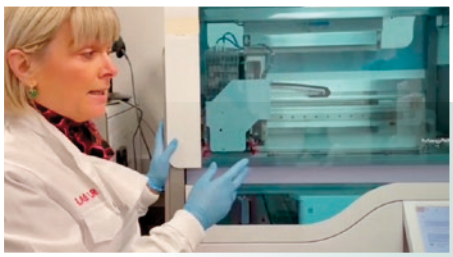
HSCP Advanced Practice Framework










Health & Social Care Professions

HSE National HSCP Office, 2023

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Foreword

This Framework is the culmination of collaboration that began over ten years ago with health and social care professionals and their professional bodies who had the vision to see that there is a benefit to working together and finding the common ground across the professions.

A commitment to providing the highest standards of health and social care to service users is a unifying feature of this group of different professions, which I am proud to represent in the HSE. This drive to continuously improve and adapt, is demonstrated in the high proportion of winners and commended projects in the annual Health Services Excellence Awards, the Spark Programme Awards and Sláintecare Integration Fund projects. It is also evident in the aspiration to develop skills, knowledge, competence and capabilities including specialist and advanced levels of practice in response to evolving needs of service users and the health service.

It gives me great pleasure to welcome this *HSCP Advanced Practice Framework* as a key milestone in unlocking access to HSCP senior clinical decision making capacity and thereby reducing pressure/ supporting on other healthcare professionals by enabling HSCPs to work at the top of their licence. This supports increased efficiency and safety, and the principle that all healthcare workers focus on doing what only they can do.

The backing of Dr Colm Henry, Chief Clinical Officer and Dr Siobhán Ni Bhriain National Clinical Director, Integrated Care was instrumental in paving the way for discussions with the Department of Health and in particular Rachel Kenna Chief Nursing Officer and Breda Rafter, Principal Officer, Strategic Workforce Planning Unit.

The development of the framework was enabled by the support of the HSCP professional bodies who, nominated members to join the HSCP Advanced Practice Working Group and responded to requests for information and examples of HSCP advanced practice.

We are indebted to Beverley Harden, National AHP Lead, National Multi-professional Lead for Advancing Practice, & Richard Collier, Lead for Advanced Level Practice & Lead for Centre for Advancing Practice, Health Education England, Jenny Keane (then) Chief Allied Health Professions Officer, Department of Health Northern Ireland, and Ms Sheila Cahalane, National Lead Advanced Practice, Office of the Nursing and Midwifery Services Director (ONMSD), HSE & Mary Doolan,(at the time) Nursing and Midwifery Planning & Development Officer, ONMSD, who shared their knowledge, experience, learning and documents in a learning event for the HSCP Advanced Practice Working Group in September 2021. This greatly assisted the development of the document. We also acknowledge permission to adapt the NHS definition for advanced practice and for the allowing us to adapt a graphic highlighting how HSCP can transform services on Page 30.

I would also like to acknowledge *Research Matters*, and in particular Dr Sinéad Hanafin and Dr Michael Shanahan for their excellent *Report of Literature Review and Policy Analysis of Advanced Practice in the Health and Social Care Professions* which provides a solid evidence base for the Framework. There is a wide range of professions, scopes of practice and jurisdictions covered in this review with a range of outcomes arising. Interpretation of findings require consideration of the context and in some cases subtle but important differences in deployment of advanced practice roles in different countries.

I wish to offer my gratitude and admiration to the members of the HSCP Advanced Practice Working Group who worked through the most difficult challenges that the HSE has faced through COVID-19 and a cyber-attack. And we look forward to expanding the membership of the Group as we move on to focus on the educational pathway for HSCP Advanced Practice with input from HSCP colleagues in HEI. Finally I want to thank the National HSCP Office staff including Eileen Walsh and Sinéad Fitzpatrick for their work. A special word of thanks is due to Sinéad Fitzpatrick, HSCP Development Manager who led the work on behalf of this Office, we have benefited from her dedication and expertise since the first work to publish the HSCP Advanced Practice Position Statement in 2014.

Jackie Reed,
National HSCP Lead

Glossary of terms

Advanced HSCP	Advanced Health and Social Care Professional
Candidate advanced HSCP practitioner	HSCP who is on an education and development pathway to advanced HSCP Practitioner
ACP	Advanced Clinical Practice
AHP	Allied Health Professional/Professions
AP	Advanced Practice and Advanced Paramedic
APP	Advanced Physiotherapy Practice
CORU	Health and Social Care Professions Regulator Ireland
ED	Emergency Department
ESP	Extended Scope Practitioners
FCP	First Contact Practitioners
GP	General Practitioner
HIQA	Health Information and Quality Authority
HSCP	Health and Social Care Professionals/Professions
HSE	The Health Service Executive
MSc	Master of Science
MSD	Muscular Skeletal Disorders
MSK	Musculoskeletal
NHS	National Health Service (UK)
NMBI	Nursing and Midwifery Board of Ireland
NFQ	National Framework of Qualifications
NTPF	National Treatment Purchase Fund
OECD	Organisation for Economic Cooperation and Development
OT	Occupational Therapy/Therapist
Physio	Physiotherapy/Physiotherapist
pCSRT	Palliative Advanced Practice Radiation Therapist
SLT	Speech and Language Therapy/Therapist

Executive summary

Objective

This Framework was created to inform policy development and key actions including the creation of a grade code for candidate advanced HSCP practitioner and advanced HSCP practitioner, which are required to realise the benefits of advanced practice in the health and social care professions for the people of Ireland and the health service.

Background

With the expressed support from the Department of Health, the HSE Chief Clinical Officer and the National Clinical Director, Integrated Care as project sponsor, the National HSCP Office established the HSCP National Advanced Practice Working Group in 2021.

