Advanced Practice: Research Report

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Summary

Background

The Health Care and Professions Council (HCPC) regulates fifteen different professions; some of these are large groups like Physiotherapists and some are much smaller such as Speech and Language Therapists (SLT). Most of the people registered by the HCPC work within their own areas of clinical expertise and defined professional scope of practice. However, an increasing number of registrants are undertaking new or additional roles beyond the traditional scope of practice for the defined profession. These roles are often shared with other medical or health professionals and persons undertaking these roles are often, but not consistently, referred to as Advanced Practitioners.

Advanced Practitioners are employed within the NHS across all four countries of the UK and are also employed by private healthcare providers. The roles they undertake vary from the highly specialised (e.g. an advanced podiatrist might specialise in biomechanics) to more general roles with greater professional autonomy and decision-making (e.g. a paramedic working in a GP Practice assessing patients with undifferentiated acute problems). As a result, there is currently no consistency in role title, scope of advanced practice, necessary underpinning education or professional accreditation across the HCPC registered professions. This study was undertaken to explore these issues and seek opinion on the need for additional regulatory measures for persons working at an advanced practice level.

NB: For the purposes of this study, advanced practice was considered to encompass all roles, regardless of role title, where the level of practice undertaken was considered to be advanced.

Method

Three approaches to data collection were undertaken to ensure the differing opinions across all HCPC registered professions, different stakeholders and the four nations of the UK were collected. Data were collected through:

1. A UK wide survey of HCPC registered healthcare professionals;
2. A UK wide survey of organisations delivering AHP & scientific advanced practice education;
3. A series of focus groups and interviews across a range of stakeholder groups.

Findings

The concept of advanced level practice was not consistently understood or interpreted across the different stakeholder groups. Those participants identifying as working at an advanced practice level undertook a range of activities both within and out with the traditional scope of practice of the registered profession adding a further layer of complexity. Educational support and availability for advanced level practice varied across professional groups and inequity of accessibility and appropriateness of content were raised as concerns. There is no consensus across participant groups on the need for regulation of advanced level practice. Perceived advantages to additional regulation were the consistent and equal educational and employer governance expectations, particularly where multiple professional groups are undertaking the same role, all be it with a differing professional educational foundation and lens. However, while some voices across the participant groups felt regulation was essential to assure practice standards and reduce risk of role title misuse, there was equally a lack of appetite for regulation that inhibited agility to respond to, and reflect, the rapidly changing healthcare environment and evolving scope of advanced level practice. Importantly, no evidence was presented from any participant group that advanced level practice within HCPC regulated professions presents a risk to the public

Conclusion

The study data presented in this report reflect the complexity of the concept of advanced practice within the HCPC regulated professions. Much of this is a consequence of the differing speeds of professional role development across healthcare organisations and professional groups, often related to service capacity gaps and locally developed education to support local initiatives. Despite this, there is no clear evidence, based on the findings of this research, that additional regulation of advanced level practice is needed, or desired, to protect the public. However, as the HCPC is one of the few organisations with a UK wide remit, it may have a central role in achieving unification across the 4 nations in relation to the future role expectations, educational standards, and governance of advanced level practice.

Study Context

Historically, role developments within the professions regulated by the HCPC were limited to specialty-specific competencies aimed at delivering enhanced packages of care to patients and clients.[1] These developments were most evident in the 'traditional' allied health professions (AHP).[1] Over the last two decades, the scope of professional practice has evolved at pace, driven by developments in healthcare, treatments and technology and influenced by developments or gaps in other areas of the workforce as well as changing societal expectations of health service delivery.[2-4] HCPC registrants work in diverse settings alongside other regulated and unregulated professionals with an increasing blurring of multi-professional boundaries. Nowhere is this more acutely evident than in advanced (and consultant) practice roles where professionals are working at the limits of, or beyond, the traditional focus and scope of practice of their registered profession. Advanced practice requires individuals to operate at an expert clinical level, but it also expects a range of different skills and capabilities across 3 other pillars including: leadership and management; education and training; research, audit and service evaluation. It also describes a higher level of knowledge and clinical skills, with further development opportunities into non-medical consultant roles.

Over the last decade, various strategic policies have been published aimed at standardising expectations of advanced practice across the health and care sectors, providing assurance of the capabilities and competence of individuals across all four countries of the UK.[5-9] A key driver for these was to expand the advanced practice workforce across a range of clinical areas, creating opportunities for individuals from diverse clinical backgrounds (and professions) to contribute to the same patient care functions. To this end, they have established a set of criteria for education programmes and individual practitioners to achieve.

Despite parallel national frameworks for advanced practice and multiple professional body strategies, the expectations and implementation of advanced practice remains variable with multiple role titles and differing educational preparation, remuneration, autonomy and supervision. This may, in part, reflect the differing stages of development of advanced practice within the registered professions[10] and different healthcare infrastructures across the four UK countries, together with the plethora of terms associated with practice advancement. To consider whether additional regulatory measures are required in relation to advanced practice, all these factors need to be considered to contextualise the presented evidence and ground the findings in the perceptions of the HCPC registered professions and key stakeholders.

Research objectives

Aim:

To identify the regulatory challenges and risks presented by registrants advancing practice and how the HCPC should respond to these to ensure public protection and support professionalism and good practice.

Objective 1:

To determine what advanced practice activities are being undertaken across HCPC regulated professions within the UK and whether these activities lie within the scope of the individuals regulated profession.

Objective 2:

To determine regulatory measures considered necessary by registrants and stakeholders to support advanced practice and ensure public safety.

Objective 3:

To determine the education and training expectations for advanced practice across the four countries of the UK.

Background

The following summarises select literature related to advanced level practice with key references cited to support statements. It is not a comprehensive review of the literature.

Advanced Level Practice

There is no definition of advanced practice that is both standardised and accepted across the UK.[11] Advanced level practice is defined by four separate framework documents reflecting the four countries of the UK.[5-8] These were developed, in part, following the 2016 Nuffield Trust report 'Reshaping the workforce'[11] which was commissioned by NHS employers, with the aim of providing practical guidance on non-medical workforce development to ensure services continue to meet patient needs. Although differing in specific content, all four frameworks provide:

- a definition of advanced level practice;
- the capabilities required across the 4 pillars of advanced level practice (expert clinical practice; leadership and management; education and training; research, audit and service evaluation);
- the education and support requirements for advanced level practice;
- advice for employers with regard to planning and implementation.

It is understood that all four pillars of advanced practice should be evident within roles at this level in the UK, but evidence suggests this is not always the case.[12] Further, where all pillars are evident, these are not equally emphasised within role expectations and a lack of consistency in job description and role title exists[13,14] across organisations and roles. Importantly, while the capabilities related to three of the pillars of advanced level practice (leadership and management; education and training; research and audit and service evaluation) might be more easily defined and evidenced in terms of activity and achievement, what constitutes advanced level clinical practice is more problematic as it is variable, dynamic, evolving, responsive to local clinical needs and often considered through a profession specific lens.

For a large profession such as nursing, understanding the changing landscape of advanced level clinical practice might be addressed by a single dominant professional body (e.g. Royal College of Nursing) guiding the interpretation of advancing clinical practice and providing professional unity across specialisms and organisations. However, the HCPC professions (AHPs, Psychologists and Scientists) are a grouping of distinct individual professions with differing pre-registration education programmes, different protected professional titles and represented by a large number of professional bodies. As such, members of one professional group may lack appreciation of the underpinning education, clinical roles and activities of another. Further, as the primary function of professional bodies is to promote, advocate and advance the activities of the individual profession rather than all groups, the potential for professional tension and protectionism exists, particularly where clinicians are working at professional boundaries and sharing roles traditionally undertaken by others.[15,16]

The dynamic nature of advanced level clinical practice also presents difficulties in aligning professional and organisational understanding across professional groups. This is also subject to

change over time as activities and interventions previously considered to be advanced level practice become integrated within profession-specific competency frameworks and standards for entry level registrants.[15] Similarly, where roles are shared across professional groups, a threshold clinical competency for one group may be considered advanced level practice when undertaken by another, causing further confusion in interpretation and implementation.[17] This ambiguity and lack of demarcation between advanced level practice and core profession roles and responsibilities both within and across HCPC regulated professions leaves the nature of advanced level practice open to interpretation by educators and employers and consequently, may present risk. However, providing an inclusive, task level, time responsive, scope of advanced level practice would be difficult, if not impossible, for a multi-professional regulatory body if they were to acknowledge all actual and potential facets of practice. The General Dental Council (GDC)[18] is the only regulatory body that has published guidance on scope of practice at task level in relation to specific registrant groups within dentistry. Similarly, and more recently, the *Skills for Health* publication "Core Capabilities Framework for Advanced Clinical Practice (Nurses) Working in General Practice / Primary Care in England"[19] specifies the core capabilities that can be expected of a nurse working at an advanced level of clinical practice within this care setting in England. Once again, this relates to a single regulated profession working within a clearly defined environment.

The Advanced Practice Workforce

The advanced practice workforce currently contributes to service delivery across primary and secondary care and include many of the HCPC regulated professions as well the larger, and perhaps more established, advanced practice nurse roles. Advanced level practitioners provide care throughout the patient journey from initial clinical presentation to conclusion of care[20] and are being increasingly employed within, and beyond, the NHS.[21-23]

Evidence for the impact of advanced practice roles on patient outcomes is sparse and still emerging[24,25] but advanced level practice paramedical roles are cited to be of value in reducing hospital admissions.[26] An objective approach to measuring the impact of these roles in practice has not been identified. There are also no consistent, systematic measures to capture the number people working at an advanced level of practice across the four countries of the UK or across healthcare organisations and sectors. Where data capture has been undertaken, it has represented a specific speciality area or has used a specific Agenda for Change Band (e.g. AfC Band 7) to represent advanced level of practice without differentiating the various roles within this band or considering the inconsistent approach to banding potentially adopted across the UK. Importantly, no data was identified on the advanced practice workforce in Wales.

The future development of the advanced practice workforce is important[22,23] but barriers to further expansion exist including access to appropriate education and professional protectionism, which can result in opposition and resistance to non-medical workforce development.[27] This latter point could represent a major factor in prohibiting maximisation of the full potential of advanced level practice with some professional groups voicing their concerns around role substitution for financial saving in the context of acute workforce shortages and potential associated risks to patient safety.[28,29]

Education for Advanced Level Practice

In terms of education preparation for advanced level practice, within the frameworks of all 4 countries of the UK, the necessary education provision to support working at an advanced level of practice is stated to be 'Masters level' (Framework for Higher Education Qualifications (FHEQ)[30] level 7 which can include level 7 apprenticeships) or 'equivalent'.[5-8] However, while this at first may appear to be clearly stated, the interpretation of 'Masters level' is not consistent across the AHP groups. Significantly, there is no consensus on whether 'Masters level' education indicates a single level 7 module, postgraduate certificate, postgraduate diploma or a full Master's Degree award, although some would advocate that only the latter is able to evidence learning across all four pillars of advanced practice.[31,32] Similar confusion exists with regards to equivalence and while Health Education England, through the Centre for Advancing Practice, are developing a portfolio route for practice accreditation[33] in collaboration with professional bodies and other stakeholders as a potential method of evidencing equivalence through experience, this approach is not being consistently developed across all UK nations. Interestingly, while the same education criteria apply to the nursing profession, transitional arrangements are in place until December 2020 for nurses currently working at an advanced level of practice and who do not have a full Master's to be credentialed by the RCN. Once credentialed as working at an advanced level of practice, these nursing professionals will not be required to complete a full Master's degree in the future.[34]

Organisations providing advanced level practice education are typically Higher Education Institutions (HEI) or organisations aligned with a HEI. However, a number of professions access advanced level education offered through, or in collaboration with, a Medical Royal College or professional body. A further small number of educational programmes are also accredited by a Medical Royal College, where a defined professional group undertakes a programme of study that maps to the approved College curriculum.[35]

Unlike other regulatory bodies where the threshold level of education to enter the profession is standardised, wide variation exists across the HCPC regulated professions and increasingly, HEIs are offering pre-registration Master's degree programmes to attract candidates already holding a Bachelor's degree award and wishing to change career direction. For these candidates, difficulty exists in clearly differentiating the specific level 7 educational requirements to evidence threshold and advanced level capability and practice. This is further exacerbated in the cases of Practitioner Psychologists whose entry level qualification is a Doctorate (level 8) qualification and it is not clear if these professionals would need to undertake additional level 7 study to evidence advanced level education when the original award was of a higher academic standing. Added to this inconsistency is the variation in the content of education programmes offered to support advanced level practice both within and between groups. All of these factors may contribute to reports that some managers and education commissioners lack confidence in, and understanding of, the educational preparation for advanced level practice and as a result, have set additional requirements locally to determine and assess the clinical competencies of advanced practice candidates.[17,36]

To address variation in education, Health Education England (HEE) has created a Centre for Advancing Practice to support and develop nationally (England) agreed education and training standards. The Centre has commenced inviting education programmes to seek accreditation against these advanced practice standards.[33] A similar or alternative approach to addressing education standardisation has not yet been published in the other nations of the UK. This lack of UK wide

agreement on educational standards may leave practitioners vulnerable as many may seek to attend educational programmes outside of their geographic nation of residence or employment, particularly where a limited number of programmes exist, on the assumption that there is educational equivalence.

A directory of clinicians working at an advanced level of practice is also currently in development in England although some professional bodies and Medical Royal Colleges have already developed processes for professional accreditation (e.g. Society and College of Radiographers advanced practitioner accreditation)[37] or credentialing of advanced practice (Royal College of Emergency Medicine (RCEM)).[35] However, the processes of accreditation or credentialing are not consistent across professions and not available to all individuals who might be working in that, or a similar, role.[35,38]

Regulation

Regulation of any health professional is for the protection of the public with respect to cognate profession.[39] The Professional Standards Authority in 2009[40] stated that:

> *"The core focus of regulatory bodies is professionals' fitness to practise. Where the nature of a profession's practice changes for some professionals to such a significant extent that their scope of practice is fundamentally different from that at initial registration – rather than more subtly evolving over time – regulatory bodies may need to consider whether action is necessary to assure the professional's fitness to practise in the context of a very different nature of practice where risk to the public is evident. Such cases would be where the standards for practising proficiently in these roles are significantly different to those assessed against at initial registration, going far beyond ordinary progression within a given scope of practice, and where the risks to patients from these roles are of a qualitatively different nature from those ordinarily associated with the practice of the profession. However, much of what is often called advanced practice appears to represent career development within a profession over time and not a fundamental break with a profession's practice such that the risks to patient safety are not adequately captured by the existing standards of proficiency and ethical duties – which set a framework in which a professional can develop and extend their practice within a profession's scope of practice".*

Whilst at inception advanced level practice was envisaged to be an extension of practice within the traditional scope of the registered profession,[40] the changing demands of healthcare, technology enablement[41] and the need to create a flexible healthcare workforce mean that this may not be true today or going forwards. The recently introduced, profession independent, medical speciality-focussed Advanced Clinical Practitioner role[33] (e.g. primary care; acute medicine; paediatrics) that is being implemented in both primary and secondary care settings attests to this thereby increasing the number of clinical roles undertaken by health professionals that might be considered outside of the traditional scope of the initially registered profession. As a result, questions around the need for regulation of advanced level practice have arisen.

Regulation of advanced level practice has previously not been adopted by policy makers but changing perceptions of what constitutes advanced level practice is, and might be, prompting

reconsideration of the need for regulation. Currently, no regulatory body has implemented specific regulation for this level of professional practice, although the Nursing and Midwifery Council (NMC) are currently considering the need for regulation within their 2020-25 strategy.[42] The General Medical Council, have also been asked by the Department of Health & Social Care, supported by all 4 governments of the UK, to regulate physician associates and physician associates (anaesthesia), new medical associate professions (MAPs) considered equivalent in some aspects of clinical practice to middle grade doctors. [43] However, a change in law is needed to facilitate this additional regulation and it is therefore unlikely that a system of formal regulation will be in place before 2022. Importantly, the purpose of regulation must be clear when considering the case for additional regulation. Where a professional group is currently unregulated and risk to patients and public exists then the arguments are clear. But in the case of evolving professional practice, where the risk to the public reflects that of the regulated cognate profession, then the arguments of additional regulation of advanced level practice become opaque and merge with other registrant motivations for change including: supporting career progression; increasing the professional status of registrants; maximising a registrant's potential and/or, promoting the effectiveness of the use of advanced practice roles in service design and delivery. Despite these competing arguments for additional regulation, it is essential that the protection of the public remains paramount in the decision-making with regards to need for additional regulation. On exploring the literature, evidence of risk to the patients and public as a consequence of advanced level practice was not identified, with the exception of a Prevention of Future Death report issued by a coroner[44,45] which suggested that the governance of advanced level (nursing) practice in one identified case, presented a degree of patient safety risk.

Coroners have a statutory duty to issue a Prevention of Future Death (PFD) Report when in the coroner's opinion, action should be taken to prevent future deaths. These reports can be issued to a person or an organisation and are crucial in identifying what went wrong and actions necessary to prevent reoccurrence.[44] An Advanced Nurse Practitioner featured in a PFD report where a patient death occurred. The Coroners' concerns regarding the advanced practice nurse role suggested that a lack of a regulatory body, appraisal, revalidation and employer responsibility for the advanced practitioner could impact patient safety. The report stated:

> *"During the course of the Inquest it came to my attention that there is no regulatory body for advanced nurse practitioners. It would appear they are not subject to the same stringent appraisal and revalidation processes such that GPs currently are, despite the fact that they may perform similar duties and can have parallel roles. I also became aware that some advanced nurse practitioners may independently buy into a partnership and may not have an employer directly responsible for their appraisal. Therefore, some may potentially be operating as independent practitioners without any supervision or regulation. I am concerned that this may have a significant impact on patient safety" (Judiciary, 2016)* [45]

Although limited evidence, this raises questions regarding the governance of advanced level practice and advanced practitioners. Additionally, as many HCPC regulated professionals work independently, the different employment environments and governance structures may alter perspectives on patient safety and advanced level practice.

In contrast the Professional Standards Authority[40] states:

> *"... There is currently no systematic evidence, from fitness to practise cases or other sources, regarding whether professionals are taking on new roles and responsibilities where they are not competent to do so and thereby putting the safety of patients at risk".*

Evidently with the production of a PFD report in the case involving an advanced level practitioner,[45] this is now not the case. However, in their response to the PFD report issued against the nurse in the above case, the NMC (regulatory body) believed that the "*statutory framework and the process of revalidation are sufficient to protect the public in respect of advanced practice*" and they did not take any further action.[46]

Governance of Advanced Practice

It cannot be ignored that the Coroner's comments above[45] call into question the governance of advanced practitioners, especially when working independently as many professions regulated by the HCPC may do. Governance in a healthcare setting can be defined as the regulation of behaviour of healthcare providers and the accountability mechanisms for those providers.[47] With regards to advanced level practice, it is unclear what local arrangements are in place in the UK across the different healthcare settings and sectors or indeed within and across non-healthcare specific environments where some HCPC regulated professions may practise. NHS organisations will normally have locally determined governance policies, but it is not known if, or how, employers are approaching complaints or concerns around fitness to practise of advanced practitioners. It is also not known if these complaints are brought to the attention of the professional regulator by the employers, who could be financially and/or reputationally incentivised not to refer employees to the regulator. In this regard, cases may only become known if the professional themselves, colleagues, or a member of the public makes a referral to the regulator. In the HCPC Fitness to Practice Annual Report 2019,[48] the most common mode of referral was via the public (47% of referrals) although these did not specifically relate to advanced level practice. Consequently, this raises the question of whether members of the public would know which regulatory body to approach in the case of advanced level practice where the activity was such that the professional's cognate profession was unclear. Inadequate practice governance and employer accountability are also considered a source of risk to patients by the Professional Standards Authority[40] who state:

> *"The main sources of risks to the safety of patients and other members of the public from professionals taking on new or higher-level practices are the same as the sources of risks from other types of practice. These are that professionals may take on roles and responsibilities which they lack the capability to perform safely and effectively or if professionals/employers do not ensure there are appropriate safeguards in place in their practice..."*

> *"…The source of the risk may be the same, but because the roles and responsibilities being taken on are different – in terms of activities being undertaken and clinical accountability for them – the nature of the risk to patients and the public may vary accordingly. The crucial challenge in protecting the public is ensuring that there are adequate governance arrangements to mitigate the risks to patients associated with individual professionals*

practising outside their scope of competence or practising without appropriate safeguards in place".

There is a lack of robust data on patient safety outcomes in relation to advanced level practice in the UK. This may reflect the main drivers for change and promoting adoption of advanced level practice being imperatives such as efficiency savings,[49] reduced demand on medical colleagues[50] and reduced waiting lists.[51] It is important that patient safety with regards to advanced level practice is further evaluated going forwards, particularly as these roles are promoted as part of the solution to service delivery and workforce capacity challenges.[23,52]

Public Understanding of Advanced Practice

The level of public understanding of what constitutes advanced level practice, the education and training undertaken to support it, and the different professional groups acting in this sphere, is unclear and needs greater national advocacy.[53,54] Public appreciation of the differing AHP groups is already reported as vague with many being referred to as nurse or doctor, often dependent on gender or style of uniform worn.[55] Despite this, evidence from primary care suggests that patients are generally satisfied with the care they receive from advanced clinical pracitioners[56.57] although similar evidence from patients attending secondary care was not identified.

Regulatory Options

Following review of the literature, several regulatory options are available to the HCPC with regards to advanced level practice. These are:

1. No change to existing regulatory framework;
2. Develop a policy position on the approach that should be taken towards advanced level practice, signposting registrants to the relevant external support materials;
3. Develop detailed guidance and resources (multi-professional or profession specific) to inform the approach registrants should take in advanced level practice roles;
4. Develop annotation of the HCPC Register for Advanced Practice qualifications or evidence of equivalence. In accordance with the HCPC policy statement on annotation, this would only be undertaken if it were deemed necessary to protect the public;
5. Introduce softer regulatory levers such as engaging and influencing employers to develop consistency in roles and governance/safeguards through future professional liaison and engaging with educators to promote consistency and quality in education delivery across advanced practice programmes.

The tri-phase research undertaken in this project intends to offer insight into registrant and stakeholder appetite for these options or alternative suggestions.

Method

A tri-phase investigation was undertaken with each work package being conducted concurrently to ensure that all objectives were met in accordance with the research brief. Ethical approval for the study was provided by the University of Bradford Health Ethics Committee. An advisory group was formed of stakeholders in the advanced level practice arena and a reference group established of representatives of many of the professional bodies representing HCPC regulated professions.

Work Package (WP) 1: UK wide survey of HCPC registered healthcare professionals

To address points 19a-19c in the research brief, a cross-sectional, electronically distributed JISC survey was developed to establish current advanced practice roles and scope of advanced practice activities across the HCPC registrant groups. The survey comprised of a series of closed and fixed response questions with opportunity for free text clarification. The questions were filtered based on role of participant (undertaking advanced practice, manager of those work at an advanced practice level, interest in/aspiration to undertake advanced practice but not currently working at that level) and explored:

- HCPC registered profession(s);
- Country of practice within the UK;
- Job title, role and Agenda for Change pay band;
- Year of professional qualification; Year of initial HCPC registration;
- Highest Educational level (e.g. BSc/MSc/PhD/other);
- Where registrants were undertaking advanced level practice:
    - What clinical setting was the work undertaken in?
    - What duties/skills were considered to be advanced practice?
    - Whether advanced practice activity was considered to be within the scope of current professional practice and registration?
    - Whether their advanced practice was overseen/regulated by another body or organization (e.g. RCP; RCGP; RCEM)
    - The underpinning education expected by employer to undertake advanced practice role.

