. ACP education will continue to evolve to meet the needs of the population. As ever, there is real willingness on the part of universities to provide the education required by employers and the workforce, but significant challenges remain.
- HEE has asked universities, employers, healthcare professionals and interested others to collaborate on the design of a national ACP academy, bringing together existing quality assurance and accreditation functions for both professionals and education courses.
- Delegates began to discuss possible system, regional or national procurement of ACP apprenticeship programmes or modules<sup>2</sup> and the benefits of collaboration to create economies of scale, adopt a place-based approach and secure necessary programme provision across England.
- HEIs stressed the need for timely funding decisions and long-term investment to allow for planning and programme development. More certainty about the future would allow universities to develop capacity, capability and teams.
- Important questions remain, particularly around the approach to specialist competencies in ACP curricula. This report makes recommendations for next steps for HEE, HEIs and the Council.

### Footnotes

- 1 Throughout this report ACP refers to advanced clinical practice, as a level of practice, as opposed to advanced clinical practitioner, as a role.
- 2 These are variously referred to by universities as modules or units, in this report we use the term module.

## 3 Background to the Council/HEE collaboration project

In March 2018 the Council was commissioned by HEE to lead a project on the development of ACP in England, focusing on the interface with universities.

This project is part of HEE's development and implementation of the 2017 *Multi-professional framework for advanced clinical practice in England* and coincides with the introduction of an advanced clinical practitioner apprenticeship in England.

With the national framework published, HEE identified a need to work with universities to engage educators in the transformation of services. As the representative of UK universities educating nurses, midwives and AHPs, the Council of Deans of Health is a key facilitator of this engagement and is ideally placed to bring stakeholders together with HEIs, to understand and summarise what is needed by HEIs to develop ACP education and to help stimulate any further work required.

The Council created a steering group to drive its work on advanced practice in England. The group includes representatives from universities, HEE, AHP, nurse and midwife professional organisations, the Association of Advanced Practice Educators (AAPE) and NHS Employers. Full membership can be found in Appendix A.

The Council's work with HEE on ACP aims to achieve the following outcomes:

- HEI advanced practice leads and deans gain better awareness and understanding of ACP policy developments and are enabled to appraise their existing provision and plan changes for the future
- HEIs engage in discussion around the HEE framework and introduction of the apprenticeship
- HEE and other stakeholders gain an understanding of HEI perceptions, expectations and pressures and obstacles to implementation of the framework and apprenticeship in HEIs
- HEIs, HEE and other stakeholders are given an opportunity to suggest and agree next steps to advance ACP development across England

The Council has agreed that where the next steps identified include further work for HEIs, it will, throughout the course of this project, seek to enable and facilitate necessary discussion.

### 3.1 ACP education survey June 2018

In June 2018 the Council ran a simple survey to explore members' attitudes to developments in ACP education. The survey was created to provide a benchmark for the Council's project work. It was cascaded to deans, heads of school and course leads in England through the Council's news bulletin and through the Association of Advanced Clinical Practice Educators (AAPE) network. The Council received 68 responses. Respondents' free text comments added depth and context to the answers given to our questions. The results of this survey are referred to throughout this report, along with comments made by representatives of universities at the conference in September.

## 4 Policy context

### 4.1 The multi-professional framework for advanced clinical practice in England (2017)

The 2017 *Multi-professional framework for advanced clinical practice in England* was the culmination of a concerted effort by multiple stakeholders including HEE, NHS Improvement and NHS England to introduce consistency, clarity and shared understanding around ACP, recognising that advanced clinical practitioner roles and education have developed differently in different professions and regions of England. HEE is currently engaged in wide-ranging project work with a range of organisations to create the necessary conditions for full implementation. This includes discussions around a new national academy for advanced practice, the development of an e-portfolio and the introduction of system, regional or national procurement. Advanced practice is thought to be a priority area of development for some Sustainability and Transformation Plan (STP) areas. At least one is now commissioning ACP education in line with its workforce plans.

### 4.2 The advanced clinical practitioner apprenticeship

The funding for ACP education is changing. Courses once commissioned by Health Education England have been affected by national and local cuts to workforce development budgets, but a new source of funding is now available in the form of an advanced clinical practitioner apprenticeship. The apprenticeship standard has its own educational and assessment requirements, which have already started to drive change in ACP education. Universities and employers delivering the apprenticeship will be putting apprentices through a full Masters award as opposed to more loosely defined 'Masters level' education which otherwise includes PGCert, PGDip and experiential learning routes. Universities are also restructuring courses to include integrated end point assessment (EPA).

### 4.3 Challenges for ACP education in England

Results of the Council's ACP survey in June 2018, indicate a good level of awareness of the national ACP framework (67% felt they were extremely or very familiar with it). Respondents felt somewhat less familiar with the advanced clinical practitioner apprenticeship. Nevertheless, results suggest that these two policy developments are already impacting on education provision. 70% of respondents had made or were planning changes to their ACP curricula in light of the framework and almost 80% had made or were planning changes to curricula in light of the apprenticeship.

Based on the stated aims of the multi-professional framework, a number of specific challenges have been identified for ACP education in England including:

- Ensuring that professionals working at the level of ACP have the knowledge, skills and behaviours relevant to their professional setting and job role (**specialist competencies**)
- Promoting implementation and application that allows for local context but results in sufficient **consistency** to help transform the workforce in line with the Five Year Forward View
- **Encouraging collaboration between educators and employers** to allow practitioners to develop their abilities, particularly their clinical capabilities and for supervisory and assessment purposes
- The framework aspires to an **outcome driven approach** as opposed to focusing the developmental input or educational process undertaken
- Promoting **portfolio approaches and increased consistency and transparency** of processes for the accreditation or recognition of relevant prior learning or prior experiential learning (AP[E]L/RP[E]L)

- **Collaborating across an area or place if necessary** to optimise cost effective training with sufficient flexibility to develop specialty specific competence and broad capability. **Specialist modules in particular** may need to be delivered across England or regionally to be educationally and financially viable
- ACP developments must be multi-professional and encompass **inter-professional learning** and support
- Responding to **apprenticeship requirements and colleges' involvement in credentialing** programmes

Council members' feedback suggests there is an additional overarching challenge:

- **Enabling ACP education to flourish**

These themes were largely reflected by discussion at the Council's ACP conference and form the structure of this discursive report.

