Evaluation of the Health Education England (HEE) South West Pilot of Supported Training for Emergency Care Advanced Clinical Practitioners (2019-2022)

FINAL REPORT

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Authors:

Suzanne Ablard (Research Associate)[1]
Joanna Sutton-Klein (Research Assistant)[1]
Colin O'Keeffe (Research Fellow)[1]
Jedidah Mould (Research Associate)[1]
Fiona Sampson (Senior Research Fellow)[1]
Maxine Kuczawski (Research Associate)[1]
Susan Croft (Consultant in Emergency Medicine)[1]
Suzanne Mason (Professor of Emergency Medicine)[1]
Lisa Munro-Davies (Advancing Practice Clinical Faculty Lead)[2]

1. Centre for Urgent and Emergency Care Research (CURE), School of Health and Related Research, University of Sheffield, Sheffield, UK
2. South West Regional Faculty for Advancing Practice, Health Education England, UK

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Table of Contents

Section A:

Glossary

- **Clinical Lead for the Pilot:** Credentialed Emergency Care Advanced Clinical Practitioners (EC ACPs) who were appointed as clinical leads for the Health Education England South West (HEE SW) pilot. Primarily responsible for monitoring the progression of pilot EC ACPs throughout their training and report any concerns back to HEE SW. Also, provide support to Consultant EC ACP Leads with regards to the implementation of the HEE SW pilot within the Emergency Department (ED).

- **Consultant Emergency Care ACP Lead:** Provides overall leadership for the clinical training, development, and supervision of the ACP team within the ED. Also responsible for the implementation of the HEE SW pilot within the ED.

- **Credentialed ACP Lead:** Works within EDs taking responsibility for the leadership and strategic development of Advanced Practice staff, both trainees and qualified, as well as supporting educational supervisors, and engaging directly with Higher Education Institutes (HEIs) for the delivery of academic modules, in addition to their clinical role.

- **Educational Supervisor:** A consultant who has completed the Royal College of Emergency Medicine (RCEM) ACP supervisor study day and is responsible for the overall supervision and management of a specified ACP trainee's educational progress during their training.

- **Non-pilot Emergency Care Advanced Clinical Practitioners (Non-pilot EC ACP):** Trainee Emergency Care ACPs undertaking existing EC ACP training. Some NHS Trusts may have applied for funding for course fees for the MSc in Advanced Practice via the NHS Apprenticeship scheme. However, the only condition of the NHS Apprenticeship scheme is that 20% of paid time must be released for educational activity; it offers no further direct training or educational support.

- **Pilot Emergency Care Advanced Clinical Practitioners (Pilot EC ACP):** Trainee Emergency Care Advanced Clinical Practitioners (EC ACP) participating in the HEE SW pilot. The HEE SW pilot aimed to establish whether EC ACP training could be better delivered and training improved if the following was provided: course fees and salary support to enable trainee supernumerary working; access to a variety of specialty wide placements (anaesthetics, ICU, and acute medicine); regional peer support to create a community of practice for trainees and trainers; regional training; and annual reviews of training.

- **MSc in Advanced Practice:** The MSC in Advanced Practice is mainly a generic programme of learning covering the 4 pillars of Advanced Practice at Masters level.

Exact module composition varies; it usually includes teaching on clinical examination, research, and prescribing, and will require the completion of a dissertation. Completion of an MSc in Advanced Practice is a requirement of the RCEM credentialing process.

- **Multi-professional framework for advanced practice:** A national framework published by Health Education England (HEE) in 2017, which was developed to ensure national consistency and understanding about advanced level practice. According to this framework: "Advanced clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a Masters level award or equivalent that encompasses the four pillars of clinical practice: leadership and management; education; and research, with demonstration of core capabilities and area specific competence."

- **Royal College of Emergency Medicine (RCEM) e-portfolio:** EC ACPs (predominantly nurses and paramedics working in emergency care) who wish to complete EC ACP credentialling with RCEM must complete an e-portfolio to collect evidence against each requirement in the EC ACP curriculum.

- **Royal College of Emergency Medicine (RCEM) credentialing:** Mechanism whereby trainee and established EC ACPs present evidence of their achievements and competences to be evaluated against the RCEM EC ACP curriculum. A trained panel assesses the evidence contained in the e-portfolio to decide whether the trainee EC ACP has achieved the defined competencies.

- **South West Regional Faculty for Advancing Practice (South West Faculty):** A regional body within HEE that was set up in 2020 (11 months after the HEE SW pilot was established). The South West Faculty provides support and guidance to aspiring and current advanced practitioners, organisations, and Sustainability and Integrated Care Systems (ICS). They aim to lead and promote advanced practitioners as part of national and regional workforce solutions, to enable practitioners to practice to their full potential.

- **Workplace based training:** EC ACPs undertake supervised practice within an ED (usually for a minimum of 3 years) completing workplace-based assessments which can be used as evidence for their RCEM e-portfolio.

Section B:

Key findings

- Those who enter Emergency Care Advanced Clinical Practitioner (EC ACP) training having already completed the MSc in Advanced Practice may be ready for RCEM credentialling quicker than EC ACPs who must complete the MSc in Advanced Practice alongside their workplace-based training and RCEM credentialing requirements.

- The current separation of MSc in Advanced Practice and RCEM portfolio requirements increases workload through duplication of effort for EC ACP trainees who are completing both simultaneously. Streamlining through better integration of the current requirements for separate portfolios may help reduce this workload burden.

- Supported placements into aligned areas (ICU/anaesthetics/acute medicine) have the potential to enhance training and skills acquisition. However, the COVID-19 pandemic limited placement opportunities for many trainee EC ACPs so the full impact of placement opportunities on EC ACP training cannot be determined.

- Transitional anxieties such as moving from their baseline profession (e.g. nurse or paramedic) into the ACP role are common amongst trainee EC ACPs and should be anticipated and acknowledged with appropriate support available.

- Support from other EC ACPs is beneficial for trainee EC ACPs, particularly when they transition into the role.

- EC ACP training, as for others, is compromised by workload pressures in EDs limiting training opportunities. However, ring fenced time for education delivery from senior ED clinicians as in an ‘Educator Day model’ has the potential to support completion of RCEM portfolio requirements for trainee EC ACPs.

- Trainee EC ACPs continue to struggle to define the ACP role and where it fits within multidisciplinary teams within the ED.

- EC ACPs discussed the value of increasing skills regarding the clinical pillar of the multi professional framework but the other three pillars (leadership and management; education; research) were not discussed.

Section C:

Executive Summary

Background

Advanced Clinical Practitioners (ACPs) are healthcare professionals who come from any regulated healthcare professional background (e.g. nurses and paramedics). ACPs undertake extended clinical and educational training to develop the knowledge and autonomous skills to independently assess, investigate, and treat patients.

Previously, individual EDs chose how they trained EC ACPs resulting in ACPs being trained and utilised in an ad hoc manner. Some NHS Trusts may have applied for funding for course fees for the MSc in Advanced Practice via the NHS Apprenticeship scheme. However, the only condition of the NHS Apprenticeship scheme is that 20% of paid time must be released for educational activity; it offers no further direct training or educational support. It was not unusual for trainee EC ACPs to spend over 6 years "in training" before they complete the Royal College of Emergency Medicine (RCEM) credentialing.

Attempting to tackle these problems a pilot for supported EC ACP training funded by Health Education England (HEE) was initiated within 5 emergency departments (EDs) across South West (SW) England. The aim of the pilot was to establish whether EC ACP training could be better delivered and training improved, with training time decreased from 6+ years, if the following was provided: course fees and salary support to enable trainee supernumerary working; access to a variety of specialty wide placements (anaesthetics; ICU; acute medicine); regional peer support to create a community of practice for trainees and trainers; regional training; and annual reviews of training.

Timeline of significant events

September 2019: Health Education England South West (HEE SW) pilot starts

March 2020: COVID-19 pandemic – continues throughout the duration of the HEE SW pilot

August 2020: HEE centre for Advanced Practice established and regional centres for Advanced Practice set up (e.g. South West Regional Faculty for Advancing Practice)

Study overview

Our study was undertaken across 5 EDs which had participated in the HEE pilot. Prior to the implementation of the pilot, all these EDs had employed trainee EC ACPs in small numbers utilising the NHS Apprenticeship funding to support course fees with no other additional funding support available for trainees or supervisors. Typically, prior to the implementation of the pilot, it would take a minimum of 4 years but often 6+ years for EC ACPs to achieve RCEM credentialling in these EDs. During this pilot all EDs continued to train pre-existing and new non-pilot EC ACPs alongside the new pilot EC ACPS.

We used surveys and semi-structured interviews to compare the experiences and views of undertaking EC ACP training between EC ACPs funded by the HEE SW pilot (pilot EC ACPs) and EC ACPs not participating in the HEE SW pilot (non-pilot EC ACPs).

We also undertook semi-structured interviews with Consultant EC ACP Leads and Clinical Leads for the HEE SW pilot to explore their experiences of supervising pilot EC ACPs and implementing the HEE SW pilot in their ED.

Results

1. Survey

Thirteen pilot EC ACPs and 5 non-pilot EC ACPs completed the survey. The relatively small sample size necessitates that only cautious conclusions can be drawn from the survey results.

All pilot and non-pilot EC ACPs said they had a named supervisor, and a portfolio to complete, and most said they had protected time to attend University. Most pilot and non-pilot EC ACPs had an RCEM credentialing target.

All pilot and non-pilot EC ACPs were predominantly satisfied with their training experience. Pilot and non-pilot EC ACPs were least satisfied with the opportunities to undertake placements in other departments. It is important to note that whilst pilot EC ACPs were expecting to attend speciality wide placements as part of the pilot, due to the COVID-19 pandemic placement opportunities were severely restricted. This was out of the control of the HEE SW pilot.

Non-pilot EC ACPs tended to report greater self-assessed confidence managing common conditions compared to pilot EC ACPs, possibly because they had been in training for longer than pilot EC ACPs. Pilot EC ACPS reported mixed experience with regards to how confident they felt performing practical techniques, with pilot EC ACPs reporting being most experienced in defibrillation and suturing. Pilot EC ACPs reported feeling less experienced with x-ray interpretation and arterial blood gas analysis. Non-pilot EC ACPs reported feeling most experienced suturing and less experienced performing defibrillation. It is important to note that these findings are based on self-assessed "confidence", rather than objectively assessed "competence". We did not have access to the trainee EC ACPs competency assessments to observe how well placed these confidences are.

2. Interviews

Twenty-five interviews: 13 pilot EC ACPs, 5 non-pilot EC ACPs, and 7 strategic leads (2 Clinical Leads for the pilot, and 5 Consultant EC ACP Leads).

See table 1 for an overview of the themes and sub-themes identified.

