Purpose and research aims

1. This is a research brief for the Health and Care Professions Council (HCPC) to invite proposals from external researchers. The intention of commissioning this research is to provide an evidence base following extensive engagement and data collection, to inform the next stages of the HCPC's project exploring advanced practice (AP)[1]. This project aims to identify the regulatory challenges and any risks presented by registrants' advancing their practice, and how the HCPC should respond to these to ensure public protection and supporting professionalism/good practice.

2. A budget of up to £65,000 is available for this work (depending on the scope of the research).

About the HCPC

3. The HCPC is an independent professional regulator set up to protect the public. We register the members of 15 different professions. We set and maintain standards which cover education and training, behaviour, professional skills and health; approve and monitor educational programmes which lead to registration; maintain a register of people that successfully pass those programmes; and take action if a registrant's fitness to practise falls below our standards.

4. We were set up in 2002 and now regulate 15 health and care professions (around 280,000 registrants), including, for example, biomedical scientists, operating department practitioners and radiographers. Nurses and midwives are regulated by a separate body, the Nursing and Midwifery Council.

5. We also have powers to annotate or mark entries in the Register. These powers are set out in the Health and Social Work Professions Order 2001 ('the Order') and in the Health and Care Professions Council (Parts and Entries in the Register) Order of Council 2003. Currently, there are only two types of annotation on the HCPC register for: prescribing rights (a legislative requirement that entry to this type of practice is

[1] The term 'advanced practice' is commonly used in Scotland, Wales and Northern Ireland, whereas 'advanced clinical practice' is used in England. Each of the four countries of the UK have a national framework for AP. These frameworks set out: a definition of AP for all health and care professionals; the capabilities required for APs across four pillars (clinical practice. education, research, and leadership and management); education support requirements; and advice for employers with regard to planning and implementation.
See: Multi-professional framework for advanced clinical practice in England, https://www.hee.nhs.uk/sites/default/files/documents/Multi-professional%20framework%20for%20advanced%20clinical%20practice%20in%20England.pdf;
The AHP Advanced Practice Education and Development Framework (Musculoskeletal) 2012, http://www.ahpadvancedpractice.nes.scot.nhs.uk/media/251474/msk%20framework%20(final).pdf;
Framework for Advanced Nursing, Midwifery and Allied Health Professional Practice in Wales, https://www.wales.nhs.uk/sitesplus/documents/829/NLIAH%20Advanced%20Practice%20Framework.pdf;The Advanced AHP Practice Framework Guidance for Supporting Advanced Allied Health Professions Practice in Health and Social Care Northern Ireland https://www.health-ni.gov.uk/sites/default/files/publications/health/AHP-Framework.pdf

limited to those with the appropriate qualification on the register) and more recently for podiatrists who undertake surgery (a voluntary measure).

Background to the project

6. Regulation of AP is at the level of the AP's core (cognate) profession. There is no regulation specific to the advanced level of practice/role or advanced practice education programmes, nor is statutory registration of a practitioner's standard level work necessary to work at AP level.

7. Some of the regulators, such as the General Dental Council, have produced guidance on the activities its registered professions are trained and competent to undertake. The HCPC does not collect information on scope of practice. Whilst our generic Standards of Proficiency (SOP) inform scope of practice across professions, we do not prescribe the areas in which our registrants work, instead, *'registrants must ensure that they practice safely and effectively within their chosen scope of practice'.*

8. For decades there have been repeated calls from a number of organisations and professional groups to introduce some form of regulation of AP.

9. In 2016, the Nuffield Trust published its 'Reshaping the workforce to deliver the care patients need'[2] report, commissioned by NHS Employers. The report found that equipping the existing non-medical workforce with additional skills would be the best way to:

    - manage the growing burden of chronic disease more effectively;
    - release some cost savings; and
    - help bridge workforce gaps.

10. The report cautions that this should be implemented well to ensure no unintended consequences. It also highlighted that '…*these new extended roles are not formally recognised by professional regulators. This can leave staff anxious as to whether they are operating outside of their professional scope of practice and therefore make them unwilling to take on the new role.*'

11. Following the Nuffield Trust report, each of the four countries set out to provide an advanced practice frameworks to support the development of these roles and ensure safe, high-quality and effective delivery of care. These frameworks set out:

    - a definition of AP for all health and care professionals;
    - the capabilities required for APs across four pillars;
    - education support requirements; and
    - advice for employers with regard to planning and implementation.