### Recommendation

With a rapidly developing policy environment, the Council should seek to provide regular updates on ACP to members

## 5 Ensuring that professionals have the knowledge, skills and behaviours relevant to their professional setting and job role (specialist competencies)

### 5.1 Where do specialist competencies fit in?

Despite the publication of the national Framework, which seeks to create shared understanding of advanced practice, the conference revealed some ongoing ambiguity about the distinction between advanced clinical practice and clinical specialism, with the definition of advanced practice still raising questions for some individuals in Trusts and education. This came up several times in the case of clinical nurse specialist roles. Most conference delegates agreed that advanced practice is 'a level of practice' not a specialist skill, but the role of specialist clinical skills and education within advanced practice is still a source of debate.

The Framework says:

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

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

10 of the 11 clinical skills capabilities set out in the framework are generic. The last competency states that professionals working at the level of ACP should be able to 'evidence the underpinning subject-specific competencies ie knowledge, skills and behaviours relevant to the role setting and scope, and demonstrate application of the capabilities to these'. The framework also states 'it is essential that practitioners are developed to be clinically competent within their specialty, sector and setting.' It seeks 'adoption of national specialist clinical standards into programmes, where they exist'.

The introduction of the advanced clinical practitioner apprenticeship may create a new tension or dynamic between existing specialist education and advanced practice if employers seek to have specialist courses restructured and rebranded to access apprenticeship funding while retaining substantial clinical specialist content. This is a likely scenario in the context of cuts to professional development funding.

### 5.2 Provision of specialist competencies

University provision of advanced practice education is typically based on a generalist core. Over 60% of the Council's survey respondents said that their ACP students in 2018/19 would take both generic clinical modules and clinical modules relevant to their own area of clinical work. 15% said modules would be relevant to students' own areas of work. However, 23% said they were providing only generic clinical modules.

At the conference, Beverley Harden, National Lead, HEE, emphasised that ACP is not a generic role<sup>3</sup> but is a level of practice undertaken within a specialist field. It is vital that education meets the need for ACP across all professions. HEE is challenging HEIs to look at ways to provide advanced practice learners with the specialist clinical skills appropriate to their role (which could include generalism as a specialty for community roles). If employers are to use the apprenticeship levy to invest in ACP education over other types of apprenticeship, HEE suggests that they will want ACP education to deliver clinical competencies applicable to the apprentice's role. At the conference AAPE joined HEE in challenging the long-term viability of ACP courses with little emphasis on clinical skills.

#### Footnote

<sup>3</sup> Note that the advanced clinical practitioner apprenticeship slightly complicates this definition as in this case advanced clinical practitioner is very clearly defined as a role.

Comments on the survey indicate that respondents also perceive an increasing demand for advanced specialist clinical skills. Though one survey respondent said funding was targeting more generalist roles, others reported grappling with employer demand for more specialised curricula.

***'There seems to be some disconnect as we have found some employers expect specialists at a very high level, but through the role of ACP.'***

A few respondents mentioned an aspiration to create courses to appeal to staff in more specialist roles or to broaden the appeal of courses to a wider range of professionals.

Respondents' comments on the ACP survey's question about generic and specialist curricula content demonstrate the complexity, and trade-offs, involved in delivering specialist modules. At the conference, AAPE noted that many universities are still very supportive of a broad, generalist approach. There certainly seemed to be support for continuing to educate advanced clinical practitioners with broad clinical skills. Some delegates made a case for continuing to provide generalist, holistic clinical skills with an expectation that care will increasingly be provided to patients with complex co-morbidities and delivered by autonomous clinicians in community and out of hours contexts.

***'This is a generic role first and foremost with specialism as an added extra'***

## 5.3 Practical challenges facing education in the provision of specialist competencies

Council members have highlighted a number of practical challenges in providing specialist competencies in ACP education:

### 5.3.1. Uncertainty about the specialist competencies required

If more specialist provision is required, questions arise about how specialist this should be. One provider said it offered generic provision up to the final module which splits into three broad areas of practice. Providing more specialist content means deciding on whether this should be structured around profession, clinical skills (eg emergency care, mental health, intensive care, reporting, rehabilitation, public health, perhaps underpinned by credentialing) or the needs of subsets of the population (elderly care, child health). There is also a question about how specialist competency is reflected in course titles. Some conference attendees felt that the number of different course titles should be kept to a minimum to encourage mobility in the workforce, including between primary and secondary care.

### 5.3.2. Specialist content is more readily available for certain specialties than others

Survey respondents said that specialist content was more readily available for certain specialties than others and that some professions had not yet fully conceptualised ACP. HEIs teach advanced practice to a wide range of professionals so need particular clarity where there are specific expectations and educational needs in different professions. Universities will want to work to maintain a consistent approach to education while allowing flexibility on specialty skills requirements. It is important that ACP is clearly articulated for all professions to allow optimal workforce deployment.

### 5.3.3. Challenges in delivering specialist clinical modules for smaller specialties

The more specific the approach to specialist competencies, the more challenging it will be for HEIs or employers to achieve economies of scale without collaboration. One survey respondent admitted:

*'I don't think educationally we are able to provide ACP education for all specialties'.*

There are different models for delivering specialist clinical skills within ACP courses, including remote education, professional body awards and work-place support. As well as offering opportunities, some of these approaches pose challenges for university course accreditation under current rules, particularly for quality assurance processes.

### 5.3.4. Fitting specialist competencies in the ACP programme

Some universities are reviewing their ACP programmes to accommodate specialist competencies. One respondent said the curriculum was 'mostly generic because there isn't space to fit in everything otherwise'. Increasing specialist content entails creating programme space, which some HEIs are doing by reducing the credits for dissertations. Others referred to the application of ACP education to clinical specialism through assignments, a work-based dissertation or practice based assessments. HEIs are highlighting the challenge of ensuring that research and service development skills and not just advanced clinical skills are embedded in roles.

### 5.3.5. Next steps

HEE recognises that ambiguity remains around the relationship between specialist practice and advanced clinical practice. It has suggested assembling a working group, including the Council, to produce a clarifying position statement.

## Recommendation

The Council should work with HEE and others to clarify the role of specialist competencies and specialism more generally in ACP education, using examples, so that clinicians, managers and HEIs understand requirements across the workforce or by professional group.

## 6 Promoting implementation and application that allows for local context but results in sufficient consistency to help transform the workforce in line with the Five Year Forward View

ACP courses currently vary considerably across England for a variety of reasons, including historical differences in funding models, differences in institutional approaches to education between universities and the variety of professional influences on curricula.