As the survey was directed at all HCPC registered professionals, pre-distribution survey feedback on questions and phrasing was sought from HCPC project liaison lead and the reference group to ensure that appropriate data were captured and nuances in professional language appreciated. Minor changes to phrasing were made to survey based on this feedback.

Distribution of the survey link was via HCPC registrant email, newsletter and website. All professional bodies were also asked to advertise the survey and share the survey link with their members to maximise engagement. Additionally, the survey was promoted to potential respondents via social media. The survey was open for participation for 5 weeks (25 Aug 2020- 01 Oct 2020).

Survey data were downloaded into a password protected database for analysis. Descriptive statistics were generated and presented in summary tables with graphical representation where appropriate

to enable comparative analysis within and between professional groups and across UK Nations. The survey details are provided in Appendix 1.

Work Package 2: UK survey of organisations delivering advanced practice education

To address points within 19d and 19e in the research brief, a cross-sectional survey was undertaken. The focus was on Higher Education Institutions (HEI) and other relevant education providers who offer programmes of study to support advanced level practice for AHPs and scientists. As with WP1, the survey comprised of a series of closed and fixed response questions with opportunity for free text clarification. The survey content and phrasing were informed by feedback from members of the project advisory group. The survey included questions relating to:

- Whether the education provided was multi-professional or profession specific in focus;
- Entry requirements;
- Type and level of education provided;
- Formal and or informal status of education;
- Whether formative and summative assessment included both academic and clinical components;
- Engagement of education providers with clinical practice placements;
- Supervisory and/or mentorship requirements of the programme;
- Alignment with home country ACP framework;
- Links to professional body or other accredited organisational standards;
- Transferability of qualification between care environments or clinical specialties;
- Level of stakeholder involvement or consultation in education content and design.

The survey was distributed through the Association of Advanced Practice Educators. The survey was also shared by Health Education England through their database of respondents to previous work undertaken relating to advanced practice education. Neither organisation shared their database of contacts with the research team and therefore breadth of distribution is unclear. The survey was also distributed through educators identified in the volunteer database of registrants interested in contributing to the work gathered by the HCPC as well as volunteers identified from early respondents to the survey in Work Package 1. The survey was also advertised through social media networks. The survey was open for 5 weeks (27 Aug 2020- 02 Oct 2020).

Survey data were downloaded into a password protected database for analysis. Descriptive statistics were generated and presented in summary tables with graphical representation where appropriate to enable comparative analysis between Educational Programmes. The survey details are provided in Appendix 1.

Work Package 3: Stakeholder Interviews

To address points 19d and 21 in the research brief, semi structured interviews were undertaken with key stakeholders to elicit their perceptions regarding: the scope and autonomy of advanced level practice; necessary underpinning education; perception of risk and impact of advanced level practice on patient safety; and assurance, accountability and regulation of those working at an advanced practice level. Interview question guides can be found in Appendix 2.

A purposive sampling approach was adopted to recruit participants with the relevant characteristics using volunteer data of registrants interested in contributing to the work gathered by the HCPC as well as volunteers identified from early respondents to survey in WP1. All volunteers working in Scotland, Northern Ireland or Wales who identified themselves as interested in, or working at, an advanced level of practice were invited to participate in a focus group interview. Due to the larger volume of volunteers from England, stratification by profession was undertaken and an equal number of registrants from each invited to participate in a focus group. Where large numbers of volunteers within a profession existed, the first 5 volunteers listed and employed by different organizations were invited to participate. In total, eight stakeholder groups were identified to participate in interviews:

1. Chief AHP and Chief scientific Officers across the four nations of the UK;
2. Individuals working at an advanced level of practice;
3. Other healthcare professionals (not HCPC registered) & registrants not working at advanced practice level
4. Trade Unions (not combined with professional bodies)
5. Employers
6. Educators
7. Professional Bodies
8. Patients and Public

All focus groups and interviews were undertaken using online platforms (Corporate Zoom or Microsoft Teams) and were undertaken over a 4-week period (7 Sep 20 – 2 Oct 20). Interviews were recorded and initially transcribed using ZOOM auto transcription or Otter AI transcription. All invited participants were provided with an information sheet and consent form. Consent to interview/focus group participation and to being recorded were also confirmed immediately prior to interview commencing. After the interview, all participants were sent a copy of the recording and auto-transcription for verification and invited to share any further comments by email.

The interview and focus group auto-transcriptions were corrected post-interview by members of the research team to ensure accurate data for analysis. The interview transcripts were analysed using the Braun and Clarke[58] 6 stage approach to thematic analysis to draw out the main themes and categories.

Results

Registrant survey (WP1)

Summary of registrant participants

A total of 3716 responses were received. 26 individuals identified themselves as dual registrants and therefore included in both professions in Table 1 with specific details in Table 2. The overall response rate was 1.3%.

Table 1: Response rate by profession

Registered profession	**Total registrants** (at 8.9.20)	**Responses** No. (%)
Arts Therapists	4461	32 (0.7)
Biomedical Scientist	23,367	231 (1.0)
Chiropodist/Podiatrist	13,026	195 (1.5)
Clinical Scientist	6,424	155 (2.4)
Dietitian	9,693	209 (1.3)
Hearing Aid Dispenser	3,352	19 (0.5)
Occupational Therapist	40,386	283 (0.6)
Operating Department Practitioner	14,540	285 (1.8)
Orthoptist	1,505	45 (2.9)
Paramedic	29,760	764 (2.1)
Physiotherapist	56,699	601 (0.9)
Practitioner Psychologist	24,996	166 (0.6)
Prosthetist/Orthotist	1,105	14 (0.9)
Radiographer	36,078	537 (1.2)
Speech and Language Therapist	16,823	206 (0.9)
Total	**282,215**	**3742** (1.3)

Table 2: Responses indicating dual profession registration

Registered professions	**Responses** No.
Biomedical Scientist & Clinical Scientist	12
Chiropodist/Podiatrist & Paramedic	1
Chiropodist/Podiatrist & Physiotherapist	1
Clinical Scientist & Hearing Aid Dispenser	1
Clinical Scientist & Orthoptist	1
Operating Department Practitioner & Paramedic	2
Operating Department Practitioner & Physiotherapist	1
Paramedic & Physiotherapist	2
Practitioner Psychologist & Diagnostic Radiographer	1
Diagnostic Radiographer & Therapeutic Radiographer	4
Total	**26**

The greatest proportional responses by profession were from Orthoptists, Clinical Scientists and Paramedics. The lowest proportional responses were from Practitioner Psychologists, Occupational Therapists and Hearing Aid Dispensers (audiology).

The majority of respondents were working at, or towards, an advanced level practice although respondents represented a wide cross section of roles (Table 3).

Table 3: Respondent roles

Respondent Role	**Responses** No (%).
Academic	151 (4.1)
Advanced Practitioner	994 (26.7)
Consultant Practitioner	319 (8.6)
HCPC registrant working in clinical practice	1198 (32.2)
Manager & Advanced practitioner	337 (9.1)
Manager	298 (8.0)
Trainee advanced practitioner	290 (7.8)
Not currently working	40 (1.1)
None of the above	89 (2.4)
Total	**3716**

The majority of respondents reported working primarily for the National Health Service (NHS) in primary (n=672/2451; 27.4%) or secondary care (n=1085/2451; 55.9%) settings. However, a large number of respondents worked across differing health and care settings including the independent sector.

Responses from advanced level practitioners

1940 respondents (n=1940/3716; 52.2%) identified themselves as working at, or towards, an advanced level of practice. 12 of these respondents identified themselves as dual profession registrants and therefore included in both professions in Table 4.

Table 4: Participants working at or towards an advanced level of practice by profession

Registered profession	**Responses by profession** No. (%)
Arts Therapist	16 (50.0)
Biomedical Scientist	67 (29.0)
Chiropodist/Podiatrist	100 (51.3)
Clinical Scientist	101 (65.2)
Dietitian	53 (25.4)
Hearing Aid Dispenser	7 (36.8)
Occupational Therapist	112 (39.6)
Operating Department Practitioner	69 (24.2)
Orthoptist	28 (62.2)
Paramedic	460 (60.2)
Physiotherapist	373 (62.1)
Practitioner Psychologist	122 (73.5)
Prosthetist/Orthotist	7 (50.0)
Radiographer - Diagnostic	271 (63.8)
Radiographer - Therapeutic	81 (72.3)
Speech and Language Therapist	85 (41.3)
Total	**1952 (52.2)**

While the majority of survey respondents working at or towards an advanced level of practice resided in England (n=1615/1940; 83.3%) responses were received from Scotland (n=150/1940; 7.7%), Wales (n=102/1940; 5.3%) and Northern Ireland (n=36/1940; 1.9%). A further 38 survey respondents (n=29/1940; 2.0%) working at, or towards, an advanced level of practice resided in areas of Crown dependency or overseas.

Respondents who identified themselves as working at, or towards, an advanced level of practice held a diverse range of role titles (Table 5).

Table 5: Role title of participants working at, or towards, an advanced level of practice

Title	**Responses** No. (%)
Extended Scope Practitioner	68 (3.5)
Clinical Specialist	233 (12.0)
Trainee Advanced Practitioner	205 (10.6)
Advanced Practitioner	738 (38.0)
Trainee Consultant Practitioner	22 (1.1)
Consultant Practitioner	259 (13.4)
Other	*415 (21.4)*
Total	**1940**

The advanced practitioner and clinical specialist titles were in use across all professions. Similarly, the consultant practitioner title was absent only from Operating Department Practitioner (ODP) and Orthoptist respondents. In contrast, the extended scope practitioner was less commonly reported with the largest groups being physiotherapy and chiropody/podiatry. Importantly, role title was not commensurate with specific Agenda for Change (AfC) bands (Table 6) which brings into question the validity of previous studies where level of practice has been associated with AfC band.

Table 6: Role title of participants by AfC Band

AfC Band	**Role Title**	**Number of respondents**
Band 6	Advanced Practitioner	33
	Clinical Specialist	13
	Extended Scope Practitioner	5
	Other	47
	Trainee Advanced Practitioner	54
Total Band 6		152
Band 7	Advanced Practitioner	392
	Clinical Specialist	123
	Consultant Practitioner	2
	Extended Scope Practitioner	20
	Other	126
	Trainee Advanced Practitioner	131
	Trainee Consultant Practitioner	7
Total Band 7		**801**
Band 8a	Advanced Practitioner	244
	Clinical Specialist	65
	Consultant Practitioner	18
	Extended Scope Practitioner	32
	Other	105
	Trainee Advanced Practitioner	15
	Trainee Consultant Practitioner	10
Total Band 8a		**489**
Band 8b	Advanced Practitioner	34
	Clinical Specialist	14
	Consultant Practitioner	67
	Extended Scope Practitioner	6
	Other	43
	Trainee Advanced Practitioner	1
	Trainee Consultant Practitioner	5
Total Band 8b		**170**
Band 8c	Advanced Practitioner	7

	Clinical Specialist	1
	Consultant Practitioner	71
	Extended Scope Practitioner	1
	Other	29
Total Band 8c		**109**
Band 8d	Advanced Practitioner	6
	Clinical Specialist	6
	Consultant Practitioner	45
	Other	11
Total Band 8d		**68**
Band 9	Advanced Practitioner	2
	Consultant Practitioner	21
	Other	7
Total Band 8d		**30**
Other (Non-AfC banding)	Advanced Practitioner	20
	Clinical Specialist	11
	Consultant Practitioner	35
	Extended Scope Practitioner	4
	Other	47
	Trainee Advanced Practitioner	4
Total other		**121**
Grand Total		**1940**

Importantly, at least 1 respondent from each of the HCPC regulated professions identified themselves as being employed at Agenda for Change band 8a or higher although, as indicated in Table 6, this banding may not correlate with any specific role title or role expectation.

Education level underpinning advanced practice roles was varied (Table 7) and this was noted across all AfC bandings suggesting that education level was not an essential factor in appointment to advanced practice roles or in seniority.

Table 7: Highest education qualification of those working at, or towards, advanced level practice

Highest Academic qualification	**Responses No (%)**
Bachelor's Degree (BSc or BA)	324 (16.7)
Postgraduate Certificate	217 (11.2)
Postgraduate Diploma	315 (16.2)
Master's Degree (MSc or MA)	789 (40.7)
Doctorate	189 (9.7)
Other	106 (5.5)
Total	**1940**

A significant proportion of respondents (n=793/1940; 40.9%) felt that they were working outside of the traditional scope of practice of their registered profession(s). This was particularly reported by Orthoptists (n=21/28;75.0%), Paramedics (n=240/460; 63.5%) and ODPs (n=43/69; 62.3%). Many ODPs described working across inpatient wards and outpatient clinics in a variety of clinical specialties beyond their traditional environment. In contrast, other respondents described their 'out of traditional scope' practice as an area which is acknowledged to relate to their cognate profession (e.g. Chiropody/Podiatry in lower limb function or wound care assessment; Paramedics working in pre-hospital critical care or hazardous area response team (HART); Diagnostic Radiographers reporting imaging examinations; Orthoptists specialising in a clinical field related to ophthalmology e.g. stroke or glaucoma). Examples of reported advanced level practice activities across HCPC registered professions are provided in Table 8 with a comprehensive summary by profession across the 4 countries of the UK provided in Appendix 2.

Table 8: Examples of Advanced Level Practice by Professional Group

Profession	**Examples of Advanced Level Practice**
Arts Therapists	Integrative arts counselling psychotherapy
Biomedical Scientist	Bone marrow morphology Clinical electron microscopy Cytology Histopathology reporting (various) Non-lab based clinical transfusion Workplace and forensic drug testing
Chiropodist/Podiatrist	General and acute medicine of the whole body Emergency medicine/trauma Diagnostic ultrasound and steroid injections Orthopaedic triage in primary and secondary care Surgery
Clinical Scientist	Ultrasound Toxicology MRI physics (cardiac) Cardiology
Dietitian	Advanced practice in metabolic medicine Clinical assessment of neurology patients Eating disorders and weight management Food allergy assessment Insulin adjustment in diabetes
Hearing aid dispenser	Specialist counselling and rehabilitation therapy
Occupational Therapist	Medical assessment of patients in ambulatory care Advanced clinical assessment, diagnostics, interpretation and diagnosis Part of hospital at home team doing full clinical assessments Psychological therapy Injection therapy
Operating Department Practitioner	Advanced critical care practitioner on adult intensive care ward Anaesthesia associate Surgical assistant – clinics, theatre and wards Endoscopy Working as surgical care practitioner but registered as ODP
Orthoptist	Diagnose and manage glaucoma patients

	Medical retina uveitis ad Botulinum Toxins injections
Paramedic	Advanced care practitioner in Emergency medicine Aeromedical retrieval/SAR/offshore medicine Day to day triage, assessment over the phone, video consultation, prescribing & referring patients to another specialist Work in primary care including women's health, menopause, HRT, long term care management and care planning See, treat, discharge, admit role in urgent care setting
Physiotherapist	ACCP covering critical care and major trauma in Resus Advanced clinical practice (not physiotherapy) – manage patients on 5 hospital wards My role is similar to that of a junior doctor with limited physiotherapy aspects Botulinum Toxin injections Diagnostic ultrasound, injection therapy and prescribing First contact practitioner in primary care Multi-role mental health specialist Requests x-rays and blood tests Emergency Practitioner, predominately a nurse practitioner role
Practitioner Psychologist	Primary care occupational psychology Spiritual psychology and complementary medicines Independent consultant to public and private organisations and charities Counselling psychologist Expert witness
Prosthetist/Orthotist	MCAS [primary care musculoskeletal clinical assessment service] triage
Radiographer – Diagnostic	Bone marrow biopsy practitioner Image reporting (range of imaging modalities) Endoscopy Ultrasound Fine needs aspiration and cytology Video urodynamics, lithotripsy, vascular ultrasound, chest and ascitic drainage Vascular access and interventional radiology
Radiographer - Therapeutic	Brachytherapy Independent prescriber Obstetric sonography Patient clinic reviews (various)
Speech & Language Therapist	Role similar to specialist advisory teacher with national reach Palliative care matron Care and diagnosis of dysphagic patients Ultrasound Inpatient stroke services but my clinical duties are no longer that traditionally of an SLT

A number of respondents indicated that they have medicines management within the scope of their advanced level practice, either independently prescribing (n=413/1940; 21.4%), supplementary prescribing (n=185/1940; 9.6%) or using a patient group direction (n=677/1940; 35.0%). Almost half of the respondents also referred for imaging investigations (n=910/940; 47.1%).

Responses from Managers

635 respondents (n=635/3716; 17.1%) identified themselves as managers and responses were received from all HCPC registered professions (Table 9). The large majority of managers (n=505/635; 79.5%) were employed by the NHS.

Table 9: Manager participants by profession

Registered profession	**Responses by profession** No	**Combined manager / advanced practice role** No (%)
Arts Therapist	7	6 (85.7)
Biomedical Scientist	63	16 (25.4)
Biomedical Scientist & Clinical Scientist	2	2 (100)
Chiropodist/Podiatrist	25	17 (68.0)
Clinical Scientist	27	23 (85.2)
Dietitian	51	16 (31.4)
Hearing Aid Dispenser	4	2 (50.0)
Occupational Therapist	68	28 (41.2)
Operating Department Practitioner	38	15 (39.5)
Orthoptist	10	6 (60.0)
Paramedic	78	45 (57.7)
Paramedic & Physiotherapist	1	1 (100)
Physiotherapist	96	59 (61.5)
Practitioner Psychologist	37	32 (86.5)
Prosthetist/Orthotist	4	2 (50.0)
Radiographer - Diagnostic	60	40 (66.7)
Radiographer - Therapeutic	15	7 (46.7)
Speech and Language Therapist	49	20 (40.8)
Total	**635**	**337 (53.1)**

The majority of manager respondents resided in England (n=517/635; 81.5%) but responses were also received from Scotland (n=52/635; 8.9%), Wales (n=33/635; 5.2%) and Northern Ireland (n=18/635; 2.8%). A further 15 manager survey respondents (n=15/635; 2.4%) resided in areas of Crown dependency or overseas.

Of the managers not identifying themselves as also undertaking advanced level practice, the majority (n=207/298; 69.5%) reported having advanced practitioners employed within their professional service although only 37.3% (n=111/298) directly managed advanced level practitioners.

With regards minimum academic qualification expected of someone working at an advanced level of practice, opinion between managers varied (Table 10). Importantly, the majority of managers (n=11/15; 73.3%) identifying a doctorate qualification as a minimum standard represented those professions where doctoral education and training is established as part of threshold or post qualification education (Clinical Scientist; Practitioner Psychologist). Those selecting other option

identified professional CPD and single academic modules as expected education level. Data were missing from 140 responses suggesting uncertainty may exist in expectation.

Table 10: Minimum qualification expected for working at an advanced level of practice

Highest Academic qualification	**Responses No (%)**
Bachelor's Degree (BSc or BA)	93 (14.6)
Postgraduate Certificate	63 (9.9)
Postgraduate Diploma	67 (10.6)
Master's Degree (MSc or MA)	230 (36.2)
Doctorate	15 (2.4)
None	4 (0.6)
Other	23 (3.6)
Data Missing	140 (22.1)
Total	**635**

Views on HCPC regulation of advanced level practice

The majority of respondents (n=2904/3716; 78.2%) agreed that the HCPC should be regulating advanced level practice. This was generally consistent across respondent roles (Table 11). It is noticeable that the level of agreement declines where the respondent identified themselves as an advanced or consultant practitioner and this is particularly evident when considering responses from managers who also undertake advanced level practice themselves.

Table 11: Respondents who agree the HCPC should regulate advanced level practice by role

Respondent Role	**Responses** No (%).
Academic	125 (82.8)
Advanced Practitioner	702 (70.6)
Consultant Practitioner	204 (64.0)
HCPC registrant working in clinical practice	1034 (86.3)
Manager & Advanced Practitioner	232 (68.8)
Manager	252 (84.6)
Trainee Advanced Practitioner	250 (86.2)
Not currently working	36 (90.0)
None of the above	69 (77.5)
Total	**2904**

Where information on UK nation of employment was collected (advanced practitioners and managers; n=906) a similar pattern was observed (Table 12).

Table 12: Location of respondents who agree the HCPC should regulate advanced level practice

UK Country	**Manager** No (%).	**Manager & Advanced Practitioner** No (%).	**Advanced/Consultant Practitioner** No (%).
England	195 (85.5)	196 (69.0)	746 (69.3)
Northern Ireland	9 (64.2)	4 (100)	21 (72.4)
Scotland	27 (81.8)	13 (68.4)	69 (61.6)
Wales	16 (88.8)	8 (57.9)	56 (73.7)
Other	5 (100)	11 (73.3)	14 (73.7)
Total	**252**	**232**	**906**

With the exception of Clinical Scientists (63.2%) and Practitioner Psychologists (49.4%), the level of agreement that the HCPC should regulate advanced level practice was similar across professional groups (Table 13). As 26 individuals identified themselves as dual registrants, those agreeing that the HCPC should regulate advanced practice were included in both professions for analysis.

Table 13: Professions of those who agree that the HCPC should regulate advanced level practice

Registered profession	**Responses** No. (%)
Arts Therapist	23 (71.9)
Biomedical Scientist	188 (81.4)
Chiropodist/Podiatrist	143 (73.3)
Clinical Scientist	98 (63.2)
Dietitian	175 (83.7)
Hearing Aid Dispenser	16 (84.2)
Occupational Therapist	218 (77.0)
Operating Department Practitioner	275 (96.5)
Orthoptist	37(82.2)
Paramedic	624 (81.7)
Physiotherapist	475 (79.0)
Practitioner Psychologist	82 (49.4)
Prosthetist/Orthotist	10 (71.4)
Radiographer	392 (73.0)
Speech and Language Therapist	167 (81.1)
Total	2925 (78.2)

Views of participants on the advantages/benefits of additional HCPC regulation

The main advantages/benefits of regulating advanced level practice were identified by participants as: greater professional standing with other professions (n=2739/3716; 73.7%); assurance to employers of knowledge and skills (n=2732/3716; 73.5%) and greater consistency in education and

training standards (n=2676/3716; 72.0%) (Table 14). Those indicating 'other' perceived benefits overwhelmingly stated that they did not believe the HCPC should regulate advanced level practice in free text comments.

Table 14: Perceived advantages/benefits of HCPC regulating advanced level practice

Advantage/Benefit	**Response agreement** No (%)
Assurance to employers of knowledge and skills	2732 (73.5)
Assurance to self of knowledge and skills	2050 (55.2)
Greater consistency in education and training standards	2676 (72.0)
Greater professional standing with other professions	2739 (73.7)
Greater standardisation of advanced practice	2589 (69.7)
Improved protection and safety of service users	2308 (62.1)
Increased pay, recognition, and reward	1608 (43.3)
More opportunities for advanced practice/innovation	1998 (53.8)
Improved clinical governance and management of clinical risk	2260 (60.8)
Greater understanding and clarity of the public (patients and service users)	1979 (53.3)
Other	206 (5.5)

When considering the perceptions of managers, a similar level of response agreement was identified (Table 15). Once again, the majority of those reporting 'other' indicated a belief of no benefit of HCPC regulating advanced level practice.