[2] https://www.nuffieldtrust.org.uk/files/2017-01/reshaping-the-workforce-web-final.pdf

12. We are regularly contacted by registrants asking for advice and support in relation to extended scope of practice; quite often in relation to advanced clinical practice roles. Some registrants raise concerns about how to ensure they are acting within the scope of the SOPs in their new roles; for example, ODPs moving in to surgical care practitioner roles.

13. Health Education England (HEE) have also asked for our view on the approach we believe should be taken with regard to the regulation of advanced clinical practice roles. It is in response to these requests for further information and guidance that the HCPC council agreed to undertake this project.

Background/context to the research

14. The HCPC has undertaken some initial desk-based research to scope available literature on AP in relation to our registrants' professions, and to attempt to map evidence against the following areas to inform the next steps of the project:

- What AP is: definition(s), scope of practice, level of practitioner autonomy, complexity and any evidence of patient safety risk.
- Available profile/workforce data on AP in England, Wales, Scotland, Northern Ireland and projected growth.
- Differences and commonalities across multiple professions, across health and care settings, geographies (including across the four countries of the UK).
- Educational preparation/requirements.
- The number/locations of Higher Education Institutions (HEIs) that deliver or plan to deliver AP education programmes, their content and pre-requisites to enroll.
- Information about existing regulatory measures for AP and voluntary/professional body measures (accreditation/credentialing).
- Brief history/background to the regulation of AP debate.
- Potential additional regulatory measures/options.
- Potential advantages and disadvantages to additional regulation.
- Any international comparators for regulation of AP for Allied Health Professionals (AHP).
- Potential implications for the HCPC's regulatory functions (if any additional measures were introduced).
- Evidence of existing key stakeholder viewpoints with regards to potential additional regulatory measures and any evidence in support of/against their reasoning/rationale.

15. The desk-based research presented a number of challenges in finding systematic evidence in alignment with the areas above:

- Defining AP itself is not straight forward, (both nationally and internationally) as there is substantial variation in terminology/proliferation of job titles within and across HCPC's registrant's professional groups and ways of describing AP.

- The majority of literature/research relates to advanced nursing practice (ANP), not HCPC's registrants' professions' AP. Existing AHP literature is limited to a small number of the professions of our registrants, which are those professions in which AP is most established.
- Research that has been done tends to be disparate, difficult to access and/or is of questionable reliability/robustness. Most, if not all, of the literature is predominantly qualitative and discursive and not really focused on the same core questions we are exploring in this project (about the potential for additional regulation).
- While there is some limited literature on experiences of AP in a selected country of the UK, there is no robust comparative analysis across all four countries.
- The literature identifies issues with the lack of effective post-implementation evaluation of AP, in terms of patient safety outcomes.
- The literature is not as up to date as we might hope (as is the nature of any peer reviewed academic literature) and therefore there is a possibility that AP may have evolved in the last couple/few years, along with perceptions about it.

16. This lack of consistent/available evidence is likely to be related to the relative newness of AP, particularly for some of our registrants' professions (some do not seem to have adopted AP but are perhaps likely to in future). It is also likely to be a result of the (piecemeal) way in which AP in particular professions has emerged in response to service needs in different geographies, areas of practice and settings.

17. What we found from this desk-based research was that there are a number of areas where further research and analysis is necessary to satisfy the evidence requirements. Additional data is necessary to justify any additional regulatory measures and to provide the HCPC with assurance about the nature/level of risk to patient safety presented by AP. It will also be necessary to gather additional evidence to undertake further engagement with stakeholders on an informed basis (so that we can describe AP accurately), and ultimately for the HCPC Council to appraise the options and make a decision based on the evidence.

Scope of proposed research

18. While we do not intend to prescribe the methods for delivering the desired evidence outcomes, we would expect the research to include both qualitative and quantitative methodologies. We also seek thematic analysis of the data and a final research report.

19. We propose commissioning research to identify a range of facts, opinions and experiences, from a range of stakeholders, across a range of settings, professions and geographies:

    a. What exists in terms of AP in each of the four countries of the UK: how and which settings and localities is it manifested? The identification of metrics that capture structures, role levels (eg entry level registrant, AP, consultant), Agenda for Change pay bands, educational level, job titles, roles that exist across the

multiple professions (only HCPC registrants) and settings that use AP and evidence of projected growth is also required.

b. The nature, scope of practice, level of risk, complexity and degree of autonomy of AP across the multiple professions/ work settings, and to what extent these differ from an AP's cognate profession.
c. The extent to which AP differs or has commonality between and within the multiple professions.
d. Perceptions of AP registrants, employers, educators, professional bodies and other key stakeholders (including those listed in paragraph 21) about:
    i. AP in practice including the areas listed in b (currently and projections for the future), AP education, training, support/mentoring, supervision and continual professional development;
    ii. associated patient safety risk (if any);
    iii. existing regulation, governance, assurance and accountability mechanisms in place to protect against such risk; and
    iv. the prospect of additional regulation, if favoured, views on what that should look like/how it should work in practice.
e. What exists in terms of AP educational and training preparation in each of the four countries of the UK (including HEI masters and apprenticeships)? The identification of metrics that capture commonalities/differences across entry requirements, competencies, practical and theoretical components and assessments, etc is also required.