The objective of the Group was to develop an agreed evidence-based framework for advanced practice in the health and social care professions, to improve access to senior clinical decision-making and timely access to care for the people of Ireland. Progressing advanced practice is a key commitment for the National HSCP Office in *HSCP Deliver, A Strategic Guidance Framework for Health and Social Care Professions 2021-2026.* The HSCP Office had previously led the development of a *HSCP Advanced Practice Position Statement* (2014) and toolkit through engagement with HSCP.

The *Report of Literature Review and Policy Analysis of Advanced Practice in the Health and Social Care Professions* which underpins this framework, highlights a strong policy context and support for the establishment of advanced practice in the HSCP. The Department of Health (2017, p. 6) for example, note that "*the development of specific areas of HSCP advanced practice offers further opportunities to deliver previously hospital-based services in the community, improve patient satisfaction and flow as well as the opportunity to relieve pressure on GP practices*".

The Framework

The *HSCP Advanced Practice Framework* describes the key elements required to recognise existing advanced practice in the HSCP and for the development of future HSCP AP based on core principles which can be summarised as, appropriate person-centred, evidence informed, effective, safe and sustainable services and care to meet the prioritised needs of the population. The framework is comprised of

- an agreed definition of HSCP advanced practice,
- required competencies in four pillars of advanced practice,
- development pathways,
- key considerations such as regulation, legislation, clinical governance,
- education and credentialing
- a plan for implementation including evaluation,
- Exemplars of HSCP innovation and service development which meets the criteria for advanced practice.

The National HSCP Office identified the need to separate the connected work stream which complements this framework, which describes the educational pathway for Advanced Practice in HSCP. This Educational Pathway for Advanced Practice in the HSCP, developed with input from HSCP colleagues in the Higher Education Sector, describes the educational requirements for HSCP who which to engage in advanced practice and to make recommendations on how best to meet these needs. In so doing, this contributes to building a suite of tools, guidelines, and resources to support the recognition, development and realisation of advanced practice in the HSCP.

In conclusion the *HSCP Advanced Practice Framework* supports the establishment of advanced practice in the HSCP in order:

- To enable the Irish health and social care services to meet increasing demand for health and social care for the for all service users across the lifecycle.
- To support the implementation of *Sláintecare* which requires health care professionals including HSCP working at the top of their license.
- To deliver new integrated models and pathways of care focused on early interventions to prevent avoidable emergency department presentations and admissions, and reduce waiting lists for scheduled care, by increasing senior decision-making capacity.
- To bridge the gap between healthcare needs and staff available to deliver the required health and social care services.
- To support expansion and retention of vital HSCP services across the domains of diagnostics, therapeutic, rehabilitation, disability, mental health and recovery, acute care, primary care, psycho-social care, health promotion and prevention, by providing a career pathway and enable development and progression in these professions.

HSCP Advanced Practice Framework

Objective/Purpose

The objective of this Framework is to provide an evidence-informed and agreed definition of advanced practice, advanced practice competencies, development pathways and implementation plan needed to inform policy development and support the introduction of two new grade codes which are required to formally establish and recognise advanced practice in the health and social care professions. In so doing, senior clinical decision making capacity will be increased to enable the health service to meet the ever expanding healthcare needs of the people of Ireland.

There are challenges in meeting demand across the breadth of the health and social care services in Ireland and internationally. There is a global shortage of healthcare workers and in Ireland and there are large numbers of vacant HSCP posts across healthcare settings and grades. This has a direct impact on service delivery. At the time of writing there are 83,477 adults and children waiting for hospital admission/ day case procedures ("National Treatment Purchase Fund", 2023) and the national data on the emergency department experience time in September 2022 shows 5,352 people, of whom 1,674 were 75 years and older, waited longer than 24 hours before being discharged or admitted.

We have many positive examples of the impact of HSCP expert clinical assessment and management on patient flow and Emergency Department (ED) decompression, alleviating pressure on health services. For example the Frailty Intervention Therapy (FIT) team, Beaumont Hospital (see below under benefits to service users), and OPTIMEND – Optimising Early Assessment and Intervention by Health and Social Care Professionals in the Emergency Department. OPTIMEND was a single site randomised controlled trial (RCT) which aimed to test the impact of an ED-based HSCP team on the quality and safety of care of older persons as compared to usual care. The HSCP team provided an assessment of functional, mobility, cognitive and psychosocial needs as well as interventions to enable safe discharge for the service users and their family. In this study, the effect of the ED-based HSCP team resulted in a shorter length of ED stay and reduced rates of hospital admissions when compared to usual care.[1]

Based on the available evidence, it is expected that recognition and progression of advanced practice in the HSCP will improve service user care, enable access to diagnostics, increase staff satisfaction and assist with recruitment and retention of HSCP disciplines.

Introduction and Context

Health and Social Care Professionals (HSCPs) account for 25% of the HSE clinical workforce (18,920) working autonomously in the 26 different professional disciplines in therapy, diagnostic and psycho-social domains through the lifespan in both acute and community settings.

The National HSCP Office was established in 2017 to strategically lead and support HSCPs in the design, planning, management, and delivery of people-centred integrated care.

In 2021, the National HSCP Office committed to "promote and champion development of advanced HSCP practice so that the opportunities to transform service delivery are achieved" in *HSCP Deliver, A Strategic Guidance Framework for Health and Social Care Professions, 2021-2026,* (Health Service Executive, 2021, p. 32).

