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**Transforming Nursing, Midwifery  
and Health Professions' (NMaHP) Roles:**  
pushing the boundaries to meet  
health and social care needs in Scotland

# 07

## Paper 07

### Transforming Nursing Roles Advanced Nursing Practice – Phase II

In partnership with



**Healthier  
Scotland**  
Scottish  
Government

## **Transforming Nursing Roles Advanced Nursing Practice - Phase II**

### **Introduction**

The Transforming Roles paper on Advanced Nursing Practice (ANP)<sup>1</sup> set out core competencies, education priorities and supervision requirements for ANP roles in Scotland. Following publication, the Advanced Practice Short Life Working Group (SLWG) agreed to a second phase to expand this work to include:

- Core Competencies for Acute, Primary Care, Mental Health and Paediatrics/Neonates
- Metrics for measuring outcomes
- Non-clinical time
- Supervision
- Advanced Practice Academies

This report is the key output from the second phase of the SLWG work programme. It is intended that the contents of this report be viewed as an addendum to the Advanced Practice Phase I document<sup>2</sup>. The established core competencies for all Advanced Nurse Practitioners (ANPs) in Phase I remain overarching, including for example, competencies relating to assessment, diagnosis, treatment and discharge. This report sets out competencies for the broad families of ANPs identified above, and has been developed to complement and build on the core competencies set out in the Phase I report.

### **Area Specific Competencies**

Agreed competencies for practice ensures safe, effective and person centred care, and remains embedded within the Nursing and Midwifery Council (NMC) code and in nursing governance structures.

Following the publication of the phase I report<sup>3</sup>, a number of key speciality areas were identified as requiring an expansion of core clinical competencies to give more specific support and direction to employers and ANPs. These are:

- Adult Acute Care
- Paediatric Acute Care
- Neonatal Acute Care
- Adult and Paediatric Mental Health
- Adult and Paediatric Community Care

ANPs are experienced and highly educated Registered Nurses who manage the complete care of a patient, not solely any specific condition. Four pillars of practice define the core role and function of the ANP:

- Clinical Practice
- Leadership
- Facilitation of Learning
- Evidence, Research and Development

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<sup>1</sup> The Scottish Government (2017) Transforming nursing, midwifery and health professions roles: advanced nursing practice. Chief Nursing Officer Directorate. <http://www.gov.scot/Publications/2017/12/3061/1>.

<sup>2</sup> ibid

<sup>3</sup> ibid

The competencies set out in this document focus on clinical practice. Further detail on practice relating to the non-clinical aspects of the ANP role is presented in the NHS Education for Scotland (NES) Advanced Practice Toolkit.<sup>4</sup>

## **Comprehensive History Taking**

The ANP undertakes comprehensive person centred assessment of physical, mental, psychological and social needs. In addition, the ANP will consider strengths and assets - actively involving the person, their family and carers, and support available from service partners. This includes a full analysis and interpretation of an individual's history including identification of alternative/augmentative communication needs.

## **Clinical Assessment**

The ANP carries out comprehensive clinical examination of the patient in their entirety, inclusive of physical examination of all systems, mental health assessment and remote assessment where appropriate and can:

- Rapidly assess a patient using the Airway, Breathing, Circulation, Disability, Exposure (ABCDE) approach and/or Mental State Examination to intervene clinically in a timeframe that reflects the risk, as well as assessing and managing the ongoing care needs of those presenting with chronic illness;
- Request and undertake diagnostic tests / investigations;
- Demonstrate effectiveness in prioritising, escalating, de-escalating, providing self-help or management advice and refer for treatment/assessment/decision support in a timely manner within the clinical context of their role;
- Deliver person centred care by supporting patients to make informed decisions relating to their treatment and provide consent;
- Prioritise and manage workload to meet the needs of patients;
- Analyse and synthesise findings from various assessments, clinical tests and investigations;
- Demonstrate an understanding of the principles and processes of child and adult protection legislation to ensure the safeguarding of children and vulnerable adults;
- Undertake assessments of related co-morbidities for individuals with a learning disability and develop with the patient a care plan that reflects the complexity of their health;
- Request and undertake multidisciplinary/agency health and social services assessments.

## **Differential Diagnosis**

The ANP applies high level decision-making and assessment skills to formulate appropriate differential diagnoses based on synthesis of clinical findings. This requires clinical reasoning to manage risk while dealing with undifferentiated client groups across the age spectrum.

## **Investigations**

The ANP has the autonomy and authority to apply judgement and clinical reasoning to request, where indicated, appropriate diagnostic tests/investigations based on differential

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<sup>4</sup> NHS Education for Scotland (2018) Advanced Practice Toolkit, <http://www.advancedpractice.scot.nhs.uk/>.

diagnoses and act on previously requested results of tests/investigations working collaboratively with other healthcare professionals.

Table 1: ANP led investigations by area of practice

<p><b>Acute Care</b></p>	<p>The Acute Care ANP is able to request and interpret the following investigations:</p> <ul style="list-style-type: none"> <li>• Chest X-rays</li> <li>• 12-lead Electrocardiogram (ECGs)</li> <li>• Arterial Blood Gases</li> <li>• Routinely requested blood tests</li> </ul> <p>Depending on specialist area, the Acute Care ANP may be able to request and act on other investigations such as Pulmonary Function Tests, Echocardiograms, Ultrasound scans, Exercise Tolerance Tests, Magnetic Resonance Imaging (MRI) and Computed Tomography (CT).</p>
<p><b>Primary and Community Care</b></p>	<p>The Community and Primary Care ANP is able to request and act upon the reports of the following investigations:</p> <ul style="list-style-type: none"> <li>• Chest X-rays</li> <li>• 12-lead ECGs</li> <li>• Echocardiograms</li> <li>• Ultrasound scans</li> <li>• Routine investigations that relate to men’s health and women’s health, and in particular sexual health</li> </ul> <p>The Community and Primary Care ANP is able to request and interpret the following investigations:</p> <ul style="list-style-type: none"> <li>• Pulmonary function tests</li> </ul> <p>Depending on service requirements, there may be additional investigations that the ANP is able to request, interpret and act upon.</p>