Table 15: Manager perceived advantages/benefits of HCPC regulating advanced level practice

Advantage/Benefit	**Response agreement** No (%)
Assurance to employers of knowledge and skills	477 (75.1)
Assurance to self of knowledge and skills	328 (51.7)
Greater consistency in education and training standards	471 (74.2)
Greater professional standing with other professions	461 (72.6)
Greater standardisation of advanced practice	461 (72.6)
Improved protection and safety of service users	385 (60.6)
Increased pay, recognition, and reward	254 (40.0)
More opportunities for advanced practice/innovation	318 (50.1)
Improved clinical governance and management of clinical risk	404 (63.6)
Greater understanding and clarity of the public (patients and service users)	342 (53.9)
Other	46 (7.2)

Views of participants on disadvantages/challenges of additional HCPC regulation

The main disadvantages/challenges of regulating advanced level practice were identified as: increased cost of registration (n=2513/3716; 67.6%); difficulty in regulating multi-

professional practice (n=1999/3716; 53.8%); and duplication of effort with other professional bodies or credentialing organisations (n=1610/3716; 43.3%). However, level of agreement with statements of disadvantage/challenge were noticeably less than the statements of advantage/benefit suggesting respondents perceived fewer disadvantages than advantages (Table 16). Those responding 'other' reported varied viewpoints with no dominant perception reported.

Table 16: Perceived disadvantages/challenges of HCPC regulating advanced level practice

Disadvantage/Challenge	**Response agreement** No (%)
Bureaucratic exercise only	1368 (36.8)
Confusion for the public	684 (18.4)
Duplication of effort (already accredited/credentialed)	1610 (43.3)
Difficult to regulate multi-professional practice	2000 (53.8)
Increased cost of registration	2513 (67.6)
Increased risk of litigation, complaints, investigations and potential hearings	755 (20.3)
Reduced opportunities for advanced practice/innovation	694 (18.7)
Would not recognise my multi-professional scope of practice	998 (26.9)
Would limit future role development opportunities	711 (19.1)
Other	169 (4.6)

Manager responses once again reflected the perceptions of the wider participant group with those responding 'other' sharing varied viewpoints (Table 17).

Table 17: Manager perceived disadvantages/challenges of HCPC regulating advanced level practice

Disadvantage/Challenge	**Response agreement** No (%)
Bureaucratic exercise only	245 (38.6)
Confusion for the public	118 (18.6)
Duplication of effort (already accredited/credentialed)	274 (43.1)
Difficult to regulate multi-professional practice	364 (57.3)
Increased cost of registration	409 (64.4)
Increased risk of litigation, complaints, investigations and potential hearings	88 (13.9)
Reduced opportunities for advanced practice/innovation	115 (18.1)
Would not recognise my multi-professional scope of practice	160 (25.2)
Would limit future role development opportunities	116 (18.3)
Other	33 (5.2)

Education survey (WP2)

Summary of survey participants

Responses were received from 31 unique education programmes offered by Higher Education Institutions (HEIs) and which were accessible to at least 1 HCPC registered profession. The majority were received from HEIs in England, with no responses from Northern Ireland (Table 18).

Table 18: Location of the HEIs providing advanced level education

Country	**Responses** No. (%)
England	20 (64.5)
Scotland	7 (22.6)
Wales	4 (12.9)
Northern Ireland	-
Total	**31**

Responses indicated that the education programmes were not accessible to all HCPC registered professionals (Table 19) and although the majority of programmes were titled 'Advanced Practice/Practitioner' (n=22/31; 71.0%) and open to multiple professions (including Nursing and Pharmacy) a small number of the programmes (n=6/31) were uni-professional (e.g. MSc Diagnostic Imaging (Diagnostic Radiographers); or MSc Sports and Exercise (Physiotherapy)).

Table 19: Programme accessibility by profession

Profession	**Responses** No. (%)
Arts Therapists	3 (9.7)
Biomedical Scientist	5 (16.1)
Chiropodist/Podiatrist	12 (38.7)
Clinical Scientist	6 (19.4)
Dietitian	16 (51.6)
Hearing Aid Dispenser	4 (12.9)
Occupational Therapist	17 (54.8)
Operating Department Practitioner	10 (32.3)
Orthoptist	6 (19.4)
Paramedic	24 (77.4)
Physiotherapist	28 (90.3)
Practitioner Psychologist	4 (12.9)
Prosthetist/Orthotist	5 (16.1)
Radiographer - Diagnostic	15 (48.4)
Radiographer - Therapeutic	14 (45.2)
Speech and Language Therapist	10 (32.3)

The professions with the greatest access to advanced level practice education programmes were Physiotherapists, Paramedics, Occupational Therapists and Dieticians. The professions with the least access to advanced level practice education programmes were Arts Therapists, Hearing Aid Dispensers and Practitioner Psychologists.

There was general consistency in the academic level of education with all respondents confirming that their programme contained content considered to be FHEQ Level 7 and only one programme having content considered to be FHEQ level 6. Programme delivery was predominantly part-time (n =25/31; 80.6%) and accessible only as a traditional postgraduate award (n=18/31; 58.1%). Only three programmes (n=3/31; 9.7%) identified themselves as purely an apprenticeship pathway (England), with an additional 10 programmes offering both traditional and apprenticeship routes (England).

The majority of programmes (n=29/31; 93.5%) included education components related to all four pillars of advanced practice with emphasis being predominantly on clinical skills development (n=20/31; 64.5%) or research. Eighteen programmes (n=18/31; 58.1%) included a defined clinical placement component although variation in requirement and expectation of this was evident (i.e. variation in expected placement learning hours and placement learning activities). All clinical placements were assessed using a portfolio of learning to evidence development of skills. Nine programmes (n=9/31; 29.0%) included a mandatory non-medical prescribing module and a further five programmes offered this as an optional module (n=5/31; 16.1%).

Twenty-two programmes were led by a non-HCPC registered healthcare professional (nurses n=21 and healthcare educator n=1) and they were invited to provide their views on the regulation of advanced practice by the HCPC. The majority of respondents believed that additional regulation of advanced level practice is required (n=20/22; 90.9%).

The main advantages/benefits of regulating advanced level practice by this group were identified as:

- Protection and safety of service users (n=21/22; 95.5%)
- Greater consistency in education and training (n=20/22; 90.9%)
- Assurance to employers (n=20/22; 90.9%)

The main disadvantages of regulating advanced level practice were identified as:

- Difficulty in regulating multi-professional practice (n=17/22; 77.4%)
- Increased cost of registration (n=11/22; 50.0%)
- Duplication of effort (n=9/22; 40.9%)

Summary of interviews and focus groups (WP3)

Focus group and interview categories were identified to fulfil the research brief and question schedules were considered and confirmed by the study advisory board (Appendix 1).

Participants were invited from a register of interest created by the HCPC in advance of this study, supplemented by consent to invite responses as part of registrant survey (WP1). In addition, individual invitations for interview were sent to health education leaders across the home countries and those leading national policy for health and care professions. A total of 31 individual interviews or focus groups were undertaken. These consisted of:

1. Chief AHP, Chief Scientific Officers and national education leads (all 4 Nations) (x11 interviews)
2. Practitioners identifying themselves as working at an advanced level:
    - England (x3 focus groups)
    - Scotland (x3 focus groups)
    - Wales (x2 focus groups)
    - Northern Ireland (x1 focus group)
3. Other healthcare professionals (not HCPC registered) & registrants not working at an advanced level of practice (x2 interviews with nurses)
4. Trade Unions (not combined with Professional Bodies) (x2 interviews)
5. Employers (x1 focus group)
6. Educators (x2 focus group)
7. Professional Body (x3 focus groups)
8. Patients and Public (service user) (x1 focus group)

The numbers of persons invited, agreeing to participation and attending interview/focus groups are provided in Table 20.

Table 20: Details of focus group and interview participation

Groups*	**Invited for interview/focus group**	**Agreed participation**	**Participants Attending interview/focus group**
Advanced Practitioner			
England	50^	28	14
Northern Ireland	12	5	4
Scotland	51	18	11
Wales	55	8	3
Other healthcare professionals (nurses – respondents England only)	9	2	2
Trade Unions (UK wide)	4	2	2
Employers	15	7	3
Educators	30	13	11
Professional Bodies	85	12	11
Patients and Public	30	4	2
Chief AHP and Chief Scientific Officers and National Education Leads (all 4 countries of UK)	15	11	11

*Coding key for quotations ensuring anonymity in Appendix 5
^Selected randomly from across professions and geographic locations

In total, 30 hours of interview data were transcribed and analysed to identify and categorise emerging themes. Participants included practicing representatives from all HCPC registered professions. Notes were made by those conducting the interviews and focus groups to inform interpretation. All interviews were reviewed by at least two members of the research team to ensure salient points were extracted. Narrative data were then aggregated to develop the categories and themes.

The narrative data highlighted that opinions on the topic of advanced level practice and regulation are strong and disparate within and between professions, countries and organisations emphasizing the complexity of advanced level practice in the UK.

The main themes arising from the interviews and focus groups were:

- Defining and differentiating advanced level practice from professional scope, role and title;
- Professional identity or generic identity (when multiple professions undertaking same or similar role);
- Equality of opportunity for advanced level practice development;
- Contrasting views on need for advanced practice regulation;
- Employers' role in governance, scope of role and role description.

Defining and differentiating advanced level practice from professional scope, role and title

Focus group and interview participants conflated the terms advanced level of practice and advanced practitioner (role title). This was particularly evident when participants questioned why the focus of the study was advanced level practice (inferring the role of an advanced practitioner) and did not consider consultant practice (inferring the role of a consultant practitioner) at the same time.

> *"Obviously we're looking at advanced practice, advanced levels. What about consultant level of practice? How is that being considered within this?"* PB2/S2

> *"There's something about doing them in tandem because our consultant practitioners are really saying, well what stands us apart from an advanced practitioner?"* PB2/S6

> *"Currently a newly qualified practitioner psychologist is fit to practice at that level [advanced practitioner] and therefore the development is to consultant level status"* GOV1/S2

As a result, while respondents used the same language, the meaning and understanding of the terms was not consistent and the lack of a clear definition or understanding of advanced level practice was identified as a barrier by advanced practitioners and professional bodies.

> *"I think it's really difficult and really challenging with the title advanced practice to really understand what it means. If I use physio as an example, you have people who are very much specialised, so in neuro or respiratory, and I think are you a specialist practitioner? Or are you an advanced practitioner?* ENG3/S3

> "*When you think of the wider community and people's understanding of say things like advanced and consultant, specialisms all mean different things to different people. You know, over recent years, one's frequently been to meetings, particularly things on advanced practice, which is obviously very topical now, where one's actually started off in saying, well we actually need to define between us what we mean by this because I think we're all using the same words, but we actually don't mean the same thing when we say them. And without wanting to muddy the waters, we still have the use of words like 'advanced' for some of the support [worker] roles."* *PB2/S5.*

> *"I think there are some people in very senior post who think they're doing advanced practice, and they may not be, and I think there are people who are definitely doing advanced practice and may have a different title where it may be a locally agreed. So I think until you've got a very clear definition of what is advanced practice for each specialty, because I think there's so much variety in the practical world of how different healthcare professionals work, that one person's idea of advanced practice is different to another and there's going to be organizational and regional differences. So, to answer your question … I can't answer your question, because I don't know the cut-off point. I have my own ideas of that. But they will differ from other people in my profession and it's that lack of clarity that I think is one of the biggest challenges that face you"* *PB3/S4*

This inconsistent use and interpretation of role titles was also identified as a possible risk, particularly where potential for false representation of skill set existed.

> *"And that to me is where the regulators have to step into the space, even if it's only saying, you cannot call yourself an advanced practitioner unless you are a registered health professional, and you have achieved some kind of competence. And that, to me, is where the huge risk is, so falsely representing yourself as an advanced practitioner I think is something the regulators need to look at. And you cannot leave that to employers, because quite clearly employers are assigning titles to people who are not even registered health professionals."*
>
> ED2/S5

Confusion was further exacerbated by the multitude of role titles used by those working at an advanced level of practice (Table 5) which may, or may not, be transferable across professions or organisations.

> *"I'm doing my master's dissertation at the moment, and I'm looking at physios working in advanced practice and inpatient settings ... there's like 17 different job titles that people are using within that advanced practice role, lots of different MSc's … at the moment I think it's very unstructured as to what advanced clinical practice is."* ENG3/S3

> *"It's one of my pet hates is the job titles … I've been a critical care paramedic, a specialist paramedic in critical care … and all the services that have jobs similar to mine are either advanced paramedic practitioner if you're in London, specialist paramedic in the South West, now critical care paramedic here … but they're all the same job"* ENG2/S8

Despite national frameworks for advanced level practice across all four countries of the UK, the lack of consensus across and within HCPC professional groups with respect to clearly defining advanced level practice and differentiating this from role title and agenda for change banding continues to present challenges for professional unity.

Professional identity or generic identity

Respondents working at an advanced level of practice expressed uncertainty in relation to how best to introduce themselves to patients, particularly where they considered their scope of practice to be outside the traditional scope of their registered profession or they were working in an emerging Advanced Clinical Practitioner role. This uncertainty was not restricted to any country of the UK.

> *"It's really difficult because I'm dressed like a nurse, I'm a paramedic, and there's all sorts of weird titles, which is half the difficulty. So I normally say I'm one of the advanced practitioners, but it really does depend on who I'm speaking to… but I'd like to be called an advanced clinical practitioner. I think it's a generic title and it shouldn't matter what my background is, it's a core set of capabilities. But in truth, I get called all sorts of things, often nurse"* WAL2/S2

> *"I'm an advanced clinical practitioner in diabetes, endocrine and general medicine. I trained for two years full time in acute medicine and emergency care but my background is a*

podiatrist…[my role] is substantively different [from registered profession], although I can lead on the lower limb issues in the Trust, my day to day is completely different to what I was doing as a podiatrist, whilst I've got key transferable skills, and I can bring in my, my medicine of the lower limb, which I've then expanded to the whole body. Obviously, the upper body is quite different to the lower body…it's just taking those acute medical skills that I had in podiatry and expanding them to be able to do chest examinations, to be able to prescribe for arrhythmias for exacerbation of COPD, asthma… so I'd say it's completely different…I would introduce myself as an advanced clinical practitioner…I wouldn't say I'm an advanced clinical practitioner podiatrist because it causes confusion" ENG2/S2

"Quite often, in my role in primary care, patients are expecting to speak to a doctor, they're kind of getting used to speaking to a nurse, and particularly around long-term chronic disease management…However, my role is very much acute care, so I am seeing the urgent, on the day, stuff and doing a lot of telephone triage, and in that role, patients aren't used to speaking to a paramedic and their expectation is [to speak to] a GP. So we've had lots of discussions in the practice about how we introduce ourselves, because what we don't want to do is falsely lead patients into thinking we're speaking to a level of clinical practice that they're not accessing. But equally, we want them to have the assurance that the clinician they are speaking to, is qualified to deal with their condition. So we're using a very generic term of advanced practitioner. And that's how we're introduced in the practice, simply as one of the advanced practitioners within the practice. So we're not using a role specific term, simply to avoid patient confusion". SCO3/S2

"I'll always say advanced practitioner but whether I say physio would be dependent on the reason why that patient is there…if I'm seeing someone who comes under the role of the traditional physio I'll say 'Hi I'm [name], I'm an advanced practice physio'…If I'm seeing someone with abdominal pain or dizziness or something that's not traditionally a physio role I'll say 'hi I'm [name], I'm the advanced practitioner'…it's just very confusing" SCO1/S4

This perception of patient confusion and potential anxiety over declaring professional role was supported by services users who stated they would have greater confidence in a doctor or advanced practice nurse than an advanced practice AHP undertaking the same clinical role.

"I'd be more confident with the nurse purely on the basis that they would have had better training and competencies in interpersonal skills and assessing clients [than] some of the other professions. They [other professions] don't necessarily have the same level of contact with the patient they [nurses] do, like a radiographer would take the images, the X rays, but they wouldn't necessarily engage with the patient or their family member or carer. At that moment in time the information is passed on to GP, or the hospital consultant that deals with the patient. So [I'd] be concerned how they engage with the patient. PPI/S1

[Does the term 'nurse' give you confidence?] "*Yes, it does. Because I'm involved in nurse education [service user group member] … I know how rigorous their training and the breadth and depth of the training that's involved to qualify as a nurse. And I know there are lots of sessions on assessing the patient holistically. Whereas I've never been involved to the same*

extent with a podiatrist or a radiographic program. So, I don't know whether they have those skills to engage and assess a client" PPI/S1

"…as a patient, we don't know what training people have had when they actually are dealing with us as patients. If I knew they'd had that type of generic training…but you don't know what training people have had when they tell you they're an advanced practitioner…and are they dealing with something that they did have prior knowledge of?" PPI/S2

This emphasises that patients may better understand the terms 'doctor' and 'nurse' as generalist care workers who specialise but, may not fully understand the wider scope of individuals working at an advanced level of practice across HCPC registered groups or the underpinning education to support it.

Equity in opportunity for advanced level practice development

Not all healthcare providers offer the same services and therefore vary in their service resource demands. As such, development opportunities for advanced level practice also vary and are driven by the needs of healthcare services locally. Historically, advanced level practice was viewed as a delegated task, normally representing an activity previously undertaken by a medical professional and delegated to a non-medical professional where insufficient medical capacity existed. This pattern of identifying where advanced level practice might address a shortfall in medical capacity is reported to persist.

"There's not a ceiling in role. We're all pushing boundaries with pushing into doctors' roles and taking some of their responsibility." WAL1/S3

"I think they're the future [advanced practice roles]. I think they will complement GP's, and when I say GPs, I mean the plethora of titles that the doctors have, and I see us almost being abused in some respects, and that language is not great, but I am worried that we're becoming a cheaper model of the NHS… But actually, in some cases that's completely effective and right to do. I just worry that we're replacing that experience and that skill level that GPs or doctors bring to the table." WAL2/S2

The perception that employers viewed advanced level practice as the skill or competence to undertake a clinical task, rather than valuing the wider development related to reasoning, leadership and decision-making that are integral to advanced level practice was echoed across stakeholder groups. As a result, support for the development of wider advanced level practice capabilities was reported to be limited.

"So, it really worries me that with no safeguards in place for what on earth is advanced practice, I'm seeing everybody trying to do it on the cheap and reduce it to just a bit of clinical training. And what we saw happen in [a UK country] was that they said, we don't want these advanced practitioner things. They think they need to do research, they think they need to do leadership, they think they need to do education, we just want them working clinically." GOV2/S1

"My job, and I'd say a lot of other people's, it's so clinical, that to find time to do [research], even to do the two research modules prior to my Masters, I had to kind of just do them myself because there wasn't a need in the service for them, so they weren't funded and weren't worried about me doing them". NI/S2

"I'm funding my last two modules [of MSC] because the NHS doesn't recognise that the research and dissertation is anything to do with advanced practice. They funded my leadership module because I was in a management post otherwise, I would have to have done that myself as well". WAL2/S2

Employer support for those working at an advanced level of practice to access education across all 4 pillars of advanced practice was also perceived to be influenced by the availability of education funding without clarity of how knowledge and skills might be applied and used in practice.

"I think it has a lot to do with funding as well. Because within [region], the allied health professionals can get some HEE funding for ACP roles, but they have to do APACS [advanced clinical assessment & consultation skills] and NMP [non-medical prescribing]. And it's not necessarily relevant, but because they're getting the funding, then they go on those modules." ED2/S6

"Within Wales, initially I was trained by [employer] and my master's was funded, and I had all my development supported by them. And it was a very good structure. At the end of the training, however, they didn't know what to do with us". WAL1/S3

Lack of appreciation of the added value of higher academic education may explain the variation in interpretation of the statement 'master's level or equivalent' with respect to the educational standing of those working at an advanced level of practice. With the exception of Healthcare Scientists, no stakeholder group could clearly explain the meaning of this statement.

"I don't know what is equivalent to a Master's level. I actually asked my manager that at one point and she gave me a very managerial answer which didn't answer the question basically. So, so I don't know. And I think that's why you need to say master's level."

SCO1/S2

"What masters? You know, masters in what? You could have a master's in something completely different to the profession that you're doing, and just because you have a Master's doesn't mean you're an advanced practitioner in your current field. It's just, I don't know, there's obviously a lot of experienced staff who haven't had the opportunity to do a master's and you'd be hard pressed to tell them that they've not got an equivalent level of experience or qualification, but it's also master's <u>level</u>. Well, my PG cert is master's level, but it's not a full Master's. So how much of a master's level do you need to get that [advanced practitioner title] title?" SCO1/S2

"I think we see advanced practitioners who have just amassed one component, one PGD [postgraduate diploma] or PGC [postgraduate certificate] which may enable them they feel

to be classed as an advanced practitioner by the employer, the employer may call them an advanced practitioner, but I believe, from the professional body perspective, that we would look for a full Master's qualification". PB2/S2

"I personally don't like the Master's thing ... So, I have an MSc in evidence based health care, which was the most painful thing I've ever done in my life … there are some people who are exceptional clinicians and have the potential to work as advanced practitioners who are not particularly academic. And sitting a master's program for them would be a challenge. So, what would equivalent to a Master's actually mean, you could have somebody who just had a natural ability to do something, and the skills to safely deliver that without necessarily having an academic qualification. I know, that's probably a bit controversial." PB3/S4

Within this research, cross-professional and cross-country alignment appeared to have occurred, or was developing, only in scientist education with clarity on 'Master's level or equivalent' education being provided alongside a clear approach to assessing level 7 equivalence.

"Within science, we've got quite a well-structured postgraduate set of qualifications. We've got a mixture again, depending on what professional group you're in … We've also got out of modernising scientific careers came the sort of STP program, and the high scientific training program. And then we also have sort of a portfolio, which sort of includes M level qualifications, which are through some of the professional bodies such as the Institute of Biomedical Science … and I think it gives a foundation for actually being able to make a judgement as to whether someone can sort of deliver and operate at that sort of level." PB3/S5

"A clinical scientist is an advanced practitioner, it's as simple as that. I mean ... basically if you finished the STP course, you're an advanced practitioner because you are operating at Level 7" GOV3/S2

Contrasting views on need for regulation of advanced level practice

No consensus over the need for additional advanced practice regulation was evident within or between professional groups or countries of the UK within the interviews and focus groups. Support for HCPC regulation and/or annotation of advanced practice was reported by some participants across all stakeholder groups.

"The HCPC should regulate it … I think that maybe you get an annotation on your registration, you know, like you do with your prescribing …" ENG1/S1

"If we are recognising that level of practice, and if we're spending an awful lot of time and effort in supporting people to consider advancing their practice, it would be good to see that annotation on register" GOV4/S2

"I think it's essential, I think it's really, really important that we have it … so I personally feel it's really important. It's really important for the public, it's really important for our patients

out there and above all, it's really important to demonstrate the responsibility on the individual that is in these roles, and that they very clearly understand they are now on a register [and] they must perform to that standard." GOV5/S2

"I think advanced clinical practice or advanced practice is somebody working outside of the traditional boundaries and as such it needs further governance and a further governance structure around that and a higher level of accountability. As we've heard, you will work in a greater scope and therefore I think there needs to be a greater accountability in order to safeguard the public and the practitioner, and the Trust and the reputation of HCPC as well." ENG2/S4

"I do worry greatly, that maybe we're not being as rigorous in terms of the education, but particularly the assessment, of all advanced practitioners, because some engage with educational programs, and some don't go anywhere near it … it may not mean that we need full regulation, but we certainly need a position statement from the regulators in terms of what can and what can't be done." ED2/S5

However, other participants did not share the same opinion on need for regulation, primarily due to the lack of standardisation and definition of what is advanced level practice across the differing professions in a rapidly changing healthcare environment.