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1 Other significant differences (intervention versus control) included lower rates of hospital admissions from the ED (19.3% versus 55.9%, $p < 0.001$), higher levels of satisfaction with the ED visit ($p = 0.008$), better function at 30-day ($p = 0.01$) and 6-month follow-up ($p = 0.03$), better mobility ($p = 0.02$ at 30 days), and better self-care ($p = 0.03$ at 30 days; $p = 0.009$ at 6 months). For more information: Dr Rose Galvin Profession: Associate Professor in Physiotherapy University of Limerick Contact details: School of Allied Health, University of Limerick Email: rose.galvin@ul.ie.

In Ireland and internationally there is growing demand for health and social care services, alongside critical staff shortages. Our population is increasing and for the first since 1851, we have over 5 million people including a significant older and ageing population with increasing health and social care needs.

The Irish Longitudinal Study on Ageing, 2020 provides important information regarding the population health needs of older people. Frailty affects 18% of adults aged 58 and over, 22% aged 65 years and over and 33.3% aged 75 years. Of those over 58 years old and frail, half have a disability relating to activities of daily living. (Kenny *et al*., 2020). The authors note that healthcare utilisation is focused on medical services compared with community based multidisciplinary care suggesting:

> potential challenges for older adults in accessing services which focus on pre/rehabilitation in the community (e.g. physiotherapy), which address risk factors for frailty (e.g. dietetics), which provide support for loss of functional capacity (e.g. home help) or those services which offer a social outlet for an older adult or respite for an informal carer (e.g. day centre care). (Kenny *et al.,* 2020, p. 11)

The significant investment in community care services to establish community healthcare networks is transforming healthcare delivery with a focus on care closer to home. This has seen an unprecedented increase in numbers of health and social care professional posts in community and primary care services. Structural reforms required for implementation of Sláintecare is also based on the network model. Specialist teams and hubs for older persons and people with chronic disease, require input of specialist and advanced practitioners to realise the goal of hospital emergency department avoidance and early intervention. This can be achieved through agreed referral pathways utilising the full range of skills and capabilities of the MDT including HSCP.

The development of the new children's hospital, expansion of national network of paediatric healthcare, and investment in community CAMHS and primary care services for children requires a stable skilled HSCP workforce. Disability services for children and adults are dependent on a range of health and social care professions including social care workers, social workers, audiologists, psychologists, dietitians, as well as speech and language therapists, physiotherapists and occupational therapists.

Implementation of the National Cancer Control Programme relies on HSCP such as radiation therapists, radiographers, medical physicists, medical laboratory scientists, clinical and counselling psychologists, social workers and many other HSCP services.

Expanding the development pathway for HSCP will contribute to a more sustainable HSCP workforce and support recruitment and retention of HSCP in services with significant staff shortages and difficulties filling vacant posts. Implementation of Sláintecare calls for all staff to work at the top of their licence to meet the growing healthcare requirements and to deliver integrated care closer to home.

Rationale for implementing advanced HSCP practice

Advanced practice in health and social care professions is well established in other jurisdictions, in particular Australia, England, Wales and Northern Ireland. Furthermore, there is evidence of HSCP engagement in advanced practice in Ireland both in published research (e.g. Fennelly *et al.* 2018) and in examples shared with the National HSCP Office see page 34. In Ireland, an evidentiary review carried out by the Irish Society of Chartered Physiotherapists reports that the earliest examples of Advanced Physiotherapy Practice (APP) date back to 2002 when a spinal pain triage service commenced in Tallaght University Hospital. Since then, a number of additional APP services have been developed and implemented and there is published evidence relating to advanced practice physiotherapy since 2011 for adult and paediatric services. Culpan *et al.* (2019) also highlight a long history in respect of radiographers, noting that advanced practice roles in radiography have been reported on for more than 30 years, although they highlight that these roles are more poorly developed outside of the UK.

In HSE funded research conducted by the ESRI, modelling to offset the projected increases in workforce requirements in the acute settings included advanced HSCP[2] practitioners at 2-4% of HSCP workforce (and HSCP assistant grades) (Keegan *et al.*, 2022). A similar project led by the ESRI is planned which will focus on workforce requirements in the community setting. The HSE is leading development and implementation of modernised care pathways that are aimed at diverting care from the acute setting, reducing waiting lists and supporting HSCP and nurses to work to the top of their licence. Examples of HSCP supporting these pathways include near patient care testing (medical science), delivering radiology services integrated with the National Image Management Information System (NIMIS), in the community in Mayo, the MSK Triage programme, rapid ambulatory physiologist-led discharge facilitating (RAPID) monitoring service, and the Mid West Community Healthcare Community Fibreoptic Endoscopic Evaluation of Swallowing (FEES) Service.

A number of policy documents have identified the following drivers for advanced practice:

- **The capability and competency of health and social care professionals in delivering care**
  Irish Institute of Radiography and Radiation Therapy, 2016; Academy of Clinical Science and Laboratory Medicine, The Medical Laboratory Scientists Association, Joint Position Paper 2016; National Office for Health and Social Care Professionals, 2020; NHS England, 2019
- **The support it provides for appropriate, cost-effective, value-based, safe person-centred, integrated care that responds to service needs and reform**
  Department of Health, 2017; Department of Health and Human Services, 2019; Health and Social Care Northern Ireland, 2019; Academy of Clinical Science and Laboratory Medicine, The Medical Laboratory Scientists Association, Joint Position Paper 2016; NHS Wales, 2016; Welsh Government, 2020
- **Improvements in the service user journey and in service user flow through health services**
  Department of Health, 2019; Department of Health and Human Services, 2016
- **Improvements in services (e.g. improvements in access to services, relieving pressure on medical services, increases in hospital avoidance, early discharge)**
  Department of Health and Human Services, 2016; Health and Social Care, Northern Ireland 2019

Note: Rationales for implementing advanced HSCP practice. Reprinted from *Report of Literature Review and Policy Analysis of Advanced Practice in the Health and Social Care Professions* (p. 7), by S. Hanafin, M. Shannon, Á. Symons, S. Fitzpatrick, Research Matters. Copyright 2022 by Research Matters. Reprinted with permission.