Table 1. Overview of the themes and sub-themes:

Acquisition of knowledge	
1. Knowledge gaps	• Trainee EC ACPs have significant clinical experience, but their clinical decision making is driven by pattern recognition; they have seen the patient presentation numerous times and can pre-empt the final diagnosis based on this. However, they lack clinical knowledge about the pathophysiological mechanisms underlying a clinical diagnosis.
2. Synergy between MSc in Advanced Practice and workplace-based training	• A disconnect was identified between the clinical and academic elements of the training. • One suggestion provided by respondents was that medical colleagues could be invited to lecture on the MSc in Advanced Practice to create greater synergy between the academic and clinical elements of their training. There may be other strategies that could be useful in this context, but these were not voiced by the respondents.
3. Workload pressure	• Trainee EC ACPs highlighted the immense struggle they experience balancing demands associated with the clinical and academic elements of their training and significant life events. • Streamlining the requirement for separate portfolios for the clinical and academic elements of their training was suggested by respondents.
Structure versus flexibility	
1. Pre-existing skills and experience	• While not a stated goal of the pilot, some respondents perceived an expectancy that EC ACPs could be trained and ready for credentialing within 3 years (possibly as the pilot itself was funded for 3 years). Completion of training in 3 years was considered challenging for many EC ACPs due to the variability in the pre-existing skills and knowledge of staff entering ACP training programmes. • Identifying credentialing targets on a case-by-case basis was an alternative approach suggested by respondents.
Leadership and supervision	
1. External oversight	• Additional supervision and oversight by HEE SW provided an enhanced training experience. • The specific extra funding given to EDs by HEE SW was described as “invaluable”.
2. Supervision of trainee EC ACPs	• Trainee EC ACPs were satisfied with the overall support received from medical colleagues and other EC ACPs. However, increased ED pressures reduced senior ED staff capacity to conduct workplace-based assessments for trainee EC ACPs which are essential for completion of the RCEM e-portfolio. • Some Consultant ED teams had implemented “educator days” where consultants had protected time to deliver

	training and supervision to all ED trainees (not just EC ACPs).
Transitioning into the ACP role	
1. Expert-novice-expert transition	• The transition moving from being an "expert" senior decision maker in their baseline profession (e.g. nurse or paramedic) to becoming a "novice" trainee ACP was challenging for all trainee EC ACPs. • Peer support from other trainee EC ACPs was described as invaluable. It was felt medical colleagues did not necessarily understand the unique challenges experienced by trainee EC ACPs.
2. Role identity	• Trainee EC ACPs described struggling to embrace the ACP title, describing themselves as a nurse or paramedic with extended skills rather than an "ACP". • ACPs encountered difficulties referring patients to radiology and other specialities across the hospital because of a lack of awareness or misunderstanding of the ACP role.

Conclusion

Overall, trainee EC ACPs participating in the HEE SW pilot were predominantly satisfied with their training experience. There is evidence that elements of the HEE SW pilot enhanced training experiences, such as opportunities to attend specialty wide work placements, and external oversight of training progress. Challenges experienced by trainee EC ACPs tended to be out of the control of the HEE SW pilot, such as: exponential pressures on EDs leading to reduced senior ED clinician capacity to provide training and educational opportunities; transitional anxieties moving from their baseline profession (e.g. nurse or paramedic) into the ACP role; and educational, personal, and work-based pressures. It is important to note that the HEE SW pilot took place during the COVID-19 pandemic, which meant elements of the HEE SW pilot were not able to go ahead as planned. For example, placement opportunities were severely restricted, and face to face regional support days could not be organised due to government restrictions on social contact at the time (but virtual training opportunities were implemented and delivered as an alternative). Despite this, respondents were supportive of the HEE SW pilot and could see the long-term benefits of a supported training structure on EC ACP training.

1. Background and study aims

1.1. Background

Advanced Clinical Practitioners (ACPs) are healthcare professionals who come from any regulated healthcare professional background (e.g. nurses and paramedics). ACPs undertake extended clinical and educational training to develop the knowledge and autonomous skills to independently assess, investigate, and treat patients. There is evidence these roles improve both service outcomes and quality of patient care.[1-2]

Historically there has been variable role definitions and training routes for ACPs resulting in these roles being introduced in an ad hoc manner, to address gaps in service provision.[3] Attempting to tackle this variation and to bring a clearly defined quality standard into Advanced Practice training, Health Education England (HEE), NHS England (NHSE) and NHS Improvement (NHSI) co-produced a multi-professional framework for advanced clinical practice in England.[4] According to this framework:

"Advanced clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of: clinical practice; leadership and management; education; and research, with demonstration of core capabilities and area specific competence." [4]

The multi-professional framework is the first time that a national framework defining advanced practice has existed in England. It aims to create a shared understanding of what advanced level practice entails and includes an overview of how ACPs can be deployed to deliver better patient care. However, despite the development of this improved definition, training and supervision for new ACPs still varies considerably across specialties and sites.[3] Furthermore, it is often reported that ACPs are not working to their full potential, primarily operating within the clinical pillar of their role, exacerbating the misconception that ACPs are primarily seen as a solution to filling workforce gaps. Often their capabilities and potential within the other three pillars, especially research and education, are less visible and less well recognised.[5]

Building on previous work aiming to standardise ACP roles, the Royal College of Emergency Medicine (RCEM) in collaboration with HEE have published an Emergency Care ACP curriculum which is fully endorsed by the General Medical Council (GMC).[6] On completion of their emergency care training the ACP goes through a credentialing process where they provide evidence (e.g. completion of the MSc in Advanced Practice and RCEM e-portfolio) to demonstrate they have achieved defined curriculum competencies. Furthermore, in 2020 HEE established a Centre for Advanced Practice with the core purpose of developing agreed national training standards for advanced practice education that meet the requirements of the multi-professional framework. The Centre is developing scope of practice specific capability frameworks and credentials across a range of areas, aiming to integrate these within the MSc in Advanced Practice wherever possible to streamline training whilst maintaining standards in education and practice. Both elements aim to generate greater consistency in the

educational pathways of future ACPs, with the long-term goal of ensuring employers have a workforce consisting of qualified, credentialed ACPs. Further research should assess the impact of the multi-professional framework and training programmes on role identity issues in the long term.

In September 2019 a pilot of supported training for EC ACPs was implemented in 5 emergency departments (EDs) across South West (SW) England funded by HEE. The aim of the pilot was to establish whether EC ACP training could be better delivered and training improved, with training time decreased from 6+ years, if the following was provided: course fees and salary support to enable trainee supernumerary working; access to a variety of specialty wide placements (anaesthetics; ICU; acute medicine); regional peer support to create a community of practice for trainees and trainers; regional training; and annual reviews of training.

Prior to commencement of the pilot, individual EDs organised the training for EC ACPs within their department. It was not unusual for trainee EC ACPs to spend over 6 years "in training" before they finish completing the MSc in Advanced Practice and other requirements of RCEM EC ACP credentialing. Some NHS Trusts may have accessed funding for course fees for the MSc in Advanced Practice via the NHS Apprenticeship scheme. However, the only condition of the NHS Apprenticeship scheme is that 20% of paid time must be released for educational activity; it offers no further direct training or educational support.

Table 2 highlights the similarities and differences between the HEE SW pilot and existing EC ACP training

Table 2. Differences between existing EC ACP training and the HEE SW pilot

	Existing EC ACP training	HEE SW pilot
Who co-ordinates the training?	Individual NHS Trusts	Originally HEE SW Associate Dean for Workforce Transformation, but since 2020 the HEE SW pilot has been supported by the HEE South West Regional Faculty for Advancing Practice
How much funding is received?	None. MSc Tuition fees only available via application from NHS Apprenticeship scheme	Tuition fees for the MSc in advanced practice (where the NHS Apprenticeship scheme not accessed); funding for additional courses (e.g. life support and x-ray interpretation); salary support for trainee EC ACPs (100% year one; 80% year two; 50% year three); and funding for consultant educational supervision (0.25 PA per week per trainee)
Required to complete the RCEM e-portfolio?	Yes	Yes
Required to complete a MSc in Advanced Practice?	Yes	Yes
Required to attend annual quality reviews?	No	Yes
Required to attend formalised placement opportunities?	No	Yes (anaesthetics, ICU, and acute medicine)
Required to have supernumerary time?	20% time release for study (if applied for funding through the NHS Apprenticeship scheme)	Yes: Year 1 – 100%; Year 2 – 80%; Year 3 – 50%

1.2. Study aims

The purpose of our study was to evaluate the HEE SW pilot. Specifically, we explored:

- The experiences of trainee EC ACPs participating in the HEE SW pilot (Pilot EC ACPs) compared to trainee EC ACPs who undertook standard EC ACP training (Non-pilot EC ACPs).

- The experiences of Consultant EC ACP Leads and Clinical Leads for the HEE SW pilot who were involved in the supervision and implementation of the pilot training programme.

Section D:

2. Methods

2.1. Design and setting

The study was undertaken across 5 EDs involved in the HEE SW pilot commencing September 2019: University Hospitals Plymouth NHS Trust, Taunton and Somerset Foundation Trust, Torbay and South Devon NHS Foundation Trust, University Hospitals Bristol NHS Foundation Trust, and North Bristol NHS Trust. Prior to the implementation of the pilot, all these EDs had employed trainee EC ACPs in small numbers utilising NHS Apprenticeship scheme funding to support course fees with no other additional funding support for trainees or supervisors. Typically, prior to the implementation of the HEE SW pilot, it would take at least 4 years but often over 6+ years for EC ACPs to achieve RCEM credentialling in these EDs. All EDs continued to train pre-existing and new non-pilot EC ACPs alongside the new pilot EC ACPS.

Our service evaluation comprised two work packages:

Work package 1:

We undertook an online survey of pilot EC ACPs and non-pilot EC ACPs in each ED. The survey collected demographic information, details of their work history, confidence and competence managing patient conditions and performing practical techniques, and satisfaction with their training.

Work package 2:

Using an inductive approach, we undertook semi-structured online (via Google Meet) or telephone interviews with pilot EC ACPs and non-pilot EC ACPs to explore their experiences of undertaking EC ACP training (e.g. support and supervision, clinical and external educational opportunities, peer support and support from other colleagues, work placements), including ideas about how EC ACP training could be improved in the future. Trainee EC ACPs were also asked about their thoughts on career progression and role identity.

We also undertook semi-structured online (via google meet) or telephone interviews with strategic leads (Consultant EC ACP Leads, and Clinical Leads for the HEE SW pilot) involved in the delivery of the HEE SW pilot, as well as the supervision of pilot EC ACPs. Interviews explored: the barriers and enablers encountered with regards to the implementation of the HEE SW pilot, comparisons between existing EC ACP training and the new HEE SW pilot, and any changes they would like to make to the new HEE SW pilot.

2.2. Sampling

Pilot EC ACPs (work packages 1 and 2):

All trainee EC ACPs participating in the HEE SW pilot who commenced training between September 2019 and September 2020 were eligible to participate.

Non-pilot EC ACPs (work packages 1 and 2):

All trainee EC ACPs not participating in the HEE SW pilot working within the same 5 EDs as the pilot EC ACPs were eligible to participate, irrespective of when they first started their training. Some had already been in training for a number of years prior to the HEE SW pilot cohort commencing their training.

Strategic Leads (work package 2)

Consultant EC ACP Leads in each of the departments where the pilot EC ACPs were employed, and the Clinical Leads for the HEE SW pilot were identified and invited to participate.

2.3. Recruitment

Pilot EC ACPs:

The SW HEE team (which later became the SW Regional Faculty for Advancing Practice) provided us with the contact details (e.g. name e-mail address, and location of work) of the pilot EC ACPs.

Non-pilot EC ACPs:

Consultant EC ACP Leads working in the 5 EDs helped us identify eligible trainee EC ACPs who were not supported by the HEE SW pilot, and provided us with their contact details (e.g. name and e-mail address).

Strategic Leads:

The SW HEE team provided us with the contact details (e.g. name and e-mail address) of the Clinical Leads for the HEE SW pilot and the Consultant EC ACP Leads working in the 5 EDs.

All eligible participants were sent a study pack which included a cover letter, information sheet, link to the survey (Pilot EC ACPs and non-pilot EC ACPs only), and consent form. On completion of the survey (if applicable) and consent form a member of our study team contacted the participant to arrange a time and date for the interview.

2.4. Data collection

Work package 1:

We designed a self-report survey which incorporated elements of an earlier survey used in the EDiT Study which evaluated junior doctor training.[7] A trainee EC ACP working at Barnsley

Hospital NHS Foundation Trust piloted the survey. Based on their feedback the number of questions included in the survey was reduced and the order of the questions was re-arranged to improve participant engagement. The survey was administered online via the survey tool Qualtrics (www.qualtrics.com). A copy of the survey can be found in Appendix 1.

Work package 2:

In collaboration with the funders of this evaluation, we designed a semi-structured interview guide which was adapted for each of the participant groups. The interview schedules were piloted on a trainee EC ACP and a Consultant EC ACP Lead working at Barnsley Hospital NHS Foundation Trust. No significant changes to the interview schedule were suggested by the participants. Interviews were conducted online (using Google Meet) or over the telephone and audio recorded using an encrypted voice recorder. On completion of the interview, participants received a £30 shopping voucher to thank them for their time. A copy of the interview schedules can be found in Appendix 2.