The main objective of the national ACP framework is to introduce greater consistency between programmes, increase transparency of process and promote the transferability of educational modules. This seems already to be having an impact. Although the national framework is not mandatory, 70% of survey respondents had made or were planning changes to their ACP curricula in light of the framework. While some universities value the current diversity of courses and autonomy of HEI approaches, many conference attendees supported attempts to introduce greater consistency and standardisation. It has been suggested that, if HEE does continue to fund advanced practice courses, this funding could be more clearly linked to expectations that courses will be in line with the national framework.

### 6.1 Creation of a national academy of consultant and advanced clinical practice<sup>4</sup>

HEE has asked HEIs to collaborate across the system on the design of a national academy, encompassing both advanced and consultant practice. HEIs have been encouraged to engage through ongoing collaboration between HEE and the Council and through a new virtual group for advanced and consultant practice development. [There is also some academy development in Scotland, which has recently established three regional academies for advanced nurse practice, though these serve a different purpose.]

The current intention is to create a national academy to develop routes into ACP and to set and maintain standards working collaboratively with existing quality assurance and accreditation bodies, including the Royal College of Nursing's advanced practice credentialing process and the Society of Radiographer's accreditation process. The academy may seek to:

- create standardised routes to ACP, including some core national routes for certain areas of specialism
- maintain a directory or list of practitioners (non-regulatory)
- establish accreditation of ACP programmes
- offer routes of equivalence to recognise the existing workforce
- encourage collaboration between education providers
- drive workforce transformation.

Creating a body or framework which can encompass a variety of existing initiatives requires significant infrastructure, and ongoing resource for accreditation or list maintenance once implemented. Its creation will undoubtedly be challenging. HEE has been clear that it is unlikely to work without widespread engagement and co-production. Questions remain about the role and functions of the academy and what practitioners, employers, educators, mentors, supervisors and assessors can expect from it. Universities may want to consider whether accreditation of ACP programmes would be helpful or excessive in the context of existing quality assurance measures. HEE has established a virtual reference group which all are free to join.<sup>5</sup>

## 6.2 Challenges in promoting consistency

### 6.2.1 Inconsistency in the workforce

Many of the challenges in increasing consistency in ACP lie outside education, in the workplace. Some comments referred to ambiguity about advanced clinical practitioner roles in practice. This is not the focus of this report but should be noted as it contributes to the wider sense of uncertainty.

*'The vision is sometimes misunderstood and the level of practice not completely understood in terms of organisational commitment and support.'*

*'There is still an awful lot of work that needs to be undertaken to ensure that ACP role potential is optimised and that adequate funding is available to support them.'*

*'There is some misunderstanding around the role of the ACP amongst commissioners and some but not all employers.'*

### 6.2.2 Inconsistency or lack of clarity in expectations for ACP education

Universities have highlighted areas of uncertainty and lack of clarity in employer, local and national expectations of ACP education.

There is some confusion whether or not ACP education should be a full Masters award, with a suggestion that the apprenticeship and non-apprenticeship should be aligned:

*'The national vision is...getting clearer but it is difficult when you have a consensus statement published and then three months later the apprenticeship standard says something rather different!'*

Some HEIs have highlighted an apparent disconnect between national expectations and the expectations and requirements of local employers:

*'The difficulty we have experienced in our region is that the HEE ACP document was apparently clear but there is an unwritten curriculum that we are being required to meet and that ambiguity has been very difficult to deal with.'*

Ambiguity around the requirements for individual professions in ACP education, as outlined above, is also an obstacle to consistency.

*'What is required clinically from an advanced practitioner in each profession?'*

Some HEIs would also welcome clarification about the role of work-based learning and assessment in ACP education, with some calling for standardisation of hours of practice and competency documents for assessment in practice:

*'We need clarification regarding whether a portfolio and linked capability assessment is viewed as essential for an ACP programme. Currently some MSc ACP programmes are very flexible with no synoptic portfolio requirement, and minimal formal competency or capability assessment.'*

Some at the conference asked for a tangible framework or toolkit setting out desired outcomes with examples of delivery models, specifications of competencies for specific clinical areas and examples of best practice. One suggested a shared repository for HEIs to share experience and good practice from developing ACP programmes.

There is clearly still scope for refining what is required from ACP programmes in the coming years. Conference attendees called for clarification around prescribing (and expanding the definition to include medicines optimisation), and the future of ACP for staff in commissioning, public health and social care roles.

#### Footnotes

4 There is no title yet for this new academy

5 To join visit [hee.nhs.uk/ACP\\_reference\\_group](http://hee.nhs.uk/ACP_reference_group)

### 6.2.3 University rules and autonomy

Attempts to increase consistency in the design of ACP courses may be complicated by varying university rules on course composition. This has already proved to be an obstacle for some HEIs seeking to accommodate the apprenticeship EPA where the necessary credits do not fit with the university's approach to awards. There are similar obstacles to standardisation in HEIs' approaches to the accreditation or recognition of prior learning (see section 9). Conference attendees also highlighted variable approaches to entry criteria and some uncertainty about what could be considered to be equivalent to a BSc for Masters level entry.

### 6.2.4 Lack of regulation

Lack of regulation of advanced clinical practitioner roles is repeatedly raised as an obstacle to consistency.

***'How can we ensure universal acceptance of the role and standardisation of the role nomenclature and definition without professional regulation?'***

Most advanced clinical practitioners are professionally regulated by the Nursing and Midwifery Council (NMC) or the Health and Care Professions Council (HCPC) (or by the General Pharmaceutical Council in the case of pharmacists). The NMC requires nurses to revalidate, the HCPC does not but does have requirements for continuing professional development. The title of advanced clinical practitioner is not protected. Some respondents said they felt 'advanced clinical practitioner' should become a protected title with clear role standardisation:

***'Lack of regulation results in the continuation of a plethora of roles adopting the title of advanced clinical practitioner. How is this to be addressed?'***

***'We need to consider the extent that we believe that the practitioner's cognate discipline ie profession in which they are registered, should be explicit in their title and their description of their role to the person in receipt of care.'***

There are a range of views on the separate regulation of advanced clinical practitioners. Some believe that an additional system, such as a voluntary directory, may be required to achieve greater consistency in the use of the title and to arrive at more uniform expectations of those holding these roles. There is a clear link here to patient safety and public protection, particularly with the growing role of advanced clinical

practitioners in clinical diagnosis and complex decision making. There will likely be continuing debate on the regulation of advanced clinical practitioner roles, particularly as the Department of Health and Social Care has announced its intention to regulate physicians associates and physicians assistants (anaesthesia).