"We've always said, you're all registered professionals. I have a scope of practice, I have a duty to work, let's go to practice end of. It should be enough. What worries me is what is scope of practice? And does it have a start and finish? I don't think anybody knows. And I think the other issue for me is, what we're missing, and I think this has been conflated with regulation…what we're missing is standardization of advanced clinical practice … and the worst thing we could do in the world is to pin down something that should be light of foot and nimble, able to respond to the system, without a draconian regulation"
GOV2/S2

I'm not a fan of advanced practice being given a particular annotation [on HCPC register] because, as I've said, how do you define what that is … I wouldn't be overly supportive of having an additional annotation for advanced practice, I don't think that will be helpful. I think it creates another ceiling and I don't know where we would stop having additional GOV6/S2

"I think, because we are a group of 15 professions, and not just one, it would be very, very difficult to apply, you know, a standard across the board to say what advanced practice is for everyone within the HCPC. And you certainly wouldn't want it the way that the nurses are where there are certain things that you have to do to be an advanced practitioner, such as the prescribing, that could just never work with the HCPC because clearly some professionals are in and some professions not. And the scope of practices is just so vast across the whole range of the HCPC" ED1/S4

"I don't think you can regulate, independent of your core and base registration, for advanced practice, I think the only difference that you could make is, ooh let's throw it out there, where

an investigation occurs into your practice, maybe because of a clinical error or because of a complaint, the recognition that you are working at a level or role that is different from the core role? And that's where, to a degree, I think you have to … you have to look at the level that the person is expected to practice at by their employer, and the level of clinical decision making, they're expected to engage in when a problem occurs, rather than try to regulate that in advance. Because I think it would be almost impossible to regulate that in advance, because, as we've already seen, there is a marketplace for the role, and employers will always move much faster than the regulatory authorities can move, be that HCPC, or nurse regulation, or GMC, or whoever … so if you try and regulate it at this point in time, in five years time, that [advanced practice] is going to be different, because it will have evolved."

SCO3/S2

Governance, scope of role, role description and risk

Participants across all stakeholder groups identified the importance of employer governance and the responsibility of employing organisations in supporting advanced level practice, in particularly defining job role and scope of advanced level practice.

"I think the job descriptions and the role descriptions, they're absolutely key. And that's the bit where I'm not sure that we've kind of always been as good as we should be." EMP/S4

"I do not believe that employers understand the important scope of practice, I don't believe the individuals do … and I think the issue is, you're completely right, it's virtually impossible to get your job description updated without running the risk of it going back out to banding and coming back three bands lower than you went in … and from a governance perspective, the real challenge is that most Trusts do not understand at all what they are doing with this workforce and do not understand the risk, or the need to keep things updated … So, there's a real risk and issue around anything contemporary being held on anybody's scope of practice. And what happens if the one thing I do is the one thing that's not listed on that little bit of paper, because, you know, I might be putting in central lines, but I only learned that last week, and it's not in my bit of paper … it's open to absolute challenge and the [regulators need to] engage in this conversation not to tell us what we can't do, but tell us what we can do and how we hold this [advanced practice] safe" GOV2/S2

Importantly, stakeholders alluded to ongoing conversations which were attempting to differentiate personal scope of practice as a health and care professional from professional scope of practice defined by the professional body to enable increasing blurring of practice boundaries. However, once again, the employer responsibility for employee activity was identified as essential.

"where we've got clinicians who are finding it difficult to anchor themselves in the profession, they should, as long as they're working within a job description, in a Trust, where they have vicarious liability, their Trust are happy that they have the skills, knowledge and behaviours to perform the duties that are within their job description. So … one of our professional advisors wrote about the difference between the scope of practice of [profession], versus the scope of practice of you as a [named professional] and your personal scope. So, I would say what [name] is describing is she's developed her own personal scope of practice and has got

training and competence to do so. And she's working within the boundaries of a role which recognizes and accepts that she might be working outside of the scope of [profession]. So, there's something about the person's scope, and the scope of the profession in a wider sense." PB2/S6

Concern also existed where practitioners worked across differing organisations or independently, particularly where employment or regulatory requirements varied for those practicing in, and across, public and private health and care sectors or where the protected title no longer reflected the activities of the individual.

"Job descriptions are crucial. People need to understand the expectations on them, and exactly what they can or shouldn't be doing. And, yeah, absolutely crucial that people understand exactly what it is because that's where things go wrong, you know, if people have a misunderstanding of what's within their responsibilities, that's when mistakes happen. And then ultimately, again, it's the individual that's left facing the consequences, so job description is absolutely crucial… and that's where it gets really blurred about people doing different jobs on different days. If you're a registered professional for a certain profession being required to act at a certain level, then that would be the measure that you would be expected to work towards, regardless of what day of the week it is. It's not possible that there can be two sets of standards for you to be measured against depending on what job you perform" TU2/S2

"There's no definition in professional regulation terms of Audiologist. 'Hearing Aid Dispenser' is the regulated title. But because it is so outdated … the title itself is not particularly respected by the people who own it. Because it is so outdated, it doesn't recognize the fact that audiology is not about dispensing or selling hearing aids. It's about helping people to live more fulfilled lives by being able to hear better and therefore participate in every aspect of society around them … NHS audiologists are not registered with HCPC. They are a voluntary registration in the main with the RCCP. But as 'Hearing Aid Dispenser' is a protected title and a protected function [sale of hearing aids], this mean that you cannot practice audiology in the private sector unless you are registered [with the HCPC]. So, there are different regulations in NHS and in the public and private sectors." PB1/S2

As a result of the differences in regulation for threshold practice, some stakeholders, argued that the focus of HCPC should be regulation of threshold practice in areas which could present greater public risk. This particularly related to practitioners working in foot health, psychology therapies, physiologists and branches of scientific careers, audiology and sonography but could be extended to include the increasing responsibilities of assistant and associate roles across all HCPC registered professions.

"I think for my particular professional group, some level of streamlining and clarity around what is regulated and what is not because, you know, out of the 12 psychological professions, only four are subject to regulation, which is the practitioner psychology group. There's another eight, who are the largest groups within NHS and other health and care organisations where the NHS commission services and provides training for some of those

professions, but they are not subject to statute regulation. Most probably have some level of accreditation process, but we all have a range of different titles, and it's incredibly confused. Well, it's incredibly confusing for the public and … I'm not sure some of my colleagues even understand the landscape…so sorting out the multitude of professions and regulation around that is what I would want to see." GOV1/S2

Interestingly, stakeholder focus group participants did not perceive advanced level practice in and of itself to present an increased risk to patients although the increased risk inherent in decision making within advanced practice roles was acknowledged.

"I think actually, as advanced practice, when you're working in an extended role, we have to adhere to the gold standard, all the time, because we have so much more need to evidence what we're doing … so I actually think that my risk, my decision-making is, in some ways, more solid. So, the risk is less because we have we have to adhere to that." SCO3/S5

"No there isn't an increased risk to the patient because we would be as competent as [others/doctors] in the role we were in." NI/S2

"We certainly in my job, we take more risk. But it's more acceptable, because we've got the knowledge, the experience, the education, and the exposure to that. And we're supported in taking those risks and making the decision when it's appropriate to do that or not do that. And understand it potentially better." ENG/S7

"I think there's less safety check in an advanced practice role. Now, I don't think that's unsafe, I think that is safe as long as the person is suitably qualified and has suitable experience, but I do think there is a greater risk associated with it. And that's why I think it's, it's essential that advanced practitioners are working at a specified level and are fully aware of that job role and the risk associated with that job role and have evidenced that their learning is at that level." WAL1/S2

Discussion

The Health & Care Professions Council (HCPC) are an independent statutory regulator whose role is to protect the public. This is achieved by setting standards for professional education, training and conduct and keeping a register of professionals who meet these standards thereby assuring public confidence in the professions it regulates. The HCPC also approves education programmes that lead to registration and takes action if registrant falls below the standards. The HCPC does not promote the professions it regulates nor represent the views of the regulated professions as these are the functions of professional bodies.[59]

The aim of this research was to:

- Identify the regulatory challenges and risks presented by registrants advancing practice and how the HCPC should respond to these to ensure public protection and support professionalism and good practice.

To achieve this aim, three objectives were identified:

1. To determine what advanced practice activities are being undertaken across HCPC regulated professions within the UK and whether these activities lie within the scope of the individuals regulated profession.
2. To determine regulatory measures considered necessary by registrants and stakeholders to support advanced practice and ensure public safety.
3. To determine the education and training expectations for advanced practice across the four countries of the UK.

The following discussion triangulates the evidence from all 3 work packages to respond to the research aim and objectives above.

Confusion in language adoption and understanding

Respondents within surveys, interviews and focus groups reported confusion in understanding the term 'advanced level practice' or 'advanced practice'. As identified previously, interview and focus group participants conflated the terms advanced level of practice and advanced practitioner (role title) and free text comments from survey participants re-iterated this confusion seeking clarity in interpretation.

> *"I think it's really difficult and really challenging with the title advanced practice to really understand what it means. If I use physio as an example, you have people who are very much specialised, so in neuro or respiratory, and I think are you a specialist practitioner? Or are you an advanced practitioner?* ENG3/S3

> *"I still think we need much more clarity around the definition of advanced practice"* RSD/141

> *"I believe there is still work to be done around defining what an advance practitioner AHP role would be and scope of practice"* RSOT/195

> *"Advanced practice as a general term can mean a variety of things…a clear definition and understanding of what an advanced practitioner is with potentially a part B register for each profession might be useful"* RSODP/241

> *"It might help the survey to have a clear definition of advanced practice, or to explore what this means. I have the impression that it may mean one thing to people in one profession and another to people in another profession"* *RSPP/618*

Despite all four countries of the UK having framework documents for advanced healthcare practice,[5-8] concerns over what is meant and understood by the term 'advanced (level) practice' were raised by survey and focus group/interview participants and stakeholders from across the groups. This lack of consensus or shared understanding of the term both across and within professions is likely to have influenced survey responses detailing advanced practice environments and activities undertaken.

Advanced practice activities vary both between and within professional groups

The descriptions of advanced practice activities were inconsistent both within, and across, professional groups and healthcare environments (Table 8 and Appendix 2). Importantly, respondents within surveys, interviews and focus groups also reported inconsistent Agenda for Change Banding (Table 6) and pay for undertaking roles locally agreed to be advanced practice and this was a source of frustration.

> *"There seems to be major inequality in terms of salaries in advanced practice and also in terms of what physiotherapists are allowed to do as part of the role. E.g. some can order scans, some still have to pass this back to the GPs. Bandings differ from Trust to Trust. There needs to be much more regulation whilst allowing for differences in certain roles".* RSP/584

"As a reporting radiographer I am currently split banded, as are the other reporters in my Trust. We get paid Band 6 four days and Band 7 one day a week" RSDR/648

"Parity across the country for what is considered advanced practice and the appropriate pay banding and recognition of increased responsibility" RSDR/698

"One of the barriers to advanced practice is the rigid pay/post system under Agenda for Change. I aspire to be an advanced practitioner and have developed a research capability to my role. However, this is not recognised within my post/banding, and therefore have no opportunity for advancement in the existing structure." RDSLT/787

"I consider that I'm working at an Advanced level as a prescriber with an MSc but I don't have an official title of Advanced Practitioner. I've been practising at this level since a Band 5. My advancement to Band 6 had little to do with my advanced qualifications and now I'm not convinced that further study will make a difference for further advancement." RSPOD/47

Respondents also raised concerns that current discussions and frameworks around advanced level practice were NHS centric thereby overlooking activity within the private and other care sectors.

"The whole advanced practice is based on NHS development processes. This needs to change to encompass all in the profession and to include private practice practitioners. Completely out the loop." RSP/580

"I have serious concerns with the number of people who currently claim to be advanced practitioners, particularly in Paramedic Practice, with little or no evidence that they regularly work in an advanced practice setting. This also applies particularly to the private and volunteer sector." RSPARA/378

"This does not only apply within the NHS, so please look beyond simply this environment. Pro sports PTs have been emergency response providers, trained in airway manoeuvres and adjuncts use, thoracocentesis, mini-trach installation, wound management and concussion assessment amongst other things for some time, with no real clarity on whether it is within their scope of practice to do so, and therefore no guarantee of protection if sued either in terms of professional support for confirming work was within scope of practice or guarantee of indemnification through CSP insurance." RSP586

Discussions within focus groups and free text survey comments also reiterated the changing health and care environment requiring a 'new type' of health care practitioner, the Advanced Clinical Practitioner, operating within a scope of practice that extended beyond that of the traditional scope of the registered profession.

"I believe that I may be the only diagnostic Radiographer background profession who is pursuing a [ACP] role in acute medicine and therefore my skill set is now outside of my background profession. This will be difficult for HCPC advanced practice governance to

capture. However, until this group of ACPs is adopted by a medical professional group for governance, HCPC remains my governing body" RSDR/660

Clarification is required when an individual pursues the ACP role with ACP MSc & NMP [non-medical prescribing] but remains registered as, for example, a therapy radiographer, despite their sphere of practice having completely altered. What can they prescribe? Where does liability lie? What happens when you're audited? " RSTR/728

"I feel very strongly that ACPs need to be regulated separately from base professions. The scope of my practice is so qualitatively different to that of an SLT it could be argued that existing HCPC standards do not adequately capture the risks associated with my duties." RSSLT/788

"There still seems to be some confusion about the role, scope & grade of ACP roles and some attempt at standardisation would help professionals, organisations & the public develop a better understanding of these roles." RSSLT/794

"The public find it confusing that in an ED [Emergency Department] clinician role, I have a different registering body to the doctors in the same role. Employers use the separate registration to claim 'difficulty' in allowing certain practices (Requesting CT, prescribing certain drugs). Public and other colleagues often genuinely ask if I have 'qualified as a doctor now' or note that I'm 'no longer a Paramedic'. Neither are true, nor will they ever be, but they find the complexity of the legal status and nomenclature confusing when they are used to defined roles such as doctor, nurse, paramedic, physiotherapist which are synonymous with a traditional registering body and public perception." RSPARA/369

Public confusion over the role and underpinning education of Allied Health, Psychology and Science professionals working in advanced practice was evident in the service user focus group discussion. While this involved only two members of the public, greater clarity and understanding over the role and scope of nurses and doctors was claimed. Importantly, both participants stated that they would have greater confidence in a nurse undertaking an advanced practice role than another non-medical profession suggesting that action is required to build public knowledge and confidence in the broader, higher level, knowledge and skills of HCPC registered professionals.

Despite the apparent lack of public awareness, it is clear that a wide range of advanced practice activities are being undertaken by HCPC registered professions. However, it is also apparent that the specific activity undertaken is often determined by local organisational need rather than the profession and this may further contribute to apparent confusion over whether an activity is within or outside the scope of the profession. It is also unclear how the personal attributes and capabilities aligned with advanced level practice are being encouraged.

Development of advanced level practice is based on service need (task) and not the person

Focus group and interview participants generally believed that employers and employing organisations viewed advanced level practice as the skill or competence to undertake a clinical task,

rather than valuing the wider development related to reasoning, leadership and decision-making that are integral to someone working at an advanced level practice. This was evident in discussions relating to scope of practice, job descriptions and support for education. Survey respondents also raised similar concerns regarding employer restrictions on advanced practice development and recognition.

> *"There is little to no support for advanced practice without the vision/imagination of employers. They need to embrace advanced practice as something that moves the department to a greater scope of practice with a greater role to play. Currently, personally I have felt that [in] undertaking an advanced role I have been considered least of all. I am seen as a nuisance and left in the margins. The HCPC need to explain the importance to workplaces/institutions of advanced practice - the assumption you don't need to is a mistake!"* RSBS/28

> *"I have found that as an OT I have been limited in many posts due to not having a nursing qualification … Health employers do not see the skills or are restricted in looking for a person with skills and knowledge as it is based on registration."* RSOT/206

> *"I feel that it's difficult working at this level with no clear standard. It makes us feel very vulnerable. Employers refuse to update job descriptions to reflect additional duties - does our indemnity insurance cover us?? One employer has even censored the word scope of practice to practitioners, so that the work is as fluid as possible, but it makes us feel vulnerable and unprotected. In house training [for advanced practice role] cannot be provided by managers and is then off loaded to the doctors. The doctors are overworked and struggle to understand the concept [of advanced practice]. Managers can't explain what training is needed and therefore little to no training is provided. Our nursing colleagues have good leadership, by seniors who are trained, understand, support and advise. I feel that those individuals who have gone down this route [advanced practice] have done so in-efforts to improve care to patients but at a detriment to their career progression."* RSTR/732

> *"Members of the public do not understand the difference between regular and advanced practitioners unless they are familiar with the field. Advanced practice, in my professional view, includes being able to step outside of the normal scope of practice. The HCPC is not able to confirm whether AP's [Advanced Practitioners] are fulfilling their role as there are no guidelines, except the internal regulations imposed by the employers themselves (and who regulates them?) This may already breach numerous HCPC guidelines, including, only perform the duties that you are qualified to do. Who is to say that an AP [Advanced Practitioner] is qualified [to do] without evidence or guidelines? Hence the need for the HCPC to get involved is required"* RSPARA/684

The findings of this research suggest that employers are not fully engaged with supporting those working at an advanced level of practice to access education to support all four pillars of advanced practice or value the wider learning and development these pillars provide. This lack of understanding or appreciation of the wider constructs of advanced practice, or the added value of higher academic education, may also explain the variation in interpretation of statement 'Masters

level or equivalent'. No group of stakeholders could clearly explain the meaning of this statement from a multi-professional perspective and even representatives of the Professional Bodies differed in their interpretation as identified previously.

Interestingly, despite 'Masters level or equivalent' education being expected across all four nations to support advanced level practice, this phrase was poorly understood across all stakeholder groups with the exception of Clinical Scientists where a recognised structured education and training programme (STP) existed. The perception of whether education alone is sufficient to prepare a candidate to work at an advanced practice level appears to depend on the assumption of symbiotic and parallel clinical and academic learning. However, 41.9% of education survey respondents indicated that their advanced practice programme did not include a defined clinical placement which may undermine successful application and translation of theoretical knowledge to the practice setting and the perceived value of wider education. Registrant survey respondents who identified themselves as working at an advanced level of practice held a range of qualifications (Table 7) with only the small majority (50.4%) holding a full Master's degree or higher. This may in part reflect the varying accessibility to advanced clinical practice programmes across HCPC registered professions (Table 17) but variation in expected level of education was also evident in responses from managers (Table 10) suggesting that education expectations are locally or professionally derived and, as suggested in focus group discussions and free text survey comments, dependent on clinical service need and funding availability rather than a clear development plan for those working at, or aspiring to, advanced level practice.

Inequity in opportunity to develop advanced level practice

Frustration was evident from respondents in terms of equity of opportunity and support to develop advanced level practice, particularly in comparison to nursing. This related to funding for postgraduate education as well as access to suitable education programmes.

> *"I think we have to consider our funding models in terms of postgrad education for AHPs… somebody else spoke about the very clear course that advanced practice nurses have that has been supported very clearly with a huge amount of money. And we do not have resources for our advanced practice education in the same vein"* SCO3/S6

> *"The biggest challenge we've got is we're trying to cram all the different professions into something that was [initially] defined by nursing … and the biggest problem we have with nursing is that they believe that every nurse who does advanced practice should prescribe".* GOV2/S2

> *"I believe there is still work to be done around defining what an advance practitioner AHP role would be and scope of practise. Current advance practitioner courses are Nurse/medical model orientated which does not fit with occupational therapy practice. Furthermore, health organisations are focused on potential advanced practitioners having non-medical prescribing. Shouldn't it be that advanced practitioner roles should be there to diversify MDTs- rather than squeezing other professions into a medical model/medical role."* RSOT/195

Variation in availability, and accessibility, of postgraduate education programmes to support advanced level practice was also noted across the different professional groups (Table 17). While access to the majority of programmes was not limited to a single profession, programme designs often reflected nursing ideals with a number including mandatory independent prescribing modules. Unfortunately, this added to respondent frustrations with the current rules around which professional groups could, or could not, independently prescribe being seen as a significant barrier to advanced practice development, particularly into generic advanced clinical practitioner roles and calls for changes to non-medical prescribing rules were evident from members of many professional groups.

> *"Within our trust we've got advanced critical care practitioners, and it's something that I've inquired into before. And so physio, nurses and pharmacists are able to do that role but dietitians aren't yet because we can't be independent prescribers. And so, because we can only be supplementary prescribers, we can't apply for that role"* ENG2/S4

> *"A concern I have is how to regulate advanced clinical practice for AHPs when there are differences between the training that is undertaken at Master's level. Specifically, occupational therapists are not able to undertake non-medical prescribing which I am finding opens up a big divide as far as future employment opportunities go."* RSOT/165

> *"Clinical scientists need to be added to the professions permitted to do non-medical prescribing to give greater flexibility of the role"* RSCS/93

> *"Due to current poor recognition and limitations due to the medicines act, advanced practice is out of reach to many ODP's who are more than able academically and clinically to become advanced practitioners. Many [education] programmes demand prescribing as an element of the training program. This is leading to discrimination and a double standard as this does not allow those ODP's to progress without changing professions which is not the way forward. There should be equal opportunities*" RSODP/253

> *"In my opinion, 'Advanced Practitioner' as a title, should only be used by those persons who have completed an MSc in a relevant subject and prescribing for ACP's should be unrestricted as for Nurses due to the variation and specialist practice."* RSPARA/399

> *I think there is a real lack of clarity around the advanced clinical practitioner role, particularly if working within medical teams outside of traditional AHP roles. My understanding is that I would not be able to undergo prescriber training for this role which would limit job opportunities. I hope that regulation would help to address this. I feel strongly that AHPs should have equal opportunities to nurses in advanced practice and it does not feel like this is the case at present."* RSSLT/773

While some respondents argued that it is a change in perception of healthcare organisations and personnel of what advanced level practice is that is required, rather than a change in non-medical

prescribing rights, the strongest opinion across stakeholder groups was that HCPC regulated professions should not be prevented from independently prescribing by profession. Instead, limitations on prescribing should reflect the scope of the role undertaken. This was also reflected in comments by those responsible for leading AHP advanced practice services.

> *"So prescribing … we are talking with Department of Health and Social Care about the ability for Advanced Practice to be the demarcater that allows somebody to go forward for prescribing. But because advanced practice doesn't exist [as a protected title], we're back into our vicious circle."* GOV2/S2

> *"Myself, I'm an advocate of regulation, and that's for several reasons. One is that I think that the title being able to be used by anyone is risky, for the public, and implies the wrong thing to other professions. I think that there are numerous legal tie ups if you like, that exist at the moment. So if you take prescribing, for example, I can prescribe something as a nurse that the physio can't prescribe, that the pharmacist might be able to or might not. And actually, if you had a regulated title that you then put prescribing legality against, it makes a level playing field."* OHP1/S1

Need for regulation of advanced level practice

While the results of both the registrant and education surveys indicated that the majority of respondents were in favour of additional regulation for advanced level practice, no consensus was evident within, or between, stakeholders, professional groups or countries of the UK within interview or focus group data collected as part of this research.

Results of the registrant survey identified the main advantages/benefits of regulating advanced level practice to be: greater professional standing with other professions (n=2739/3716; 73.7%); assurance to employers of knowledge and skills (n=2732/3716; 73.5%) and greater consistency in education and training standards (n=2676/3716; 72.0%) (Table 12). Importantly, while the small majority of respondents identified improved protection and safety of service users (n=2308/3716; 62.1%) and greater public understanding and clarity of advanced level practice, and in turn improved public confidence (1979/3716; 53.3%) (Table 14), these were not the highest ranked advantages/benefits of additional regulation supporting the position that registrant appetite for additional regulation is multi-factorial and role dependent.