2.5. Analysis

Work package 1:

Survey data was downloaded to Microsoft Excel and analysed descriptively.

Work package 2:

Interviews were transcribed verbatim and thematically analysed using an inductive approach following the stages described by Braun and Clarke: familiarising ourselves with the data; generating initial codes; searching for themes; and reviewing, defining and naming themes.[8] Data were compared across interviews to look for similarities and differences between them. One member of the study team (SA) completed most of the analysis (Pilot EC ACPs, Consultant EC ACP Leads, and Clinical Leads for the HEE SW pilot) and another member of the study team (JM) completed the analysis for the non-pilot EC ACPs. Emerging themes were discussed with the wider study team and the research funders. The research funders provided contextual information which helped us interpret and understand the results within the wider policy context. NVivo 12.0 (QSR International),[9] was used to help structure the analysis.

2.6. Ethical considerations

The School of Health and Related Research (ScHARR) Ethics Committee, based at the University of Sheffield, granted ethical approval for the study (Ref 037842).

Section E:

3. Work package 1 results

3.1. Sample characteristics

Thirteen pilot EC ACPs and 5 non-pilot EC ACPs participated in the survey.

The relatively small sample size necessitates that only cautious conclusions can be drawn from the survey results.

3.2 Demographics and professional background

Pilot EC ACPs:

There were 8 female pilot EC ACPs (62%) and 5 male pilot EC ACPs (38%). Most of the pilot EC ACPs (n =10, 85%) were aged between 35-44 years. All the pilot EC ACPs surveyed had professional backgrounds in either nursing or paramedicine, with a roughly even split between these. All 13 pilot EC ACPs were from a white ethnic background.

The mean length of time that the pilot EC ACPs had worked in their previous profession (e.g. nurse or paramedic) was 11 years, with a range of 6-20 years.

Non-pilot EC ACPs:

There were 2 male non-pilot EC ACPs (40%) and 3 female non-pilot EC ACPs (60%). The non-pilot EC ACPs were aged between 35-54 years. All 5 non-pilot EC ACPs were from a white ethnic background. Most of the non-pilot EC ACPs had professional backgrounds in nursing (n=4, 80%).

The mean length of time that the non-pilot EC ACPs had worked in their previous profession (e.g. nurse or paramedic) was 14 years, with a range of 9-24 years.

See Table 3 below for more detail on demographic and professional background.

Table 3: Demographics and professional background

Variable	Pilot EC ACPs N (%)	Non-pilot EC ACPs N (%)
Gender		
Male	5 (38)	2(40)
Female	8 (62)	3 (60)
Age		
18-24	0 (0)	0 (0)
25-34	2 (15)	0 (0)
35-44	10 (77)	3 (60)
45-54	1 (8)	2 (40)
55-64	0 (0)	0 (0)
64+	0 (0)	0 (0)
Ethnicity		
Asian or Asian British	0 (0)	0 (0)
Black or Black British	0 (0)	0 (0)
Mixed	0 (0)	0 (0)
White	13 (100)	5 (100)
Any other ethnic group	0 (0)	0 (0)
Previous profession prior to becoming an ACP		
Nurse	6 (46)	4 (80)
Paramedic	7 (54)	1 (20)

3.3 Baseline information about ACP training

The non-pilot EC ACPs had been in training longer than the pilot EC ACPs, with 4 (80%) in training between one and three years prior to pilot EC ACPs. No pilot EC ACPs had been in EC ACP training prior to joining the pilot Most of the pilot EC ACPs were undertaking adults only training (n=9, 69%), whereas half of the non-pilot EC ACPs were undertaking adult only training (n=2, 40%) and half were undertaking adult and paediatric training (n=2, 40%). All the pilot EC ACPs and non-pilot EC ACPs had named supervisors and portfolios, and most of the pilot EC ACPs (n=12, 92%) and non-pilot EC ACPs (n=4, 80%) reported having protected time to attend university. Most of the pilot EC ACPs (n=11, 85%) and non-pilot EC ACPs (n=4, 80%) had a target RCEM credentialing date.

See Table 4 below for detailed baseline information on EC ACP training.

Table 4. Baseline information about EC ACP training

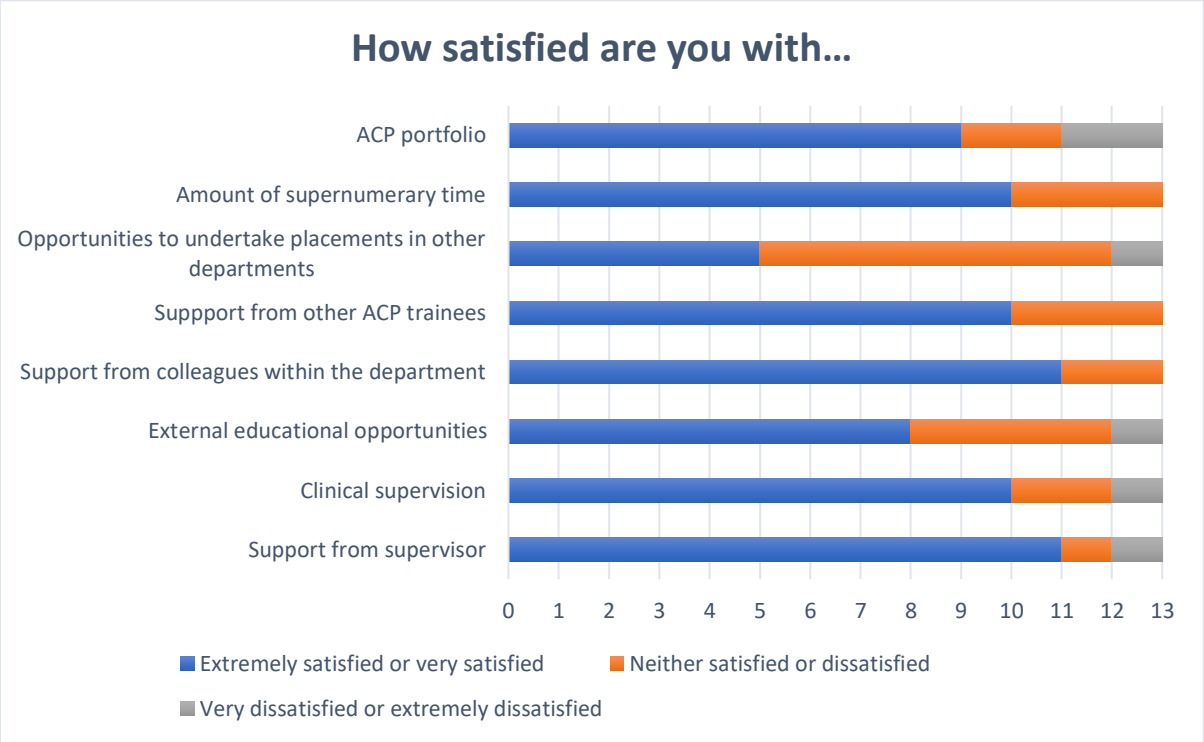
	Pilot EC ACP N (%)	Non-pilot EC ACP N (%)
When did you start ACP training?		
2016	0 (0)	1 (20)
2017	0 (0)	1 (20)
2018	0 (0)	2 (40)
2019	4 (31)	0 (0)
2020	9 (69)	1 (20)
What training route are you taking?		
Paediatrics	1 (8)	0 (0)
Adults	9 (69)	2 (40)
Both (Adults and Paediatrics)	3 (23)	2 (40)
Not known	0 (0)	1 (20)
Do you have a named supervisor?		
Yes	13 (100)	5 (100)
No	0 (0)	0 (0)
How often do you meet with your supervisor?		
Two or more times a month	3 (23)	0 (0)
Once a month	3 (23)	0 (0)
Once every two months	6 (46)	3 (60)
Once every four months	1 (8)	0 (0)
Once every six months	0 (0)	1 (20)
Infrequently	0 (0)	1 (20)
Do you have a portfolio?		
Yes	13 (100)	5 (100)
No	0 (0)	0 (0)
Are you given protected time to attend university?		
Yes	12 (92)	4 (80)
No	1 (8)	1 (20)
Do you have an RCEM credentialing date?		
Yes	11 (85)	4 (80)
No	2 (15)	1 (20)
How confident are you that you will meet your RCEM credentialing date?		
Very confident	0 (0)	2 (40)
Confident	6 (46)	1 (20)
Not sure	4 (31)	0 (0)
Unconfident	2 (15)	2 (40)
Very unconfident	1 (8)	0 (0)

3.4. Satisfaction with training

Pilot EC ACPs

Pilot EC ACPs were most satisfied with the support they received from their supervisor, other colleagues within the department, and other ACP trainees. Pilot EC ACPs were least satisfied with the opportunities to undertake placements in other departments. As part of the HEE SW pilot, pilot EC ACPs were expecting to attend specialty wide placements (anaesthetics; ICU; acute medicine). However, due to the COVID-19 pandemic placement opportunities were restricted for most trainee EC ACPs. This likely explains the dissatisfaction with placement opportunities. See figure 1 for detailed information about how satisfied pilot EC ACPs were with different aspects of their training.

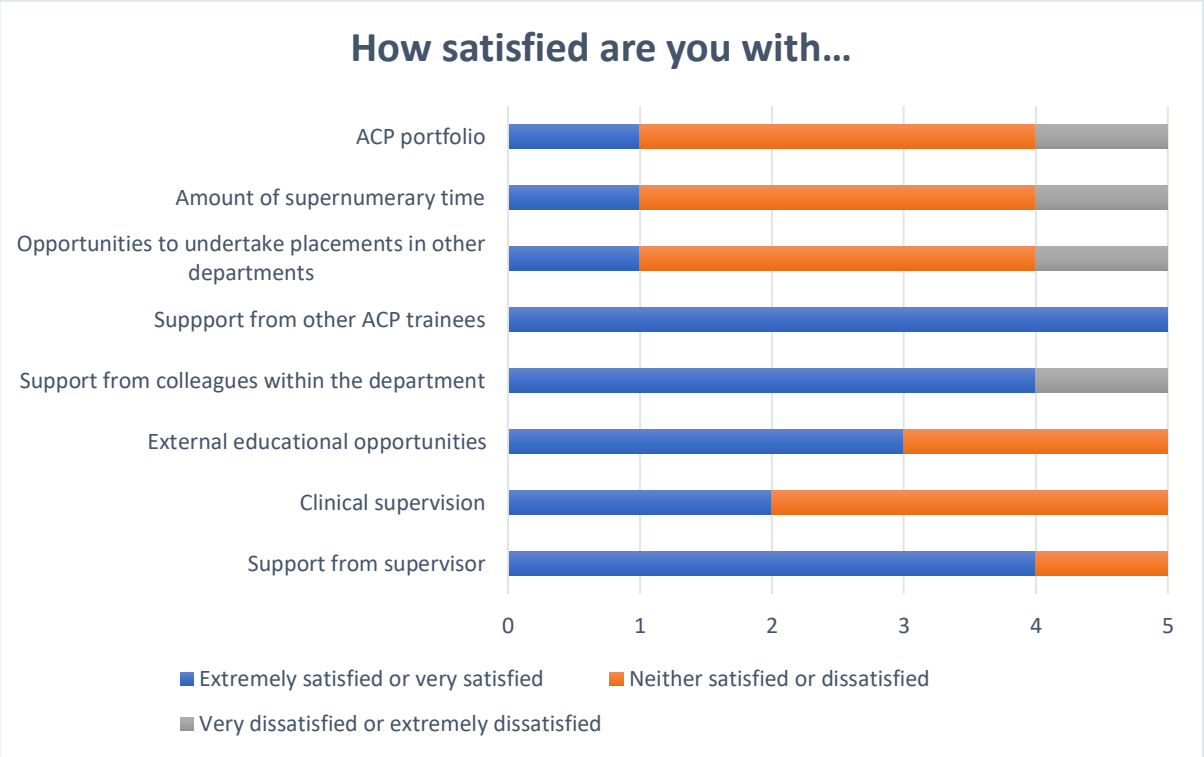
Figure 1. Pilot EC ACPs - Satisfaction with training



Non-pilot EC ACPs:

Non-pilot EC ACPs were most satisfied with the support they received from their supervisor, other colleagues within the department, and other ACP trainees. Non-pilot EC ACPs were least satisfied with the ACP portfolio, amount of supernumerary time, and opportunities to undertake placements in other departments. See figure 2 for detailed information about how satisfied non-pilot EC ACPs were with different aspects of their training.