***'We need careful consideration of whether – at this moment – regulation is a realistic goal, an aspiration, or not something we are actively pursuing...If it is a goal, then what should our next steps be? And how can we reconcile regulatory aspiration with the broad, flexible, level-orientated approach to ACP we are currently taking – the concern being that the broader and more flexible something is, the harder it is to contain and to regulate.'***

### 6.2.5 Negotiating ACP across professions

Multi-professional involvement in ACP is an important given for Council members. It does however present some challenges in increasing consistency in the provision of ACP education.

***'Some disciplines and roles map to the ACP framework more clearly than others'***

***'Whilst the ACP framework is on the whole clear, some elements, eg holistic advanced assessment, diagnosis and treatment, are more difficult for some of the professions to meet than others.'***

Several respondents felt certain professions or specialisms were more engaged in ACP developments than others, particularly those with nationally standardised competencies. This includes standards from the Royal College of Emergency Medicine (RCEM) for Emergency Care Advanced Clinical Practitioners and those from the Faculty of Intensive Care Medicine (FICM) for Advanced Critical Care Practitioners.

***'I think in terms of the multi professional vision some AHP professions are less well engaged and collectively nurses are probably more concerned with advanced practice and more engaged in debate than AHPs.'***

***'Some such as critical care have a clear vision, but there are disparate views across professional disciplines.'***

Physiotherapy and paramedics were picked out by respondents alongside nursing as being most engaged in ACP.

***'I feel that there is clear steerage for nursing in the field both nationally and locally however for AHPs I feel this is less well defined'***

***'ACP for nursing seems well understood. I feel concerned about the smaller professions' clinical expert route or expectations of this expert clinician not being fulfilled by the ACP pathway'.***

It has been suggested that clarification is needed around the role of holistic 'advanced health assessment skills' in ACP for each profession. One conference attendee noted that different professions may also require different approaches to research skills.

***'Are advanced health assessment skills required for all advanced clinical practitioners across all major body systems and in relation to mental health, an understanding of diagnostic principles as well as specialist application? If not, how do we determine who does/doesn't need what – and what are the risks?'***

Based on discussion at the conference and subsequently in the Council's ACP steering group, members seem to feel that core clinical learning is important for all professions. Members on the steering group suggested that a strong message should go out that core clinical learning is required for all learners on ACP courses, though there may still be some debate about what this should include.

***'Those in specialised roles in our experience do need and value skills across all major body systems'***

### Recommendations

HEIs should engage in the construction of any national academy for advanced practice and help to define what this will offer to and mean for HEIs.

Additional guidance with case studies would help support the national framework's objective of increasing consistency across England. As ambiguity seems to remain this seems to be a pre-requisite for moving forward. HEIs would welcome a toolkit setting out desired outcomes with examples of delivery models, specifications of competencies for specific clinical areas and examples of best practice.

As the framework and any national academy come into full operation, HEIs and employers will require continuing dialogue and will need to be able to pose questions and gain clarification from HEE in a rapidly changing environment. This suggests that the Council should remain active in this policy space alongside AAPE and professional organisations.

## 7 Encouraging collaboration between educators and employers to allow practitioners to develop their abilities, particularly their clinical capabilities and for supervisory and assessment purposes

### 7.1 Collaboration with employers

Increased collaboration across the system seems to be a prerequisite of progress. Employers and STPs are seeking to take an increasingly place-based approach to workforce planning and universities should be part of these discussions.

In its *UK principles to support high quality advanced clinical practice education* (2017), AAPE states 'effective education for advanced clinical practice relies on establishment of a partnership between the student, work-place and the HEI'. Employer/provider partnerships will be particularly key for apprenticeship delivery.

Universities are already working closely with employers to shape the future of ACP. Over 90% of survey respondents reported discussing delivery of the advanced clinical practitioner apprenticeship with local employers. Comments indicate that in some cases employers have been 'extensively involved' through stakeholder meetings in reviewing and co-producing ACP curricula. Some respondents had planned changes to existing provision in response to employer requirements.

HEIs and employers are also expected to collaborate in the future on the assessment of ACP prior experiential learning and existing skills. Local arrangements for assessing portfolios of evidence are recommended and are intended to involve local partnerships comprised of experienced clinicians, postgraduate medical educators, HEI staff or professional bodies. Work-based assessment requires a high degree of trust or collaboration between HEIs and practice.

### 7.2 Employers' role in ACP education

Employers may be part of the solution to increasing specialist competencies in ACP education by providing more work-place based learning and assessment.

The national framework says:

***'A key element of the preparation for individuals to practice at the level of advanced clinical practice will be a formal assessment of achievement of the capabilities, specific to the context of their practice.'***

***'There will be a strong need for collaboration and working across professional and organisational boundaries to ensure that learning and assessment in practice delivers practitioners who consistently meet the required outcomes in all settings.'***

The framework mentions the 'development of bespoke local support' to facilitate the role of employers including 'a collaborative programme to appraise portfolios utilising existing clinical experts and educators within service', 'work based units to ensure meaningful clinical exposure and assessment' and workplace assessment.

Conference attendees made a number of comments and suggestions about the HEI-employer relationship and role of the employer in ACP education. Several talked about the way that service demands were shaping programme provision but also dictating the opportunities for clinical supervision, protected learning time, contact hours and appropriate placements. One HEI said that more contact hours were required to cover the entire ACP curriculum.

***'Service demand needs can affect student experience and ability to achieve/progress and experience quality, clinically relevant teaching'***

Some universities highlighted concerns about employer support for ACP students and graduates. There were several calls for increased support in practice for ACP mentorship, and a greater understanding of mentorship and sign-off by doctors.

Conference attendees highlighted the importance of employers finding suitable roles for ACP graduates.

One said

***'there needs to be greater engagement with practice partners to ensure they understand the ACP role and support students in moving into ACP roles at the end of the ACP course'.***

Another reported that changes in management in a Trust had resulted in no advanced clinical practitioner post being available at the end of a sponsored course.

Collaboration between HEIs and employers is key in ensuring that the right students are put through ACP education. Some universities reported that some students sent by Trusts were not ready for Masters level education. There were also reports that some non-graduates struggle with the ACP course, particularly the research module. Some HEIs are looking for solutions to this problem such as bridging programmes.