Like the focus group and interview participants, registrant survey respondents reiterated the career limitations resulting from local role development without national guidance for education and accreditation. Further, while expectations remain poorly defined in terms of what 'Masters level or equivalent' means to individual professions, employers or individual registrants across the UK, an opportunity may exist to clarify and unify the educational expectations across HCPC regulated professions should additional regulation or annotation be agreed.

> *"I've seen the application of such roles within my workplace; however, it leaves the staff member with an inability to move job to another hospital. This is usually because they are trained to very specific purposes and for set goals with no proven ability in the way of*

accreditation or award (certificate etc). Accreditation would benefit individuals because they would have proof of achievement, knowledge and training." RSBS/18

"I think with accreditation comes unity. It provides a cohesiveness that is otherwise lacking. It will enable greater accountability and governance. It will bring opportunity for parity with regards to prescribing, radiology requesting and job opportunity. It will improve public confidence by ensuring that the standards of advanced practice are maintained and CPD is regularly undertaken." RSCH/51

"Regulation is needed to prevent pseudo advanced roles. The HEE multi professional framework is not followed, the level of practice needs validation like the RCEM portfolio. Advanced practice is not the academic qualification, it is an entry level and should be regulated as such." RSPARA/429

While those participants supporting additional regulation argued that such action would ensure employers established clear governance processes and accepted responsibility for local practice standards, the same arguments were used by those opposing additional regulation.

"The benefits of furthering regulation of advanced practice are: increased income for universities in offering adv practice programmes and increasing recruitment of AHP students, professional networks that will profit from supporting regulation through increasing membership and providing accredited programmes and employers who will be able to limit the training of staff as once they have achieved 'advanced practice' they will not need to ensure that they have the additional frameworks that are necessary to support the advancing and changing practice. The HCPC lobbying NHS inspectorates to generate and audit standards of advanced practice would be a better way to support practice. This would ensure that organisations rather than individuals accept the responsibility of assuring standards of practice." RSP/572

Importantly, focus groups discussions and interviews across stakeholder groups also raised the importance of up-to-date role descriptors and clear employer governance structures. Consequently, the findings of this research recognises that to address the feedback and concerns of registrants in relation to the regulation of advanced practice, a multi-agency approach would be required with HCPC being a central party being one of the few independent stakeholders within a UK wide perspective.

"This work has to be in partnership with the key stakeholders and a true joint venture of equals. If we are to deliver consistent, safe practice with transparent and measurable advanced practice roles/skills acquisition and measurable standards to ensure safe practice whilst supporting innovation and creativity in a safe and secure environment to ensure patient and public safety and confidence this will need to be a fluid and trusting relationship between all parties."

RSCH/77

"Although the HCPC has an important role to play, the ability of the NHS or wider to adjust its working to respond to demand could be harmed by introducing too much control over roles. Standards are useful but can be developed between prof bodies and others such as Health Education England and NHS Education for Scotland in a more rapid way and to meet varying demand locally. There is also a need to introduce a way to 'register' non-professionals such as assistants to create space for roles to change within the qualified practitioner such as has been developed through nursing associates. This would provide greater potential for people to begin working for the NHS throughout the length of the skills escalator from support worker to consultant or senior management." *RSDR/645*

Within both the registrant survey free text comments and stakeholder focus groups and interviews, concerns over the safety of the non-registered workforce were raised and alongside this, the apparent NHS centricity of discussions and documents relating to advanced level practice. As a result, a number argued that the focus of new regulation should be standardisation of education and practice for these non-registered groups where they perceived greater risk to the public, rather than advanced level practice although it is accepted that this would require parliamentary approval.

Limitations

This research has a number of limitations that need to be acknowledged when interpreting and applying the findings. While the registrant survey attracted more than 3000 responses, this only represented 1.3% of total HCPC registrants with no professional group attracting a respondent volume greater than 2.9% of registered professionals. The purpose of the survey was to gather the perspectives of those interested in, aspiring to be or working at an advanced level of practice and it may be that the large majority of registrants meeting these criteria completed the survey. However, there is currently no accurate register of persons working at an advanced level across the public, private and independent sectors and differing professions and we have to assume that the findings reflect current registrant opinion. Importantly, the research has identified that use of Agenda of Change pay band as a proxy for advanced level practice does not capture the real picture of activity calling into question this approach to quantifying the volume of advanced level practitioners.

Focus group participants volunteered or self-selected to participate in this study and therefore motivation for participation should be considered when interpretating the findings. It may be that participants had particularly strong views or opinions, and this may have unduly influenced the data although techniques to ensure all everyone had opportunity to contribute were adopted. Similarly, it is uncertain how confident participants felt to share their opinion or reflect on experience within the online focus group environment. Importantly, some groups had fewer participants than expected. In particular, employer participation was disappointing despite a large number of volunteers initially.

Conclusion

The findings of this research have identified that advanced level practice activities were varied both within and across HCPC registered professional groups in terms of both clinical undertaking and practice environment. As such, describing advanced level practice in terms of roles and activities that might be evident to patients and the public is complex. While the majority of participants in this research were AHPs, data from Scientists and Practitioner Psychologists also confirmed the complexity of defining advanced level practice and the conflation of terms with the role of advanced or consultant practitioner. This lack of clarity and consensus in understanding of the term 'advanced level practice' combined with uncertainty over breadth of professional scope of practice may explain the large number of participants from across professional groups who described their practice as being beyond the traditional scope of their registered profession. This was particularly, but not exclusively, true for new clinical roles developed as medical support roles and confusingly being referred to as 'Advanced Clinical Practitioner' or ACP roles.

The purpose of regulation is to protect the public from poor or inappropriate practice and improve public confidence by setting standards of education and practice to be adhered to. Currently, the term used to describe the standard of education required to support advanced level practice is 'Masters level or equivalent' but no participant or stakeholder group could easily define or explain what this means in a multi-professional context, and differing interpretations, expectations and achievements were reported. As a result, an advantage of additional regulation for advanced level practice would be the consistent and equal expectations in terms of education and governance, particularly where multiple professional groups are undertaking the same role, all be it with a differing professional educational foundation and lens. However, while some participants felt regulation was essential to assure education and practice standards and reduce risk of role title misuse, there was equally a lack of appetite for regulation that lacked agility to respond to, and reflect, the rapidly changing healthcare environment and evolving scope of advanced practice. Importantly, access to appropriate advanced practice education was not equitable across professional groups with some groups being particularly disadvantaged due to small numbers and wide geographic disparity. The move to online education as a consequence of COVID-19 19 may assist in alleviating this disparity and improving access to education but work is required to ensure ongoing funding and employer support for advanced practice education beyond the acquisition of clinical skills.

No evidence was presented from any participant group that advanced level practice presents a greater risk to the public. While evidence from a single coroner report [44,45] intimates that the governance of advanced level nursing practice may present a risk to patient safety, no evidence was identified suggesting this is true for HCPC regulated professions. This could reflect the lack of consideration of advanced practice within reporting of practice failures or could represent the small number of practitioners working at an advanced practice level. Consequently, to understand the real risk to public, more detailed data and exploration of reporting systems is required. This should include details of the number of advanced level practitioners across the 4 countries of the UK to enable the incidence and prevalence of patient safety events to be accurately determined and compared with general registrant incident volumes.

The study data presented in this report reflects the complexity of the concept of advanced level practice across the HCPC registered professions. Much of this is as a consequence of the differing speeds of professional scope development across healthcare organisations, sectors and professional groups, often related to service capacity gaps and locally developed education to support local initiatives. Importantly, the findings of this research suggest that while there was evidence of registrant appetite for additional regulation of advanced level practice, this was not consistent across professions, roles or grades. Further, no evidence, with respect to HCPC regulated professions, was found to support the premise that additional regulation is needed to protect the public as is the purpose of regulation, although other benefits of additional regulation or annotation have been outlined. However, as the HCPC is one of the few organisations with a multi-sector UK wide remit, it may have a role in advocating unification across the four nations of the UK in relation to the future expectations, educational standards, and governance of advanced level practice.

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References

1. McPherson K, et al. A systematic review of evidence about extended roles for allied health professions. *J Health Serv Res Policy* 2006; 11:240-7.

2. Evans C, et al. Characterising the evidence base for advanced clinical practice in the UK: A scoping review protocol. *BMJ Open* 2020; 10:e036192

3. McGee P, et al. *Advanced Practice in Healthcare: Dynamic Developments in Nursing and Allied Health Professions*. 4th edn. 2019. Oxford: Wiley.

4. Copnell G. Modernising allied health professions careers: Attacking the foundations of the professions? *Journal of Interprofessional Care* 2010; 1: 63-9.
5. Scottish Government. *Transforming nursing, midwifery and health professions roles: Introduction.* 2017. Scotland: CNOD. Accessed 3rd July 2020. Available at: https://www.gov.scot/binaries/content/documents/govscot/publications/corporate-report/2017/12/transforming-nursing-midwifery-health-professions-roles-introduction/documents/00529745-pdf/00529745-pdf/govscot%3Adocument/00529745.pdf

6. Health Education England. *Multiprofessional Framework for Advanced Clinical Practice.* 2017. London: Health Education England. Accessed 3rd July 2020. Available at: https://www.lasepharmacy.hee.nhs.uk/dyn/_assets/_folder4/advanced-practice/multi-professionalframeworkforadvancedclinicalpracticeinengland.pdf

7. Department of Health (NI). *Advanced AHP Practice Framework*. 2019. Accessed 3rd July 2020. Available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/AHP-Framework.pdf

8. National Leadership and Innovation Agency for Healthcare Framework for Advanced Nursing, Midwifery and Allied Health Professional Practice in Wales. 2011. Accessed 3rd July 2020. Available at: https://www.wales.nhs.uk/sitesplus/documents/829/NLIAH%20Advanced%20Practice%20Framework.pdf

9. UK Health Departments. *Modernising Scientific Careers – The UK way forwards*. 2010. London: DoH. Accessed 3rd July 2020. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138326/dh_113990.pdf

10. Hardy M, et al. The concept of advanced radiography practice: an international perspective. *Radiography* 2008; 14:e15-e19

11. Imison, C., Castle-Clarke, S. and Watson, R., 2016. Reshaping The Workforce To Deliver The Care Patients Need. [online] The Nuffield Trust. Accessed 20 October 2020. Available at: https://www.nuffieldtrust.org.uk/research/reshaping-the-workforce-to-deliver-the-care-patients-need

12. Milner, R.C. and Snaith, B., 2017. Are reporting radiographers fulfilling the role of advanced practitioner? *Radiography,* 23(1), pp.48-54.

13. Bryant-Lukosius, D., DiCenso, A., Browne, G. and Pinelli, J., 2004. Advanced practice nursing roles: development, implementation and evaluation. *Journal of advanced nursing*, 48(5), pp.519-529.

14. East, L., Knowles, K., Pettman, M. and Fisher, L., 2015. Advanced level nursing in England: organisational challenges and opportunities. *Journal of nursing management*, 23(8), pp.1011-1019.

15. Gilmore, L.G., Morris, J.H., Murphy, K., Grimmer-Somers, K. and Kumar, S., 2011. Skills escalator in allied health: a time for reflection and refocus. *Journal of Healthcare Leadership*, 3, pp.53-58.

16. Sevens, T.J. and Reeves, P.J., 2019. Professional protectionism; a barrier to employing a sonographer graduate? *Radiography*, 25(1), pp.77-82.

17. Kennedy, C., Brooks Young, P., Nicol, J., Campbell, K. and Gray Brunton, C., 2015. Fluid role boundaries: exploring the contribution of the advanced nurse practitioner to multi-professional palliative care. *Journal of Clinical Nursing*, 24(21-22), pp.3296-3305.

18. General Dental Council. 2019. Scope Of Practice. [online] Accessed 18 October 2020. Available at: https://www.gdc-uk.org/information-standards-guidance/standards-and-guidance/scope-of-practice

19. Skills for Health. 2020. Core Capabilities Framework For Advanced Clinical Practice (Nurses) Working In General Practice / Primary Care In England. [online] Accessed 26 October 2020]. Available at: https://www.skillsforhealth.org.uk/services/item/724-advanced-clinical-practice-core-capabilities-for-nurses-working-within-general-practice-settings-in-england

20. Swan, M., Ferguson, S., Chang, A., Larson, E. and Smaldone, A., 2015. Quality of primary care by advanced practice nurses: a systematic review. *International Journal for Quality in Health Care*, 27(5), pp.396-404.

21. NHS Digital. 2019. Advanced Practitioners- Staff Group And Care Setting May 2019 AH2939 - NHS Digital. [online] NHS Digital. Accessed 26 October 2020. Available at: https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2019-supplementary-information-files/advanced-practitioners--staff-group-and-care-setting-may-2019-ah2939

22. NHSE. 2019. NHS England » NHS Five Year Forward View. [online] Accessed 26 October 2020. Available at: https://www.england.nhs.uk/five-year-forward-view/

23. Richards, M., 2020. Diagnostics: Recovery and Renewal. [online] England.nhs.uk. Accessed 25 October 2020. Available at: https://www.england.nhs.uk/wp-content/uploads/2020/10/BM2025Pu-item-5-diagnostics-recovery-and-renewal.pdf

24. Saxon, R.L., Gray, M.A. and Oprescu, F.I., 2014. Extended roles for allied health professionals: an updated systematic review of the evidence. *Journal of multidisciplinary healthcare*, 7, p.479.

25. Hardy M et al. Does radiography advanced practice improve patient outcomes and health service quality? A systematic review. The British Journal of Radiology, 2016; 89:1092

26. NICE . 2018. Overview | Emergency And Acute Medical Care In Over 16S: Service Delivery And Organisation | Guidance | NICE. [online] Accessed 26 October 2020. Available at: https://www.nice.org.uk/guidance/NG94

27. Henderson, I., Mathers, S.A., McConnell, J. and Minnoch, D., 2016. Advanced and extended scope practice of radiographers: the Scottish perspective. *Radiography*, 22(2), pp.185-193.

28. Kessler, I. and Nath, V., 2019. Re-evaluating the assistant practitioner role in NHS England: Survey findings. *Journal of nursing management*, *27*(3), pp.625-632.

29. Gregory, W.J. and Jones, A.K.P., 2020. "Practitioner Substitution": replacing a retiring consultant rheumatologist with an appropriately skilled advanced practice Physiotherapist: a 12-month evaluation. *Physiotherapy*, 107, pp.e124-e125.

30. THE FRAMEWORKS FOR HE QUALIFICATIONS OF UK DEGREE-AWARDING BODIES Publication Date: 03 Nov 2014. Accessed 28th October 2020. Available at: https://www.qaa.ac.uk/docs/qaa/quality-code/qualifications-frameworks.pdf

31. Jones, A., Powell, T., Watkins, D. and Kelly, D., 2015. Realising their potential? Exploring interprofessional perceptions and potential of the advanced practitioner role: a qualitative analysis. *BMJ open*, 5(12).

32. Madi, M., Hamzeh, H., Griffiths, M., Rushton, A. and Heneghan, N.R., 2019. Exploring taught masters education for healthcare practitioners: a systematic review of literature. *BMC medical education*, 19(1), p.340.

33. Health Education England. 2020. Advanced Practice. [online] Accessed 26 October 2020. Available at: https://www.hee.nhs.uk/our-work/advanced-clinical-practice

34. The Royal College of Nursing. 2020. Credentialing | Professional Development | Royal College Of Nursing. [online] Accessed 26 October 2020. Available at: https://www.rcn.org.uk/professional-development/professional-services/credentialing

35. RCEM. 2018. Emergency Care ACP. [online] Accessed 26 October 2020. Available at: https://www.rcem.ac.uk/RCEM/Exams_Training/Emergency_Care_ACP/Emergency_Care_ACP.aspx?WebsiteKey=b3d6bb2a-abba-44ed-b758-467776a958cd&hkey=8244ccaf-e85a-4b1e-8f8d-152484810137&New_ContentCollectionOr

36. Thompson, J., McNall, A., Tiplady, S., Hodgson, P. and Proud, C. 2019. Whole systems approach. *J Health Organ Manag.* Jun 28;33(4):443-459. doi: 10.1108/JHOM-11-2018-0337.

37. Society and College of Radiographers advanced practitioner accreditation. Accessed 28th October 2020. Available at: https://www.sor.org/career-progression/advanced-practitioners/advanced-practitioner-accreditation

38. Crouch, R. and Brown, R., 2018. Advanced clinical practitioners in emergency care: past, present and future. *British Journal of Hospital Medicine*, 79(9), pp.511-515

39. HCPC 2020. HCPC What We Do. [online] Accessed 16 October 2020. Available at: https://www.hcpc-uk.org/about-us/what-we-do/

40. Professional Standards Authority. 2009. Advanced Practice: Report To The Four UK Health Departments. [online] Accessed 26 October 2020. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/advice-to-ministers/advanced-practice-2009.pdf?sfvrsn=38c67f20_6

41. Topol, E., et al. 2019. The Topol Review — NHS Health Education England. [online] The Topol Review — NHS Health Education England. Accessed 23 October 2020. Available at: https://topol.hee.nhs.uk/

42. NMC. 2020. Developing Our New Strategy For 2020-2025. [online] Accessed 20 October 2020. Available at: https://www.nmc.org.uk/about-us/shaping-the-future/shaping-the-future-close/

43. GMC, 2020 Accessed 28th October 2020. Available at: https://www.gmc-uk.org/pa-and-aa-regulation-hub/map-regulation

44. Patient Safety Learning. 2020. Learning From Prevention Of Future Deaths Reports - Patient Safety Learning. [online] Accessed 23 October 2020. Available at: https://www.patientsafetylearning.org/blog/learning-from-prevention-of-future-deaths-reports

45. Judiciary. 2016. Benjamin Orrill. [online] Accessed 25 October 2020. Available at: https://www.judiciary.uk/publications/benjamin-orrill/

46. Judiciary. 2017. [online] Accessed 25 October 2020. Available at: https://www.judiciary.uk/wp-content/uploads/2016/10/2016-0367-Response-by-NMC.pdf

47. World Health Organisation. 2020. WHO Governance. [online] Accessed 24 October 2020. Available at: https://www.who.int/healthsystems/topics/stewardship/en/

48. HCPC 2019. Fitness To Practise Annual Report 2019. [online] Accessed 20 October 2020. Available at: https://www.hcpc-uk.org/about-us/insights-and-data/ftp/fitness-to-practise-annual-report-2019/

49. NHS Providers. 2018. Making The Most Of The Money: Efficiency And The Long-Term Plan. [online] Accessed 24 October 2020. Available at: https://nhsproviders.org/making-the-most-of-the-money-efficiency-and-the-long-term-plan

50. Spence, D., 2016. Reducing general practice workload. *British Journal of General Practice*, 66(649), pp.431-431.

51. Harding, K.E. and Bottrell, J., 2016. Specific timely appointments for triage reduced waiting lists in an outpatient physiotherapy service. *Physiotherapy*, 102(4), pp.345-350.

52. NHS. 2019. NHS Long Term Plan. [online] Accessed 19 October 2020. Available at: https://www.longtermplan.nhs.uk/

53. Gill, S.D., Stella, J. and McManus, L., 2019. Consumer preferences regarding physiotherapy practitioners and nurse practitioners in emergency departments–a qualitative investigation. *Journal of interprofessional care*, 33(2), pp.209-215.

54. Evans, C., Pearce, R., Greaves, S. and Blake, H., 2020. Advanced Clinical Practitioners in Primary Care in the UK: A Qualitative Study of Workforce Transformation. *International journal of environmental research and public health*, 17(12), p.4500.

55. Timmons, S. and East, L., 2011. Uniforms, status and professional boundaries in hospital. *Sociology of health & illness*, 33(7), pp.1035-1049.

56. Thomas, N. Nurse practitioner consultations in primary health care: A case study-based survey of patients' pre-consultation expectations, and post-consultation satisfaction and enablement. *Prim. Health Care Res. Dev*. 2018, 1–8.

57. Gerard, K.; Tinelli, M.; Latter, S.; Blenkinsopp, A.; Smith, A. Valuing the extended role of prescribing pharmacist in general practice: Results from a discrete choice experiment. *Value Health* 2012, 15, 699–707

58. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative research in Psychology*, 2006; 3(2):77-101.

59. HCPC. Why your registration matters. Accessed 9th October 2020. Available at: https://www.hcpc-uk.org/registration/your-registration/why-your-registration-matters/

Appendix 1: Advisory Board Organisations

Advanced Practitioner AHP

Advanced Practitioner Healthcare Scientist

Association of Advanced Practice Educators

Department of Health, Northern Ireland

Health Education England (HEE)

NHS Education for Scotland

NHS Employers

Patient & Public (PPI) Representative

Council of Deans for Health

HCPC

Appendix 2: Advanced Practice Activity

Examples of Advanced Practice activity and environment as described by WP1 survey participants across the 4 UK countries by profession

NB: Every unique description of advanced practice activity or environment has been listed within the tables below to capture breadth of advanced practice across HCPC regulated professions. Statements exclude those from dual registered respondents to remove uncertainty over which role the practice related to. Statements have not been amalgamated or summarised to ensure no errors in interpretation due to misunderstanding of professional language and nuance occurred. Where practice was considered advanced or out of the traditional scope of registered profession due to practice environment, without clarification of activity, this has also been stated.