Figure 2. Non-pilot EC ACPs – satisfaction with training



3.5. Career development

Most pilot and non-pilot EC ACPs were clear about what their future career development looked like. See figures 3 and 4 below for detailed information on career development.

Figure 3. Pilot EC ACPs – career development

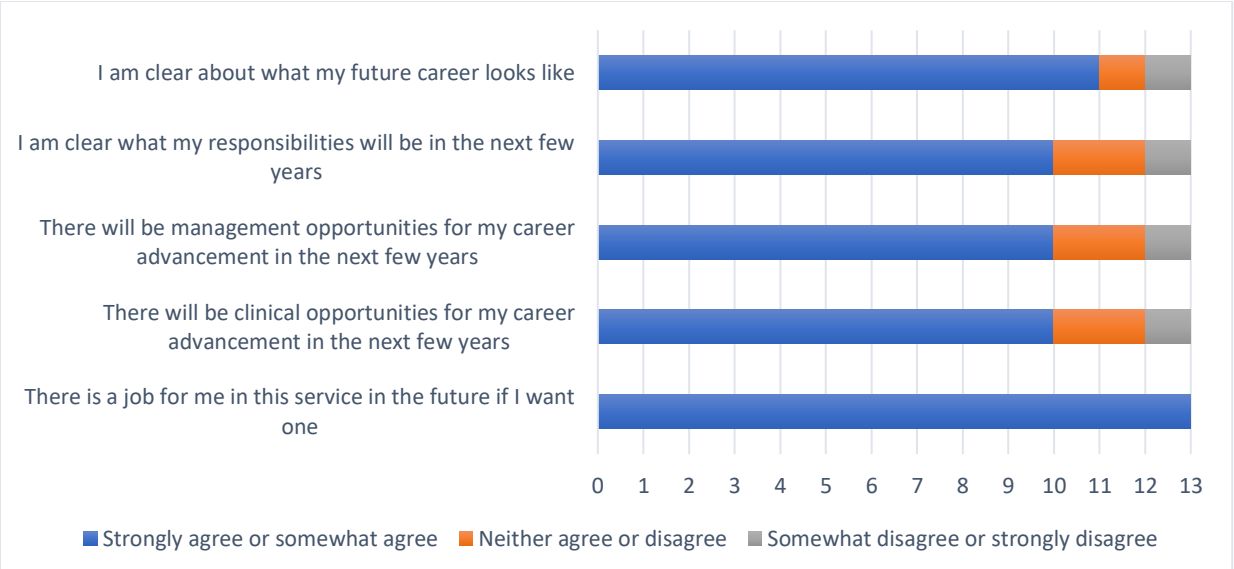
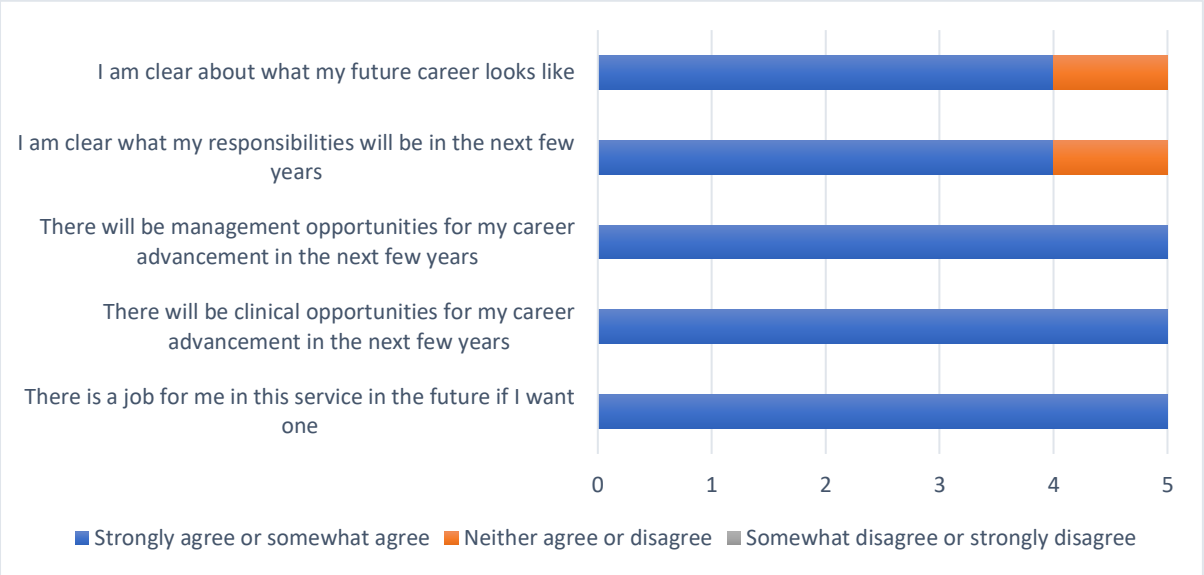


Figure 4. Non-pilot EC ACPs – career development



3.6. Attitudes towards work and job

The majority of pilot, and non-pilot EC ACPs were aware of what was expected of them with regards to their work. See figures 5 and 6 below for detailed information about attitudes towards work and job.

Figure 5. Pilot EC ACPs – attitudes to work and job

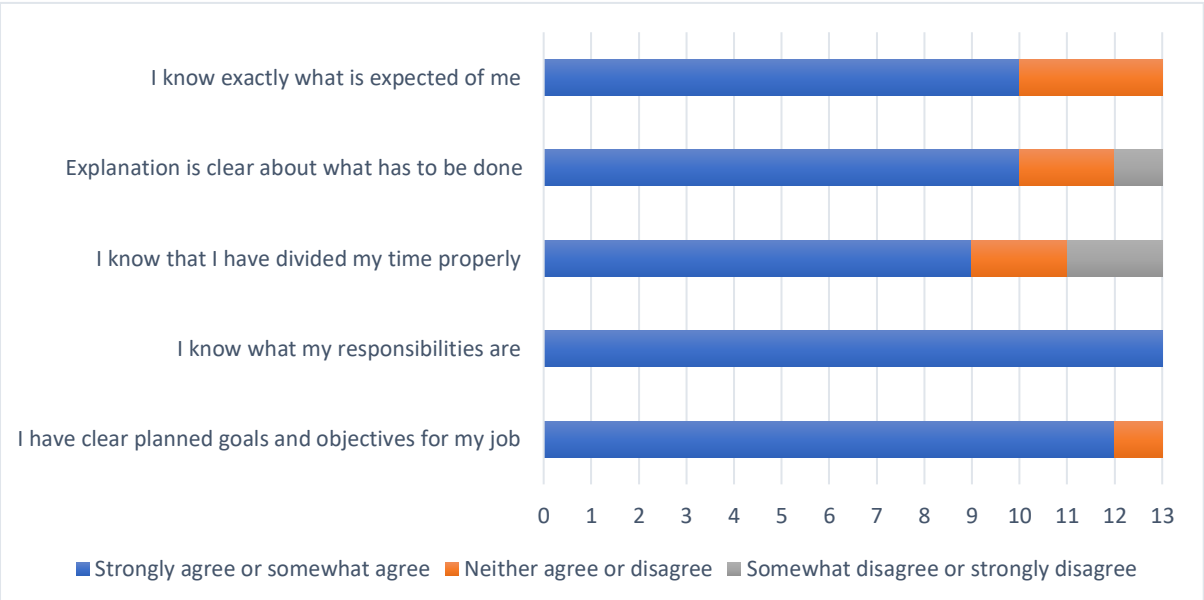
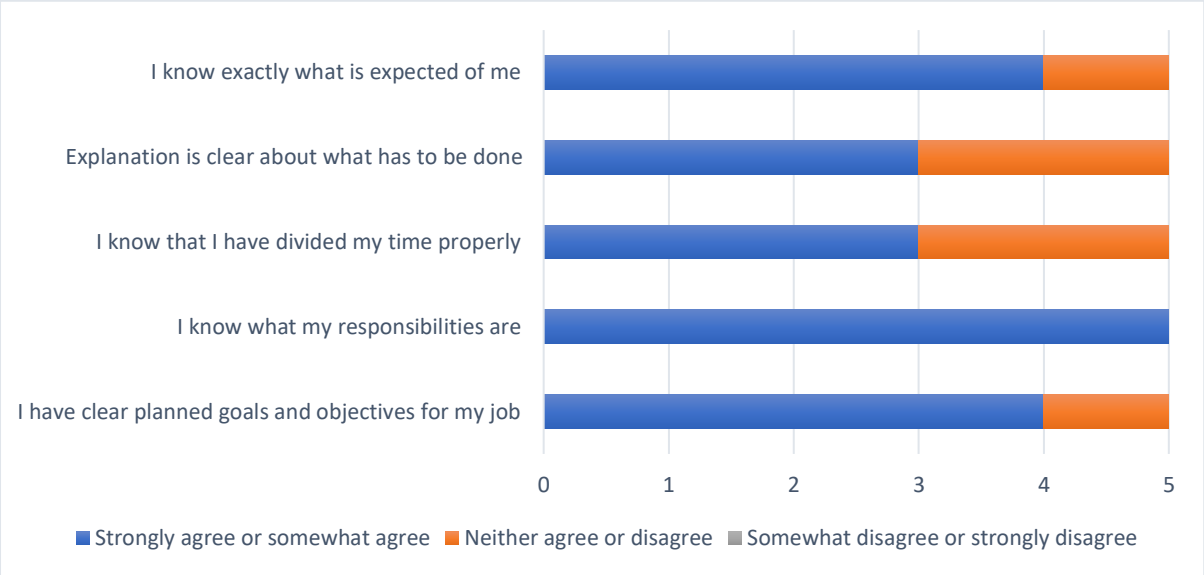


Figure 6. Non-pilot EC ACPs – attitudes to work and job



3.7. Support from manager and colleagues

Most pilot and non-pilot EC ACPs felt well supported by their managers or supervisors, and colleagues. See figures 7, 8, 9 and 10 for detailed information about support from your manager and colleagues.