### 7.3 Impact of the apprenticeship

The introduction of the apprenticeship is likely to have a profound effect on the role of employers in ACP education. Under the apprenticeship, employers will be required to sign-off competencies and it is likely more clinical educators will be required. The Institute for Apprenticeships defines quality work learning environments as including appropriate supervision, coaching and mentorship, agreed frequency of development and progression monitoring, assessment of competency and recognition of apprentices' increasing independence and autonomy.

The apprenticeship opens the possibility of very significant market disruption if some employers decide to pursue a model of in-house provision with validation by remote universities (this in turn would create challenges for quality assurance processes). In-house and increased employer-based provision could also undermine the benefits of inter-professional education and cross-professional fertilisation.

Just as universities sometimes struggle to meet employer expectations for ACP education delivery, universities sometimes feel they that employers need to have a clearer understanding of their role in ACP education. One survey respondent commented that local employers were very keen on the apprenticeship but had

***'not fully recognised the organisational issues of release of senior staff for the course and to complete their workplace learning aspects.'***

Other practical problems mentioned included a shortage of ACP mentorship resources, employer capacity for support, insufficient supervision or study time or deployment in inappropriate roles.

### Recommendations

Employers and HEIs need to work together to agree realistic expectations of both parties' role in ACP education.

A partnership role between employers and HEIs is required to develop a strategic approach to capacity building.

## 8 The framework aspires to an outcome driven approach as opposed to focusing the developmental input or educational process undertaken

Educators often talk about outcomes-based approaches to education (for example in relation to the new NMC standards for nursing). In the context of the framework, we understand the 'outcome driven approach' to include reference to equivalence-based routes to ACP, and perhaps also to indicate an openness to in-house training. [Interestingly, while the framework advocates an outcomes-based approach, the apprenticeship route is grounded in process.]

For Council members, educational experience is still key. Concerns have been raised by Council members about 'in house training' leading to achievement of an advanced level of practice. The Council believes there is a need to ensure rigour across all four pillars with an associated standard of learning and assessment. Dedicated developmental input and educational process also help to expose ACP students to multi-professional approaches.

### Recommendation

The continuing value of higher education input and rounded education must be clearly articulated as the ACP framework is implemented.

## 9 Promoting portfolio approaches and increased consistency and transparency of processes for the accreditation or recognition of relevant prior learning or prior experiential learning (AP[E]L/RP[E]L)

### 9.1 Recognition of experience

The national ACP framework specifies a 'Masters level award or equivalent' as the baseline for advanced practice. For some this leaves open a question of whether this is equivalent to education through a postgraduate certificate, diploma or MSc. This also leaves open the possibility of recognition and validation of prior experience rather than education, indeed HEE has funding to develop the 'equivalence route' for ACP and has established a task and finish group to explore this.

This equivalence route to demonstrating advanced practice capabilities and Masters level thinking and practice is raising lots of questions for universities. HEI staff wish to understand the minimum requirements expected, how these are best measured and tested and the risks and benefits of validating this route to ACP.

### Member example – Wessex Advanced Clinical Practice Project

*Contributed by Dr Helen Rushforth, Senior Lecturer/ Programme Lead, MSc Advanced Clinical Practice, University of Southampton*

**A current project which explores aspects of a potential future approach to recognising equivalence is the 'Wessex Advanced Clinical Practice Project' funded by Health Education England (Wessex) and being undertaken jointly with the University of Southampton and Bournemouth University. This project is focused on a group of established Advanced Clinical Practitioners who have not had the opportunity to undertake Masters level Advanced Clinical Practice education and/or formal competency assessment.**

**As project participants they have the opportunity to undertake a clinically and educationally supported mapping process, gap analysis and development plan to identify their learning and assessment needs. For some this is then followed by the opportunity to undertake a Masters level advanced practice portfolio and practice based competency assessment via a 'Work Based Learning' module. Those not ready for the portfolio/competency assessment have the opportunity via the project to undertake education (normally a taught module) to fill a key identified gap in their learning, with a view to this being the basis of future further education if needed, and ultimately competency verification. Ninety participants are currently involved in the project across the two universities; the two year project is due to complete with its final report in June 2019.**

## 9.2 Accreditation or recognition of prior learning

AAPE expects ACP education providers to maximise strategies for recognition of prior learning or experiential learning AP[E]L/RP[E]L 'to optimise demonstration of experiential learning and transferability in recognition of on-going challenges of continuing professional development funding and release for study'. AAPE notes that the assessment of practical skills will require rigour.

Universities vary in their approach to the recognition of prior learning or experiential learning. Some do not allow this at all, some charge students for this (at variable rates) and others do not. AP[E]L/RP[E]L carries different weight across universities that do allow this. AP[E]L/RP[E]L can variously count for a maximum of 33%, 50% or 66% of programme credit. Approaches to non-medical prescribing in particular vary, partly depending on how long ago this skill was acquired.

### '15/30 credits in one organisation would be 20/40 in another – RPL/APL challenge ++'

A more consistent approach to AP[E]L/RP[E]L could help enable the validation and recognition of specialist modules provided by medical royal colleges or other colleges of allied health, nursing and midwifery. At the moment, there are still challenges getting professionally quality assured courses recognised by universities. Though recognition of externally provided education can be challenging, it is not without precedent. The Chartered Society of Physiotherapy (CSP) undertook work in the 1990s to enable physiotherapists to secure appropriate CPD across multiple institutions.

Developments of this nature would shape the market in coming years and may lead to the development of regional or national centres for advanced practice for certain professions or specialist clinical skills education. Increased portability and greater consistency in education provision could also promote the recognition by local universities of specialist modules delivered remotely.

### Recommendations

HEIs may wish to review and develop their approach to AP[E]L/RP[E]L in light of the current policy environment for ACP.

HEIs need clarity on requirements for the 'equivalence route' and their role in assessing competencies and Masters level thinking.

## 10 Collaborating across an area or place if necessary to optimise cost effective training with sufficient flexibility to develop specialty specific competence and broad capability

Collaboration between universities may be necessary to allow the delivery of specialist clinical competency education at a viable scale. System, regional or national commissioning of courses or modules could help ensure that appropriate specialist competencies can be taught to all professional groups as part of ACP education. For universities, this may mean creating courses and regulations that allow more frequently for the incorporation of nationally-recognised modules delivered by others, creating a more portfolio-based approach to education at this level.