Benefits for service users

The benefits of HSCP senior clinical decision making for service users and service users is demonstrated in the examples below:

Health Service Excellence Award Winning Frailty Intervention Therapy (FIT) team, Beaumont Hospital:

- In 2022, 46% of all service users ≥75 years who presented to the Emergency Department (ED) were seen by the FIT Team (n=6212). The service provides a holistic assessment of the overall needs/wants of the service user based on the gold standard of care for our frail older adults-a comprehensive geriatric assessment. This front door assessment allows anticipation of potential complex needs and directing the service user to the appropriate pathway. Coordinating each discharge carefully, minimising future crisis, FITT input improves service users' ability to remain at home for longer before representing to ED. A pre- (2014) and post- (2018) FITT data review showed that service users in April 2018 remained at home significantly longer at day 7, 30, 60 and 90. Cumulatively, these ≥75 year old service users remained at home an extra 2698 days before representing. Extrapolating to one year, this figure is 32,376 days. FITT positively impacts length of stay (LOS) for admitted service users by assisting in the selection of appropriate service users for the Specialist Geriatric wards. Comparing 2016 to 2019: shows 34%

2 Five HSCP were included in this analysis Dietetics, Occupational Therapy, Physiotherapy, Social Work and Speech and Language Therapy.

increase in the number of service users ≥65 years discharged whilst requiring 2.7% less bed days. FITT is one element in the overall system change within the Care Of the Older Persons services which assisted in reducing the Long term Care (LTC) conversion ratio, through measures above and day hospital management of service users with complex needs between community and the acute setting.

The *National MSK Physiotherapy Triage Programme*

- The MSK initiative is delivered across by Advanced Practice Physiotherapists (APPs) who triage referrals to Consultant Orthopaedic Surgeons and Consultant Rheumatologists. Between 2012 and 2017, 84,770 new patients were assessed – and in 2022 there was more than 160,000 service users removed from combined Orthopaedic and Rheumatology waiting lists[3].

Physiotherapy orthopaedic triage clinic in a children's hospital

- In a paper published by Ó Mír *et al.* (2016), an evaluation of the efficiency of the *physiotherapy orthopaedic triage clinic* at one children's hospital site using a prospectively gathered database of 2,650 service users managed by the clinic, revealed that over the three years 2010-2013 the mean waiting time was reduced from 101.9 weeks prior to the initiation of the service to 15.4 weeks.

The Mid West Community Healthcare Community Fibreoptic Endoscopic Evaluation of Swallowing (FEES) Service

- This service which provides access to fibreoptic endoscopic evaluation of swallowing (FEES) to service users outside of acute care settings, won the HSE Healthcare Excellence Award in the Innovation in Service Delivery category in 2022.

The Occupational Therapy/Hand Therapy Led Elective Hand and Wrist Clinics,* St James's *Hospital

- This services has triaged and treated 587 service users at the OT-led hand and wrist clinic, with 405 (69%) discharged without requiring consultant referral.

Readiness for Advanced Practice

The majority of HSCP entry to practice education programmes are at a minimum level 8 on the National Framework for Qualifications. Health and Social Care Professionals are committed to continuing professional development to expand the services offered to service users as evidenced by the numbers who self-fund courses up to and including Irish National Framework of Qualifications (NFQ) level 9 and 10 qualifications (e.g. Radiographers who complete the MSc. Ultrasound in order to provide access to vital diagnostics and for medical scientists a level 9 qualification is required to be eligible for senior grades).

The Radiography Review, 2020 which included representation from the Department of Health, the HSE and unions, included a commitment to a pilot of advanced practice which commenced in 2023.

Regulation

Regulation has been introduced for designated HSCP through the Health and Social Care Professions Act 2005. This has universally been welcomed by the professions. Existing regulation under the Health and Social Care Professions Act (2005) does allow for advanced practice, where designated professionals 'must act within the limits of your knowledge, skills, competence and experience.' (Health and Social Care Professions Act 2005, rev. 2021, p. 29)

3 Personal communication.

Workforce

The lack of opportunities for career progression is a significant factor for the increasing challenges with regard to staff retention in the Health and Social Care Professions has been raised in many fora, including the consultation process for the development of *HSCP Deliver, A Strategic Guidance Framework for the Health and Social Care Professions 2021-2026*. For many HSCP who wish to progress, their only option is to leave their professions to access promotional roles, with the loss of significant skills, expertise and experience from the clinical services. Unlike other clinical colleagues, there is no recognised career pathway beyond clinical specialist and dual appointments across clinical and academic settings is a rarity.

There is a need to focus on increasing supply, enhancing recruitment and retention of our HSCP workforce in response to current challenges associated with increased demand, national and global workforce shortages, the impact of COVID-19 and lack of clinical career pathway for many HSCP.

Summary

Despite the impetus for advanced practice, it is clear that there has been greater progression in policy development around this area in Australia and the UK compared with other jurisdictions.

This document provides an agreed, evidenced-based and phased approach to the introduction of advanced practice in the health and social care professions, which aligns with existing policy (Department of Health, 2019), to support policy makers, HSCP, and service providers to plan and take required actions to enable implementation.

Development of the Framework

In 2014 a position statement *Progressing Advanced Practice in the Health and Social Care Professions* was published by the National HSCP Office arising from collaboration with HSCP. This process included a survey of HSCP through the Professional Bodies, two consultative workshops in 2013 during which representatives from HSCP professions and Professional Bodies presented evidence of extended scope and advanced practice in Ireland and contributed to the development of the position statement.