<p><b>Mental Health</b></p>	<p>The Mental Health ANP is able to independently request and act upon:</p> <ul style="list-style-type: none"> <li>• Further diagnostic tests/investigations including routine Bloods, ECG;</li> <li>• Further physical diagnostic tests and investigations. Review of results within scope of practice at a competent level;</li> <li>• The application of protective and safeguarding legislation</li> <li>• Use of evidence based mental health assessment tools across all specialties.</li> </ul> <p>Mental Health ANPs are able to assess and manage risk to inform decision-making for care, support and treatment planning.</p>
<p><b>Paediatric Acute and Community Care</b></p>	<p>The Advanced Paediatric Nurse Practitioner:</p> <ul style="list-style-type: none"> <li>• Has the autonomy appropriate to their scope of practice and context of clinical area to request diagnostic tests based on differential diagnoses</li> <li>• Is able to accurately interpret and act on laboratory/ diagnostic data.</li> </ul>
<p><b>Neonatal</b></p>	<p>The Advanced Neonatal Nurse Practitioner (ANNP) is able to request and act upon the following investigations:</p> <ul style="list-style-type: none"> <li>• All routine blood tests relevant to the neonate;</li> <li>• Neonatal X-rays;</li> <li>• Neonatal Cranial ultrasound scan;</li> <li>• Neonatal abdominal, chest and hip ultrasound;</li> <li>• Arterial Blood Gases.</li> </ul> <p>Depending on specialist area and level of competence, the ANNP may also be able to request and act on other investigations including:</p> <ul style="list-style-type: none"> <li>• Neonatal ECG</li> <li>• Neonatal Electroencephalography (EEG)</li> <li>• Neonatal Cerebral Function Monitoring (CFM)</li> <li>• Neonatal Echocardiogram</li> </ul>

## Treatment

The ANP formulates an action plan for the treatment of the patient, synthesising clinical information based on the patient's presentation, history, clinical assessment and findings from relevant investigations, using appropriate evidence based practice. The ANP is an independent prescriber and also implements non-pharmacological related interventions/ therapies, dependent on situation and technical requirements of care. The ANP must be able to initially and independently manage a broad range of presenting conditions. The following list of treatments is not exhaustive, but is intended to highlight the key conditions an ANP should be familiar with.

Table 2: ANP led treatments by area of practice

<p><b>Adult Acute Care</b></p>	<p>Adult Acute Care ANPs are able to manage all aspect of patient care relating to the following:</p> <ul style="list-style-type: none"> <li>• Medical Emergencies, including anaphylaxis, respiratory failure, cardiac arrest, sepsis, shock, and the unconscious patient</li> <li>• Common presentations, including abdominal pain, acute pain, bleeding, breathlessness, chest pain and palpitations, collapse/black out/syncope (fainting) and pre-syncope, acute confusion/delirium, altered consciousness and disturbed behaviour, diarrhoea and vomiting, dizziness and vertigo, falls, fever, fits/seizures, headache, head injury, jaundice, limb pain, swelling and abnormalities, the oliguric patient, poisoning, rash, suicidal ideation, nausea and vomiting, weakness and paralysis, and wound assessment and management.</li> </ul> <p>The Acute Care ANP will also have a good working knowledge of symptom management in palliative and end of life care.</p>
<p><b>Primary and Community Care</b></p>	<p>Primary and Community Care ANPs are able to manage all aspects of patient care relating to the following:</p> <ul style="list-style-type: none"> <li>• Medical Emergencies: Anaphylaxis, respiratory failure, cardiac arrest, sepsis, shock, and the unconscious patient</li> <li>• Common Presentations: Abdominal pain, acute pain, bleeding, breathlessness, chest pain and palpitations, collapse/ black out/syncope and pre-syncope, acute confusion/delirium, altered consciousness and disturbed behaviour, diarrhoea and vomiting, dizziness and vertigo, falls, fever, fits/seizures, headache, head injury, jaundice, limb pain, swelling and abnormalities, the oliguric patient, poisoning, rash, suicidal ideation, nausea and vomiting, weakness and paralysis, and wound assessment and management</li> </ul>

	<ul style="list-style-type: none"> <li>• Palliative care (long term conditions and end of life care): Skills, knowledge and competence to manage treatment</li> <li>• Paediatric: symptom management of common childhood presentations, acute and non-acute conditions e.g. viral illness, rashes, infectious diseases, croup, asthma</li> <li>• Women’s health: family planning and sexual health, coil insertion, sexual issues/screening</li> <li>• Men’s health</li> </ul> <p>In the telehealth/telecare setting, as well as in direct consultation, the ANP should be able to quickly identify potential stroke, acute coronary symptoms, sepsis, urgent mental health conditions including acute confusional state, cognitive impairment and increased risk linked to suicidal thoughts and take appropriate management actions.</p>
<p><b>Mental Health</b></p>	<p>Across all mental health specialties including Forensics, Old Age Psychiatry, Children and Adolescent Mental Health Services (CAMHS), Perinatal, Addictions, Rehabilitation, Psychiatric Liaison, Acute Hospital and Community, the Mental Health ANP is able to:</p> <ul style="list-style-type: none"> <li>• Differentiate, advise and educate on a range of mental health presentations</li> <li>• Provide suicide and self-harm management and treatment</li> <li>• Understand, and possess knowledge and competence, to manage a range of Mental Health and associated disorders</li> <li>• Differentiate between treatments for depression, dementia and delirium and correct management across all settings</li> <li>• Assess and advise on managing acute behavioural disturbance across all settings</li> <li>• Manage physical healthcare issues within the limitation of the area of practice</li> <li>• Manage acute substance misuse and detoxification across all settings.</li> </ul> <p>Understand both pharmacological and non-pharmacological management of delirium and the management of stress and distress.</p>