HEIs acknowledge the challenge of providing ACP education to small groups of professionals and the risk of courses not running if there is not sufficient interest. This is a particular challenge for any specialist clinical skills component for smaller areas of practice or the smaller professions.

***'ACP, specialist education for specialist roles and small numbers for higher education apprenticeships are difficult to reconcile.'***

***'A national centre for specialties would help some rarer specialisms like neonatal but how in a competitive world do we manage specialist education nationally?'***

At the Council's September conference, delegates began to discuss possible national procurement of ACP programmes or modules and the benefits of collaboration to create economies of scales, the adoption of a place-based approach and necessary programme provision across England. At the October workshop, John Clark of HEE mentioned the possibility of HEE creating a national repository for specialist clinical content for the range of ACP pathways, making content freely available to HEIs to use, thereby also achieving a degree of national consistency. The Council, AAPE and HEIs will want to be part of developing any such proposals.

There seems to be a genuine appetite for greater collaboration and cross-university planning and working, though one conference attendee said they thought that the apprenticeship reduces the possibility of collaboration.

***'We need a way of collectively sharing out the business in the most efficient way in a competitive world.'***

***'There are many geographically close HEIs running similar courses at the risk of being unviable'***

***'[We need] more collaboration re who does what in HEIs – cannot compete for the same market'***

Collaboration between HEIs or national commissioning could make a positive contribution to ensuring provision is available and thereby securing a future workforce with the desired skills, perhaps creating 'centres of excellence' across England in the process. National commissioning or collaborative approaches to regional procurement could also help to tackle geographic cold spots.

Universities' approaches to AP[E]L/RP[E]L, the degree of standardisation of curricula and flexibility to recognise provision by other universities may determine whether national tendering is required for entire ACP courses or for specialist modules to be ported into locally-provided ACP education. Though universities often allow AP[E]L/RP[E]L, to varying degrees, students do sometimes want a programme with a cohesive approach and not all will want to take modules provided at a distance from their home.

### Recommendations

HEIs need to have input into strategic decision-making and workforce planning at national, regional and local level, including on STPs and LWABs. This is critical to the development of effective place-based approaches and collaborative approaches to delivery.

HEIs will need to collaborate with HEE, employers and one another to deliver specialist competencies.

## 11 ACP developments must be multi-professional and encompass inter-professional learning and support

The national framework recommends 'delivery of inter-professional learning and support where feasible, to support workforce transformation, by building relationships, trust and respect'. AAPE too says ACP curricula should provide inter-professional learning opportunities. This is recognised as important for all healthcare education but is particularly relevant for the multi-professional focus of ACP developments.

Both survey respondents and conference attendees raised concerns about the risks of creating more specialised content for ACP courses. Increasing clinical specialism in advanced practice education risks reducing interprofessional learning and multi-professional approaches. It was also noted that certain professions are demanding their own ACP programmes, which diminishes opportunities for inter-professional learning and support.

One survey respondent said

*'I am concerned that the emphasis on role rather than level of practice will diminish interprofessional learning and teaching'.*

### Recommendation

Multi-professional and inter-professional approaches to ACP education should be upheld.

## 12 Responding to apprenticeship requirements and Colleges' involvement in credentialing programmes

### 12.1 Adapting to apprenticeship requirements

The introduction of the advanced clinical practitioner apprenticeship has already prompted universities to review and change ACP course structure. 80% of survey respondents had already decided to provide the advanced clinical practitioner apprenticeship and almost 80% of respondents had made or were planning changes to curricula in light of the apprenticeship. Several said they were still investigating viability and resource implications or were in discussion with employers.

Over the past year, the Council has played an important role in highlighting universities' struggles with the bureaucracy of apprenticeship delivery, particularly in healthcare subjects and particularly during the set-up phase. The Council has already called for a national contract or practical assistance with the processes involved in apprenticeship provision. This is a concern for all healthcare apprenticeships, including ACP programmes. If the advanced clinical practitioner apprenticeship is to succeed, universities would benefit from help in understanding both generic apprenticeship and programme-specific requirements and from help in dealing with apprenticeship bureaucracy (contracting and tendering in particular). At the conference, attendees valued the opportunity to hear about the advanced clinical practitioner apprenticeship from HEE and from Pat Hibberd, University of Birmingham, who was part of the trailblazer group and took a lead in the development of the integrated EPA.

Many of the comments on the evaluation forms after the event indicate that universities want further detailed guidance on the apprenticeship.

One said it is a case of

***'the blind leading the blind...HEIs and employers don't know who to contact/speak to progress these programmes'.***

Another said:

***'We are all currently asking each other each other a myriad of questions which often no one can answer, and in fear of moving forward with programmes which wouldn't pass Institute for Apprenticeships (IfA) inspection due to missing or incorrectly interpreting some crucial elements we are unaware of. There would be great value in a toolkit specific to advanced clinical practitioner apprenticeship implementation'.***

One conference attendee suggested there is regional variation in understanding of how to make the most of the levy.

It has been suggested that apprenticeship guidance could include:

- IfA apprenticeship requirements that all HEIs need to be aware of
- clarity on the processes involved in setting up the apprenticeship
- requirements for validation and approvals – who validates and how can HEIs ensure they have the necessary knowledge and experience?
- guidance regarding tendering and procurement
- guidance on recognition of prior learning for apprentices and how to support students who have already undertaken some higher level study eg advanced health assessment or non-medical prescribing. Are there particular constraints for the apprenticeship? What would be the impact on funding of recognising prior learning?
- guidance on English and Maths requirements for those who cannot produce the requisite evidence

- guidance on reporting requirements
- further guidance regarding final EPA, perhaps including agreed 'learning outcomes' and other standardised elements derived from the EPA requirements
- scope and boundaries of 'external assessment'
- guidance regarding the provider register and EPA register
- current and future options for non-levy paying employers
- signing off on final awards
- financial and reporting requirements
- the implications of exiting an apprenticeship at PG Dip or PG Cert level
- signposting of other key sources where relevant.

### 12.2 Next steps

Following feedback at the Council's conference, HEE has committed to producing guidance on this apprenticeship encompassing the points above.

A national model of procurement for the advanced practice apprenticeship is currently being developed with a target date for launch of December 2018.