Key areas to be addressed in the research

20. We propose that the research/resources should cover views of registrants:
    a. across the four countries;
    b. across different professions;
    c. at different bands/levels (including those undertaking AP and those who aren't, and those who have undertaken or are undertaking educational preparation for AP);
    d. within different modes of practice (private, primary care, community, etc) and
    e. with and without line management or clinical supervision responsibilities.

21. In addition, the views of other stakeholders including: Chief Allied Health Professions Officers, Chief Scientific Officers, employers, professional bodies, representative/trade union bodies, other professions (who work with APs) and educators (national bodies and HEIs) across the four countries of the UK. It will be helpful to gauge the views of those that do not use AP in their services to understand any reasons/barriers.

Research governance

22. We expect that all relevant stakeholders should be appropriately involved in the conduct of HCPC commissioned research. Proposals should clearly outline how the involvement of relevant stakeholders will be addressed during the research process.

23. We expect the PI to develop a detailed project plan with key milestones from the outset of the commission. This will be agreed with the project lead and regularly updated as required for the duration of the research. The PI is also required to report on a regular basis to the HCPC lead for the work about the progress of the research and particularly to ensure that the project stays on track in terms of achieving agreed milestones.

24. Sign-off from the HCPC lead will be required at key stages to be agreed with the appointed research team to include the text of discussion guides.

25. The PI may be required to present their findings at a Council meeting to be determined (and this should therefore be factored into costings).

26. Payment of the research budget will be made in instalments, with funds released at key stages subject to the research being completed to a satisfactorily high standard. We anticipate the following.

    - Half of the budget paid on agreement of contracts.
    - Half of the budget paid on sign off of the final report.

Final report

27. The report arising from the completed research will be used by the HCPC to produce further engagement materials and to inform the outcome of the project.

28. The final report will include the following:

    - Information about the research methodologies adopted.
    - Findings from the research, including quantitative analysis (with visual aids), qualitative analysis and thematic analysis.

Next steps and anticipated timescale

29. Proposals for this work should be submitted by email to the Policy and Standards Team mailbox:

    Email: policy@hcpc-uk.org

30. If you have any queries regarding the research brief, or the tender process, please contact Charlotte Rogers, Policy Manager:

    Email: Charlotte.Rogers@hcpc-uk.org

31. There is no prescribed format for submitting research proposals. However, they should include the following:

- A proposal for how the research would be conducted.
- An outline timescale including key milestones.
- Any ethical considerations or approval needed (and how these will be sought).
- Arrangements for research governance.
- The researcher(s) CV(s).
- A breakdown of costs.

32. We anticipate the following timescales for this work. Please note, in the event that the number of proposals received delays the process of appointing the researcher(s)/research team to carry out this work, these dates may change.

Action	**Timetable**
Invitation for proposals issued	9 June 2020
Deadline for proposals	6 July 2020
Short-listing	6-10 July 2020
Interviews	16 & 17July 2020
Researcher(s)/research team appointed	22 July 2020
Interim findings report (mid-research)	22 September 2020
Deadline for draft report	15 December 2020
Deadline for final report	22 December 2020
Presentation on findings and Q&A with Expert Reference Group	First or second week of January 2021 (date TBC)

33. We anticipate a budget of up to **£65,000** (depending on the scope of the research). This budget is inclusive of all costs, including VAT (if applicable) and any contribution overheads (if applicable).

Short-listing criteria

34. Our decision to shortlist or appoint will be based on the research brief, and on an overall assessment of how far the proposal has addressed the HCPC's needs. We will particularly assess research proposals as to the extent to which they meet or exceed the following indicative criteria:

- The proposal demonstrates understanding of the role of the HCPC as a regulator.
- The proposal demonstrates understanding of the research aims.
- The proposal describes appropriate methodologies.

- The proposal demonstrates the involvement of an appropriate range of stakeholders.
- The proposal demonstrates a commitment and ability to deliver the project on time to an appropriately high standard.
- The proposal represents value for money.