The publication of this document marked a starting point in describing and providing examples of this level of practice in Ireland, to inform HSCP, policymakers, educators and the Health Service Executive (HSE). A HSCP Advanced Practice toolkit followed in 2016 to support HSCP who identified potential to develop their level of practice to meet a particular service need.

In 2021 following discussions and expressions of support from the HSE Chief Clinical Officer, the HSE National Clinical Director, Integrated Care, and the Strategic Workforce Planning Unit, Department of Health, regarding enhancing senior clinical decision making roles and advanced practice (AP) in the Health and Social Care Professions, the National HSCP Office established a HSCP Advanced Practice Working Group. The group included nominees from Professional Bodies and was actively engaged in all elements of the Framework development.

A learning event which took place in September 2021, greatly assisted the National Working Group and included: Beverley Harden National AHP Lead, National Multi-professional Lead for Advancing Practice, & Richard Collier, Lead for Advanced Level Practice & Lead for Centre for Advancing Practice, Health Education England, Jenny Keane (then) Chief Allied Health Professions Officer, Department of Health Northern Ireland and Ms Sheila Cahalane, National Lead Advanced Practice, Office of the Nursing and Midwifery Services Director, HSE & Mary Doolan, (at the time) Nursing and Midwifery Planning & Development Officer.

The National HSCP Office commissioned a review of the literature and policy analysis in 2021, and the *Report of Literature Review and Policy Analysis of Advanced Practice in the Health and Social Care Professions* (2022) guided and informed this framework.

The review identified that HSCP advanced practice has progressed to a greater extent in Australia, England, Wales and Northern Ireland compared to other jurisdictions and that there is evidence of advanced practice in HSCP in Ireland particularly in physiotherapy. The authors found consistent evidence that advanced practice in the health and social care professions is effective, efficient, can reduce costs and lead to other service benefits. High levels of service user satisfaction are also reported.

Furthermore the authors note that there are many areas in policy, legislative and educational contexts established in support of the development of advanced practice in nursing and midwifery that are likely to be transferable to HSCP advanced practice.

The completion of the HSCP Advanced Practice was informed by an open consultation process with almost 50 responses from professional bodies, groups, clinical programmes, other bodies and individuals and over 300 suggestions were reviewed and feedback incorporated. Engagement with service users was kindly facilitated by the HSE, Partnering with People who use Health Services Programmes.

Key elements of the HSCP Advanced Practice Framework

Core Principles

A set of guiding principles provide standards to ensure that advanced practice is developed and focused on the needs of the service users and/or services and the required resources to support advanced practice are utilised judiciously. These principles are also concerned with ensuring the appropriate structures are in place to support safe practice and appropriate governance and supervision.

Definition and Competencies

To support clarity in understanding of advanced practice for HSCP, a clear definition and competencies are described for health and social care professions and may be used as is and/or adapted for specific professions/groups of professions working in an area of practice etc. In addition, the differences between clinical specialist and advanced practice are delineated to assist in promoting both roles. It is acknowledged that there may be HSCP working at advance practice level in clinical specialist roles, however being a clinical specialist does not necessarily lead to progression to advanced practice, nor is this the only route to becoming an advanced practitioner.

Governance, Regulation and Legislation

Governance and regulation are discussed outlining expectations for all stakeholders on required structures and processes to support candidate advanced HSCP practitioners and advanced HSCP practitioners and to assure services users and service managers regarding HSCP advanced practice. Ensuring safety and highest standards of practice are discussed in this section. Reference is made to changes in legislation to enable expansion of the scope of clinical specialist and advanced practice and associated impact on service provision.

Education

Educational requirements are based on the four pillars of practice. This section is focused at macro level on the three essential aspects of educational pathway for HSCP Advanced practice: 1.development of competence and capability, 2. Clinical governance – supervision, performance review, and 3. Credentialing. A separate work stream will focus on a detailed description of education requirements for progressing advanced practice in the HSCP and a development of a plan to address these needs.

Core Principles underpinning HSCP Advanced Practice

Table 1: Core Principles Underpinning HSCP Advanced Practice

Person centred care and evidence based practice are central to establishment of HSCP Advanced Practice and:
• Is developed to address prioritised population based health and social care service needs. • Complies with legislative, professional and healthcare standards and requirements, including human rights and anti-discrimination legislation and related measures to ensure persons rights are promoted and protected. • Implementation represents value for money • Clinical governance (including supervision and credentialing where applicable) is in place to maximise service user safety
HSCP undertaking advanced practice: • are appropriately educated, qualified, and competent to fulfil the capabilities and attributes of advanced clinical practice: clinical practice, leadership and management, education and facilitation of clinical learning, evidence, research & development • have clearly defined roles, responsibilities and accountabilities • Long term sustainability, succession planning and future proofing are considered in implementation

Definition

Advanced practice is delivered by experienced, registered[1] health and social care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a minimum NFQ level 9 award[2] or equivalent, evidence of learning that encompasses the four pillars of:

(i) clinical practice

(ii) leadership and management

(iii) education and facilitation of clinical learning, and

(iv) evidence, research and development;