<p><b>Paediatric Acute Care</b></p>	<p>In response to medical emergencies, the Paediatric Acute Care ANP is able to perform a full ABCDE assessment:</p> <ul style="list-style-type: none"> <li>• Airway - Obstructed or partially obstructed airway (Croup, anaphylaxis, foreign body, Tracheitis and Epiglottitis)</li> <li>• Breathing - Bronchiolitis, Asthma and Pneumonia</li> <li>• Circulation - Sepsis, Hypovolemia (Diarrhoea and Vomiting, blood loss), Diabetic Ketoacidosis and Duct dependent heart defects</li> <li>• Disability - Status Epilepticus, altered consciousness, head injury and Hypoglycaemia</li> <li>• Exposure – Burns</li> </ul> <p>Paediatric Acute Care ANPs have a sound understanding of child protection legislation, ensure that legislative requirements are being met with their setting and take a lead role in educating colleagues within MDTs and improving systems for compliance.</p>
<p><b>Neonatal</b></p>	<p>The Advanced Neonatal Nurse Practitioner is able to manage all aspects of care relating to the neonate including:</p> <ul style="list-style-type: none"> <li>• Neonatal Resuscitation: Advanced Neonatal Resuscitation appropriate to gestational age and clinical presentation both at birth and in the hospital or community (neonatal transport) setting</li> <li>• Birth Asphyxia: Hypoxic Ischaemic Encephalopathy (HIE), Therapeutic Hypothermia (Total Body Cooling)</li> <li>• Management of the Preterm Baby: An in-depth knowledge of holistic management of the preterm neonate from birth to discharge appropriate to gestational age and clinical presentation.</li> <li>• Neonatal Respiratory Disease: Respiratory Distress Syndrome, Bronchopulmonary Dysplasia, Transient Tachypnoea of the New-born, Persistent Pulmonary Hypertension of the New-born, Pneumothorax, Congenital Pneumonia, Congenital Diaphragmatic Hernia, Pleural Effusion, Immune and Non-immune Hydrops Fetalis</li> <li>• Common Congenital Abnormalities/Birth Trauma</li> <li>• Neonatal Sepsis: Aetiology, management and treatment of early and late onset sepsis.</li> <li>• Neonatal Jaundice and Haemolytic Disease: Blood group incompatibility, maternal antibodies, maternal infection, investigations and management of neonatal jaundice.</li> <li>• Neonatal Congenital Heart Disease: Aetiology, management and treatment of common neonatal congenital heart conditions.</li> </ul>

- Neonatal Seizures
- Inborn Errors of Metabolism/ Metabolic Disease

Depending on the specialist area and level of experience, the ANP may also have in-depth knowledge of management of the surgical neonate.

## **Admission, Discharge and Referral**

The ANP has autonomy and authority to admit to and discharge from identified clinical areas, dependent on patient need at time of review. This includes the autonomy and authority to refer to, and work in partnership with, all appropriate health and social care professional groups and agencies.

## **Generic Competencies Relating to the Non-Clinical Pillars of Practice**

- **Facilitation of Learning:** ANPs are able to apply the principles of teaching and learning to support others to develop knowledge and skills, acting as a mentor to junior staff and taking responsibility for their own CPD.
- **Evidence, Research & Development:** ANPs are able to demonstrate an understanding of the research process and how research findings can be applied to practice. They are able to critique and synthesise research evidence to inform practice. In addition, ANPs have a working knowledge of Quality Improvement methodology and the ability able to apply it within their own area of practice.
- **Leadership:** ANPs demonstrate an ability to monitor and assure quality of care acting as change agents and role models. ANPs are competent in clearly stating their position or case, using supporting evidence where available, and are able to lead to ensure the best outcome for patients. They will advocate for improved safe, effective and person centred services across professional and service boundaries and can demonstrate effective leadership that uses critical and reflective thinking. ANPs promote evidence-based innovation.

The ANP will work within the scope of their professional practice, demonstrating an awareness of their own limitations in knowledge, understanding and clinical competence, and recognise when to seek expert advice in accordance with the Code<sup>5</sup>.

## **Metrics**

A key requirement for the development of the ANP roles is the development of benchmarking indicators focused around outcomes that can be applied across all established and new roles.

A number of factors have led to the current focus on outcomes in health care, including:

- Increased emphasis on providing quality care and promoting patient safety;
- Regulatory requirements for health care organisations to demonstrate care effectiveness;
- Increased health system accountability and changes in the organisation, delivery and financing of health care.

It is recognised that ANPs play an important role in determining patient and system outcomes. In particular, there is growing evidence of the positive impact that ANP care has on patient outcomes in terms of promoting access to care, reducing complications and reducing costs of care through improving patient knowledge, self-care management and

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<sup>5</sup> Nursing and Midwifery Council (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates. London: England,  
<https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf>

patient satisfaction. ANPs are recognised as being integral to developing and sustaining the capacity and capability of the health and care workforce now and in the future.

It is important therefore that ANPs are able to measure and articulate the impact of their care on patient outcomes, including both their professional impact as well as being able to demonstrate their contribution to health and care delivery. This is particularly important in relation to the Scottish Government's Vision for Health and Social Care Integration<sup>6</sup> and the need to ensure public value.

## **Principles**

Metrics should relate to both quality of care and patient outcomes. It is common within the academic literature for nursing roles to be assessed using a range of measures based around traditional medical/systems outcomes such as length of stay, admission rates and mortality. Further research is required to develop measures that have a focus on the role and contribution of nursing, which would specifically be able to demonstrate the ANPs unique contribution.

There are a number of underpinning principles that should be applied when developing ANP metrics for patient outcomes. These are outlined below:

Principle 1: Metrics should be both qualitative and quantitative and triangulated to demonstrate effectiveness.

Principle 2: Metrics that measure effectiveness of practice must be based on key result areas/ outcomes and align with service needs.

Principle 3: Where possible, metrics should be based upon existing data sources and systems to support a Once for Scotland approach and minimise additional work required for data collection.

Principle 4: There must be clear methods for displaying outcomes of ANP practice through time (scorecards/dashboards etc.). These should be aligned to the national nursing assurance framework, Excellence in Care.

## **ANP Metrics**

In addition to the above principles, the following points also contribute towards good practice:

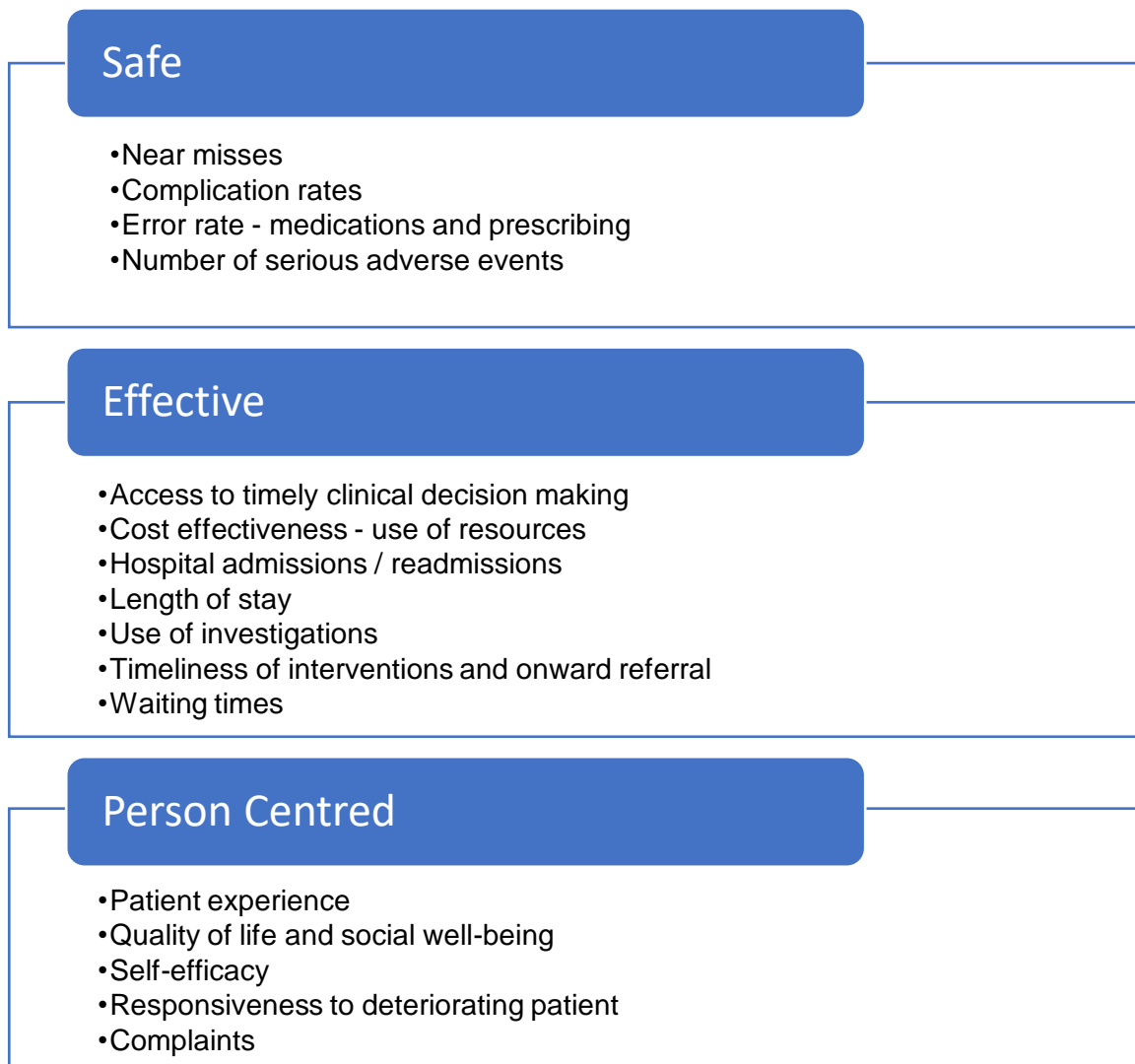
- Metrics should be SMART:
  - S: Specific (clear, precise and directly attributable to ANP practice)
  - M: Measurable (amenable to evaluation)
  - A: Appropriate (consistent with overall goal and identified priorities)
  - R: Reasonable (realistic and feasible to achieve)
  - T: Time-limited (outline a specific timeline for achievement)

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<sup>6</sup> The Scottish Government (2016) Health and Social Care Delivery Plan. December 2016, <https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2016/12/health-social-care-delivery-plan/documents/00511950-pdf/00511950-pdf/govscot%3Adocument/00511950.pdf>

- Appropriate metrics will vary according to the ANP's area of practice and service requirements. As such, they will to some extent be context dependent and require flexibility in their application.

Figure 1: Examples of metrics for use by ANP teams



The examples provided here are intended to illustrate only. Metrics may change over time to reflect changes to services and priorities.

Metrics for clinical practice should not be viewed in isolation from the other three pillars of advanced practice that are also fundamental to the role. Metrics that demonstrate the impact of the non-clinical pillars should also be identified according to the specific Advanced Practitioner role.

Data should be collected through time and must also demonstrate the effective ANP decision-making elements of the role. ANP teams (of any size) should measure their impact on patients and service by using a basket of meaningful metrics appropriate to the area of practice. The number of metrics should be kept limited but should demonstrate safe, effective and person centred care. It is recommended that at least one measure be chosen for each of these.

## **Non-Clinical Time**

The environment in which ANPs function remains complex and demanding. To meet these needs, the ANP must work within the four pillars of advanced practice:

- Clinical practice
- Facilitation of Learning
- Leadership
- Evidence, Research & Development

ANPs require specific non-clinical time to allow working across the four pillars. It is recommended that as a minimum, 3.75 hours per calendar week, pro rata, be allocated as non-clinical time on an ongoing basis. This should be built into workforce planning and made clear during job planning processes, both for individuals and at an organisational level. As part of this, job planning should be an explicit aspect of managing individuals and teams.

## **Clinical Supervision**

Supervision for ANPs and the supervisory role required was discussed extensively during the preparation of the Phase I paper. All ANPs should be prepared to make constructive use of supervision, have a named Clinical Supervisor and be offered at least four Clinical Supervision sessions per year.

Further information on Clinical Supervision can be found on the NES website at the following link: <https://learn.nes.nhs.scot/3580/clinical-supervision>

## **Continuing Professional Development (CPD)**

Developing staff to work as an ANP is a significant investment for the employer and commitment for the individual. To ensure that organisations benefit from such an investment and that ANPs continue to deliver robust up-to-date evidence based care, it is imperative that ANPs have opportunity and access to high quality CPD. Each ANP retains a professional responsibility to reflect on and develop their practice in line with the NMC Code and Revalidation requirements. It is essential that CPD activity is planned within work programmes and sufficient time is allocated

## **Supporting Professional Activities (SPA)**

Specific SPAs should be negotiated with the ANPs line manager and resource must be made available to enable the undertaking of these activities.

## **Job Title**

This paper is focused on the roles and responsibilities of the Advanced Nurse Practitioner. As Advanced Practitioner roles develop across professions, where these relate to nursing, nurse should be included in the title (e.g. Advanced Nurse Practitioner) and clearly stated on identification badges and local workforce data capture.

## **Transition**

It is recognised that there are highly trained, highly competent ANPs, whose roles have been established prior to the Scottish Government's Transforming Roles programme. Current developments will not in any way, disadvantage established ANPs.

