# Advanced clinical practice within the diabetes multidisciplinary team: a reflective review

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**Key words**

- Advanced clinical practice
- Multidisciplinary team
- 360-degree feedback

**Article points**

1. Advanced clinical practice (ACP) is a level of practice delivered by experienced, registered healthcare practitioners
2. A small, low powered, cross-sectional study aimed to demonstrate that multidisciplinary working can help provide sustainable workforce solutions, as well as improve the working of the multidisciplinary team
3. 360-degree feedback is an excellent adjunct to clinical supervision
4. Low-powered studies can be scaled up to demonstrate benefit
5. The lower-limb diabetes MDT is an ideal place for cultivation of ACPs

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**Advanced clinical practice (ACP) is a level of practice delivered by experienced, registered healthcare practitioners. It incorporates a high degree of autonomy and complex decision making and is underpinned by a master's level award or equivalent. Most ACP roles within the UK are undertaken by nurses and it is of vital importance that allied health professionals are actively encouraged to develop their skills and knowledge through the lens of the multidisciplinary framework for advanced clinical practice and to actively seek out apprenticeship opportunities. This small, low-powered, cross-sectional study aims to demonstrate that multidisciplinary working can help provide sustainable workforce solutions and improve the workings of the multidisciplinary team (MDT). A total of 100% of respondents agreed that the ACP was able to demonstrate improved MDT working across the four pillars of advanced clinical practice. 360-degree feedback is an excellent adjunct to clinical supervision and its ability to be scaled up makes it a valuable tool in evidencing the impact of advanced clinical practice.**

The role of the advanced nurse practitioner (ANP) was pioneered in the US in the early 1940s (Sheer and Wong, 2008), it was not until the 1980s, however, that Burke-Masters and Stilwell (1984) pioneered the role within the UK (Jones, 1997). It was then developed into a formal training programme by Stilwell in 1991; however, this was primarily for nurses (Sheer and Wong 2008). The advanced practice programme has drastically evolved and has been ubiquitously adopted by universities within the UK, to be delivered at Master's (MSc) level (Jones 1997; Sheer and Wong 2008). The advanced practice toolkit (Scottish government, 2008) established a foundation on which advanced practice should be built and this was further consolidated in the multi-professional framework for advanced clinical practice (MPF) in England (Health Education England [HEE], 2017).

In 2017, HEE explicitly stated their support for multi-professional advanced clinical practice (Duncan, 2021). They recognised that the evidence consistently demonstrates that multi-professional team working delivers better outcomes for patients and more satisfying work for clinicians (HEE, 2017). HEE (2017) goes on to define advanced clinical practice as a level of practice delivered by experienced, registered healthcare practitioners. It incorporates a high degree of autonomy and complex decision making and is underpinned by a Master's level award or equivalent. The Master's level award should encompass the four pillars of advanced clinical practice i.e. education, leadership, research and clinical practice. The four pillars are further broken down into area specific capabilities to which the advanced clinical practitioner (ACP) must be able do demonstrate competence through benchmarking. This recognition, support and definition has helped to shape the development of advanced practice, training programmes throughout

the UK. HEE are undertaking the mammoth task of accrediting advanced clinical practice programmes with the goal of providing a register/directory of ACPs who are able to demonstrate competence against the standards set out within the MPF for advanced practice. Such a register will provide greater practitioner recognition, ensure parity in education and practice, which will inevitably increase public confidence; facilitating a truly multi-professional (ACP) workforce to be developed and delivered.

In order for a programme to become accredited it must meet the standards set out in the MPF and be submitted for accreditation by HEE. For an individual practitioner, however, to gain accreditation with the centre for advancing clinical practice, they must demonstrate they have either completed an accredited course, an accredited legacy programme or apply through a e-portfolio (supported) route. The centre for advancing clinical practice is accrediting programmes in a sequential manner, starting with the most recent.

Legacy programmes are described as a previous version of the programme submitted to HEE for approval or the previous version of an advanced practice programme that already holds HEE accreditation. HEE notes that legacy programmes will align to the date the programme was validated by the education provider but will be no longer than 5 years from the validation date of the existing programme (HEE, 2022). The e-portfolio route provides an alternative route for accreditation and is suitable for experienced practitioners that have a significant body of evidence which can be mapped to the MPF with little or no gaps; applications for this route have now closed but it is expected that further opportunities will be made available (HEE, 2022).