Figure 7. Pilot EC ACPs – Support from manager

Figure 8. Non-pilot EC ACPs – Support from manager

Figure 9. Pilot EC ACPs – Support from colleagues

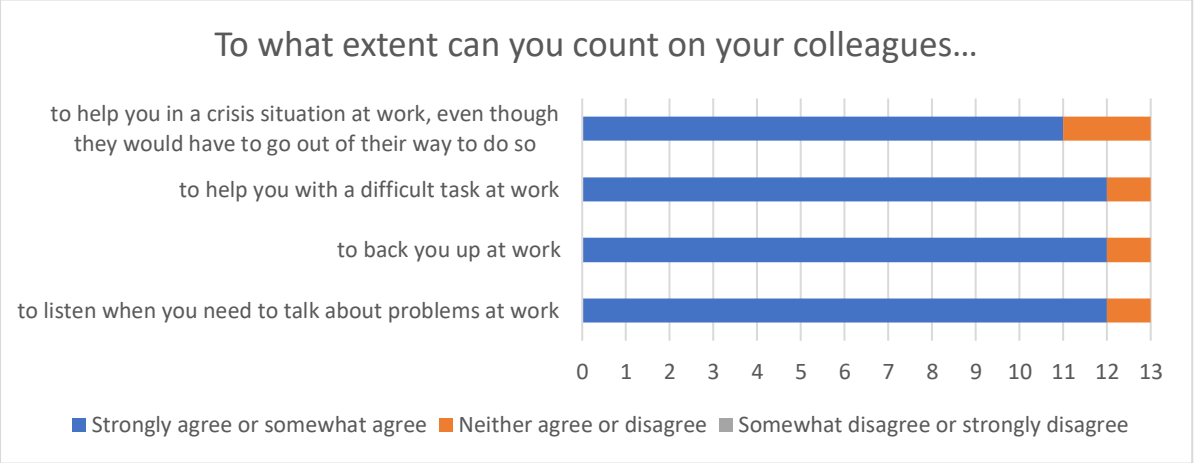
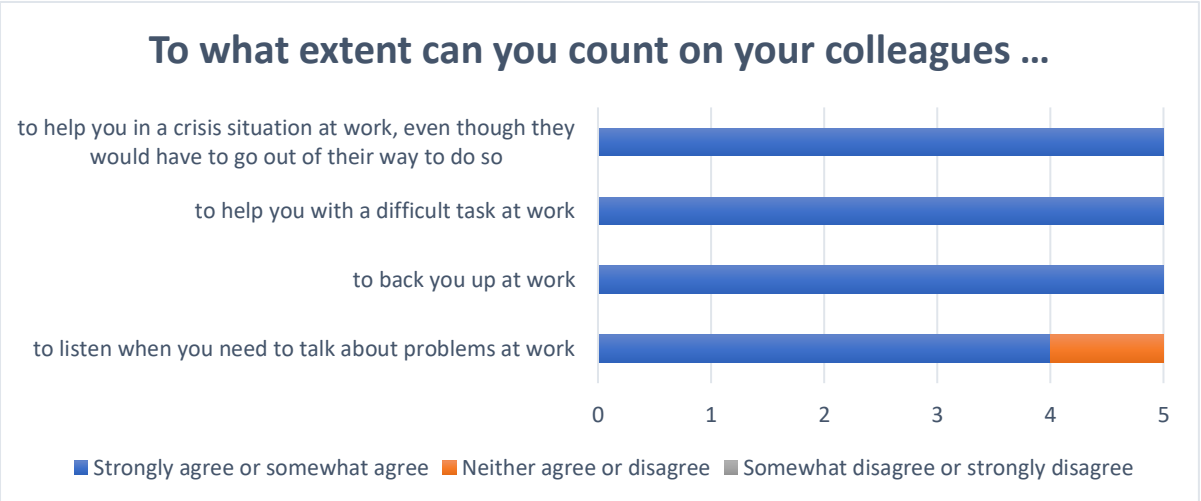


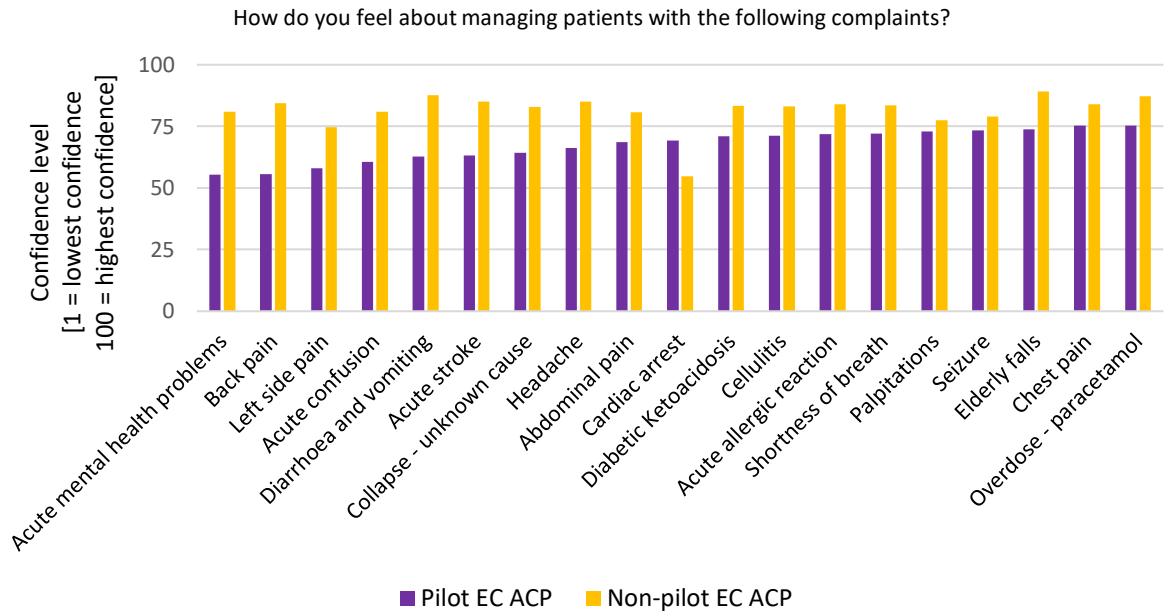
Figure 10. Non-pilot EC ACPs – Support from colleagues



3.8 Confidence managing common conditions and performing practical techniques

Pilot and non-pilot EC ACPs were asked to rate their confidence with managing common conditions. Non-pilot EC ACPs tended to be more confident managing common conditions compared to pilot EC ACPs, likely reflecting their longer duration in training compared to pilot EC ACPs. See figure 11 for detailed information about confidence managing common conditions and performing practical techniques.

Figure 11. Graph to illustrate confidence with managing conditions



Pilot and non-pilot EC ACPs were asked how experienced they felt in carrying out specific techniques. Pilot EC ACPS reported mixed experience with regards to how experienced they felt performing practical techniques, with pilot EC ACPs reporting feeling most experienced in defibrillation and suturing. Pilot EC ACPs felt less experienced with x-ray interpretation and arterial blood gas analysis. Non-pilot EC ACPs were most experienced suturing and less experienced performing defibrillation. See figures 12 and 13 for detailed information about experiences performing common practical techniques.

Figure 12. Pilot EC ACPs – experience performing common practical techniques

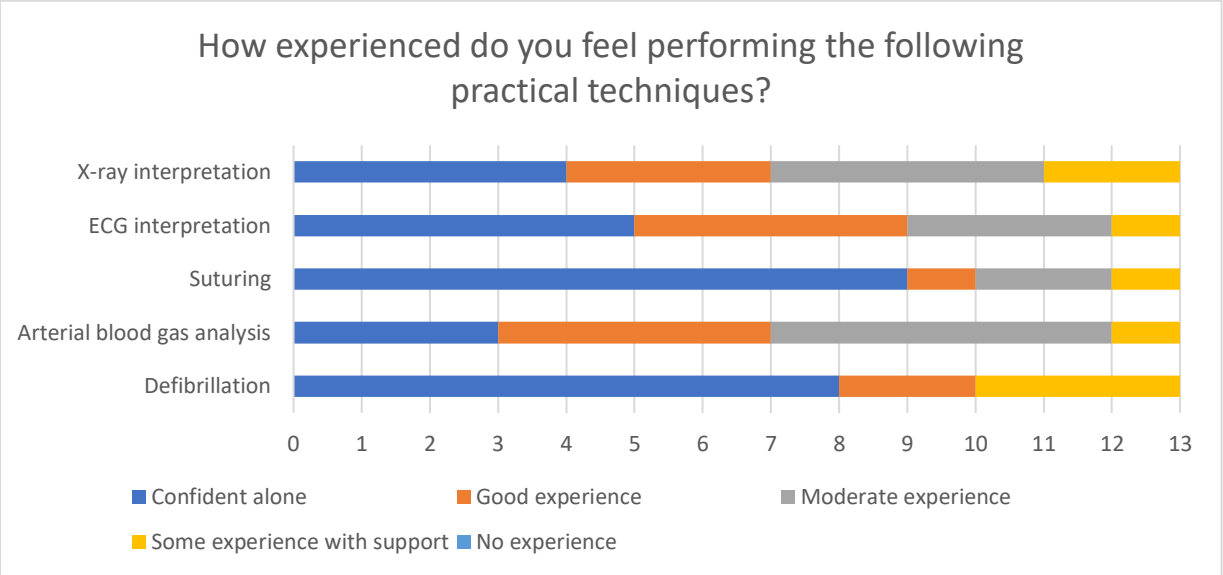
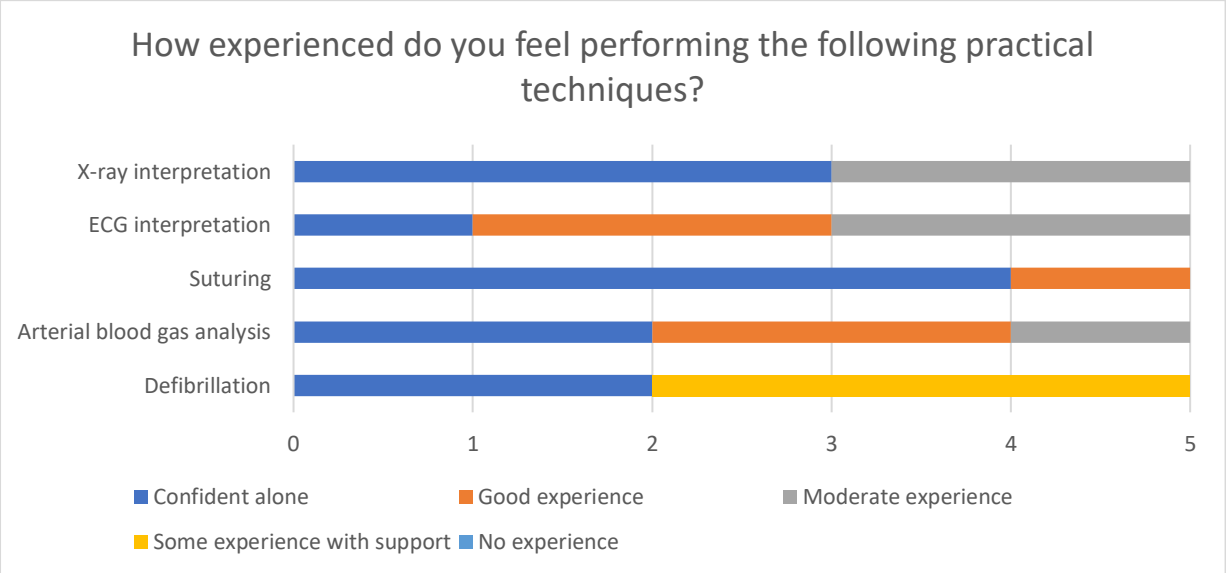


Figure 13. Non- pilot EC ACPs – experience performing common practical techniques



3.9. Summary

Due to the small sample size only cautious conclusions can be drawn from the survey data and limited comparisons made between the two groups (pilot and non-pilot EC ACPs).

However, the survey data does show that both pilot and non-pilot EC ACPs were predominantly satisfied with their training experience, with the greatest satisfaction directed towards the amount of support they received from their supervisor, other trainee ACPs, and work colleagues. Whilst pilot and non-pilot EC ACPs were least satisfied with opportunities to attend placements; it is important to note that the survey was undertaken during the COVID-19 pandemic when opportunities to attend placements was limited.

There were mixed results with regards to reported experience / confidence performing common practical techniques and managing patient presentations for both the pilot and non-pilot EC ACP groups. There was some evidence that non-pilot EC ACPs were more confident managing common patient presentations, perhaps because they had been in training for longer, however further research with a larger sample size would need to be undertaken to confidently conclude this. Furthermore, it is important to note that these findings are based on self-assessed “confidence”, rather than objectively assessed “competence”. We did not have access to the trainee EC ACPs competency assessments to observe how well placed these confidences are.

Section F:

4. Work package 2 results

25 people took part in the interviews: 13 pilot EC ACPs, 5 non-pilot EC ACPs, and 7 strategic leads (2 Clinical Leads for the HEE SW pilot, and 5 Consultant EC ACP Leads).