It is recommended that competence review processes should be used to assess established ANPs against national definitions to match against the appropriate role and level of practice. Further professional development should be based on training needs analysis. For those who meet all the requirements, there will be no need to undertake further training or education. This decision should be made in partnership with the ANP and their employer, with senior nursing teams providing appropriate oversight.

## **Advanced Practice Academies**

Over recent years, there has been a significant increase in the number of ANP roles within the workforce in Scotland. Newly developed processes for supervision and support have led to discussion about regional planning and the professional development of ANPs. Three ANP academies have been established – in the West, North and East of Scotland.

## **Purpose**

The “Academy” approach is intended to unite a number of Health Boards to support the professional development of Advanced Practice across the Nursing Midwifery and Allied Health Professions (NMaHP) structures. The key function of the Academy is to develop a cohesive, consistent approach to the development of Advanced Practice across health and care services in Scotland, focusing on the development and maintenance of competence and capability, as well as leading on the development of new advanced roles. Academies support Advanced Practice programmes at partner Higher Education Institutions (HEIs) by providing expertise and facilitating support and supervision.

Strategic partners to the Academies include Higher Education Institutions and employers of ANPs within the independent sector, such as General Practitioners.

Each Academy has a two-tier structure. At the primary level of the academy, there is a network of support, learning and professional development for Advanced Practitioners across Health Boards, focusing on the clinical and professional requirements of these demanding roles, and providing opportunities for competence and capability development. This tier also includes a mentoring and supervision sub group, bringing together the mentors and supervisors of Advanced Practice.

The second tier comprises a group of senior leaders from Health Boards and HEIs, to provide an overarching view of Advanced Practice. This leadership/oversight group is intended to supplement any local Advanced Practice groups within each Board.

## **The Shared Learning Network/CPD Events**

One of the ongoing challenges for Advanced Practice support and development is capacity and capability within Health Boards. Some Health Boards in Scotland may lack a critical mass of practitioners within a given clinical area, particularly in areas such as Primary Care, Paediatrics and Mental Health. Working as a diverse group of Boards enables a network of shared learning approaches, such as critical companion groups and action learning sets. Sharing resources and faculty, including in areas as simulation and clinical

skills, is key for shared learning. The shared learning approach will also allow Advanced Practitioners to work across Health Boards to facilitate learning.

As part of the academy requirements Health Boards in Scotland are committed to delivering one full day of Continuous Professional Development every 12 - 18 months, aiming for 3 - 4 per calendar year across all Health Boards. Some boards may wish to work together on these events due to scale, i.e., smaller Boards may not individually have the resources to regularly generate such events.

### **Mentoring and Supervision Group**

The Academy seeks to optimise the mentoring and supervision approaches within Health Board. Each Academy has a Mentoring and Supervision Group to bring established and new mentors together to share best practice, implement agreed approaches to supervision and allow peer review and support. As these approaches strengthen, there will be opportunity for mentors and supervisors to work across Health Boards, to support quality assurance on the implementation of training and education, including assessment of competence.

### **The Leadership Group**

The membership of the Leadership Group consists of two to three identified individuals with responsibility for the professional development of Advanced Practice within Health Boards. This should be multi professional, to allow appropriate NMAHP representation.

The specific role and function of the Leadership Group is to:

- Lead on Advanced Practice development;
- Develop links with key stakeholders in each Health Boards;
- Give guidance and support in the implementation of Transforming Roles (Advanced Practice)
- Develop a shared network for learning and development for Advanced Practitioners across Health Boards. This will include the development of shared CPD opportunities;
- Develop a shared approach to supervision and support;
- Adopt professional oversight of the development of competence structures and assessment processes;
- Develop shared governance approaches to Advanced Practice. An example of this approach can be found in Annex B.

It is envisaged that the next phase of development within the Academy structure would be a research and Quality Improvement subgroup, generated in partnership with HEI colleagues.



## Annex A

### ANP Governance: Example from the West of Scotland Advanced Practice Academy Leadership Group

Significant discussions have taken place on the subject of governance for ANPs. The West of Scotland ANP Academy document has been included below as an example good practice. It is important to note that this is only an example and other regions may require different structures and processes.

An academy is a network of Health Boards, working together to provide oversight of Advanced Practice whilst supporting the learning and professional development of ANPs across Boards, focussing on the development and maintenance of competence and capability.

ANPs require effective clinical supervision throughout their careers, but it is particularly crucial during their early development. Supervision should include a combination of competency frameworks, academic and local education programmes, and effective supervision. Each of these are essential to evaluate the clinical competence of a practitioner. Governance structures should be embedded in to Boards' quality assurance frameworks.

The table below represents the governance framework that all ANPs within the three Health Boards that form the academy should be working to.

<b>Clinical Competence</b>
<b>Competence Frameworks</b> <ul style="list-style-type: none"><li>• Each ANP should have a core competence framework underpinned by the four pillars of advanced practice: leadership; clinical practice; evidence, research &amp; development; and facilitation of learning.</li><li>• The competence framework will demonstrate the ANP's core competence in comprehensive history taking, clinical assessment, differential diagnosis, investigations and treatment – including independent prescribing and admission/discharge/referral</li><li>• Each competence framework should demonstrate comprehensive and progressive evidence of practice within the ANP's clinical setting</li><li>• Any area specific competencies should be demonstrated as an addendum to the above</li><li>• A competence framework should take no longer than 3 years to complete</li></ul>
<b>Competence Sign Off</b> <ul style="list-style-type: none"><li>• In line with the triangle of capability principle of, competence should be signed off by a lead clinician in the area of practice, peer review and line manager</li></ul>
<b>Maintaining Competence</b> <ul style="list-style-type: none"><li>• Annual review of 10 clinical cases by line manager/senior clinician which must include evidence of reflection and learning</li><li>• Annually signed peer review form as evidence of maintenance of competence</li></ul>
<b>Supervision</b>
<b>Line Manager Supervision</b> <ul style="list-style-type: none"><li>• Regular team meetings – attendance at 2 per year with action notes/minutes available to all team members</li></ul>

- Annual Performance Development Review (PDR) using the Knowledge and Skills Framework (KSF). 10 case notes with prescribing practice, reflection and learning points at every PDR session
- Critical companion at least once per year
- De-brief sessions following difficult/stressful cases
- Random case note reviews throughout the year
- Regular direct supervision of clinical work

#### **Peer Supervision/Support**

- Informal/ad-hoc on a shift to shift basis
- Each ANP new to post should be given a designated ANP supervisor
- Potential for linking across localities/Boards to engage in appropriate mentorship

#### **Clinical Supervision**

- Should be provided monthly as a minimum.
- Every ANP should be provided with an ANP supervisor (fully qualified/competent ANP) at the earliest opportunity
- Supervision should take place by critical companion and/or case based discussion/presentations – at a minimum of four times annually
- Supervision of prescribing practice during and following academic qualification including reflection on learning from prescribing practice
- Direct supervision of clinical work – at a minimum of annually

#### **Education**

Each ANP should complete a training needs analysis on a yearly basis to ensure that individual training needs are being met.