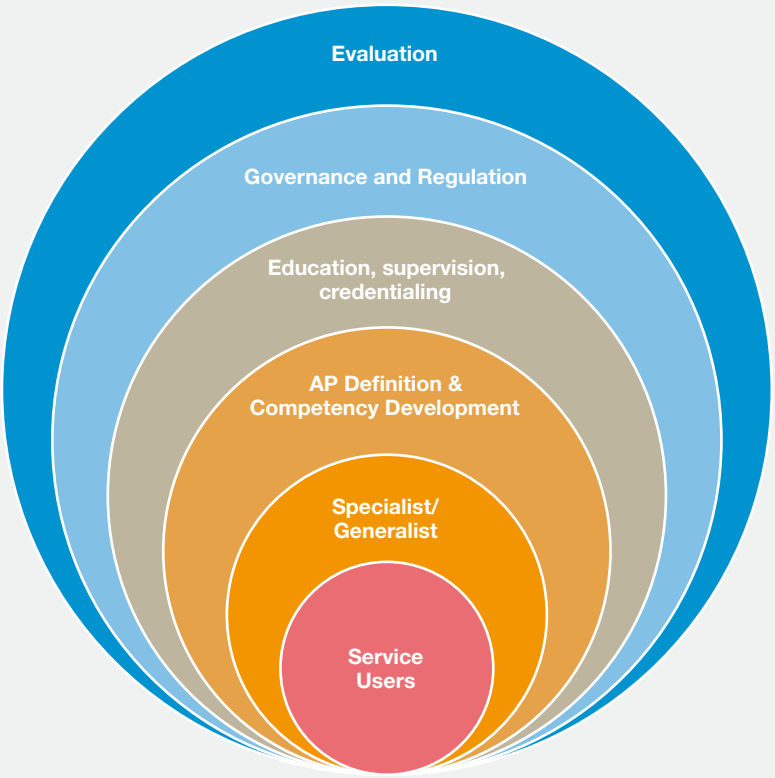
and leads to the demonstration of core capabilities and area-specific competence relevant to scope of practice and role.

Advanced practice embodies the ability to manage clinical care in partnership with individuals, service users, families and carers and other healthcare professionals. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people's experience and improve outcomes.[4]

1. *Where applicable*
2. *This National Framework of Qualifications award/evidence of learning is additional to the recognised qualification necessary for entry to practice to the profession and specific to supporting achievement of the level of competence capability and education required for Advanced Practice in the relevant area.*

4 *We gratefully acknowledge NHS England, Health Education England for permission to adapt the definition for Advanced Practice from the Multi-professional framework for advanced clinical practice in England (2017).*

Figure 1: Model for HSCP Advanced Practice



Competencies

This section outlines the expected competencies across the four pillars of advanced practice



These competencies enable HSCP managers and service managers to plan their services incorporating HSCP advanced practice. In addition they support HSCP and supervisors to benchmark competency and track development on the pathway from candidate to advanced practitioner. They also facilitate and guide the development/commissioning of education modules, courses and programmes in support of HSCP advanced practice. They may be used or modified to develop area specific competencies for professions/ groups of professions e.g. first contact practitioners.

1. Clinical Practice

1.1 Professional conduct

1.1.1 Practise in compliance with their respective code of professional conduct and within their scope of practice, being responsible and accountable for their decisions, actions, and omissions at this level of practice.

1.2 Autonomy

1.2.1 Demonstrate a critical understanding of their broadened level of responsibility, autonomy and the limits of own competence and professional scope of practice, including when working with complexity, risk, uncertainty, and incomplete information.

1.2.2 Practice autonomously and as part of a team, using advanced knowledge, skills, critical thinking, and evidence.

1.3 Clinical Practice

1.3.1 Develop and implement the highest quality clinical practice. Create a culture of continuous improvement and innovation.

1.3.2 Create and implement comprehensive service user management, as part of a multi-professional team, using advanced level clinical reasoning, shared service user decision making, evidence based clinical knowledge and skills, to achieve optimum outcomes for service user and the service/organisation.

1.4 Knowledge of disease

1.4.1 Demonstrate a high level of knowledge in relation to patterns of disease or disorder, markers of condition progression, differential diagnosis and range of treatment available at each stage of disorder or condition, including recognition of red flags and potentially complex and serious presentations and the need for expedited onward referral to the appropriate team.

1.4.2 Demonstrates a high level of awareness and recognition of the psycho-social impact of disease and disorders on service users and their families.

1.5 Clinical Assessment and Diagnoses

1.5.1 Undertake specialist assessment of service users in partnership with individuals, families, and carers using a range of methods and tools informed by theory and evidence.

1.5.2 Use expertise and decision-making skills to inform clinical reasoning when dealing with differentiated and undifferentiated individual presentations and complex situations, synthesising information from multiple sources to make appropriate, evidence-based judgements and/or diagnoses. This will involve planning, implementing, and evaluating the care delivery according to service user needs.

1.6 Clinical Management

1.6.1 Play a direct role in the management of complex service user, as part of a multi-professional team or autonomously, including assessment of the service user's relevant history, developing an investigation strategy, including where appropriate referring for, or conducting tests, interpreting results where appropriate to the profession, and agreeing a management and treatment plan in partnership with the service user and family, carers, medical staff, and the multi professional team.

1.7 Prescribing

1.7.1 Where appropriate to profession and role, act as an independent nonmedical/supplementary prescriber, able to take a history, assess, examine, diagnose, prescribe and develop a management plan including medication, and monitor response to medication.

1.8 Risk management

1.8.1 Exercise professional judgement in development of policies/procedures/guideline and protocols to support risk management as appropriate and as required, especially where there may be complex and unpredictable events and supporting teams to do likewise to ensure safety of individuals, families, and carers.

1.8.2 Demonstrate a clear understanding of the legal context for anti-oppressive practice, promotion of human rights and social justice in diverse health and social care settings and an ability to balance the risks and rights of the service user, liaising with and referring to, the relevant health and social care professionals as required.

1.9 Integrated Care

1.9.1 Use advanced understanding and ability to navigate healthcare settings. Advise and communicate as appropriate with acute hospitals, primary and social care and community teams thus ensuring seamless continuity and transfer of care for service users between other relevant healthcare professionals, health and social care services, third sector agencies, and other care settings.