We combined the results from all participants into a single narrative, providing an overview of the challenges and enablers of the HEE SW pilot and EC ACP training in general, as well as suggestions about how EC ACP training could be improved in the future. The original study design included a plan to analyse data from the pilot EC ACPs and non-pilot EC ACPs separately. However, analysis demonstrated sufficient commonalities in the views and experiences of pilot EC ACPs and non-pilot EC ACPs. Therefore, in the results, for the pilot EC ACPs and non-pilot EC ACPs we use the generic term "trainee EC ACPs". Where views and experiences differed between the 2 groups, they are separately identified as "pilot" and "non-pilot" EC ACPs. This approach still allowed for identification and reporting of any differences in the training experiences between the two groups of EC ACPs.

Data saturation was reached because the core themes generated from the data were consistent across the interviews.

4.1. Overview of themes

The results have been split into main themes and sub-themes to represent the factors which impact ACP training. See table 11 for an overview of the themes and sub-themes.

Table 11. Themes and sub-themes

Theme	Sub-theme
1). Acquisition of knowledge	• Knowledge gaps • Synergy between MSc in Advanced Practice and workplace-based training • Workload pressure
2). Structure versus flexibility – one size does not fit all	• Pre-existing skills and experience
3). Leadership and supervision	• External oversight • Supervision of trainee EC ACPs
4). Transitioning into the ACP role	• Expert-novice-expert transition • Role identity

4.1.1. Theme 1: Acquisition of knowledge

- Knowledge gaps

Trainee EC ACPs reported significant clinical experience gained through many years of working for the NHS, but they said their clinical decision making is driven by pattern recognition; they have seen the patient presentation numerous times and can pre-empt the final diagnosis based on this.

However, trainee EC ACPs and strategic leads said trainee EC ACPs lack knowledge about the pathophysiological mechanisms associated with a clinical diagnosis. Below is a quote from a Consultant EC ACP Lead describing the moment they realised the learning needs differ between EC ACPs and junior doctors:

"Had this lightbulb conversation about 4 years ago with one of the trainees who's now a senior ACP and I asked her something about cardiac output and she just looked at me like this, kind of like, "come on you know about the heart, tell me about this" … and I just realised like how little basic science they knew." [Strategic lead 5]

Trainee EC ACPs were keen to increase their knowledge of biomedical science, which in turn will strengthen their clinical decision-making skills.

- Synergy between MSc in Advanced Practice and workplace-based training

Trainee EC ACPs said there were lots of opportunities to develop their clinical knowledge during their workplace-based training through supervision delivered by medical colleagues, and completion of the RCEM e-portfolio. It was reported that a strength of the HEE SW pilot compared to trainee EC ACPs not participating in the HEE SW pilot was the opportunity to attend placements in other departments across the hospital (ICU, anaesthetics, acute medicine). Unfortunately, due to the COVID-19 pandemic many pilot EC ACPs said that placements had not gone ahead as planned, but the pilot EC ACPs who had managed to attend placements said they enjoyed the experience:

"I think it's been useful to see what happens further down the line to kind of understand the patient's journey a bit more." [Pilot EC ACP 6]

With regards to the MSc in Advanced Practice there were mixed views amongst trainee EC ACPs about how useful the modules were to their workplace-based training. Some modules (e.g. physiology and diagnostic reasoning; independent prescribing) were rated very highly, whereas others were seen as more a of a tick-box exercise (e.g. the leadership module). However, as the following quote shows, there was a view amongst some of the respondents (trainee EC ACPs and consultant ACP leads) that the MSc in Advanced Practice does not fully equip trainee EC ACPs with the knowledge they need to fulfil their role within the ED:

"I think there's a stark difference. I mean, even if you compare us to the physician's assistants, they're sort of … very sort of biomedical degree, and I think their understanding of, you know, basic pathophysiology, biochemistry, just the way they're educated is very different to us… I don't think the Masters in advance practice programmes provide that … they certainly help, but not the, you know, sort of molecular level that doctors train at…. You have to learn that yourself as you go along." [Pilot EC ACP 7]

It was suggested that medical colleagues could be invited to lecture on the clinical elements of the MSc in Advanced Practice to create greater synergy between the Masters course and workplace-based training:

"I feel it should be taught by medics, like with a medical degree. It should all be done by doctor's cos then they teach you in that style. They teach you in a style that doctors have to do because then you won't have this huge gap with your skills … the structure I need to follow is the medical model. And as much as the Universities have tried to adopt the medical model and teach it to you, it's not the same thing." [Pilot EC ACP 14]

Some trainee EC ACPs had to complete a portfolio for their MSc in addition to the RCEM e-portfolio. Whilst evidence collected for their RCEM e-portfolio could be used in their MSc portfolio, trainee ACPs said the administrative workload associated with transferring evidence across two portfolios was high:

"I think the fact we have to do two portfolio's is a complete waste of our time and we should be able to go to the University, this is our RCEM portfolio, it matches to this, everything for the four pillars is within this portfolio, and that should be enough." [Pilot EC ACP 8]

- Workload pressure

Some of the trainee EC ACPs had either fully completed or partially completed the MSc in Advanced Practice prior to starting EC ACP training. Whilst these trainee EC ACPs still experienced high workload pressure, they felt that it was more manageable compared to trainee EC ACPs completing the Masters degree alongside their clinical training:

"So I think having got most of the academic stuff under my belt already gave me an advantage as it meant I could focus much more of my time specifically on getting sort of my practical stuff, my clinical knowledge, and my portfolio sorted." [Non-pilot EC ACP 4]

Trainee EC ACPs were given one "supporting professional activities" (SPA) day each week, where they could complete educational tasks off the shop floor. Trainee EC ACPs who had to complete the MSc said their SPA day was taken up with attendance at lectures. This meant they had to complete additional work (e.g. completion of the RCEM e-portfolio) outside of work hours, leaving limited time to relax:

"The modules kind of come pretty quickly in the back, back-to-back, you don't really have any let ups from the University side of things and like I say your SPA time gets eaten by University time that then doesn't give you time to concentrate on your portfolio, then you end up in this cycle of, of getting nowhere fast, all being sort of overwhelmed with workload … you can't continue to work at 120% all the time… I don't know how long that'll be sustainable for" [Pilot EC ACP 11]

Trainee EC ACPs also said significant life events (e.g. illness) and caring responsibilities added additional pressure, impacting their rate of progression:

"Trainees are going to have life events that will distract the training and I think that has to be expected and kind of factored in … so people do have bereavement, people do have these life events that you just can't plan, become unwell … So yeah, I think I haven't been particularly focused this year … it is just life events." [Pilot EC ACP 6]

4.1.2. Theme 2: Structure versus flexibility – One size does not fit all

- Pre-existing skills and experience

The HEE SW pilot provided EDs with 3 years of enhanced funding and external support to train pilot EC ACPs, with an expectation that this additional support would improve training outcomes and reduce the time it took for trainee EC ACPs to reach credentialing, which in some cases could be 6+ years. While not a stated goal of the pilot, some respondents perceived an expectancy that EC ACPs could be trained and ready for credentialing within 3 years (possibly as the pilot itself was funded for 3 years).

Trainee EC ACPs and Consultant EC ACP Leads highlighted that the pre-existing knowledge, skills, and personal circumstances of trainee EC ACPs is highly individualized and variable when they first start training. It was suggested that decisions about RCEM credentialing targets could be made on a case-by-case basis, rather than using a one size fits all approach:

"I think it's really difficult to actually say "you should be achieving this, this, and this within this timeframe", because you know, your baseline knowledge, and understanding, happiness for the context,

previous educational experience, all of that, like your family life, all of that comes into play, and has a big impact on what you're able to do, and what your most challenging parts will be." [Strategic lead 5]

"*It's clear that people progress at different speeds… you can say you'll take three years from arrival to credentialing, but some may take five, but some may be ready in two." [Strategic lead 3]*

4.1.3. Theme 3: Leadership and supervision

- External oversight

Strategic leads felt key strengths of the pilot EC ACP training programme were the external advice and guidance provided by the Clinical Leads for the HEE SW pilot and the funding provided to EDs:

"The financial aspect of it as well, being able to create a, a post, taking it to the Trust and saying well we're going to be supported by having this amount of money to support the training definitely enabled us to create more posts or to commit to those posts in a more solid way." [Strategic lead 2]

The Clinical Leads for the HEE SW pilot were primarily responsible for monitoring the progression of pilot EC ACPs throughout their training and reported any concerns back to HEE originally but then later to the SW Faculty for Advancing Practice. As part of their role, they conducted annual quality reviews with pilot EC ACPs. The purpose of the annual quality reviews was to:

"The curriculums quite big and it just offers the opportunity to review the trainees at yearly points and just make sure that they're meeting the targets, and that they've got an expectation of what's expected a year later." [Strategic Lead 7]

One pilot EC ACP described their experience of the annual quality review in the following way:

"I was worried about that initially, I think a few of us were, but actually that was a supportive process in the end and so actually that was a really useful thing to go through." [Pilot EC ACP 1]

As part of the original plan for the pilot, HEE were going to organise regional based face to face training days for trainee EC ACPs. However, due to the COVID-19 pandemic it was not possible to organise face to face meet ups. As an alternative, Clinical Leads for the pilot set up regional based virtual training sessions but attendance at these sessions was variable. Pilot EC ACPs said they would have enjoyed the opportunity to attend formalised regional face to face meet ups. However, as shown in the following quote, organising formal meetups may be difficult:

"I think maybe something a bit more formal and structured would be good but then we've all got so much going on I don't know if that would just add to the stress of being like "oh god I've got to get to this appointment at this time on this day"." [Pilot EC ACP 3]

- Supervision of trainee ACPs

Each ED had a Consultant EC ACP Lead who was responsible for co-ordinating the trainee EC ACPs workplace-based training and supervision. To ensure patient safety, an ED Consultant either physically reviewed trainee EC ACPs patients, or had a clinical conversation with them before the patient could be discharged. Additionally, the consultant team would meet regularly to discuss trainee EC ACP progression, and to raise any clinical concerns. Trainee EC ACPs said they felt well supported by their medical colleagues, in part due to these safety measures.

Trainee EC ACPs said their experiences of workplace-based supervision changed throughout the COVID-19 pandemic. During the first COVID-19 lockdown patient attendances to EDs decreased,

which meant ED consultants were readily available to help trainee EC ACPs complete workplace-based assessments for their RCEM e-portfolios. Trainee EC ACPs reported feeling very satisfied during this period. However, as the pandemic progressed, EDs experienced exponential pressures, leading to trainee EC ACPs feeling uncomfortable asking senior ED staff to help them complete workplace-based assessments required for their RCEM portfolio because they understood the workload pressures everyone was experiencing within the department:

"Having to keep going and begging consultants can you please sign this off … it's just really frustrating cause you feel bad keeping going around and begging people for things and this is what I feel like I'm doing all the time." [Pilot EC ACP 14]

Consultant EC ACP Leads acknowledged the challenges associated with delivering high quality teaching and supervision within fast-paced service delivery environments such as the ED. They described having to balance the training needs of trainee EC ACPs alongside those of junior doctors to ensure everyone gets equitable access to learning opportunities. However, Consultant EC ACP Leads said the training and supervision needs are higher for trainee EC ACPs compared to junior doctors. Therefore, the supervision workload of trainee EC ACPs was shared amongst a team of Consultants:

"I would definitely recommend a team of consultant supervisors with time aside for supervision from the get-go and understanding that it's going to be energy and time-intensive." [Strategic Lead 5]

In some departments, ED Consultants described implementing "educator days" when an ED consultant is given protected time to provide workplace-based teaching and supervision to all EC trainees (not just trainee EC ACPs). Below is an example of how this works:

"We have introduced daily educator shifts which are 4-hour educator slots, so that, that the consultant is not clinical in as much as they're not on the numbers … they can supervise procedures, they can do workplace-based assessments, they can do, you know, one-to-one teaching, they can do simulation training, they can do all those sorts of stuff. I think that's been helpful." [Strategic Lead 5]

All ED departments participating in the HEE SW pilot were expected to have a Credentialed EC ACP Lead. Unfortunately, most departments reported experiencing difficulties recruiting and retaining credentialed EC ACPs. As the following quote shows, a Credentialed EC ACP Lead would be able to reduce some of the ED Consultant's administrative workload, freeing up time to focus on supervisory tasks which can only be completed by senior ED clinicians (e.g. workplace-based assessments):