#### **Academic Education**

- Minimum qualification achieved within 3-5 years of taking up post
- Must achieve, as a minimum, a Post Graduate Diploma in Advanced Clinical Practice
- Must achieve an independent prescribing qualification from an accredited HEI
- Should be working towards an MSc in a subject applicable to advanced nursing practice

#### **Continuous Professional Development**

- Completion of all local mandatory training programmes
- Annual attendance at simulation training
- Immediate life support as a minimum
- Where applicable, advanced life support for first responders
- Completion of course in recognition, management and escalation of the deteriorating patient
- Attendance at local continuous professional development twice per year
- Attendance at national non-medical prescribing conferences

## **Annex B**

### **ANP Supervision: Example from the West of Scotland Advanced Practice Academy**

**The West of Scotland Advanced Practice Academy supervision document outlines practice supervision for trainee ANPs, robust arrangements for ‘final sign-off’ at the completion of training and more detail on Clinical Supervision for ANPs. The document below is an example of the ways in which an Academy may strengthen the governance and practice of ANPs across Health Boards.**

#### **ANP Clinical Supervision**

##### **Definition of clinical supervision**

“Clinical Supervision is regular, protected time for facilitated, in-depth reflection on complex issues influencing clinical practice” Bond and Holland (1998, p15)

##### **NMC and Revalidation**

The NMC describe the benefits of clinical supervision as “improved capacity to identify solutions to problems, increased understanding of professional issues, improved standards of patient care, opportunities to further develop skills and knowledge and enhanced understanding of own practice” (NMC 2008). The principles of clinical supervision are closely linked to the NMC’s revalidation process.

##### **Models of Supervision**

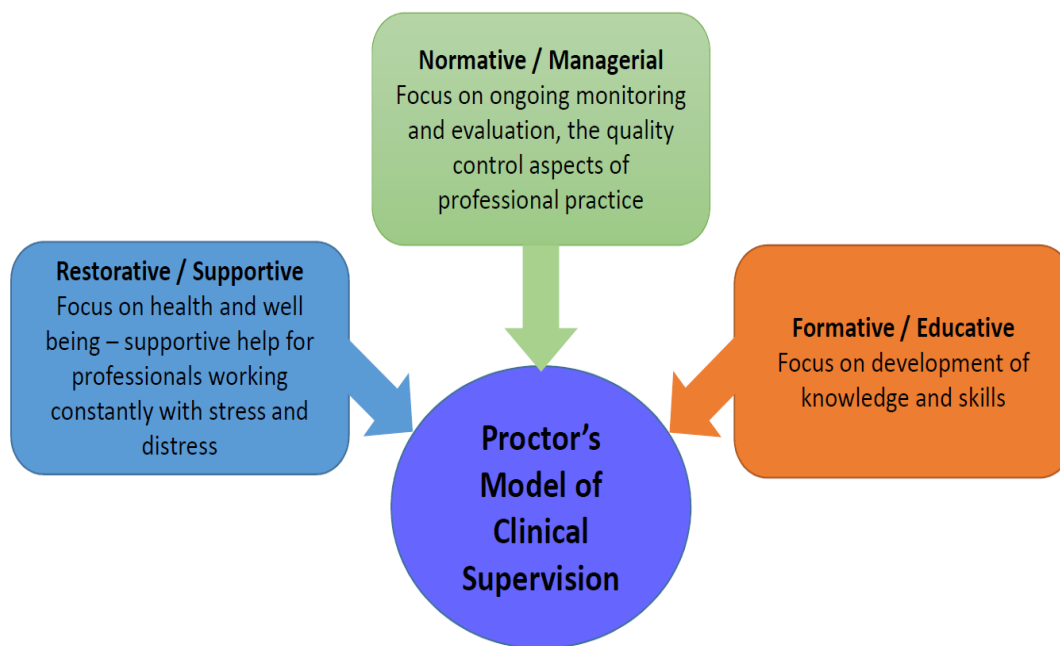
A number of different models of clinical supervision exist. These are conceptual frameworks that can guide practitioners and supervisors through the clinical supervision process. Proctor’s three-function model (Proctor 1987) is one of the most widely used; however, other models can be used.

##### **Proctor’s Model**

Proctor’s model describes three functions that need to be addressed in supervision. Namely:

- Normative/managerial
- Formative/educative
- Restorative/supportive

The focus can be on one or more of these functions and will vary according to the needs and values of the supervisee. The different functions may also overlap.



**Fig 1. Proctor's Model of Clinical Supervision**

### **Trainee to experienced ANP**

Trainee ANPs will require closer and more intense supervision than experienced ANPs.

### **Clinical Supervision for Trainees**

Trainee ANPs require supervision throughout their entire ANP education. A 'tripartite' approach is encouraged. This will involve:

- A Clinical Supervisor/trainer who will be an experienced senior clinician who is doing or is able to do the same job the trainee ANP is preparing for. This individual could be a suitably qualified and experienced ANP or they may be another suitably qualified and experienced healthcare professional, most often a consultant, General Practitioner or registrar.
- An Educational Supervisor who will be a suitably qualified and experienced educationalist (e.g. personal academic tutor). This could be the Programme Leader for the course the trainee is undertaking, or another member of the programme team the responsibility is delegated to
- The trainee's line manager who will be responsible for ensuring that the trainee is supported and appropriately clinically supervised throughout their entire training.

At least one of the Supervisors should be a senior registered nurse and ideally an Advanced Nurse Practitioner.

On occasion one individual may be able to undertake more than one of these roles. However, best practice would be to involve three separate people with distinct responsibilities.