Advanced Practice Activity – Arts Therapists			
England (n=16)	**Northern Ireland (n=0)**	**Scotland (n=0)**	**Wales (n=0)**
In Scope (13) Not stated Out of Scope (3) Autism Tutor and clinical supervisor in a training for child and adolescent integrative arts counselling psychotherapy Perinatal Mental Health (please note I am also a Registered Nurse)			

Advanced Practice Activity – Biomedical Scientists			
England (n=51)	**Northern Ireland (n=3)**	**Scotland (n=1)**	**Wales (n=5)**
In Scope (34) Refer for imaging investigations Undertake interventional procedures Advise clinicians on suitable blood products, interpret clinical impact of test results and authorise use of certain blood products Clinical reporting and MDT Diagnose slides in cellular pathology Dissecting & Reporting Dissection and reporting of histological sections Dissection and reporting of Histopathology specimens I dissect surgical specimens then microscopically examine resultant slides, and interpret histology before preparing a histology report (diagnosis Pre report cytopathology samples Referring patients for further intervention Refer for colposcopy or gynaecological investigations for cervical cytology and make diagnoses for non-gynaecological cytology Report cervical samples and make patient management decisions Report malignant and non-malignant cases for diagnostic cytology Tissue dissection in histology Undertake clinical interpretation of immunology laboratory results within agreed scope of practice with Consultant medic Use Patient Group Directive (prescribing)	In Scope (1) Not stated Out of Scope (2) Dissection in Pathology (Dissect cancer specimens) Histological dissection of cancer specimens and reporting of macroscopic description	In Scope (0) Out of Scope (1) Specimen Dissection	In Scope (3) not stated Out of Scope (2) Histopathology Workplace and forensic drug testing

<u>Out of Scope (17)</u> Refer for imaging investigations Undertake interventional procedures Dissection of specimens for diagnosis, trainee in histopathology reporting Blood testing Bone marrow morphology Interpret and describe the electron microscopy subsection of the histopathology biopsy report. Assist interpretation of electron microscopy from pathologists (locally, nationally and internationally). Cytology: Interpret morphological changes and molecular test results to promote patient follow-up/management and treatment Design diagnostic pathways in pathology and clinical interpretation/reporting of complex results Gastro-intestinal histopathology reporting/diagnosis Gynae cytology: BMS staff were not traditionally allowed to report abnormal material or manage patients – now participate in MDT and suggest management plans including imaging Gynaecological histopathology: Report histopathological material. Histopathology Reporting: Dissection, interpretation and reporting of biopsy and resection specimens for Histopathology Non-lab based clinical transfusion			

Own OPD patient case load: Clinic consultancy and advice, refer to other clinical specialities Pharmaceutical Microbiology Report Cellular pathology cases Specimen dissection: Examine and dissect specimens for histology processing. Training to report histology specimens General practice			

Advanced Practice Activity – Chiropodists/Podiatrists The activity of 5 respondents working outside of 4 countries of UK is not listed			
England (n=77)	**Northern Ireland (n=3)**	**Scotland (n=10)**	**Wales (n=5)**
<u>In Scope (n=45)</u> Use a patient group direction (PGD) Prescribe supplementary Prescribe independently Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Undertake surgical procedures Assessment and treatment of lower limb condition requiring the use of compression bandaging/compression hosiery Casting. Request bloods. Educate Hydrosurgical debridement Supply/ administer medicines on POMs annotation Toenail surgery routinely in community setting injecting local anaesthesia. Use Podiatry exemptions to the prescription only medicines (human use) order <u>Out of Scope (n=32)</u> Use a patient group direction (PGD) Prescribe supplementary Prescribe independently Refer for imaging investigations	<u>In Scope (n=3)</u> Use a patient group direction (PGD) Prescribe supplementary Prescribe independently Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Undertake surgical procedures <u>Out of Scope (n=0)</u>	<u>In Scope (n=6)</u> Use a patient group direction (PGD) Prescribe independently Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. <u>Out of Scope (n=4)</u> Use a patient group direction (PGD) Prescribe independently Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Civil and Criminal Justice systems Orthopaedics and diabetes Vascular Rheumatology podiatry with diagnostic ultrasound	<u>In Scope (n=3)</u> Prescribe independently Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. <u>Out of Scope (n=2)</u> Prescribe independently Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Vascular specialism Tissue viability Wound care High risk diabetic foot Orthopaedics and Radiology with ultrasound

Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Undertake surgical procedures Aesthetics Clinical leadership / service management, HEE lecturer role Independent researcher & NHS PI Injection Therapy Casting, advanced wound therapy List for surgical procedures to be undertaken by consultant ortho colleague POMS Acupuncture Shockwave Hyaluronic injections Refer to other health professionals including many you guys [HCPC] don't regulate Total contact casting Negative wound treatment Various types of injections Administration of IV meds Biomechanics and mobility in relation to wound care and Lymphoedema Assist consultant orthopaedic surgeon in theatre Diagnostic Ultrasound and Steroid Injections Emergency medicine/trauma General and Acute Medicine of the whole body. I work on a general medical ward and currently we are serving as an acute medical unit.			

High risk and diabetic foot High risk lower limb podiatry I assess lots of knees, and I'm a podiatrist! Injection therapies including PrP etc Medical ultrasound Often I am recommending complimentary therapies to run alongside more traditional approaches to get best outcome for the client Orthopaedic triage in primary care and secondary care (the latter leading to listing for surgery) Podiatric Surgery Podiatric surgery in itself is evolving and working increasingly in the acute sector integrated within vascular surgery to creating limb salvage teams for the diabetic and non-diabetic at risk lower limb. Working in General Practice as a specialist generalist.			

Advanced Practice Activity – Clinical Scientist The activity of 2 respondents working outside of 4 countries of UK is not listed			
England (n=77)	**Northern Ireland (n= 0)**	**Scotland (n=8)**	**Wales (n=6)**
<u>In Scope (n=68)</u> Use a patient group direction (PGD) Prescribe (supplementary) Prescribe (independent) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Undertake surgical procedures Chest drain insertion Sengstaken tube insertion Department and trust governance and SOP Give expert scientific & technical advice to clinicians, nurses, scientists, other staff groups, and patients & families. Take part in clinical related tasks such as joint reporting & dose calculations for prescribing & post treatment assessments. I have clinical responsibility for the laboratory and POCT tests in the hospital. I have a close working relationship with clinicians. Our clinical input is largely knowledge based but also scientific / technical. Prepare post mortem toxicology reports for HM Coroners and Pathologists. Prepare child protection reports based on drug screening results. Advise a wide range of professionals on the meaning of drug screening results. Liaise with Public Health and Police with regards to drug substance analysis		<u>In Scope (n=7)</u> Use a patient group direction (PGD) Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Manufacture diagnostic medicines Ensure the appropriate operation, selection, and interpretation of biochemical testing. <u>Out of Scope (n=1)</u> Sonographer	<u>In Scope (n=5)</u> Consultant advisory role in medical imaging and optical medicine IR(ME)R medical physics expert <u>Out of Scope (n=1)</u> Biochemistry /IT/Research

Principally concerned with radiation dosimetry and image optimisation including assessment of benefit and risk for research ethics submissions Provide clinical advice on treatment based on diagnostic test results Recognised as MPE and on RPA2000 register. Give specialist advice on the treatment of patients. Refer for investigations e.g. echo, bloods, pfts Report nuclear medicine images Report non-imaging investigations Lead scientific improvement and research Lead large equipment commissioning programmes Vestibular repositioning treatment for BPPV <u>Out of Scope (n=9)</u> Refer for imaging investigations I monitor and investigate outbreaks of health care associated infection, making recommendations at local and national level to reduce risk through building design, clinical practice and effective decontamination (environmental and medical equipment or medical devices) Quality control/ difficult clinical cases/ teaching of radiographers and cardiologists trying to get the best results out of CMR patients. Undertake diagnostic investigations, clinically assess the patient and escalate for consideration for surgery Infection Prevention- having trained in diagnostic microbiology			

Rather narrow specialisation in cardiac MRI physics. Cardiology Acute non invasive ventilation, ventilation clinics, NIV supported PEGs Audiology. Working autonomously within ENT Forensic Toxicology Histopathology reporting There are very few Haematology consultant clinical scientists and even fewer working in direct patient care outside pathology Toxicology			

Advanced Practice Activity – Dietician			
England (n=37)	**Northern Ireland (n=5)**	**Scotland (n=5)**	**Wales (n=5)**
<u>In Scope (n=24)</u> Use a patient group direction (PGD) Prescribe (supplementary) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. <u>Out of Scope (n=13)</u> Use a patient group direction (PGD) Prescribe (supplementary) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Refer for biochemistry/allergy blood tests Undertake skin prick testing Order and interpret blood results & advice on medication and procedures Just completing my NMP Venepuncture and canulation Day time on call - advise on emergency management to ED and ITU nationally	<u>In Scope (n=4)</u> Use a patient group direction (PGD) Prescribe (supplementary) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc <u>Out of Scope (n=1)</u> Use a patient group direction (PGD) Refer for imaging investigations Gastroenterology medical remit Phlebotomy	<u>In Scope (n=5)</u> Use a patient group direction (PGD) Refer for imaging investigations Request bloods <u>Out of Scope (n=0)</u>	<u>In Scope (n=3)</u> Use a patient group direction (PGD) Prescribe (supplementary) <u>Out of Scope (n=2)</u> Prescribe (supplementary) Mental health and eating disorders Not currently but would like to develop psychotherapy role further once qualified as a Group Analyst

Advanced Practice Activity – Hearing Aid Dispenser			
England (n=5)	**Northern Ireland (n= 0)**	**Scotland (n=1)**	**Wales (n=0)**
<u>In Scope (n=3)</u> Prescribe (independent) <u>Out of Scope (n=2)</u> Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Ear Nose and Throat Hearing Aid Dispensers generally focus on hearing instruments, and technology. As a Hearing Therapist I additionally provide specialist counselling and rehabilitation therapy		<u>In Scope (n=1)</u> Not stated	

Advanced Practice Activity – Occupational Therapist The activity of 1 respondent working outside of 4 countries of UK is not listed			
England (n=88)	**Northern Ireland (n=4)**	**Scotland (n=14)**	**Wales (n=5)**
In Scope (n=55) Use a patient group direction (PGD) Prescribe (supplementary) Prescribe (independent) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Assist Medical Consultant with therapeutic injections, co-report on imaging, administer and interpret neuropsychological tests Complete physical assessments and discuss/agree plan with CNS or consultant. Complete virtual/remote ward rounds for care homes. I refer to a GP for prescribing and diagnoses. Project Management and Consultancy, Coaching, Adaptive Leadership, Governance, Learning and development Out of Scope (n=33) Use a patient group direction (PGD) Prescribe (supplementary) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Undertake surgical procedures Assess and advise on major home adaptations	In Scope (n=2) Out of Scope (n=2) Use a patient group direction (PGD) Refer for imaging investigations Specialist personality disorder service Psychological interventions Hand therapy	In Scope (n=9) Out of Scope (n=5) Use a patient group direction (PGD) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc Hand and upper limb trauma Hospital at home doing full clinical assessments Huntington's disease I work as a psychological therapist Older peoples medicine	In Scope (n=5) not stated Out of Scope(n=0)

I have been shadowing my medical professional colleagues on their ward rounds and having some hands on physical examination experience, but very little which is disappointing I support diagnostic pathways and prescribe AAC solutions List patients for surgery Request blood tests Request support from GPs and nurses for prescribing specialist items (via FP10) as well as guiding them in the application process so that patients can access relevant further investigations and access to NHS specialist funded care. Suture removal K wire removal Take bloods, recommend prescriptions, refer for hospital admission Undertake specialist vocational assessments (e.g. Functional Capacity Evaluations) Venepuncture Catheter insertion Wound management Strength and Balance Service Advanced clinical assessment, diagnostics, interpretation and diagnosis. Although my main role is within the traditional sphere I also work on Ambulatory Care which I would never have as an OT. Medically assessing acutely unwell patients.			

Augmentative and Alternative Communication Case Management - brain injury Currently the only therapist in an in reach service, all other colleagues are nursing, also trained as a peer vaccinator Eating Disorders & Psychological Therapy Services (WAA and CAMHS) Frailty Hand therapy Housing Adaptation Team within the Housing Dept Housing Regeneration, new build design/access consultancy I spend one day a week working with the medical team on acute frailty unit. Then 3 days a week as an OT in rapid response. My MSc course requires me to work with the medical team and has a very medical focus. The course I'm on is validated by the NMC and is very task specific to nursing tasks and the ANP role. I work within an integrated Crisis Response service working with NWAS, hospitals, GPS and community staff to safely manage acutely unwell patients in the community In Reach Advanced Practice role working from a local hub. My role is generic and not occupational therapy focused, although I have the core profession of OT Injection therapy Lead Motor Neurone Disease Care Centre Coordinator			

My specialist interest is in oedema reduction, management and long term condition control. I work with a varied group of patients with conditions under the "generalised oedema umbrella" incl. conditions such as Primary and Secondary Lymphoedema, Lipoedema and Lipo-Lymphoedema. This also involves comprehensive knowledge and skills for using compression therapy and working to heal scars and / or fibrotic tissue. Orthopaedic outpatients, predominantly lower limb Palliative care, non-pharmacological symptom management, hypnosis Primary care general practice Rehabilitation but sometimes the roles are more Physio or SALT because of the lack of professional in that role Rheumatology Sensory Integration Stroke inpatients with a heavy medicine bias Test and trace Urgent care/acute medicine Vocational Rehabilitation Work in Admission Prevention Team in ED, Community and Ambulance. Creating a new role with ACP/OT within Team			

Advanced Practice Activity – Operating Department Practitioner The activity of 1 respondent working outside of 4 countries of UK is not listed			
England (n=66)	**Northern Ireland (n=0)**	**Scotland (n=1)**	**Wales (n=0)**
<u>In Scope (n=24)</u> Use a patient group direction (PGD) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Undertake surgical procedures enhanced SFA suturing, local anaesthetic, direct diathermy drain fixation suction Perform Sub Tenon Anaesthesia in Ophthalmic Procedures covered under ALS provider status including administration of Emergency IV drugs covered under EMA PSD, Canulation and Intubation Surgical First Assistant with extended scope of practice; Surgical First Assistant in Robotic surgery Induction, maintenance and emergence of anaesthesia. Insertion vascular access devices Induce & maintain anaesthesia Perform regional anaesthesia Insert picc lines <u>Out of Scope (n=42)</u> Use a patient group direction (PGD) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Undertake surgical procedures		<u>In Scope (n=1)</u> Undertake surgical procedures	

Minor interventions e.g. opening of surgical wound on ward, insertion of catheters into stomas, cannulation, phlebotomy, abgs Invasive line insertions, central and peripheral. Insert chest drains, intubate, perform echocardiography and ultrasound and independently interpret them (to name a few) Use PSDs as unable to access prescribing as an ODP Assessment and implementation of treatment plans - assess sick patients At the moment not independently but participate in surgical procedures and interventional procedures. I perform PICC line insertions under ultrasound guidance. As I am NOT able to prescribe at present this has a huge impact on my development in the role (significant reduces my chances compared to my colleagues who can). However, I am trained to undertake interventions such as lumber puncture, and insertion of drains. A&E 1 Accident and Emergency (as Clinician) Acute Medicine and Emergency Care Advanced Critical Care Practitioner Adult Intensive Care Anaesthesia associate Based on Ortho Trauma Ward Bowel screening and Endoscopy Breast surgery and oncoplastics but I know work also within clinics, surgical assessment units, theatres and wards Breast/General surgery			

Cardiothoracic Surgery Clinics Critical Care Emergency Department Endoscopist ENT General clinics and surgery Hand surgery HPB a& transplant I am a vascular access practitioner I am based on an Orthopaedic Trauma Ward - there are very few ward based ODPs I spend half of my day on a trauma ward I work on surgical assessment unit as well as theatres Intensive and Critical Care Mainly on surgical wards, surgical triage and clinics Obstetrics and gynaecology employed by medical staffing as surgical care practitioner Operating theatres Organ retrieval's, clinics and ICU Orthopaedic ACP Orthopaedics including theatre, ward and clinic duties patient clinics, ward rounds Phase One Pharmacological Research Resuscitation practice Site Practitioner Surgery, including theatres, clinics wards and assessment units Surgical ward Outpatient Department - Surgical field			

Vascular surgery wards & clinics Working as a Surgical Care Practitioner but registered as a ODP			

Advanced Practice Activity – Orthoptist 28 The activity of 1 respondent working outside of 4 countries of UK is not listed			
England (n=24)	**Northern Ireland (n= 0)**	**Scotland (n=1)**	**Wales (n=2)**
<u>In Scope (n=9)</u> Use a patient group direction (PGD) Refer for imaging investigations <u>Out of Scope (n=17)</u> Use a patient group direction (PGD) Prescribe (supplementary) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. I supply medications under exemptions for orthoptists instil some drops with consultant authorisation first post operative wound care Undertake delegated consent YAG laser posterior capsulotomy Eye Theatres General medicine route Glaucoma Medical retina Medical Retina Uveitis Screening Botulinum To Oculoplastics Orthoptic Led Shared Care Glaucoma Clinic Orthoptics Paediatric ophthalmology anterior surface disease clinics Paediatric ophthalmology, cornea and		<u>In Scope (n=0)</u> <u>Out of Scope (n=1)</u> Just passed the GC University course in prescribing certain medications but not generally used in the clinics I am involved in Neurology specifically IIH	<u>In Scope (n=0)</u> <u>Out of Scope (n=2)</u> Use a patient group direction (PGD) Refer for imaging investigations Use of Medical exemptions (and annotated on the register) having completed a post graduate course at University of Liverpool I now diagnose and manage glaucoma patients Orthoptist but working in ophthalmology medical retina clinics

anterior segment Stroke Stroke area Visual Processing Disorders Stroke Vitreo Retinal			

Advanced Practice Activity – Paramedic			
England (n=395)	**Northern Ireland (n=3)**	**Scotland (n=28)**	**Wales (n=25)**
In Scope (141) Use a patient group direction (PGD) Prescribe independently Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Undertake surgical procedures Out of Scope (254) Use a patient group direction (PGD) Prescribe independently Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Undertake surgical procedures Accident and Emergency department, working in majors and resus with extended skills using the Royal College of Emergency Medicine practice scope for Advanced Care Practitioner in Emergency Medicine ACP paramedic working in GP surgery Acute home visits. Admission avoidance Acute medicine and Community Crisis Team Advanced clinical skills in comparison to other paramedics. Advanced practice within ED/UTC/MIMI Air Ambulance Also work privately within the Event Medical and Festival environment. Cardiothoracic Critical care and anaesthetics	In Scope (1) Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Undertake surgical procedures Out of Scope (2) Pre-hospital Care: prescribe (independently) and undertake surgical procedures.	In Scope (9) Use a patient group direction (PGD) Prescribe independently Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Undertake surgical procedures Out of Scope (19) Use a patient group direction (PGD) Prescribe independently Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Undertake surgical procedures Clinical governance, patient safety and human factors. Day to day triage, assessment over the phone, video consultation, prescribing & referring patients to other specialist	In Scope (12) Use a patient group direction (PGD) Prescribe independently Refer for imaging investigations Undertake surgical procedures Out of Scope (13) Use a patient group direction (PGD) Prescribe independently Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Undertake surgical procedures Lymphoedema and cellulitis GP in hours, out of hours and emergency cover rota Primary care, undifferentiated conditions including minor illness Senior Trauma Paramedic - Ketamine/ Midazolam/ Flumazenil PGD's, Thoracostomy & Surgical Airway. BASICS - Sedation & RSI Assist, Thoracostomy & Surgical Airway. Resuscitative

Clinical Safety in Medical Device development and implementation in clinical practice Community crisis MDT Community matron team / GP hub Covering GP shifts for out of hours urgent care service. Emergency Medicine ED-based with NMP prescribing qualification Gastroenterology General practice, working at advanced level. Seeing and managing acute and long term illnesses and minor injuries. Hazardous area clinical response at the inner cordon/hot zone of medium/high incidents. Head of walk-in centre and OOH service, practicing in the same traditional walk-in centre Nurse/GP work. Helicopter Critical Care Paramedic/HEMS Hospice sector Hospital at home / Complex and Aging Medicine I also work in functional and nutritional medicine I'm also a NMC registered nurse and use knowledge and skills acquired from both my professions to complete my current role. Initially working in hospital in specialist medicine and oncology role. Now working in acute and emergency care (in hospital) Intensive care/critical care Medicine for Older People/ Frailty Mental Health		Emergency and non emergency GP Practice/Primary Care Work ED & ICU Minor injuries unit and ambulance Rotate through primary care, control centres and pre-hospital emergency medicine Telephone triage with less urgent patient decision making to treat at home rather than transfer to hospital Telephone triage and out of hours GP rota and GP house calls	Thoracotomy & amputation assist Community geriatrics

Myriad of Primary Health care, urgent care and Prehospital care. Force protection and environmental health. Neonatal intensive care retrieval Neuroscience Intensive Care Neurosurgery not ambulance based primary care setting up a frailty team Palliative Care Prison healthcare Search and Rescue Emergency Medicine Stroke medicine My scope of practice is very similar to that of a CT level doctor at the moment, whilst also learning many new skills which cover a variety of professions. For example, in addition to cannulation we are now taking arterial blood gases, venepuncture, catheters which are nursing based tasks. We are now moving on to more advance procedure such as lumbar punctures, chest drains and ascitic taps. These tasks are beyond the original scope of the paramedic but are possible due to local policies which authorise us to do these procedures. However, our scope is quite vast and varies between specialities, therefore it would be a challenge to regulate this activity although I think it would be regulated. Urgent care since 2008 injury and illness for all ages see treat discharge or admit to receiving hospitals Xray, suturing, plastering broken limbs etc DVT all that would see GP if no appointments available			

Advanced Practice Activity – Physiotherapist			
England (n=313)	**Northern Ireland (n=5)**	**Scotland (n=21)**	**Wales (n=24)**
In Scope (n=189) Use a patient group direction (PGD) Prescribe (supplementary) Prescribe (independent) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Undertake surgical procedures Advanced assessment of complex chronic pain conditions. Biopsychosocial approach to assessment and management (inc. psychological informed practice). Advanced care planning Advanced/specialist assessment/treatment/rehabilitation Refer (as opposed to merely recommend/request an opinion) for specific interventions (injection, biopsy, bloods, etc) but not complete by the ESP. Assess new tertiary referral patients in orthopaedic clinic Complex rehabilitation case management Anaesthetic Assessments Diagnostic MSK ultrasound Diagnostic ultrasound	In Scope (n=3) Use a patient group direction (PGD) Prescribe (supplementary) Prescribe (independent) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc Out of Scope (n=2) Use a patient group direction (PGD) Prescribe (independent) Refer for imaging investigations Differential Diagnosis Ambulatory Care Respiratory Hub Medico-legal/Neuro/musculoskeletal/Skeletal	In Scope (n=12) Use a patient group direction (PGD) Prescribe (supplementary) Prescribe (independent) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Hospital admission rights Out of Scope (n=9) Use a patient group direction (PGD) Prescribe (independent) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Diagnostic ultrasound Psychologically informed practice. Refer for nerve conduction studies, bloods and list for surgery Ultrasound guided procedures Advanced practice generalist role in Primary Care usually occupied by ANPs Community respiratory - mainly COPD First contact practitioner	In Scope (n=15) Use a patient group direction (PGD) Prescribe (supplementary) Prescribe (independent) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Refer to Secondary care Refer for blood tests & nerve conduction studies Out of Scope (n=9) Use a patient group direction (PGD) Prescribe (supplementary) Prescribe (independent) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Undertake surgical procedures Guided intra-muscular injections. Decision maker for best interest decision for physical and medical management in persons who do not have capacity to make those decisions Listing for surgery

Fracture manipulation Removal of k wires In process of NMP and IRMER as part of trainee role Interpret plain film X-ray List for interventions List for surgery Delegated consent taking Manage complex cases and provide second opinions Manage referral pathway as "gatekeeper" to medical consultant Plastering techniques- Ponseti Prescribe ventilation (Non invasive ventilation both acute and long term) Prescription of class 1 medical devices. Refer for blood and biochemistry Refer to secondary care Interpret results - imaging and bloods Refer onwards and refer for further investigations - neurophysiology, bloods, MRI, Pain clinic etc Request blood tests Take blood <u>Out of Scope (n=124)</u> Use a patient group direction (PGD) Prescribe (supplementary) Prescribe (independent) Refer for imaging investigations		First contact practitioner in GP Practice I run orthopaedic outpatient clinics I work as a physiotherapist and trained musculoskeletal Sonographer joint replacement Men's Pelvic Health	A&E first contact practitioner GP practice Interface msk services managing complex orthopaedic and spinal conditions MSK Hands Pain Management Part of my role involves assisting with or undertaking surgical procedures Providing guided intramuscular botulinum toxin injections to adults with long term neurological conditions.

Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Undertake surgical procedures ABGs Phlebotomy Advanced Life Support Fracture Manipulation Conscious Sedation CBGs Clerk patients with senior supervision Participate in research and quality improvement projects & presentations regionally and to peer group. Complete and interpret ABGs, chest x-rays, overnight oximetry and sleep studies, prescribe oxygen Complete medical clerking, provide in house training for junior medical team and consultant team. Currently training however will assist in surgical procedures/ perform minor local anaesthetic procedures. Do ABGs, bloods, catheterisation, cannulation, assess and triage for admission to acute surgical unit, diagnose and forward for further investigation/ treatment. Diagnose independently, conduct ward round in nursing homes and hospices, conduct home visits for patients with medical issues, liaise			

patient care with ED department and secondary care Direct list for spinal injection Extended diagnostic skills (total body physical including cardiac auscultation, abdominal examination, ECG interpretations. X Ray review. CT review.) Teaching of physios, nurses and doctors. Multidisciplinary audit and quality projects Invasive monitoring insertion Care (transfer) of level 3 patients outside of the Critical Care Unit Advanced assessment and management of critically ill and deteriorating patients Advanced anaesthetic and airway management Practice with a high level of autonomy List for surgery MSK Sonography and interventions Hydrodistension's Barbotage Order/ take bloods if monitoring patient, or for diagnostics. Place midlines Psychologically-informed practice, diagnosis, screening, suicide risk assessment, working with complex, high intensity health care users			

where there are no protocols/precedents Screen for serious spinal pathologies Interpret and act on diagnostics (when urgent or concerning pre-reporting). Independently manage patient pathways (complex case load) Refer to other secondary/tertiary care services. Clinical lead for advanced Practice Physiotherapists Lead the strategic development and updating of spinal pathways Skincare...acne & rosacea accredited clinic (ARA UK), nonsurgical cosmetic procedures; excessive sweating (axillae & feet); peels; PRP injections for skin & hair restoration; LED light therapy Use shockwave therapy Wound closure basic Emergency department advanced practitioner Accident & Emergency Department A&E - frail elderly A+E orthopaedics ACCP covering critical care and major trauma in Resus - sometimes I will be the lead airway trained person caring for a major trauma patient while we stabilise and get them to theatre/scan/critical care.			

Acute medicine Acute medicine and surgery Admission avoidance in the community Advanced Clinical Practice - not physiotherapy - by managing patients on four sometimes five hospital wards and providing independent clinical intervention out of hours and at weekends. Catering for all clinical matters - providing cga and clinical direction for the MDT, wound care, pressure area advice, catheter care advice, prescribing antibiotic / fluid resus, ordering and interpreting bloods, x-rays, us. Managing long term conditions Acting as clinical teacher, role modelling Aesthetic medicine AHP primary care. Ambulatory Care Unit (My role is much more similar to that of a junior doctor with limited physiotherapy aspects) Ambulatory Emergency Care Unit, Medical Task, Acute Medical Unit Assessment of applicants with physical and recently mental difficulties for the Blue Badge scheme and free Bus Pass scheme Botulinum toxin injection Cardiothoracics and intensive care			

Children's Orthopaedics - parallel clinic to Orthopaedic Consultant Chronic pain management, Psychologically informed Community - managing acutely unwell patients at home to avoid inappropriate hospital admission Community frailty Critical Care Critical Care (ACCP) working within the medical team (i.e. not working as a physiotherapist) Critical Care Outreach Critical care with anaesthetic lead. Currently working in community rehabilitation but focusing on applying for urgent care matron roles in the community as a physiotherapist Diagnostic ultrasound Injection Therapy Emergency Practitioner - predominately nurse practitioner roles FCP First Contact Physio in Primary Care Frailty Frailty - the scope of the role is medically based Frailty practitioner although using physiotherapy skills. GP practice			

Home and Long term trache-ventilation I specialise in complex adults with long term conditions. I also work in GP practices as a AP. I work as part of the Acute Medical Team I work in an acute frailty team in the community I work managing patients with moderate/severe frailty. Image guided injection, Nerve blocks, Spinal interface triage and complex clinic Intensive care Joint and soft tissue Injection Knee Unit - Total Knee replacement speciality , Painful Knee replacement and MDT working with Orthopaedics and Pain Clinic. Learning Disabilities Limited prescribing under HCPC regulations. Assessment and management of patients within critical care under supervision of a consultant. Insertion of cannulas, arterial lines, midline, central lines and vascath. Carry cardiac arrest bleep for whole hospital. Responsible for supervision and support of Trainee Advanced Critical Care Practitioners and junior doctors.			

Multirole mental health specialist Mental health for older people - Adult mental Health - Intellectual and developmental disorder Neurosurgery Orthopaedics lower limb Orthopaedics Orthopaedic intermediate care: between GPs and consultants including direct listing for surgery Pain Management Pain management where skills in mental health and psychologically-informed practice are used. Pain management, involving NMP and injection therapy partially- orthogeriatrics Pelvic health Pelvic health (in addition to MSK) Physiotherapist but working as a general practice ACP seeing acute on the day problems which do include traditional physio issues such as msk, neuro and respiratory assessments but also other assessments I have been trained and deemed competent in such as ENT, cardiac, gynae, mental health abdominal pain etc first port of call for patients seeking urgent appointments taking the history and performing the clinical examination, requesting			

investigations and referring on as appropriate. Physiotherapist now working in medicine for the elderly Professional football Rapid response and admission avoidance, frailty, care of elderly and end of life. Respiratory Rheumatology Screening for developmental dysplasia of the hip Service / operational Management of GPs/PCNS Spasticity management Spinal surgery Spinal Surgical Opinion Surgery Vestibular Rehabilitation Wheelchair/Postural Seating working as an FCP and also as extended practitioner in Orthopaedic clinic General Surgery Wound and Acute injuries management. Minor Illness & Mental Health			

Advanced Practice Activity – Practitioner Psychologist			
England (n=100)	**Northern Ireland (n=1)**	**Scotland (n=11)**	**Wales (n=6)**
In Scope (n=87) Use a patient group direction (PGD) Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Advanced neuropsychology leading to diagnosis of dementia Advanced talking therapy in mental health As a Consultant Clinical Psychologist and Psychoanalyst I treat patients and Supervise and train others Highly specialist psychological therapies I undertake psychological /neuropsychological interventions Mental health Psychological assessment and interventions Community Needs Analysis Training Talking therapy Out of Scope (n=13) Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Clinical psychology assessment and therapy, group and one to one Individual psychological assessments, career counselling (coaching), mentoring, group projects Advanced practice in specialist therapeutic modalities. Also advanced practice in	In Scope (n=1) Not stated Out of Scope (n=0)	In Scope (n=10) Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Out of Scope (n=1) Aviation psychology	In Scope (n=6) Not stated I train other healthcare professionals in Cognitive Analytic Therapy Out of Scope (n=0)

organisational process consultancy and systems psychodynamic work. Advanced practice in group relations work. Counselling Psychologist Expert Witness Home office detail - cannot be shared Human resources, providing a clinical psychology service for NHS staff I work in an advisory support role within the IASS organisation locally. Advice given is in the same area of work I did for 42 years as an educational psychologist with a County Council. I work mainly in family law carrying out child, adult and family assessments Independent schools Primary Care: Occupational Psychology Related: Community , Security, Trauma, Political & counselling BPS sections. Secondary care psychological services Service implementation with complex populations Spiritual psychology & Complementary Medicine Clinical Psychologists work in a huge range of roles, but my role is somewhat unique in focus (I'm mostly consulting to maritime charities and companies) but not in the types of activities I undertake (evidence based guides to mental health, training development and facilitation, mental health policy guidance, service development etc). I still draws on skills and			

knowledge developed through my training and professional development over the years.			

Advanced Practice Activity – Prosthetist/Orthotist			
England (n=4)	**Northern Ireland (n=1)**	**Scotland (n=0)**	**Wales (n=2)**
In Scope (n=3) Prescribe (independent) Out of Scope (n=1) MCAS triage	In Scope (n=1) Not stated Out of Scope (n=0)		In Scope (n=2) Prescribe (independent) Out of Scope (n=0)

Advanced Practice Activity – Radiographer (Diagnostic) The activity of 5 respondents working outside of 4 countries of UK is not listed			
England (n=217)	**Northern Ireland (n=5)**	**Scotland (n=33)**	**Wales (n=10)**
<u>In Scope (n=142)</u> Use a patient group direction (PGD) Prescribe (supplementary) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Undertake surgical procedures Authorise, protocol, perform and report CT colonoscopy Clinical reporting Contrast enhanced ultrasound Diagnostic reporting Guided canulation Guided steroid injection Image interpretation Image reporting MRI reporting Plain film image interpretation Provide a written and verbal reports on X-ray images Providing independent report of medical imaging & provide direction to referring team. Radiology lead for BCSP Report adult chest X-rays Report chest and abdominal x-rays Report independently after performing ultrasound scans independently	<u>In Scope (n=1)</u> Radiology reporting <u>Out of Scope (n=4)</u> Use a patient group direction (PGD) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Breast, undertake biopsies and other interventional techniques, ultrasound, image interpretation and reporting. Undertake the same role as radiologist. FNA cytology under ultrasound guidance of neck lumps Interventional breast biopsy Radiographic emergency care practitioner	<u>In Scope (n=23)</u> Use a patient group direction (PGD) Prescribe (supplementary) Prescribe (independent) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Perform fluoroscopy barium swallow examinations. Report Image Investigations Sonographer <u>Out of Scope (n=10)</u> Use a patient group direction (PGD) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Interpret images, refer for biopsy and take part in MDT discussion Plain film reporting Use PSDs Colonic Imaging- undertaking colonoscopy in addition to radiological imaging Diagnostic ultrasound Interventional procedures: Biopsy and Large volume excisions; breast	<u>In Scope (n=6)</u> Use a patient group direction (PGD) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Appendicular and axial reporting Report plain film radiographs <u>Out of Scope (n=4)</u> Use a patient group direction (PGD) Prescribe (supplementary) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Bone Marrow Biopsy Practitioner Ultrasound Sonographer Plain film Reporting Providing radiology support / responsible assessor role comparative to consultant radiologist

Report msk and cxr Reporting CT brain scans Reporting CT scans Reporting CT/MRI head & sinuses <u>Out of Scope (n=75)</u> Use a patient group direction (PGD) Prescribe (supplementary) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Undertake surgical procedures Assist with interventional procedures in vascular surgery theatre and angioplasty suite Deliver all breast biopsy results to patients Hycosy - insertion of speculum, catheterisation and injection of foam contrast Image interpretation and reporting Independent Reporting Independently report MRI examinations Perform CT virtual colonography examinations Provide advice and recommendations within a clinical report to referrers based on medical imaging, referral information and clinical history.		US & mammographic image interpretation Obstetric ultrasound Sonographer Paediatric Sonographer Reporting Radiographer Sonography	

Report Plain film radiographs with the option to recommend further imaging and recommend MDT consideration. Report, Leadership, Management, Justification, Lecturing. Suggest pathways and diagnoses Take full clinical patient history, physical assessment of the patient (all systems), refer to other speciality consultants, refer to allied health professionals (e.g. Physiotherapy, podiatry, dietetics), refer to district nurses; hold the referral bleep from GPs, other hospital specialities, community referrals; manage an entire episode of care for medical and surgical referrals; liaise across secondary, primary and community care to provide the best clinical management plan for the patient; perform interventional procedures such as lumbar punctures, ascitic drains, diagnostic paracentesis; training in focused ultrasound to ensure safe interventional procedures; working with multi-disciplinary colleagues across urgent and emergency care to ensure patients are treated in the best place for their needs; work with patients, their families and carers to ensure the clinical management of their			

illness/disease/condition works for them (holistic approach); write comprehensive discharge letters documenting each episode of care for the patient. Undertake pharmacological cardiac stressing Venoplasty, drain exchanges, gastrostomy/jejunostomy exchange, venograms, fistulograms, angiography Acute medicine Breast imaging - screening NHSBSP and symptomatic Breast Radiology Breast ultrasound and interventional procedures inc. breast examination Clinical reporting CT head reporting Endoscopy Stereotactic biopsy Fine Needle Aspiration Head and neck specialist sonographer, also perform groin and axilla ray biopsies, training to undertake sialograms I am a radiographer/sonographer working in Interventional radiology currently undertaking procedures previously performed by radiologists. Working at consultant level but not recognised by my trust.			

I am working in a symptomatic breast unit, performing a role traditionally performed by a radiologist. I perform adenosine stress perfusion and administer Metoprolol beta blockers under PGD. I perform stereo guided interventional procedures on the breast and double screen reading of NHSBSP images. Interventional radiology Managing the patient from consent to discharge Maternity Ultrasound MRI Reporting of spine, brain and knee examinations MSK injections and aspirations of collections MSK ultrasound specialist (USGI) Neuro CT Reporting Nuclear Cardiology Pelvic Floor Specialist-Performing proctogram examinations unassisted Vascular access-Can inject through various lines and I am trained to put cannulas in under ultrasound Post mortem imaging Pulmonary nodule reporting Radiographer led discharge. Radionuclide therapy and sentinel node localisation Rheumatology			

Running an FNA clinic Surgery Therapeutic Steroid injections Urology fluoroscopy Urology-ESWL Vascular access and interventional radiology Veterinary Profession as a Veterinary Sonographer / Advanced Practitioner as well as an Ultrasound Consultant for my own private company, delivering bespoke ultrasound training in both Medical and Veterinary fields. Video Urodynamics, lithotripsy vascular ultrasound, chest and ascitic drainages.			

Advanced Practice Activity – Radiographer (Therapeutic) The activity of 1 respondent working outside of 4 countries of UK is not listed			
England (n=68)	**Northern Ireland (n=0)**	**Scotland (n=8)**	**Wales (n=3)**
<u>In Scope (n=48)</u> Use a patient group direction (PGD) Prescribe (supplementary) Prescribe (independent) Refer for imaging investigations Undertake surgical procedures Also use PSDs and provide on treatment radiographer led review to oncology patients. Use MR Linac and Proton Therapy machines which in themselves should be considered advanced practice due to their 'newness' and speciality Consent and plan radiotherapy Contouring, follow up clinics, on treatment clinics Expert practice in radiotherapy treatment delivery, cbcbt image review and decision making, shift leader and management responsibilities, training and educating staff and involved in research as part of daily role Prescribe and plan palliative radiotherapy Independently contour nodal areas and field placement for breast patients Prescribe ionising radiation Prescribe radiotherapy treatment under a clinical protocol Prescribe radiotherapy treatments Run my own clinic		<u>In Scope (n=7)</u> Use a patient group direction (PGD) Prescribe (supplementary) Prescribe (independent) Refer for imaging investigations Focus is on clinical competency and education Work within MDT. Participate in Clinical team meetings. Review patients on xrt. <u>Out of Scope (n=1)</u> Refer for imaging investigations obstetric sonography	<u>In Scope (n=3)</u> Use a patient group direction (PGD) Prescribe (supplementary) Prescribe (independent) Refer for imaging investigations Target delineation Radiotherapy consent Plan authorization Follow up clinic <u>Out of Scope (n=0)</u>

Therapeutic radiography. Ultrasound guidance of brachytherapy Brachytherapy & planning development of brachytherapy techniques Volume areas for treatment autonomously on behalf of consultants and approve radiotherapy plans within Scope of Practice. Work autonomously within locally agreed scope of practice if this is different from PGD Working towards NMP <u>Out of Scope (n=20)</u> Use a patient group direction (PGD) Prescribe (supplementary) Prescribe (independent) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Application of radiobiology and technical knowledge to provide individual care. Assessing chemo- radiotherapy patients on treatment. Consent for radiotherapy, IRMER referrer and practitioner in justifying radiotherapy treatment Consent patients, under gynae examinations & run my own clinics Review, clinically examine and formulate management plans Undertake remote superficial radiotherapy skin mark up for radiotherapy for skin cancer. Brachytherapy is a specialised role within radiotherapy not formally assessed as part of			

our academic qualification. I have also specialised in gynaecological oncology Breast Radiotherapy Community frailty Keyworker, patient discharge Late effects MR Guided beam gated SABR with full online adaption and plan optimisation Neuro oncology On treatment + post treatment follow up review. Palliative Care Radiotherapy for lower GI cancers Radiotherapy review, information and support Role extension into referrals and consent and volumes - roles traditionally undertaken by consultants. Although still working with patients receiving radiotherapy My role includes autonomous first weekly review of H&N cancer patients. One day a week review patient in a late effects clinic helping to manage chronic effects from chemotherapy and radiotherapy. Currently training for advanced physical assessment and non-medical prescribing to be able to autonomously manage patients. Sarcoma - Management of Radiographer-led radiotherapy pathways for palliative (metastatic disease) and heterotopic ossification. Working more as a medic than Radiographer			

Advanced Practice Activity – Speech and Language Therapist The activity of 2 respondents working outside of 4 countries of UK is not listed			
England (n=66)	**Northern Ireland (n=6)**	**Scotland (n=8)**	**Wales (n=3)**
<u>In Scope (n=47)</u> Use a patient group direction (PGD) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. I assess for and recommend communication tools (low and high Tech), computer equipment and access tools as well as language and social skills developments Laryngeal Examination using laryngoscopy for diagnostic and therapeutic purposes. MDT working in assessing for dysphagia and referring on for further investigation Undertake endoscopy procedures Voice prosthesis changes are invasive as is nasendoscopy <u>Out of Scope (n=19)</u> Use a patient group direction (PGD) Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. Assess for and prescribe electronic Communication Aids - role requires interdisciplinary skills of SLT, OT and assistive technologist. There is no certification/formal professional pathway to achieve this position - comes with experience only.	<u>In Scope (n=5)</u> Refer for imaging investigations Undertake interventional procedures e.g. biopsy, therapeutic injection etc. <u>Out of Scope (n=1)</u> Trans Voice and communication Stammering in adults Voice disorders	<u>In Scope (n=5)</u> Refer for imaging investigations Mentor principal teacher Provide second opinions, consult for other practitioners <u>Out of Scope (n=3)</u> Refer for imaging investigations Mental health therapies I work as a speech and language therapist with adults who have learning disabilities within a health a social care partnership, very often my role includes social work type decisions in relation to adult support protection, adults with incapacity act etc. Mental Health Working as part of an interdisciplinary team enabling people with progressive neurological conditions to remain at home	<u>In Scope (n=2)</u> Not stated <u>Out of Scope (n=1)</u> Refer for imaging investigations Acute paediatric dysphagia

Assist with surgical procedures- voice and laryngectomy Diagnostic and therapeutic nasendoscopy Respiratory examination/diagnosis; site NGTs; decannulate tracheostomy patients Support practice development across four professional groups Undertake video-fluoroscopic diagnostic swallow evaluations; Lead FEES (swallow endoscopy clinic); Perform air insufflation tests; Perform voice prosthesis changes for laryngectomy patients Work autonomously across mental health, learning disabilities and forensic services promoting communication needs that are not recognised or understood in these sectors; deliver highly specialist training in communication needs and autism; reduce the needs of over medication in a highly complex population. Group9 Adult learning disabilities and autism - intensive support team. Assistive Technology Augmentative and alternative communication consultant - intradisciplinary role Education sector- fulfil an equivalent role to specialist advisory teacher, with national reach Education with responsibility for pupils with learning and behavioural difficulties. ENT Head and Neck cancer, laryngectomy, FEES			

I am looking at ultrasound as a screening tool I do a lot of work in sensory integration but RCSLT are now looking at whether this is part of our role in more detail. (I completed CPD courses to qualify me in SI and then refer on if assessment is recommended) I work in brain injury and tend to be sent the highly complex specialist cases that don't respond to traditional therapy. I work in the inpatient stroke service but my clinical duties are no longer that traditionally of an SLT. I form part of the medical team on daily ward round, clerk and examine patients in ED (cardiovascular, respiratory, abdominal, mental health, and neurology examinations), differentially diagnose stroke from various stroke mimics and order appropriate investigations. I also carry out clinical skills such as taking bloods, ABGs catheters, and NGT placement. Palliative care matron Practice Development Respiratory examinations/ diagnosis for dysphagic patients Respiratory service for refractory cough, complex asthma and Inducible Laryngeal Obstruction (ILO) Speech Therapy Led nasendoscopy clinics: (1. Voice Clinic, 2. FEES - (Flexible Endoscopic Evaluation of Swallowing), 3. Laryngeal Surgery for Head & Neck Cancer follow up clinic (Consultant Activity))			

Working as a Clinical Specialist in Movement Disorders (providing care to patients with Parkinson's Disease, Dystonia, Essential Tremor etc) Youth justice/social emotional behavioural difficulties			

Appendix 3: Surveys

Registrant survey

1. What profession(s) are you registered as with the HCPC? (Select from list)

2. Please select the option which most closely describes your role.
    - Trainee advanced practitioner
    - Advanced practitioner
    - Consultant practitioner
    - Manager AND advanced practitioner
    - Manager (but NOT working as an advanced practitioner)
    - HCPC registrant working in clinical practice
    - Academic BUT not involved in advanced practice education
    - Academic delivering advanced practice education
    - Not currently working
    - None of the above (please state your role)

Manager respondents

3. What geographical region do you work in? (Select from list)

4. What health or care sector do you work in? (Select from list)

5. Does your service include individuals undertaking advanced practice?
    - Yes, direct line management
    - Yes but not involved in their direct management
    - No

6. Do you also manage advanced practitioners (Yes/No – if Yes redirect to advanced practice questions)

7. What minimum qualification would you expect to enable individuals to work as an advanced practitioner? (Select from list)

8. What is the minimum post registration experience you would expect individuals to have undertaken prior to them training as an advanced practitioner?

Advanced practitioner respondents

9. What geographical region do you work in? (Select from list)

10. What health or care sector do you work in? (Select from list)

11. In relation to your advanced or consultant practice what is your role title? (Select from list)

12. What is your Agenda for Change band? Please state equivalent if non-NHS. (Select from list)
13. How many years have you been qualified in your primary HCPC registered profession? (Select from list)

14. Where did you undertake your pre-registration qualification??
    - UK
    - Overseas

15. What qualification did you undertake to achieve HCPC professional registration? (Pre-registration not your highest qualification). (Select from List)

16. What is your highest academic qualification? (Select from list)

17. What additional qualification(s), if any, did you undertake to enable you to work as an advanced or consultant practitioner? (Select from list)

18. Was, or is, your advanced practice education multiprofessional? (Yes/No)

19. Who supervised (or is supervising) your clinical development during your advanced practice education/training? (Select from list)

20. Are you working in an area you would consider outside of the traditional sphere of your registered profession? (Yes/No)
    a. If yes, please specify your area of clinical practice

21. Is your advanced practice accredited or credentialled by a (non-HCPC) body? (e.g. accredited or credentialed by professional body or a medical college) (Yes/No)
    a. If yes, please specify

22. In your clinical practice, do you currently?:
    - Use a patient group direction (PGD)
    - Prescribe (supplementary)
    - Prescribe (independent)
    - Refer for imaging investigations
    - Undertake interventional procedures e.g. biopsy, therapeutic injection, etc.
    - Undertake surgical procedures
    - Other
    - None of the above

23. How do you perceive your confidence in each of the four pillars of advanced practice? (Select from list)

24. How do the four pillars of practice contribute to your job plan? (Select from list)

Clinical (non-advanced level practitioner) respondents

25. Do you have an interest, or aspiration, in advanced practice? (Yes/No)

26. Is your aspiration for
    - Advanced practice within the scope of your registered profession?
    - Advanced practice in a field that could be considered outside the scope of your registered profession
    - Not sure
    - Other

All respondents

27. Do you believe that HCPC regulation of advanced practice is required? (Yes/No)

28. What do you believe would be the benefits of advanced practice regulation by the HCPC? (select all that apply)
    - Assurance to employers of knowledge and skills
    - Assurance to self of knowledge and skills
    - Greater consistency in education and training standards
    - Greater professional standing with other professions
    - Greater standardisation of advanced practice
    - Improved protection and safety of service users
    - Increased pay, recognition and/or reward
    - More opportunities for advanced practice/ innovation
    - Improved clinical governance and management of clinical risk
    - Greater understanding and clarity for the public (patients and service users)
    - Other

29. What do you believe would be the disadvantages/ challenges to advanced practice regulation by the HCPC? (select all that apply).
    - Bureaucratic exercise only
    - Confusion for the public
    - Duplication of effort (already accredited/credentialed)
    - Difficult to regulate multiprofessional practice
    - Increased cost of registration
    - Increased risk of litigation, complaints, investigations and potential hearings
    - Reduced opportunities for advanced practice/ innovation
    - Would not recognise my multi-professional scope of practice
    - Would limit future role development opportunities
    - Other

30. What do you believe would be the best way of assuring the public, registrants, and employers regarding advanced practice if the HCPC does not regulate advanced practice?