"We don't have a lead ACP in inverted comments at the moment … we will probably advertise that as a role and then give that person more management and more kind of steering the ship and then that will reduce the consultant workload." [Strategic lead 1]

4.1.4. Theme 4: Transitioning into the ACP role

- Expert – novice – expert transition

Most trainee EC ACPs described the transition moving from being an "expert" senior decision maker in their baseline profession to becoming a "novice" trainee ACP as challenging, resulting in a temporary loss of confidence in their skills. They compared themselves to more experienced EC ACPs, exacerbating a self-imposed pressure to achieve a high level of clinical competence quickly:

"I was very good at calling the shots and thinking, oh yeah, this patient's definitely this, this and this, here you go doctor … But it wasn't until they kind of said here you go; you make the decisions in this ACP role. I

thought well, gosh, you know, second guessing blood pressures and, you know, it's really simple tasks." [Pilot EC ACP 10]

"That leap of going from being a nurse and knowing my stuff, and knowing what I'm doing, to then … being right at the bottom of the food chain again, and a bit like, oh my god, err, what do I do? How do I do this? I don't even know how to look at an x-ray currently cos I'm that out of my depth." [Pilot EC ACP 5]

Peer support from other trainee EC ACPs was described as invaluable, because medical colleagues did not necessarily understand the personal challenges experienced by trainee EC ACPs as they transitioned into the role:

"We definitely look at things differently I'd say to doctors and so it's nice to be able to sometimes discuss things with your team of ACPs." [Non-pilot EC ACP 3]

"Just knowing that the other people that are training feel the same way as you or like you know you do something, and you feel like an absolute idiot and then the next thing they text you and say oh my god you'll never guess what I did and that makes you feel a bit better." [Pilot EC ACP 3]

- Role identity

Trainee EC ACPs described struggling to fully embrace the ACP title, often describing themselves as a nurse or paramedic with extended skills rather than an "ACP". Some trainee EC ACPs said they experienced a loss of identity when they started EC ACP training; they were no longer a nurse or paramedic, but they didn't feel like an ACP either:

"I'd gone right back to square one again, I wasn't part of the doctors, I wasn't part of the nurses, I didn't really know where I fit. I didn't know what I could bring. I didn't know whether I could do it, you know, it was just a difficult transition." [Pilot EC ACP 10]

However, pilot EC ACPs said there was an established team of EC ACPs already working in the EDs prior to them starting their training, which meant they felt medical colleagues were already aware of the EC ACP role and understood what was expected of them during their training:

"It felt quite well established, it felt like a lot of the groundwork with ACPs had been done … so it didn't feel like it's been a real battle to get the ACP role known." [Pilot EC ACP 8]

Trainee EC ACPs said issues around role recognition were more noticeable when encountering difficulties referring patients to radiology or different specialties across the hospital, because of a lack of awareness or a misunderstanding of the EC ACP role in these departments. These barriers to radiology requests were described as having an impact on their training because they had to rely on medical colleagues to make the referral on their behalf. However, access to radiology requesting was slowly being granted to EC ACPs in all ED departments:

"The policy clash between our medical requesting and what Radiology think is appropriate, has been, has been a battle." [Pilot EC ACP 9]

Section G:

5. Discussion

Until recently, in the UK, the ACP role was ill-defined , leading to confusion about role titles, job descriptions, scope of practice, and educational requirements.[10-14] It has been suggested that greater standardisation of ACP education and training would help clarify the ACP role among stakeholders.[10, 13-14] To address these challenges, the HEE SW funded a pilot providing EDs with enhanced funding to create a more structured and supported approach to EC ACP training, which was underpinned by nationally developed curricula for EC ACPs. Overall, faculty trained EC ACPs were predominantly satisfied with their training experience. Sources of dissatisfaction tended to be associated with factors external to the training programme, such as transition into the role, and role identity / recognition. A unique aspect of the HEE SW pilot compared to standard training was the specific extra funding EDs received to train EC ACPs. Training costs covered by the HEE SW pilot included: tuition fees for the MSc in Advanced Practice, funding for additional courses (e.g. life support and x-ray interpretation), salary support, and funding for consultant educational supervision. Consultant EC ACP Leads said that without this funding they would have found it difficult to persuade NHS Trusts to employ trainee EC ACPs. Continued extra funding of programmes may be required to expand ACP teams in the future. Specific features of the HEE SW pilot that provided an enhanced training experience for EC ACPs included provision of wider specialty placements (outside of emergency medicine) to provide additional clinical experience, and additional supervision and oversight provided by the Clinical Leads for the HEE SW pilot.

Overall, trainee EC ACPs (pilot and non-pilot EC ACPs) said they were satisfied with the amount of support they received from medical colleagues and other EC ACPs within the workplace. Previous literature has highlighted the importance of having a strong supervision structure in place.[10, 14-18] All trainee EC ACPs said they had been assigned an educational supervisor at the start of their training who they met with on a reasonably regular basis. This contrasts to results of a national survey of ACPs finding only 32% of ACPs had a formal structure for their supervision.[19] In the survey pilot EC ACPs reported meeting with their supervisor on a more regular basis compared to non-pilot ACPs. This may suggest that the dedicated funding for educational supervision provided by the new pilot may have led to an increase in contact time with supervisors for pilot EC ACPs. However, it is important to note that due to the relatively small sample size definitive conclusions cannot be made, but it is something that could be explored further in the future.

Whilst trainee EC ACPs were satisfied with the overall support they received during their workplace training; increased ED pressures reduced senior ED staff capacity to conduct workplace-based assessments of trainee EC ACPs which could be used as evidence for the RCEM e-portfolio. These issues are not unique to trainee EC ACPs, and have been shown to affect other trainees (e.g. junior doctors).[20-22] During interviews with consultant EC ACP leads in our study, it was highlighted that trainee EC ACPs require significantly more support compared to junior doctors, which led to a temporary increase in the workload of senior ED colleagues. Some consultant ED teams had implemented daily educator shifts, where consultants had protected time to deliver training and supervision for all ED trainees (not just EC ACPs). Such strategies could help resolve issues raised with access to training opportunities within fast paced and rapidly changing clinical environments, such as the ED.

A key aim of the pilot was to see whether the duration of EC ACP training could be decreased, if EDs were provided with an enhanced funding package including external support from HEE SW. Planned credentialling submission dates obtained post evaluation showed all 12 Pilot EC ACP trainees (in post at the close of the 36-month pilot) planned to submit for RCEM credentialling in 2022/23 and complete their training within a 4-year timeframe, well below the 6+ years that predominated prior to the introduction of the pilot. Funding for the pilot was provided to EDs for a period of 3 years, which may have contributed to a misperception amongst some Consultant EC ACP Leads and trainee EC ACPs respondents in the evaluation that Pilot EC ACP trainee were expected to complete RCEM credentialing within 3 years, which was not the case. Consultant EC ACP Leads and trainee EC ACPs said they would prefer flexibility in the duration of EC ACP training rather than having the same pre-specified timelines for everyone.

There is evidence from this study, and previous literature, of variability in the pre-existing skills and knowledge of staff entering ACP training programmes, affecting their rate of progression through their training.[14,23] Furthermore, RCEM only offer twice yearly opportunities for submission of credentialling applications. Identifying milestones and completion of RCEM credentialing on a case-by-case basis is an alternative approach suggested by respondents and a view supported by the funders of this study. Individualised learning plans (sometimes called a personal development plan) whereby the supervisor works with the trainee ACP to identify their learning and development needs, could be useful in this context.[23] Whilst faculty trained EC ACPs were expected to attend annual quality reviews, it was unclear whether their clinical or educational supervisors were using individualised learning plans. Overall, whilst timelines for completion of RCEM credentialing are important to ensure trainees don't stay in a training capacity indefinitely, an element of flexibility which takes into consideration individualised learning needs and significant life events could be useful.

It was highlighted that trainee EC ACPs need to increase their understanding of biomedical science. It was expected this knowledge would be acquired through workplace-based training, the MSc in advanced practice, and through personal learning. Concerns were raised that MSc degrees were not sufficiently clinically focused, there was a lack of medical staff teaching on MSc degrees, and some modules felt like a tick box exercise which had limited relevance to their workplace-based training. Since 2020, Advanced Practice MSc degree programmes can apply for accreditation which is a quality assurance process to ensure MSc degree programmes are meeting the standards outlined by HEE.[24] It is hoped this will improve the quality and standardisation of advanced practice MSc degree programmes in the future. Interestingly, whilst trainee EC ACPs talked about increasing their skills regarding the clinical pillar of the multi-professional framework, the other three pillars (leadership and management, education, and research) were not discussed. A similar observation has been reported in previous literature.[10, 13-14]

The volume of academic work which trainee EC ACPs must complete alongside their clinical workloads should not be underestimated. As has been shown in other studies,[19] trainee EC ACPs interviewed in this study highlighted the immense struggle they experience trying to balance demands associated with undertaking the MSc in Advanced Practice, workplace-based clinical training, and significant life events (e.g. illness, caring responsibilities). Streamlining current requirements for separate portfolios for the MSc in Advanced Practice and RCEM credentialing may help reduce this workload burden.

A theme emerged of a lack of clear role identity for ACPs, an issue identified in previous literature.[10-13,16,19] The multi-professional framework for Advanced Practice was designed to provide more clarity around the ACP role.[4] However, despite this and the enhanced external support provided by HEE SW

during the pilot; trainee EC ACPs interviewed in our evaluation still struggled to define the ACP role. It is possible that it is still too early to assess the impact of the framework and subsequent changes to advanced practice training (including the establishment of the Advanced Practice Centre and Regional Faculties) on role identity issues in the long term. As ACP teams continue to grow and become more embedded within multi-disciplinary teams', issues around role identity may resolve as awareness of their scope of practice increases. Further research should assess the impact of the multi-professional framework and training programmes on role identity issues in the long term.

5.1. Limitations

As part of the evaluation, we intended to compare the experiences of pilot EC ACPs with a control group of non pilot EC ACPs. The control group included in this evaluation comprised trainee EC ACPs who were working in the same ED as the pilot ACPs. We found the training structure for the two groups was similar, with non-pilot EC ACPs indirectly benefiting from the support from the HEE SW pilot. A future study could explore this, utilising trainee EC ACPs based in an ED without the HEE SW pilot. Unfortunately, due to time and resource restrictions it was not possible to do this as part of this evaluation.

Furthermore, due to the small sample sizes of the EC ACP groups only cautious conclusions can be drawn from the survey results. There were only 14 EC ACPs undertaking the HEE SW pilot at the time of the evaluation (13 agreed to participate in the evaluation), therefore precluding the ability to recruit a larger sample size. Once the HEE SW pilot is more established in the future, a follow-up survey could be undertaken with a larger sample size.

5.2. Conclusion

Overall, trainee EC ACPs participating in the HEE SW pilot were satisfied with their training experience. There is evidence that elements of the pilot have the potential to provide an enhanced training experience, such as opportunities to attend specialty wide work placements and external oversight of training progress. Consultant EC ACP Leads also valued the enhanced funding support package, enabling them to persuade NHS Trusts to recruit and train EC ACPs. Challenges experienced by trainee EC ACPs tended to be out of the control of the HEE SW pilot: such as exponential pressures on EDs leading to reduced senior ED clinician capacity to provide training and educational opportunities; transitional anxieties moving from their baseline profession (e.g. nurse or paramedic) into the ACP role; and educational, personal, and work-based pressures. In the future, it would be important to consider how the requirements for the RCEM e-portfolio could be better integrated into the clinical pillar of the MSc in Advanced Practice to avoid duplication of work on behalf of the trainees.

Section H:

6. Additional contextual information provided by the funders

At the end of the first year of the HEE SW EC ACP Pilot (August 2020) the National landscape in England regarding Advanced Practice training and integration into workforce planning change, with the establishment of the HEE Centre for Advancing Practice and the Regional Faculties aligned to it.