### **Responsibilities of supervisors**

- The Clinical Supervisor/Trainer will be responsible for ensuring that the trainee is appropriately clinically supervised throughout their training. This may involve one-to-one supervision, especially near the beginning of the training, or may involve ensuring that a team of suitably qualified and experienced people are available to provide supervision if the Clinical Supervisor/Trainer is not present. The Clinical Supervisor/Trainer should meet with the trainee on a regular basis to discuss progress. As a minimum, this would be on a 6-8 weekly basis. The Clinical Supervisor/Trainer will liaise with the line manager at regular intervals.
- The Educational Supervisor will be responsible for ensuring that the trainee can access the modules on the programme, will provide academic advice and support to the trainee and will liaise with the Line Manager.
- The Line Manager will be responsible for ensuring that the Supervision model is working, that the trainee is getting the personal, academic and clinical support that they need. The Line Manager is also responsible for ensuring that the trainee has appropriate time for learning built into their job plan and that they can access all appropriate learning opportunities

The three supervisors should communicate with each other on a regular basis and it would be good practice for all three to meet together with the trainee at least once a year.

The three supervisors should have open lines of communication to share progress and discuss issues.

- The trainee also has responsibilities. The trainee should liaise with the line manager on a regular basis regarding progress and should raise any issues that might impact on training and development at an early stage.
- The trainee should also share relevant information with their clinical supervisor and education supervisor as appropriate.
- The trainee is an adult learner as is expected to identify their own learning needs, assisted by the clinical and education supervisors and line manager.

### **Designated Prescribing Practitioner (DPP)**

Prescribing students can be supervised and assessed by any registered healthcare professional who is an experienced prescriber with suitable equivalent qualifications for the programme the student is undertaking.

NMC registrants who are undertaking V300 require a practice assessor and a named practice supervisor, which are two separate roles. Further information on becoming a prescriber can be found on the NMC website via the following link:

[Becoming a prescriber - The Nursing and Midwifery Council \(nmc.org.uk\)](http://nmc.org.uk)

The link to the Royal Pharmaceutical Society (RPS) document 'Designated Prescribing Practitioner Competency Framework' can be found here:

<https://www.rpharms.com/resources/frameworks/designated-prescribing-practitioner-competency-framework>

Of note the NMC medicines standards have been withdrawn since January 2019 and the RPS standards have been recommended. More information can be found via the following link to 'Professional guidance on the safe and secure handling of medicines' on the RPS website:

[Professional guidance on the safe and secure handling of medicines \(rpharms.com\)](http://rpharms.com)

### **Dissertation Supervisor**

If the trainee goes onto complete the Masters programme, then they will require a Dissertation Supervisor. This Supervisor will be appointed by the Higher Education Institution.

### **Requirements of supervisors**

The following are minimum requirements. Different Higher Education Institutions and/or additional awarding bodies (e.g. Royal College of Emergency Medicine (RCEM), The Faculty of Intensive Care Medicine (FICM), RCN) may have additional requirements.

- Clinical Supervisor/Trainer – must be a senior clinician who is technically skilled to undertake the role the trainee is preparing for. They must be registered by their Registering Body (NMC, General Medical Council (GMC), The Health and Care Professions Council (HCPC)) and not have any limitations on their practice. They also must be able to prescribe. Ideally, they should hold a masters level qualification.
- Educational Supervisor – must be part of the Programme Team at the Higher Education Institution the trainee is undertaking the qualification at. They must either be employed by the Institution or hold an Honorary Contract with that institution. Educational Supervisors must have access to the academic transcripts of the trainees they are supervising. They must hold a masters level qualification or above and ideally be an Advanced Practitioner
- Line Manager – must be willing to take on the responsibility to support the supervision of the trainee and to facilitate the training within the workplace

## Collecting Evidence

Part of the role of the supervisors is to help the trainee build a portfolio of evidence to demonstrate their competence in Advanced Practice.

## Professional Portfolio

All trainee ANPs and ANPs are expected to use the NES TURAS Professional Portfolio, details of which can be found via the following link:

<https://turasmpportfolio.nes.nhs.scot>

Within the Professional Portfolio trainees need to demonstrate the following (as a minimum):

- Record of their learning including clinical experience as a trainee
- Completion of all academic requirements (record of all modules undertaken, including results and copy of their final exit award certificate)
- Work Based Practical Assessments (formative and summative). This is likely to include:
  - Mini-Clinical Evaluation Exercise (CEX)
  - Direct Observation of Practical Skills (DOPS)
  - Case Based Discussions
  - Feedback from others
- Competencies – where appropriate competencies may be mapped to evidence elsewhere in the portfolio
- Supervision reports

Different Higher Education Institutions and/or additional awarding bodies (e.g. RCEM, FICM, RCN) may have additional requirements and may require other Portfolios to be used for different stages. Evidence can be shared between portfolios.

## Competencies

The ANP role continues to evolve and new frameworks are being developed on a regular basis. As a minimum ANPs in Scotland must meet all the 'high level' competencies for an ANP, all the Prescribing competencies **and** the competencies for one of the broad groups of ANPs (e.g. neonatal, paediatric, primary care/community, adult acute care, or mental health).

Additional competencies may be required by different Higher Education Institutions and/or additional awarding bodies (e.g. RCEM, FICM) and/or the employer.

The supervision team will help the trainee identify all the required competencies for their role.

## Final Sign-off

Completing a course of academic study is not sufficient to demonstrate that an individual is competent to practice as an ANP.

Each employer needs to ensure an appropriate mechanism is in place for 'final sign-off'. Final sign-off is required when an individual:

- Completes initial training
- Changes job especially if it's in a new speciality

Final Sign-off involves:

- The individual's line manager who will take the lead on the sign-off process
- The Clinical Supervisor/Trainer
- The Education Institution – this would usually be through evidence of completion of a programme of education (for example a copy of the Postgraduate Diploma in Advanced Practice and/or academic transcript)

The Line manager would set a date for the trainee ANP to submit a 'Share Pack' of their portfolio. The line manager would share this with the Clinical Supervisor/Trainer. Both would be expected to review the portfolio and confirm it is completed to a satisfactory standard. As a minimum, the following is expected.