#### 12.2.1 Accommodating end point assessment

Comments indicate that changes to programmes to accommodate the apprenticeship have often been driven by the requirements for integrated EPA.

Universities are grappling with drafting the EPA component. They need to present EPA as a 20 credit 'module' yet it has no associated teaching and is more assessment than traditional module. Some universities have struggled to fit EPA in course structures based on 15/30 credit modules.

***'Successful programmes are having to be shoe-horned into an apprenticeship route to secure/guarantee funding'***

Several respondents said changes had been made to the dissertation element of the course to make space for EPA; this has caused some HEIs real anxiety as the dissertation is often viewed as an integral part of Masters education. Another reported an adverse impact on opportunities during the course for teaching specialist competencies.

Some survey respondents criticised the EPA for the advanced clinical practice apprenticeship.

***'the EPA is extraordinary for academics to accept. It tests everything that has already been tested. It is excessive in its format of assessment. It demands an additional 20 academic credits which completely throws out the standard MSc design and will mean the removal of the dissertation. This is concerning as if advanced practitioners are not engaged in research who is in clinical practice?'***

***'I am concerned that the EPA has knocked out any chance of a student on an apprenticeship route engaging in research'***

One respondent felt the EPA was too difficult and that there was a risk of poor completion as a result of

***'the unrealistic and stress inducing EPA design of the apprenticeship standard'***.

### 12.2.2 Managing diverse funding routes

As apprentices come onto ACP courses, joining self-funded and HEE-funded students, the dynamics in the classroom may change, requiring adjustment from HEIs, students and employers. If employers become more involved in ACP education as a result of the apprenticeship, universities may need to find alternative approaches for self-funded students, who may not enjoy the same level of employer-support.

## 12.3 Adapting to the involvement of colleges and credentialing processes

In her presentation at the Council's conference, Carrie MacEwan, Chair of the Academy of Medical Royal Colleges, emphasised both the importance of multiprofessional working and the importance of respecting professional identity and expertise.

Various colleges and faculties are playing an increasing role in the development of advanced practice and specialist practice modules, in some cases working collaboratively with colleges for allied health professions. The Society of Radiographers has been working with the Royal College of Radiologists to develop clinical standards for imaging and sees this collaboration as being absolutely central to quality improvement in service. Credentialing of specialist skills within ACP education by colleges is also now established for emergency medicine and critical care.

It is probably true to say that this involvement has received a mixed response, which was reflected at the Council's conference in September and in the results of our member survey in June.

While some nurses, midwives and allied health professionals welcome this involvement and asked how they can best work with credentialing, others worry about the potential erosion of professional identity if advanced practitioners come to be regarded as junior doctors, aspiring doctors or used as substitutes in service. Several survey respondents mentioned college involvement. They expressed concerns about

***'Royal Colleges driving what should be a non-medical roles development'***

and the impact that this could have on fragmentation of the future workforce, professional identity and representation. One respondent voiced concerns about the fragmentation of advanced clinical practitioners into the colleges threatening to

***'dilute this substantial body of autonomous health professionals. Whilst credentialing/ accreditation is very useful for clinical career pathways in their field they need to maintain national representation as a whole and in their own right'***.

***'The fragmented nature of the different ACP clinical streams that seem to be driven by the (medical) Royal Colleges is a concern.'***

***'Advanced practice has no clear vision because so many organisations have their finger in the pie'***

We did not ask about professional identity in our survey but this topic came up in several of the comments in our free text boxes.

***'How do we maintain professional identity within the ACP role? How do we prevent complete medicalisation of the role – especially now with Royal College initiatives?'***

***'The direction of travel for ACP is also taking a medical substitution focus which is compounded by Royal College accreditation etc. This does not recognise the significant value of the base profession and the added benefits of different approaches to patient care.'***

***'[There is a] clear vision for ACP role (junior doctor role) but not for specific professional roles that incorporate all of what is required to be performing as an advanced practitioners.'***

***'However little we like the term 'medical role substitution', is there a risk that in dismissing the concept we lose sight of the reality that the greatest risk to public protection in advanced practice is arguably the aspects of our roles that sit at the interface between our own professions and medicine?'***

One respondent talked about the risks of advanced clinical practitioners being used predominately to cover medical workforce shortages

***'I am all for the advancement of nursing but not at the expense of being underpaid mock doctors. There is though also the potential for advancement of nursing and paramedic roles to be sustainably embedded in a new culture of care delivery and levelling of traditional hierarchical roles in the health service...It is a pivotal moment and I am not sure where it will go at this stage.'***

### Recommendations

HEIs urgently need clear guidance on the advanced clinical practitioner apprenticeship.

There should be a collaborative approach to standard setting for advanced practice between the colleges and faculties and professional organisations for nursing and allied health.

## 13 Enabling ACP education to flourish

### 13.1 Planning and long-term investment

Council members have highlighted the need for a long-term investment plan from HEE, employers or place-based systems to allow HEIs to develop capacity and capability.

Strategic workforce planning and long-term investment is conducive to ACP programme development. This is really important if the sector is to work against current capacity constraints to grow ACP education and to staff programmes with credible lecturers. Some universities have mentioned the difficulty in recruiting sufficient academic workforce to teach ACP when academic salaries are failing to keep pace with clinical salaries. Supporting significant growth in this area of education may require investment in educator pathways, perhaps including the use of the apprenticeship levy within universities to develop the future educator workforce.

Within universities, support for advanced clinical practice from deans, heads of school and vice chancellors can be a vital factor in building institutional capacity.

### 13.2 Timely notification of commissions

Many HEIs have stressed the need for timely funding decisions, at least six months in advance and ideally more. Some universities have reported needing to push advanced practice student start dates back from September 2018 to January 2019 as a result of late funding notification.

***'How can we be sure universities and purchasers are informed in a timely way regarding available funding at or before the start of the financial year, allowing September recruitment and provision to be undertaken in a timely and efficient way, with sufficient provision for all seeking it'.***

***'Lateness of funding decisions impacts on quality recruitment and causes stress and concern for potential students, Trusts, workforce planners and HEIs'***

One HEI reported holding ACP places for HEE funded students only for Trusts to decide not to use the funding.

### 13.3 Sufficient funding

HEE acknowledges that its support for advanced practice education varies considerably across England with education funded at different levels (MSc vs. PGDip), different levels of funding for similar courses (varying from £8,000 to £16,000 for a course) and different approaches to backfill for learners in the workplace. Universities report that some employers are unwilling to fund the dissertation element so opt for PGDip provision. Universities are calling for greater funding equity and parity of access to funding as well as funding sufficient to cover the costs of provision.