In HEE SW many of the principles and all the learning from the Pilot have informed the subsequent 2 years development of the Regional Faculty. This was assisted by the continuity provided by the HEE SW Associate Postgraduate Dean for Workforce Transformation, who had designed and oversaw the Pilot, being appointed to the role of HEE SW Advanced Practice Faculty Lead.

Now, in 2022, the HEE SW Advanced Practice Faculty 'business as usual' supports 382 trainee Advanced Practitioners across the region working in community, Primary and Secondary care across a broad spectrum of scopes of practice and professional backgrounds. All trainees receive a training grant of £6,000 + Educational Supervisor funding of £2,600 per annum for the 3 years of their MSc in Advanced Practice. The Faculty has 10 Supervision & Assessment Leads who each oversee annual quality training reviews and offer scope of practice specific training support and advice to trainees and trainers who they connect in communities of practice across the SW.

The Faculty works with individual providers and all Regional Integrated Care Boards (ICBs) to ensure that Advanced Practice training and roles are better understood, planned for and supported across the Region and in the workplace and, also works with all education providers to ensure that the MSc in Advanced Practice courses offered in region meet the now standards set by the HEE Centre for such.

Support and guidance have been developed and shared by the Faculty on a variety of topics relevant to Advanced Practice training, several of which were highlighted through the Pilot. Examples include: standards and delivery of educational supervision for trainee Advanced Practitioners, governance of Advanced Practice training and working, organisational support and recognition of Advanced Practitioner roles, dealing with imposter syndrome as an Advanced Practitioner and quality assurance in Advanced Practice training.

Of the 14 original HEE SW EC ACP Pilot trainees there are 12 remaining in post at the close of the 36-month pilot all of whom plan to submit for RCEM credentialling in 2022/23. Attrition was due to ill health (n= 1) and a change in personal circumstances (n= 1).

Section I.

7. References

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Section J.

Appendix 1: Copy of the online survey

About you

1. How old are you?

18-24	
25-34	
35-44	
45-54	
55-64	
64+	

2. How would you describe your ethnic origin?

Asian or Asian British	
Black or Black British	
Mixed	
White	
Any other ethnic group	

3. Are you?

Male	
Female	
Other	

4. What was your previous profession before starting Emergency Care Advanced Practitioner training?

Nurse	
Paramedic	
Physiotherapist / Occupational therapist	
Other (please specify)	

5. How long were you working in your previous profession (e.g. years)?

About your training

6. When did you start Emergency Care Advanced Practitioner Training (Approximate date)?

7. What training route are you undertaking?

Paediatrics	
Adults	
Both (adults and paediatrics)	

8. Are you enrolled on the new Health Education England South West pilot Emergency Care Advanced Practitioner training programme?

Yes	
No	

9. Do you have a named supervisor?

Yes	
No	

10. How often do you meet with your supervisor?

Two or more times a month	
Once a month	
Once every two months	
Other (please specify)	

11. How many hours of supernumerary time do you receive every week?

12. How many hours per week do you undertake supervised clinical practice?

13. Do you have a portfolio?

Yes	
No	

14. If yes, are your supervisors happy to use your portfolio?

Yes	
No	

15. Are you given protected time to attend University?

Yes	
No	

16. Do you have an RCEM credentialling target date?

Yes	
No	

17. How confident are you that you will meet your RCEM credentialling target date?

[Please mark you answers on the scale of 1 to 5 with 1 being very confident and 5 being very unconfident]

1 2 3 4 5

Satisfaction with your training

The following questions will ask you about your satisfaction with your training.

[Please mark you answers on the scale of 1 to 5 with 1 being extremely dissatisfied and 5 being extremely satisfied]

18. How satisfied are you with the support you receive from your supervisor?
    1 2 3 4 5
19. How satisfied are you with the amount of clinical supervision you receive?
    1 2 3 4 5
20. How satisfied are you with the external educational opportunities that you receive?

    1 2 3 4 5
21. How satisfied are you with the support that you receive from your colleagues within the department that you work?
    1 2 3 4 5
22. How satisfied are you with the support that you receive from other Advanced Clinical Practitioner trainees?
    1 2 3 4 5
23. How satisfied are you with the opportunities to undertake placements in other departments?
    1 2 3 4 5
24. How satisfied are you with the amount of supernumerary time you receive?
    1 2 3 4 5
25. How satisfied are you with the Advanced Care Practitioner portfolio?
    1 2 3 4 5

Career development

The following questions refer to how you feel about your future job and career in this service and other services.

[Please mark you answers on the scale of 1 to 5 with 1 being strongly disagree and 5 being strongly agree]

1. There is a job for me in this service in the future if I want one.
   1 2 3 4 5
2. There will be clinical opportunities for my career advancement in the next few years.
   1 2 3 4 5

3. There will be management opportunities for my career advancement in the next few years.
   1 2 3 4 5

4. I am clear what my responsibilities will be 6 months from now
   1 2 3 4 5

5. I am clear about what my future career looks like.
   1 2 3 4 5

How you feel at work and about your job

To what extent do you agree with the following statements?

[Please mark you answers on the scale of 1 to 5 with 1 being strongly disagree and 5 being strongly agree]

1. I often think about leaving my current role.
   1 2 3 4 5

2. It is very likely that I will actively look for a new job in the next year.
   1 2 3 4 5

3. I am starting to ask my friends / contacts about other job possibilities.
   1 2 3 4 5

4. I feel socially valued as a result of my work.
   1 2 3 4 5

5. I feel that others appreciate my work.
   1 2 3 4 5

6. I feel that other people value my contribution at work.
   1 2 3 4 5

7. I like this career too much to give it up.
   1 2 3 4 5

8. I definitely want a career in this profession.
   1 2 3 4 5

9. If I had all the money I needed without working, I would probably still continue to work in this profession.
   1 2 3 4 5

10. This is the ideal profession for a life's work
    1 2 3 4 5

How true are the following of your job?

[Please mark you answers on the scale of 1 to 5 with 1 being strongly disagree and 5 being strongly agree]

1. I have clear, planned goals and objectives for my job.
   1 2 3 4 5

2. I know what my responsibilities are.
   1 2 3 4 5

3. I know that I have divided my time properly.
   1 2 3 4 5

4. Explanation is clear about what has to be done.
   1 2 3 4 5

5. I know exactly what is expected of me.
   1 2 3 4 5

Support at work

The following questions refer to how you feel about the support that you receive from your manager / supervisor, that is the person to whom you are immediately responsible to for your work. To what extent does your manager / supervisor:

[Please mark you answers on the scale of 1 to 5 with 1 being strongly disagree and 5 being strongly agree]

1. Considers your personal feelings when implementing actions that will affect you.
   1 2 3 4 5

2. Take into account your personal needs.
   1 2 3 4 5

3. Ensure the interests of employees are considered when making decisions.
   1 2 3 4 5

4. Encourage staff to develop their job related skills.
   1 2 3 4 5

5. Suggest training to improve your ability to carry out your job.
   1 2 3 4 5

6. Coach staff to improve their on-the-job performance
   1 2 3 4 5

The following questions ask about the extent to which colleagues provide you with help and support. To what extent can you:

[Please mark you answers on the scale of 1 to 5 with 1 being strongly disagree and 5 being strongly agree]

1. Count on your colleagues to listen to you when you need to talk about problems at work?
   1 2 3 4 5

2. Count on your colleagues to back you up at work?
   1 2 3 4 5

3. Count on your colleagues to help you with a difficult task at work?
   1 2 3 4 5

4. Count on your colleagues to help you in a crisis situation at work, even though they would have to go out of their way to do so?
   1 2 3 4 5

Confidence and competence managing common conditions

The following section is designed to identify how confident you are in managing common medical conditions.

1. How do you feel about managing patients with the following presenting complaints?

[Select a response from 1-9 and mark a box below with 1 = lowest level of confidence and 9 = highest level of confidence]

	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Diarrhoea and vomiting									
Shortness of breath									
Collapse – unknown cause									
Acute mental health problem									
Elderly fall									
Chest pain									
Back pain									
Cardiac arrest									
Palpitations									
Abdominal pain									
Acute allergic reaction									
Left 'side' pain									
Acute stroke									
Overdose – paracetamol									
Diabetic Ketoacidosis									
Acute confusion									
Headache									
Seizure									
Cellulitis									

2. How experienced are you performing the following practical techniques?

[Select a response 1-5 and mark in the box below]

	1 No experience	2 Some experience with support	3 Moderate experience	4 Good experience	5 Confident alone
Defibrillation					
Arterial blood gas analysis					
Suturing					
ECG interpretation					
X-ray interpretation					

3. Would your management of the conditions shown been improved with:

[Please mark you answers on the scale of 1 to 5 with 1 being strongly disagree and 5 being strongly agree]

- Clearer guidelines

  1 2 3 4 5

- Better teaching

  1 2 3 4 5

- More supervision

  1 2 3 4 5

Section K.

Appendix 2: Copy of the interview schedules

Interview schedule – Trainee EC ACPs

Opening question

1. Please can you briefly tell me about your past work experience and why you decided to enrol on the emergency care ACP training programme? [Need to specify whether pilot-training programme or non-pilot]

Experiences of ACP training

2. Please can you describe your overall experience of ACP training?

    - Probe: Support and supervision / clinical and external educational opportunities / peer support and support from other colleagues / work placements (positive and negative aspects)
    - Probe: If negative aspects highlighted, ask them what could be done to improve this situation.

3. Do you have clear planned goals and objectives within your training?

    - Probe: Are these what they expected them to be as a trainee ACP?

4. Are there any gaps in your training that you feel should be addressed?

5. Do you think you should be line managed by someone from your own profession or is that not necessary?
    - Probe: conflicts in line management

Areas for improvement

6. Is there anything that could be done to improve training for ACPs?

Career progression

7. What are your thoughts on career progression within the ACP role?

Role identity

8. How have you found moving from an Allied Health Professional role to a medical model?
    - Probe: Support making this transition

9. What do you perceive the ACP role being? Do you think it will change? If so, how?

10. How do other people within your organisation perceive the ACP role?

Closing question

11. Is there anything else that you would like to discuss with regards to your experiences of ACP training or ACP training in general?

Interview schedule – Clinical Lead for the HEE SW pilot

1. Please can you briefly describe your past work experience and how you came to be the faculty supervision and assessment lead?

2. Can you briefly tell me about what the faculty supervision and assessment lead role involves? What role have you had in the implementation of the pilot training programme?

3. Would you like to discuss some of the barriers and enablers that you have encountered with regards to the implementation of the pilot training programme?

-Consultants / supervisors

-Culture in the organisation

-ACPs themselves

-ACP workload

-How were the barriers overcome?

4. Have you any thoughts on what might impact progression of the trainee ACPs?

5. Have you noticed any differences in the new pilot training programme versus how things were before? Is it better or worse?

6. How do you see ACPs working in the future within the Emergency Department?

7. Are there any changes you would like to make to the new pilot training programme?

8. Is there anything else you would like to discuss?

Interview schedule – Consultant EC ACP Lead

Opening questions

1. Please can you briefly describe your current role within [name of organisation]?

2. What involvement have you had in the new pilot ACP emergency care training programme?

Comparison between existing training and new pilot ACP training programme

3. Please can you briefly describe what ACP training was like in your department prior to the implementation of the new pilot ACP emergency care training programme?

4. Have you noticed any differences between the new pilot ACP emergency care training programme and existing ACP training programmes?

    - Probe: elements that are better or worse than the existing training programme. Things working well and areas that could be improved.

Impact of new ACP training programme on other staff

5. Has the new pilot ACP emergency care training programme had an impact on other staff within the department?

    - Probe: trainee ACPs / other healthcare staff / trainers
    - Probe: Positives and negatives
    - Probe: role conflicts / increased workload / better awareness about ACP role

Future planning

6. Do you see a future for ACPs working in your department? If yes, how do you see the ACP role working in your service in the future?

    - Probe: ongoing CPD / career development / role identity

7. Are there any changes you would like to make to the new emergency care ACP training programme?