- Record of their learning including clinical experience as a trainee.
  - A minimum of 400 hours of supervised practice<sup>7</sup> over a minimum of 1 year
  - Evidence of learning:
    - Clinical assessment
    - Clinical reasoning, judgement and diagnostic decision making
    - Anatomy and physiology
    - Non-medical prescribing
    - Leading, delivering and evaluating care
    - Worked based learning
- Completion of all academic requirements (record of all modules undertake, including results and copy of their final exit award certificate) and recorded as a non-medical prescriber with the Nursing and Midwifery Council.
  - Copy of a masters level qualification in advanced practice (or evidence of equivalence [this would normally be 120 credits with a minimum of 50% at masters level]).
  - Evidence of being recorded with the NMC as a Nurse Independent Prescriber
  - Evidence of being recorded with Health Board as a prescriber

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<sup>7</sup> Supervised practice may involve direct supervision where the supervisor is physically present with the trainee or indirect where supervision is provided at a distance or delegated to another clinician



- A range of Work Based Practical Assessments demonstrating competence is managing the broad range of patients seen within the role. This is likely to include:
  - Mini-CEX
  - DOPS
  - Case Based Discussions
  - Feedback from others
- Completed competencies – where appropriate competencies may be mapped to evidence elsewhere in the portfolio
- Satisfactory Supervision reports which confirm the trainee has completed training and has been assessed as competent performing as an ANP

The Clinical Supervisor/Trainer and Line Manager will together determine whether the trainee has:

- Passed - Satisfactorily passed all academic requirements and evidence of competence to practice in ANP role contained within TURAS Professional Portfolio
- Provisional pass – satisfactorily passed all academic requirements, but some minor gaps in evidence of competence.
- Fail – either has still to pass all academic requirements or has major gaps in evidence of competence or both.

If the trainee has passed, the line manager would inform the individual within the Board who is responsible for recording ANPs on the Scottish Standard Workforce Information System (SWISS). The trainee, employed as Band 7 Annex 21 or Band 6, would be expected to move to a Band 7 at this stage.

If a provisional pass, the line manager would set a period of time (no less than 1 month and usually no more than 6 months) for the individual to obtain the required evidence. Trainees employed as Band 7 Annex 21 or band 6 would not normally move until competence has been achieved. The trainee would not normally move to a Band 7 until after confirmation that satisfactory evidence has been submitted.

If a fail, the line manager, in consultation with others (which may include the clinical supervisor, education supervisor and Human Resources) the most appropriate course of action for the individual. This may include re-doing part of the training or termination of the traineeship.

If the Clinical Supervisor/Trainer and Line Manager cannot agree on a grade, the view of the internal moderator should be sought. If agreement can still not be reached then advice can be sought through the external quality assurance mechanism system i.e. the Academy.

### **Moderation**

A sample of portfolios will be internally moderated and externally quality assured each year. Each Board will put in place a mechanism for internal moderation.

The Advanced Practice Academy will put in place a mechanism for external quality assurance of a sample of portfolios from each board every year. This mechanism will involve a suitable expert(s) from another Board reviewing Professional Portfolios and providing feedback to the line manager, the Board Advanced Practice Lead and the Board Nurse Director.

External Experts will be recorded within their employing Board as an ANP or NMAHP Consultant and either have teaching and assessing qualification or be recognised by the Academy as an 'External Expert'.

The Academy's recommendations will be advisory only. Ultimately, it will be for the employer to determine whether an individual has met all the requirements to practice.

### **Clinical Supervision for Qualified ANPs**

The Clinical Supervision model for qualified ANPs differs significantly from the practice supervision model used for trainee ANPs. The model that should be used for qualified ANPs is the NES Clinical Supervision model, details of which can be found via the link below.

See <https://learn.nes.nhs.scot/3580/clinical-supervision>

Qualified ANPs will have a network of support and supervision that will support day-to-day practice. This network may include the on-call medical consultant, senior medical staff, ANP colleagues, other Advanced Practitioners, the individual's line manager, lead and or chief nurse and consultant nurse.

In addition to this, each ANP will have a named Clinical Supervisor who will either meet with the supervisee on a one-to-one basis or in a group with other supervisees. Supervisees should meet with their Clinical Supervisor at least once a year.

The ANPs line manager will be responsible for ensuring that each qualified ANPs has a named Clinical Supervisor.

Clinical Supervision will consist of:

1. A reflective component
2. Support from a skilled facilitator
3. Focus on clinical practice (including team dynamics, communication and personal coping)
4. Professional Development
5. Improving patient treatment and care

### **Record Keeping**

The Clinical Supervisor and Supervisee are jointly responsible for ensuring records are kept of supervision sessions. Records will help supervisees:

- revisit their discussions, reflections and action points over time

- provide evidence that they have participated in clinical supervision which can be used for revalidation
- document and commit to any agreement to take anything out of a session

## **Clinical Supervisor**

The Clinical Supervisor for a trained ANP will be an experienced senior clinical who is doing or is able to do a similar job to the ANP. Ideally this individual should be a suitably qualified and experienced ANP however they may be another suitably qualified and experienced healthcare professional for example a GP. Clinical Supervisors will undertake preparation for the role<sup>8</sup>.

## **Annual review**

ANPs are responsible for compiling, maintaining and sharing an ePortfolio<sup>9</sup> that evidences their competence to practice as an ANP. At least once a year the ANP should meet with their line manager for an annual review. If the line manager is not an ANP it would be good practice to either undertake a joint review with the ANP's Clinical Supervisor. If a joint meeting is not possible, the Clinical Supervisor should provide the line manager with a report which details the clinical supervision sessions<sup>10</sup>.

Annual review will involve the following:

- Professional Portfolio review
  - Record of learning activities, reflection, feedback from others (including clinical supervisor)
- Case notes for discussion and review which should related to the individuals level of competence, prescribing practice and include reflection as well as learning/action points (either for review by the line manager, or evidence of peer review or review by the Clinical Supervisor)
- Feedback from patients through compliments, complaints, patient satisfaction surveys or adverse events can be used to inform discussion and reflection
- Job planning – this should follow the Board's Job Planning guidance for ANPs. Job Plans should include time for Supporting Professional Activities (including Continuing Professional Development and contributions towards the other pillars of Advanced Practice: facilitation of learning, leadership, and research).

Normally the KSF would also be completed at this review and revalidation every three years.

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<sup>8</sup> Digital Resource Pack available from NHS Education for Scotland

<sup>9</sup> TURAS Professional Portfolio recommended from NHS Education for Scotland

<sup>10</sup> This can be submitted as a 'Feedback from Others' form in the TURAS Professional Portfolio

## **NMC revalidation**

Evidence of Clinical Supervision should be included within your evidence for revalidation.

## **Summary**

These guidelines set out the minimum standards for Clinical Supervision of Advanced Nurse Practitioners within the West Region. Individual Boards, Higher Education Institutions or other awarding bodies may have additional requirements.

## References

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