Along with accreditation, HEE has commissioned several frameworks, in order that ACPs may credential. Credentialing means that a practitioner may demonstrate they have undertaken multiple standardised, structured units of assessed learning, to ensure an advanced level of practice capability in specific areas of competence (HEE, 2022). Centre-endorsed credentials are designed to be utilised as an integral part of an accredited ACP MSc or to be utilised following a successful completion of the same. The Royal College of Emergency Medicine (RCEM) recently stated that ACPs whom credential with them partake in a significant undertaking and are able to perform at the level of a CT3 physician or RCEM tier 3 clinician (RCEM 2022).

## Why is there a need for ACPs

Currently, England requires an additional 46,300 full time doctors to put us on an equivalent standard with the EU average of 3.7 doctors per 1,000 people (BMA, 2022). Hooks and Walker (2020) acknowledge that these workforce shortages have provided the impetus for the introduction of ACPs. This does not mean, however, that ACPs are substitute doctors but indeed represent the natural evolution of a healthcare workforce adapting to meet the needs of the population it serves. The ability to operate physician-only-led paradigms of health care provision is rapidly becoming unsustainable. Advanced practice has been recognised as a cost-effective solution to overcoming workforce shortages (NHS England, 2017) this, however, is not the sole benefit to ACPs in clinical practice, and implementation of ACP interdisciplinary teams has repeatedly demonstrated improved mortality, morbidity, patient satisfaction, workflow and capacity within systems (Hooks and Walker, 2020).

Multidisciplinary working is key to providing sustainable workforce solutions (NHS 2019) and one method of meeting rising service demand is to ensure a workforce that can adapt and respond, by expanding and maximising existing roles (NHS 2014). ACP roles, however, are predominantly occupied by our nursing colleagues (Lawler et al, 2020). Stewart-Lord et al (2020) produced a comprehensive profile of ACP roles across allied health professionals (AHPs) in London and demonstrated that these roles are already having a positive impact on healthcare services and supporting new models of care. It is, therefore, essential that the AHP professions, particularly the smaller AHP professions, are encouraged to develop their skills and knowledge through the lens of the MPF and to actively seek out apprenticeship opportunities. Hyde (2021) discussed the perceived anxiety around uptake of the ACP role in England and postulated this appears to focus on the need for further regulation and recognition. With the implementation of the work by HEE, this hopefully will begin to realign the narrative and AHPs are more likely to enter this emergent workforce in the future.

## Where does the diabetic foot multidisciplinary team fit?

The diabetes lower-limb multidisciplinary team (MDT) is synonymous with interdisciplinary working, It represents the ideal environment for knowledge and skill sharing. With the introduction of the multi-professional advanced capabilities framework for limb viability (HEE, 2021), standards of advanced practice within these specialised teams has been established. I however, do not fit solely, within this capability framework and as a registered AHP expanded my personal scope of practice through the ACP apprenticeship into Acute and General Medicine. With 15 years'-worth of experience as a podiatrist working with differentiated and undifferentiated, chronic and acute conditions, I was fortunate enough in 2018, to obtain a trainee ACP post working in urgent care at North Manchester General Hospital. During my 2-year apprenticeship, I worked in our Acute Medical Unit, Accident & Emergency Department and our Ambulatory Care Unit, further expanding and consolidating my experience in managing differentiated and undifferentiated conditions affecting whole body systems. Had I planned my continued professional development (CPD) through the lens of the four pillars, I may have been ready for this undertaking at an earlier stage.

Once qualified, I began work within the Diabetes, Endocrine and General Medicine team. The foundations of advanced practice obtained through working in the lower-limb MDT translated very well across the four pillars within the MPF. Unknowingly, I had developed my career across the four pillars, engaging in multiple level 7 units of study, including prescribing. My role is now divided into 80% clinical and 20% non-clinical to ensure that I consciously and consistently develop within the four pillars of ACP. The 20% non-clinical time permits focus upon the three other pillars i.e. Leadership, Education and Research. A total of 10% of my clinical time is spent within the lower-limb MDT. This time enables me to retain my competencies in the lower limb, ensuring that when I am on the medical ward, I can continue to offer my specialist skills as a lower limb expert. This time also affords me the opportunity to work alongside my Podiatry colleagues and in so doing disseminate and share my knowledge and skills in managing the patient holistically. Being able to manage our patients in the same way as my medical colleagues frees up consultant time, increases capacity and provides the patient with an improved journey.