31. Do you have any further comments that you would like to add after completing the survey?

32. Please enter your contact details below if you consent to us contacting you to potentially participate in a follow-up interview

Advanced Practice Educators Survey

1. What type of programme/organisation are you responding about? (Select from list)

2. Where are you based? (Select from list)

3. Is your programme available to HCPC registered professions (i.e. allied health professions and healthcare scientists)? NB. It may also be available to other professions e.g. nursing, pharmacy. (Yes/No)

4. Which of these HCPC registered professions is your programme available to? (Select all that apply)

5. Please state the title of your programme (do not include any nested exit awards)

6. Which clinical practice/pathway areas are encompassed within your programme (these may be specific pathways or the programme focus) (Select from list)

7. Please state the FHEQ Level of your academic award (e.g. Level 7 - Masters) (Select from list)

8. What is the route of the programme? (e.g. apprenticeship vs traditional academic route) (Select all that apply)

9. Are you intending to develop an apprenticeship route for the advanced practitioner programme?

10. Is the programme delivered on a full and/or part time basis? (Select all that apply)

11. Does the programme require some attendance at the education provider premises (recognising any blended learning adjustments due to COVID-19) or distance learning only? (Select all that apply)

12. Which health professionals contribute to the academic delivery of your programme? (Select all that apply)

13. Does your programme expect or include accreditation or credentialing of individual practitioners by a specific body? (e.g. professional body or medical royal college) (Yes/No)
    a. If Yes, please specify

14. Are you intending applying for HEE accreditation for your programme? (England specific) (Select from list)

15. Please state the entry requirements for your programme, including years of experience required, if any (e.g. BSc 2:1; professional diploma; 3 years in practice) (Select from list)

16. Do your students have to be employed in a trainee or advanced practice role as an entry requirement for the programme? (Yes/No)

17. Is there a compulsory clinical placement component to your advanced practice programme? (Yes/No)

18. Is there a defined clinical practice hours/time requirement for the programme? (e.g. 250 hours across the programme or 2 days per week) (Please state)

19. Does the clinical practice component require a named mentor? (Select all that apply)

20. What are the clinical supervisory and/or mentorship requirements for your programme? (Select all that apply)

21. Does your programme include a prescribing module?
    - Yes – compulsory
    - Yes – optional
    - No

22. What (summative) assessment strategies are employed within your programme? (Select all that apply)

23. What percentage of the programme is focussed on clinical, education, leadership and research skills development? (e.g. 40% clinical component, 20% development of educational skills, 20% leadership skills, 20% research capability) (Select from list)

24. Were stakeholders consulted during the design of your programme? (Yes/No)

25. What is your professional background? (Select from list)

Non-HCPC registered professions only

(HCPC registered respondents directed to the registrant survey)

33. Do you believe that HCPC regulation of advanced practice is required? (Yes/No)

34. What do you believe would be the benefits of advanced practice regulation by the HCPC? (select all that apply)
    - Assurance to employers of knowledge and skills
    - Assurance to self of knowledge and skills
    - Greater consistency in education and training standards
    - Greater professional standing with other professions

- Greater standardisation of advanced practice
- Improved protection and safety of service users
- Increased pay, recognition and/or reward
- More opportunities for advanced practice/ innovation
- Improved clinical governance and management of clinical risk
- Greater understanding and clarity for the public (patients and service users)
- Other

35. What do you believe would be the disadvantages/ challenges to advanced practice regulation by the HCPC? (select all that apply).
    - Bureaucratic exercise only
    - Confusion for the public
    - Duplication of effort (already accredited/credentialed)
    - Difficult to regulate multiprofessional practice
    - Increased cost of registration
    - Increased risk of litigation, complaints, investigations and potential hearings
    - Reduced opportunities for advanced practice/ innovation
    - Would not recognise my multi-professional scope of practice
    - Would limit future role development opportunities
    - Other

36. What do you believe would be the best way of assuring the public, registrants, and employers regarding advanced practice if the HCPC does not regulate advanced practice?

37. Do you have any further comments that you would like to add?

38. Please enter your details below if you consent to us contacting you to potentially participate in a follow-up interview or future research in this area

Appendix 4: Interview Guides

Chief AHPs and Scientific Officers

Defining scope, complexity, autonomy, divergence from cognate professions

1. In your opinion is advanced practice a continuum of the AHP/scientist professional practice or could the scope be substantively different?
    a. Can you provide an example(s) to illustrate your answer?

2. What is the future for advanced practice roles in your national workforce strategies?
(To account for differences across nations)

3. In your opinion what scope / limitations would you like to see (if any) for advanced practice?

Education training support supervisions CPD

4. The educational preparation for advanced practice is Master's level or equivalent.
    a. In your opinion what does "Master's level or equivalent" mean?
    b. What would you consider to be equivalent to Master's level?
    c. In your opinion, how should advanced practice be supported with ongoing CPD / education?
    d. Would you have confidence in an advanced practitioner discharging their role BECAUSE they had this level of education? Please explain response

Risk/Patient safety

5. Do you believe advanced practice presents risk to patient safety?
    a. Please explain your response
    b. If yes, does this risk differ from the risk inherent within the cognate/registered profession?

Assurance and accountability & Regulation

6. Do you think the current regulation of AHP/scientists is sufficient when individuals work at an advanced practice level? (clarification on current regulations can be provided if necessary)

7. If the HCPC were to regulate advanced practice specifically, what do you think it should look like?

8. If the HCPC were to regulate advanced practice do you believe the current 3 year audit cycle of a random selection of registrants is sufficient to provide assurance?

Additional comments

9. Is there anything else you wish to add?

Advanced Practitioners

Defining scope, complexity, autonomy, divergence from cognate professions

1. In your opinion is AP a continuum of the AHP professionals' practice or is the scope of it substantively different? Please explain your answer

2. Do you feel your advanced practice is within the scope of your cognate profession? Please explain your answer.

3. In your advanced practice role, how do you introduce yourself to your patients? (to determine if use profession or alternative title)

4. Our research tells us that advanced practice titles and job descriptions vary across countries, specialities, and professions.
   a. What do you think are the reasons for this?
   b. What implications does this have for employment transferability?

5. Do you think that offering opportunities to develop as an advanced practitioner improves staff recruitment and retention? Please explain your answer

6. How do you see advanced practice roles developing in the future?

Education training support supervisions CPD

7. The educational preparation for advanced practice is "Master's level or equivalent".
   a. In your opinion what does "Master's level or equivalent" mean?
   b. What would you consider to be equivalent to Master's level?
   c. In your opinion, how should advanced practice be supported with ongoing CPD / education?

8. Are you confident in undertaking your advanced practice role because you have achieved a Master level qualification or 'equivalent'? Please explain

9. Did your employer have additional requirements internally for assessing advanced practice competency on your employment? Please explain

10. Was your educational award/qualification credentialled by an external body?
    a. If yes, do you think this gave your employer more confidence in your advanced practice ability and skills?

11. Education programmes often incorporate the four pillars of advanced practice. Was this your experience? Please explain
    (Prompt: Was greater emphasis placed on any one more than the others).

12. In your opinion who should fund advanced practice education and ongoing development?

Risk/Patient safety

13. Do you believe advanced practice presents risk to patient safety? Please explain

a. If yes, does this differ from the risk inherent within the cognate/registered profession? Please explain

14. Do you believe advanced practice presents risk to you as the practitioner? Please explain
    a. If yes, does this differ from the risk inherent within the cognate/registered profession? Please explain

15. What do you think could be done to mitigate risk?

16. Are you aware of any reported unsafe practice involving advanced practitioners? Please explain.
    a. Have you had any incidents yourself and if so how were they dealt with?

Assurance and accountability

17. In your opinion, should advanced practitioners be able to work autonomously?
    a. What does this mean to you?
    b. Should they <u>always</u> have access to supervision in practice? Please explain including who should supervise.

Regulation

18. Do you think the current regulation of AHP/scientists is sufficient when individuals work at an advanced practice level?

19. Do you think current regulation is sufficient where the sphere of advanced practice is fundamentally different from that of the cognate / registered profession? Please explain

20. Lack of regulation of advanced practice roles has been raised as an obstacle to consistency of education, training and standards of advanced practice. What are your thoughts on this?

21. Do you think regulation of advanced practice specifically could be a barrier or opportunity for workforce development, innovation and service improvement? Please explain

22. Have advanced practice workforce numbers grown sufficiently to justify the introduction of specific regulation for advanced practice?

23. If the HCPC were to regulate advanced practice specifically, what do you think it should look like?

24. If HCPC were to regulate advanced practice do you believe the current 3 year audit cycle of a random selection of registrants is sufficient to provide assurance?

25. In your opinion what else could be done to ensure public and stakeholder confidence in advanced practitioners other than additional regulation?

Additional comments

26. Is there anything else you wish to add?

Other Healthcare Professionals
(not advanced or consultant practitioners)

Defining scope, complexity, autonomy, divergence from cognate professions

1. In your opinion is AP a continuum of the AHP professional's practice or is the scope of it substantively different? Please explain your answer

2. Do you think that offering opportunities to develop as an advanced practitioner improves staff recruitment and retention? Please explain your answer

3. Our research tells us that advanced practice titles and job descriptions vary across countries, specialities, and professions.
    a. What do you think are the reasons for this?
    b. What implications does this have for employment transferability?

4. How do you see advanced practice roles developing in the future?

Education training support supervisions CPD

5. The educational preparation for advanced practice is "Master's level or equivalent".
    a. In your opinion what does "Master's level or equivalent" mean?
    b. What would you consider to be equivalent to Master's level?

6. Do you think that Master level or 'equivalent' qualification is sufficient to evidence ability to work as an advanced practitioner or do you think additional internal assessment of competency or development should be required upon employment? Please explain.

7. Do you think an advanced practice educational award/qualification that is credentialled by an external organisation provides greater confidence in the quality of education undertaken? Please explain.

8. Education programmes often incorporate the four pillars of advanced practice. In your opinion should these be equally emphasised within the education? Explain your answer.
(Clarification of pillars to be made if necessary: Clinical/Research/Education/Management and Leadership)

Risk/Patient safety

9. Do you believe advanced practice presents risk to patient safety? Please explain.
    a. If yes, does this differ from the risk inherent within the cognate/registered profession?

10. Are you aware of any reported unsafe practice involving advanced practitioners?
    a. If yes, please expand.

Assurance and accountability

11. In your opinion, should advanced practitioners be able to work autonomously?

a. What does this mean to you?
b. Should they always have access to supervision in practice? Please explain including who should supervise.

Regulation

12. Do you think the current regulation of AHP/scientists is sufficient when individuals work at an advanced practice level?

13. Do you think current regulation is sufficient where the sphere of advanced practice is fundamentally different from that of the cognate/registered profession? Please explain

14. If the HCPC were to regulate advanced practice specifically, what do you think it should look like?

15. If HCPC were to regulate advanced practice do you believe the current 3 year audit cycle of a random selection of registrants is sufficient to provide assurance?

Additional comments

16. Is there anything else you wish to add?

Trade Unions (who are not combined with professional bodies)

Defining scope, complexity, autonomy, divergence from cognate professions

1. What do you understand by the terms advanced practice and advanced practitioner?
    a. Can you give me an example of how advanced practice differs from standard practice in healthcare?

2. Advanced practice job titles and role descriptions vary across UK countries, specialities and professions. What do you think are the implications of this for employment and transferability?

3. National workforce strategies advocate for more advanced practice roles.
    a. Why do you think this is?
    b. How do you think this will this impact on the workforce you represent?

Education training support supervisions CPD

4. The educational preparation for advanced practice is "Master's level or equivalent".
    a. In your opinion what does "Master's level or equivalent" mean?
    b. What would you consider to be equivalent to Master's level?

5. In your opinion who should pay for advanced practice education, including CPD and ongoing development?

Risk/Patient safety

6. Do you believe advanced practice presents risk to patient safety? Please explain
    a. If yes, does this differ from the risk inherent within the cognate/registered profession? Please explain.

7. Do you believe advanced practice presents risk to the practitioner? Please explain
    a. If yes, does this differ from the risk inherent within the cognate/registered profession? Please explain.

8. Have you had to act on behalf of any individual or group in relation to advanced practice?
    a. If yes, what was this for?

Assurance and accountability

9. In your opinion, should advanced practitioners be able to work autonomously or should they always have access to supervision in practice? Please explain.

Regulation

10. Do you think the current regulation of AHP/scientists is sufficient when individuals work at an advanced practice level?

11. If the HCPC were to regulate advanced practice specifically, what do you think it should look like?

12. In your opinion what else could be done to ensure public and stakeholder confidence in advanced practitioners other than additional regulation?

Additional comments

13. Is there anything else you wish to add?

Employers – AHP or Scientist Managers/Lead/Director Trust Level

Defining scope, complexity, autonomy, divergence from cognate professions

1. In your opinion is advanced practice a continuum of the AHP/scientist professional's practice or could the scope be substantively different? Please explain your answer

2. Do you think that offering opportunities to develop as an advanced practitioner improves staff recruitment and retention? Please explain your answer

3. Our research tells us that advanced practice titles and job descriptions vary across countries, specialities, and professions.
   a. What do you think are the reasons for this?
   b. What implications does this have for employment transferability?

4. What is the future for advanced practice roles in your local workforce strategies?

Education / Training Support / Supervisions / CPD

5. The educational preparation for advanced practice is "Master's level or equivalent".
   a. In your opinion what does "Master's level or equivalent" mean?
   b. What would you consider to be equivalent to Master's level?
   c. In your opinion, how should advanced practice be supported with ongoing CPD / education?
   d. Would you have confidence in an advanced practitioner discharging their role BECAUSE they had this level of education? Please explain response

6. Do you have additional requirements internally for determining/assessing advanced practice competency on employment? Please explain

7. If the education/training award is credentialed by an external body (e.g. Royal College of Emergency Medicine), would this give you more confidence in the practitioners' ability and skills? Please explain.

8. Do you know what the content of the advanced practice education programmes that your employees study is? Please expand your answer.

9. Education programmes often incorporate the four pillars of advanced practice. Do you think one pillar should be emphasised more than the others?
   (Clarification of pillars to be made if necessary: Clinical/Research/Education/Management and Leadership)

10. In your opinion how should advanced practice education, including CPD and ongoing development, be funded?

Risk/Patient safety

11. Do you believe advanced practice presents risk to patient safety? Please explain
    a. If yes, does this differ from the risk inherent within the cognate/registered profession? Please explain

12. Are you aware of any reported unsafe practice involving advanced practitioners?
    a. If yes, how was this dealt with?

Assurance and accountability

13. Some professional bodies accredit advanced or consultant practice/practitioners. Do you see this as essential for assuring advanced or consultant practice quality and accountability? Please explain.

14. In your opinion, should advanced practitioners be able to work autonomously?
    a. What does this mean to you?
    b. Should they always have access to supervision in practice? Please explain including who should supervise.

Regulation

15. Do you think the current regulation of AHP/scientists is sufficient when individuals work at an advanced practice level?
    (clarification on current regulations can be provided if necessary)

16. Do you think current regulation is sufficient where the sphere of advanced practice is fundamentally different from that of the cognate / registered profession? Please explain

17. Do you think regulation could be a barrier or opportunity for workforce development, innovation and service improvement? Please explain

18. Do you think the advanced practitioner workforce numbers have grown sufficiently to justify the introduction of regulation specifically for advanced practice?

19. If the HCPC were to regulate advanced practice specifically, what do you think it should look like?

20. If HCPC were to regulate advanced practice do you believe the current 3 year audit cycle of a random selection of registrants is sufficient to provide assurance?

21. In your opinion what else could be done to ensure public and stakeholder confidence in advanced practitioners other than additional regulation?

Additional comments

22. Is there anything else you wish to add?

Educators

Introductions and clarify if participants have answered the educators survey

Defining scope, complexity, autonomy, divergence from cognate professions

1. In your opinion is AP a continuum of the AHP/scientist professional's practice or could the scope be substantively different? Please explain your answer.

2. Our research tells us that advanced practice titles and job descriptions vary across countries, specialities, and professions.
   a. What do you think are the reasons for this?
   b. What implications does this have for education and employment transferability?

Education/training/support/supervision/CPD

3. The educational preparation for advanced practice is "Master's level or equivalent".
   a. In your opinion what does "Master's level or equivalent" mean?
   b. What would you consider to be equivalent to Master's level?
   c. What opportunities are available for continual advanced practice education?

4. Following completion of your programme, would you be confident that someone could safely undertake an advanced practice role? Please explain.

5. Many employers/departments have an internal competency assessment upon employing an advanced practitioner. Do you think this is necessary? Please explain.

6. Are your programmes credentialed by an external body?
   a. If yes, do you think this gives students and employers greater confidence in the education quality? Please explain.

7. Do your programmes incorporate the four pillars of advanced practice?
   a. If yes, are these equally emphasised in your programme? Explain your answer.
   b. If no, please explain reasoning

   (Clarification of pillars to be made if necessary: Clinical/Research/Education/Management and Leadership)

8. In your opinion who should fund advanced practice education and ongoing role development?
   a. Are you aware of any barriers to accessing funding across professions? Please explain.

Risk/Patient safety

Covered under education questions

Assurance and accountability

9. In your opinion, should advanced practitioners be able to work autonomously?
   a. What does this mean to you?
   b. Should they always have access to supervision in practice? Please explain including who should supervise.

Regulation

10. Lack of regulation of advanced practice roles has been raised as an obstacle to consistency of education, training and standards of advanced practice. What are your thoughts on this?

11. If the HCPC were to regulate advanced practice specifically, what should this look like?

12. If the HCPC were to regulate advanced practice do you believe the current 3 year audit cycle of a random selection of registrants is sufficient to provide assurance?

13. In your opinion what else could be done to ensure public and stakeholder confidence in advanced practitioners other than additional regulation?

Additional comments

14. Is there anything else you wish to add?

Professional Bodies

Defining scope, complexity, autonomy, divergence from cognate professions

1. In your opinion is AP a continuum of the AHP/scientist professional's practice or could the scope be substantively different? Please explain your answer.

2. Do you think that offering opportunities to develop as an advanced practitioner improves staff recruitment and retention? Please explain your answer

3. Our research tells us that advanced practice titles and job descriptions vary across countries, specialities, and professions.
   a. What do you think are the reasons for this?
   b. What implications does this have for employment transferability?

4. What is the future for advanced practice roles in your profession workforce strategy?

Education training support supervisions CPD

5. The educational preparation for advanced practice is "Master's level or equivalent".
   a. In your opinion what does "Master's level or equivalent" mean?
   b. What would you consider to be equivalent to Master's level?
   c. In your opinion, how should advanced practice be supported with ongoing CPD / education?
   d. Do you feel employers should have confidence in an advanced practitioner discharging their role BECAUSE they had this level of education? Please explain response.

6. Education programmes often incorporate the four pillars of advanced practice. Do you think one pillar should be emphasised more than the others?
   (Clarification of pillars to be made if necessary: Clinical/Research/Education/Management and Leadership)

7. In your opinion how should advanced practice education, including CPD and ongoing development, be funded?

Risk/Patient safety

8. Do you believe advanced practice presents risk to patient safety? Please explain
   a. If yes, does this differ from the risk inherent within the cognate/registered profession? Please explain.

9. Do you believe advanced practice presents risk to the practitioner? Please explain
   a. If yes, does this differ from the risk inherent within the cognate/registered profession? Please explain.

10. Are you aware of any reported unsafe practice involving advanced practitioners?
    a. If yes, how was this dealt with?

Assurance and accountability

11. Some professional bodies accredit/credential advanced or consultant practice. Do you see this as essential for assuring advanced or consultant practice quality and accountability? Please explain.

12. In your opinion, should advanced practitioners be able to work autonomously?
    a. What does this mean to you?

Regulation

13. Do you think the current regulation of AHP/scientists is sufficient when individuals work at an advanced practice level?
    a. What about where the sphere of practice is fundamentally different from that of the cognate/registered profession? Please explain response.

14. If the HCPC were to regulate advanced practice specifically, what do you think it should look like?

15. If HCPC were to regulate advanced practice do you believe the current 3 year audit cycle of a random selection of registrants is sufficient to provide assurance?

16. In your opinion what else could be done to ensure public and stakeholder confidence in advanced practitioners other than additional regulation?

Additional comments

17. Is there anything else you wish to add?

Patients and Public

Defining scope, complexity, autonomy, divergence from cognate professions

1. Have you heard of the terms advanced practice or advanced practitioner?
   a. What do think the terms mean? If unknown, terms to be clarified to allow further question to be answered.

2. Have you ever met someone who you think may have been an advanced practitioner?
   a. If yes, how did you know?
   b. If no, where do you think you might meet an advanced practitioner?

Education training support supervisions CPD

3. What extra education and/or training do you think an Advanced Practitioner might have had? Please explain.

Assurance and accountability

4. If you had a choice, would you prefer to be seen by an advanced practitioner or a doctor? Please explain choice.
   a. If there was no choice, would you be happy to see an advanced practitioner instead of a doctor?

5. Do you think an advanced practitioner should be held accountable for your care in the same way a doctor would be? Please explain.

Risk/Patient safety

6. Are you aware that healthcare professionals are regulated?
   a. Are you aware of the different organisations that regulate healthcare professions? Please provide example
   (There are 10 in total: e.g. NMC/GMC/HCPC/SWE/GCC/GOC/PSAHSC)

Regulation

Covered in risk section

Additional comments

7. Is there anything else you wish to add?

Appendix 5: Coding guide for quotations

Code	Meaning
/S*	Identifies speaker within the focus group by number (e.g. /S3 = speaker 3)
GOV*	Identifies a Chief AHP, Chief Sc.Off. or Health Education Lead
ENG*	Identifies the Advanced Practitioner focus group in England
NI	Identifies the Advanced Practitioner focus group in Northern Ireland
SCO*	Identifies the Advanced Practitioner focus group in Scotland
WAL*	Identifies the Advanced Practitioner focus group in Wales
OHP*	Identifies interview with other health professional
TU*	Identifies interview with Trade Union
ED*	Identifies Educator focus group
EMP	Identifies Employers focus group
PB*	Identifies Professional Body focus group
PPI	Identifies Service User (Patient & Public) focus group
RSD	Registrant Survey Dietician
RSOT	Registrant Survey Occupational Therapist
RSODP	Registrant Survey Operating Department Practitioner
RSPP	Registrant Survey Practitioner Psychologist
RSP	Registrant Survey Physiotherapist
RSDR	Registrant Survey Diagnostic Radiographer
RSTR	Registrant Survey Therapy Radiographer
RSSLT	Registrant Survey Speech and Language Therapist
RSPOD	Registrant Survey Podiatrist
RSPARA	Registrant Survey Paramedic
RSCS	Registrant Survey Clinical Scientist
RSBS	Registrant Survey Biomedical Scientist
RSCH	Registrant Survey Chiropodist

*= number