1.10 Effective and Appropriate Communication

1.10.1 Establish, maintain, and effectively manage barriers to advanced, highly skilled, and effective communication with service users, carers and healthcare professionals. This includes imparting information regarding diagnosis, prognosis and treatment of complex conditions and referring to other MDT teams as appropriate to promote integrated working and to improve service user outcomes.

1.11 Person-centred Decision Making

1.11.1 Demonstrate an advanced ability to enhance and promote the rights of a person to actively participate in their healthcare management through shared decision making by taking into consideration the service user's wishes, goals, attitudes, beliefs, and circumstances.

1.11.2 Demonstrate shared decision making with all individuals involved in determining and managing goals, clinical interventions, social prescribing, and measurable outcomes to ensure integrated service user care e.g. verbal, written, and digital communication to serve the individual's best interest.

1.12 Integration of digital transformation

1.12.1 Demonstrate a knowledge of digital transformation in healthcare through the application of digital technologies to enhance or modify service user focused care.

1.12.2 Use data analysis to streamline service delivery, improve access to care for service users, carers, and relevant stakeholders; facilitate preventative care and avoidable admissions/re-admissions.

1.13 Health Promotion

1.13.1 Promote health literacy. Demonstrate an advanced ability to integrate and apply evidence-informed approaches in the presentation of health promotion and preventative care programmes e.g. work in partnership utilising behaviour change principles to promote and support the individual with continuing work/exercise participation, and the importance of social networks, clinical and non-clinical groups and services.

2. Leadership and Management

2.1 Leadership

2.1.1 Provide leadership across professional & organisational teams aiding and improving person-centred care though team development, keeping a focus on quality improvement and service excellence.

2.1.2 Lead and foster a culture of promoting a safe and supportive working environment for students', practitioners' and colleague's health and wellbeing to ensure the highest quality service user care.

2.1.3 Perform professional supervision and systematic peer review of colleagues on an individual or group basis and engage with supervision.

2.1.4 Act as a role model, provide professional leadership to the team and promote the desired behaviours of being proactive, positive, respectful, supportive reliable and trustworthy.

2.1.5 Act a supervisor, coach and mentor and seek to instil and develop the confidence of others.

2.1.6 Critically apply advanced clinical expertise in appropriate facilitative ways to provide consultancy across professional and service boundaries, influencing clinical practice to enhance quality, reduce unwarranted variation and promote the sharing and adoption of best practice.

2.1.7 Demonstrate team leadership, resilience and determination, managing situations that are unfamiliar, complex or unpredictable and seeking to build confidence in others.

2.2 Change Management

2.2.1 Assess and establish the need for change, lead and manage change at local and national level. Monitor the effectiveness and impact of change for service users, relatives, staff and services. Consider cost, efficiency, access and quality when making care decisions and improvements/ developments in practice.

2.2.2 Lead strategic review of clinical effectiveness and management of resources at local and national level and contribute to developments and innovation in services related to a relevant area of clinical practice, (e.g. national clinical programmes/national groups/clinical interest groups/local improvement groups) both within and external to the profession.

2.2.3 Continually develop practice in response to changing population health needs, engaging in horizon scanning for future developments (e.g. impacts of genomics, new treatments and changing social challenges).

2.3 Lead innovation & quality improvement

2.3.1 Provide leadership across professional and organisational teams with a focus on improving service user centred care, through quality assurance/improvement, service excellence initiatives and digital transformation, relevant to area of practice.

2.3.2 Lead and collaborate on the development of standards of practice and protocols at local/national levels. Lead in professional practice including respecting and promoting equity and diversity.

2.3.3 Recognise and is prepared to switch roles from leadership to support member of teams as necessary, within own employment area or in a mentorship role with clinicians working in similar roles.

2.4 Influencing

2.4.1 Participate and influence local policy-making activities which relate to sphere of professional practice.

2.4.2 Identify and act on opportunities to influence and develop policy and guidelines at a national level.

2.4.3 Influence practice by supporting & developing lateral thinking in self & others.

2.4.4 Work collaboratively across boundaries to develop and raise awareness of relevant policies, guidelines and strategies and influence positive changes at local and national level.

2.4.5 Network with a wide range of organisations and individuals to shape and respond to policy and strategy at national and local level.

2.4.6 Represent organisation/service/profession/HSCP at a national and international level.

2.5 Networking and Stakeholder engagement

2.5.1 Pro-actively initiate and develop effective interprofessional relationships, fostering clarity of roles within multi-disciplinary, inter-disciplinary, multi-service and inter-agency teams to encourage productive integrated teamwork.

2.5.2 Recognise all relevant stakeholders including at local, national and international level.

2.5.3 Collaborate effectively with service users and carers to ensure a partnership approach to person-centred service design, development, implementation and evaluation.

2.5.4 Initiate communities of practice/networks to collaborate on new initiatives and support dissemination of innovations proven to deliver quality improvement.

3. Education and Facilitation of Clinical Learning

3.1 Self-directed Learning

3.1.1 Critically assess and address own learning and development needs, negotiating a personal development plan to maintain currency of knowledge and skills that reflect the breadth of ongoing professional development across the four pillars of advanced clinical practice. Engage in self-directed learning, critically reflecting to maximise advanced clinical skills and knowledge, as well as own potential to lead and develop both care, services and service user advocacy.

3.2 Education and Learning

3.2.1 Facilitate collaboration of the wider team and support peer review processes to identify ongoing individual and team developmental and learning needs, and work in partnership to address these.

3.2.2 Support the wider team to build capacity and capability through evidence-based practice and interprofessional learning.

3.2.3 Educate and develop others in advanced practice by supporting and facilitating colleagues.

3.2.4 Advocate and contribute to continuous learning and development and succession planning.

3.2.5 Promote the profession and share learning and experience by presenting at local, regional and national meetings, courses and conferences.