## How do we evidence that ACPs from AHP backgrounds add value?

All practitioners should carry out regular CPD activities (Health & Care Professions Council [HCPC}, 2022). It is, therefore, expected that those working at an advanced level of practice would develop and record their practice beyond the normal threshold (Department of Health, 2010). There are multiple methods for recording professional development (HCPC 2022). It would first be advisable that through benchmarking against the MPF, the practitioner conduct a learning needs analysis, then through reflective practice and supervision, evidence both the activities and the impact of these activities. A useful tool to provide information on impact is the method of 360-degree feedback. The notion of 360-degree feedback is considered a key didactic element of medical education and should include specific information about the comparison between a trainee's observed performance and a standard; it should also incorporate a method for elaboration of how performance could be improved (Engerer et al, 2016). In the case of advanced clinical practice, the standard would be the MPF and the pillars therein.

## Method

A Google form was developed that encompassed two questions in each of the four pillars totalling eight questions, with a ninth question asking what the ACP should start doing or stop doing was incorporated so that, elaboration on how the ACP might improve could be provided. In order to ensure congruent feedback, email addresses were not collected and other than role nomenclature, feedback was provided anonymously. Twenty members of staff i.e. each member that the ACP worked with over a 24-hour period, were asked to provide feedback.

## Results

Fifteen of 20 responses were received, representing a 75% response rate. These were comprised of three health care assistants, two foundation year doctors, two internal medicine trainees, one nurse, four consultants, one podiatrist and two specialist registrars.

### Education

Q1. Does the ACP within the MDT deliver or is a source of medical education/training for peers?
Q2. Does the ACP facilitate the medical education of others within the MDT?

Some 100% of those who responded agreed or strongly agreed that the ACP is a source of medical education or training and facilitates the medical education of others within the MDT.

### Clinical

Q3. Does the ACP contribute to the clinical skills and clinical knowledge of the MDT?
Q4. Does the ACP improve patient care and the management of the departments clinical case load?

A total of 100% of respondents agreed or strongly agreed that the ACP contributes to the clinical skills and knowledge of the MDT while improving patient care and the management of the department's caseload.

### Audit/research

Q5. Does the ACP identify areas for research, audit, or quality improvement projects?
Q6. Does the ACP undertake, support or facilitates research, audit, or quality improvement projects?

One-hundred per cent of respondents agreed or strongly agreed that the ACP identifies areas for research, audit, or quality improvement projects and that the ACP undertakes, supports or facilitates this.

### Leadership

Q7. Does the ACP when appropriate, provide clinical or operational leadership within the MDT?
Q8. Does the ACP improve communication and teamwork within the MDT?

One-hundred per cent of respondents agreed or strongly agreed that the ACP, when appropriate, provides clinical or operational leadership and improves both communication and teamwork within the MDT.

### Opportunity for constructive feedback

Q9. Is there anything that the ACP should stop doing, continue doing or start doing?

No negative comments were recorded by those who responded. Thematic analysis demonstrated that the MDT found the ACP to be a highly valued asset. The ACP was appreciated as contributing to the communication within the MDT and facilitating good teamworking. The ACP was commended for their expert clinical knowledge and the support they offer to the working of the MDT. It was also acknowledged that the ACP provided excellent educational opportunities, and both supported and facilitated the education of others. The ACP was encouraged to continue working in the same manner. Nothing was identified that the ACP should stop doing and nothing was recommended for them to consider start doing either.

## Discussion

This small, low-powered, cross-sectional study also known as 360-degree feedback supports the supposition that ACPs from AHP backgrounds are able to improve the MDT within the four pillars of advanced clinical practice. While this was a small study, thematic analysis demonstrates 100% positive feedback. This has the potential to be scaled up in a further cross-sectional study, to incorporate all of the hospitals ACPs. This would provide a more accurate assessment of ACP impact. If the data could be separated into base profession, this could indeed present a descriptive narrative of the value ACPs provide within the medical team and the wider MDT.

## Conclusion

Workforce shortages have presented an opportunity for experienced registered healthcare professionals to expand their current scope of practice and take on roles and responsibilities that were traditionally undertaken by physicians. Advanced clinical practice is multi-professional and underpinned by the MPF. It is essential for clinicians to benchmark their current practice using the MPF in order to plan their professional development through the lens of the four pillars and the capabilities within. This small reflective study was low-powered, however, it has the potential to be scaled up and utilised within a Trust or even nationally to provide both quantitative and qualitative data with regards to the impact ACPs, in particular, ACPs from an AHP background, have within their respective organisations and on a national level. Integrating 360-degree feedback is an ideal tool for utilisation in the ongoing supervision of the ACP. ■


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