***'Currently ACP education is a 'postcode lottery' depending on HEE region. Some courses are fully funded, some are partially funded, some HEE regions are spending their advanced practice monies in other ways'***

Education providers have challenged the funding banding for the advanced practice apprenticeship. During the trailblazer process, a case was made for £16,000 funding. The £12,000 banding awarded for the apprenticeship may increase funding parity across HEIs for this one funding source, but is likely to leave some universities choosing not to run programmes at all, running programmes at a loss, looking to employers for additional funding, or being forced to cross-subsidise provision through income from self-funded students.

Universities are keen to understand future funding streams – whether, for example, the apprenticeship is likely to be the main route for funding in the future. For now, it seems that a range of funding options is likely to remain, including funding for modules and full courses from the NHS, HEE, employers, professionals and the apprenticeship levy. Multiple funding streams create a more complex environment for providers. Even working with several employers increases the likelihood of multiple contracts and start dates. The private and voluntary sector is another potential funding route which should not be neglected by HEIs.

With increasing workforce interest in advanced practice, universities have asked whether ACP spending will be ring-fenced, linked to targets centrally, regionally or locally or subject to national agreement on how ACP money is spent. This question remains open.

### 13.4 Adopting an evidence-based approach

Universities are keen to develop an evidence-based approach to ACP. Discussions between stakeholders could help identify the priority areas for generating evidence around ACP to achieve an optimal approach to ACP education and demonstrate a return on investment.

### Recommendations

Universities should be given adequate notice of funding for ACP programmes to allow them to recruit students and plan programmes.

HEE, employers and place-based systems (STPs, LWABs etc) should create long-term investment plans to enable HEIs to plan for programme development and to develop capacity, capability and teams.

# Recommendations

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## Policy context

With a rapidly developing policy environment, the Council should seek to provide regular updates on ACP to members

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## Ensuring that professionals have the knowledge, skills and behaviours relevant to their professional setting and job role (specialist competencies)

The Council should work with HEE and others to clarify the role of specialist competencies and specialism more generally in ACP education, using examples, so that clinicians, managers and HEIs understand requirements across the workforce or by professional group.

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## Promoting implementation and application that allows for local context but results in sufficient consistency to help transform the workforce in line with the Five Year Forward View

HEIs should engage in the construction of any national academy for advanced practice and help to define what this will offer to and mean for HEIs.

Additional guidance with case studies would help support the national framework's objective of increasing consistency across England. As ambiguity seems to remain this seems to be a pre-requisite for moving forward. HEIs would welcome a toolkit setting out desired outcomes with examples of delivery models, specifications of competencies for specific clinical areas and examples of best practice.

As the framework and any national academy come into full operation, HEIs and employers will require continuing dialogue and will need to be able to pose questions and gain clarification from HEE in a rapidly changing environment. This suggests that the Council should remain active in this policy space alongside AAPE and professional organisations.

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## Encouraging collaboration between educators and employers to allow practitioners to develop their abilities, particularly their clinical capabilities and for supervisory and assessment purposes

Employers and HEIs need to work together to agree realistic expectations of both parties' role in ACP education.

A partnership role between employers and HEIs is required to develop a strategic approach to capacity building.

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## The framework aspires to an outcome driven approach as opposed to focusing the developmental input or educational process undertaken

The continuing value of higher education input and rounded education must be clearly articulated as the ACP framework is implemented.

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## Promoting portfolio approaches and increased consistency and transparency of processes for the accreditation or recognition of relevant prior learning or prior experiential learning (AP[E]L/RP[E]L)

HEIs may wish to review and develop their approach to AP[E]L/RP[E]L in light of the current policy environment for ACP.

HEIs need clarity on requirements for the 'equivalence route' and their role in assessing competencies and Masters level thinking.

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### **Collaborating across an area or place if necessary to optimise cost effective training with sufficient flexibility to develop specialty specific competence and broad capability**

HEIs need to have input into strategic decision-making and workforce planning at national, regional and local level, including on STPs and LWABs. This is critical to the development of effective place-based approaches and collaborative approaches to delivery.

HEIs will need to collaborate with HEE, employers and one another to deliver specialist competencies.

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### **ACP developments must be multi-professional and encompass inter-professional learning and support**

Multi-professional and inter-professional approaches to ACP education should be upheld.

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### **Responding to apprenticeship requirements and Colleges' involvement in credentialing programmes**

HEIs urgently need clear guidance on the advanced clinical practitioner apprenticeship.

There should be a collaborative approach to standard setting for advanced practice between the colleges and faculties and professional organisations for nursing and allied health.

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### **Enabling ACP education to flourish**

Universities should be given adequate notice of funding for ACP programmes to allow them to recruit students and plan programmes.

HEE, employers and place-based systems (STPs, LWABs etc) should create long-term investment plans to enable HEIs to plan for programme development and to develop capacity, capability and teams.

## Appendix A CoDH ACP steering group membership

- **Ruth Taylor**, Workforce Lead, Council of Deans of Health and Senior Pro Vice Chancellor and Dean at Anglia Ruskin University [Chair]

From Health Education England

- **Beverley Harden**
- **Jane Hadfield**
- **Donna Poole**
- **Fleur Kitsell**
- **Sukvinder Kaur**
  
- **Charlotte Beardmore**, co-chair of the Advanced Clinical Practice Steering Group
- **Sally Gosling**, Health and Care Professions' Education Leads Group
- **Katrina MacLaine**, Association of Advanced Practice Educators (AAPE), UK
- **Wendy Preston**, Royal College of Nursing
- **Carmel Lloyd**, Royal College of Midwives
- **Crystal Oldman**, Queen's Nursing Institute

- **Jane Perry**, Programmes Director for Nursing and Healthcare Education, University of East London
- **Helen Rushforth**, Senior Lecturer/Programme Lead, MSc Advanced Clinical Practice, University of Southampton
- **Karen Beeton**, Head of Department of Allied Health Professions and Midwifery, University of Hertfordshire
- **Pat Hibberd**, Deputy Head, School of Nursing, College of Medical and Dental Sciences, University of Birmingham
  
- **Michelle Wayt** and **Robyn Swain**, NHS Employers
- **Rebecca Hoskins**, Nurse Consultant & ACP in urgent care, Bristol



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