3.2.6 Act as educator, supervisor, mentor and coach to support continuous professional development of individuals and the team.

3.2.7 Collaborate with the service manager, higher education institutions, practice tutors and practice education co-ordinators to provide and support practice education of students.

3.3 Programme Design, Delivery & Evaluation:

3.3.1 Assist in the design and/or delivery of education programmes, including undergraduate and post-graduate programmes, as part of a partnership approach with education providers, based on identified and emerging learning needs.

3.3.2 Establish and/or maintain mutually beneficial relationships with the higher education institutions to support development and delivery of education training and programmes relevant to learning needs.

3.3.3 Contribute to ongoing education at local and national level in the relevant areas of practice, in response to identified needs and emerging changes in service developments.

3.3.4 Lead and contribute to a range of audit and evaluation strategies to inform education and learning developments.

3.4 Service User Collaboration:

3.4.1 Engage with, appraise and respond to individuals' motivation, development stage and capacity, working collaboratively to support health literacy and empower individuals to participate in decisions about their care and to maximise their health and well-being aligned with the HSE strategy[5] and policy.

3.4.2 Collaborate with service users in developing service user-focused education materials.

3.4.3 Develop skills, awareness and model inclusion of service user.

3.5 Advocacy:

3.5.1 Advocate for and contribute to a culture of organisational learning to inspire future and existing staff.

3.5.2 Act as an advanced clinical advisor locally to the organisation, MDT team and own colleagues and nationally regarding education, learning and development and service user advocacy.

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5 (HSCP Deliver, Strategic Guidance Framework for Health and Social Care Professions 2021-2026, HSE 2021, National Healthcare Charter, HSE 2012, The HSE Corporate Plan 2021-2024, HSE, 2021, Patient Safety Strategy 2019-2024, HSE 2019).

4. Evidence, Research and Service Development

4.1 Evidence Based Practice

4.1.1 Critically evaluate and synthesise the evidence available and make appropriate judgements on implementation in practice despite incomplete or paradoxical evidence.

4.1.2 In collaboration with other staff, ensure that the approach to all levels of clinical practice is person-centred, evidence based in accordance with professional practice, national guidelines/models of care and national/local/international benchmarks.

4.1.3 Lead and develop a culture of enquiry that promotes supports and encourages participation in evidence-based practice, including research, service evaluation, quality improvement (Q.I.) and audit.

4.2 Identifying research need to inform evidence based practice

4.2.1 Take a critical approach to identify gaps in the evidence base and its application to practice, alerting appropriate individuals and organisations to these and how they might be addressed in a safe and pragmatic way and where possible also plan and deliver the research to address these gaps.

4.3 Audit and service evaluation

4.3.1 Engage in and lead audit of service and evaluation of clinical activities to ensure a person-centred focus, enhance quality, safety, productivity and value for money and mapping to national models of care/clinical pathways and guidelines/standards of care.

4.3.2 Bring critical analysis to the practice of the evolving clinical/scientific specialism, ensuring that regular review of research and evidence is undertaken so that where adaptation to practice is required, it can be made in a timely and cost-effective manner.

4.4 Practice evaluation

4.4.1 Ensure all practice is evaluated regularly to determine whether interventions are effective and remain relevant to client needs. Assess the demand and specification for evolving scientific/clinical services with service users, clinical colleagues, and other relevant stakeholders.

4.4.2 Demonstrate the advanced use of outcome measures to evaluate the effectiveness of clinical interventions and services, and uses outcomes to inform future planning and development.

4.5 Collaborative Research and Service Evaluation

4.5.1 Facilitate collaborative links between clinical practice and research through proactive engagement, networking with academic, clinical and other active researchers locally and nationally.

4.5.2 Recognise research project resourcing requirements and the need to balance the competing clinical, leadership and research demands of the role.

4.6 Research Ethics Procedure

4.6.1 Demonstrate a clear understanding of information and research governance and is able to apply to national, local policies and practice including adherence to the most up to date HSE Policy for data protection and most up to date guidance for the governance, management and support for health research.

4.7 Dissemination of findings

4.7.1 Disseminate evidence-based practice, audit, quality improvement projects and research findings to relevant audiences (service users, clinicians, academic community, professional groups, health and policymakers) using various media and fora (e.g., local, national and international conferences)

4.7.2 Lead, facilitate and/or participate in clinical knowledge translation and dissemination in training sessions/journal clubs, case reviews and other fora.

4.7.3 Document research, case studies, critical reviews and share with colleagues and the public at local, national level as appropriate and in a suitable format.

HSCP Specialist Practice and HSCP Advanced Practice

Currently in Ireland the grade of advanced practitioner does not exist but for many HSCP there is a specialist grade that shares some competencies with advanced practice. This section aims to highlight the value of both roles and delineate the differences between specialist practice and advanced practice. HSCP may become clinical specialist on a pathway to advanced practice but this is not a requisite step. At the time of writing there is no recognition or grade code for HSCP advanced practice in Ireland and there are a number of HSCP specialists who may meet the criteria for advanced practice.

A HSCP specialist has developed skills in an area that requires further education, training, and practice beyond that of a staff grade or senior grade health and social care professional. A HSCP specialist may have completed recognised postgraduate level qualification, where one is available and/or other relevant training and education often at their own expense. This pathway may be referred to a continuum from 'newly qualified' to 'expert'. Some specific professions will require masters level education or higher to take up a specialist role which may be a barrier in the absence of funding for academic programmes for HSCP.

Understanding HSCP specialist and advanced practice

Table 2: Understanding Specialist and advanced practice

HSCP Specialist	HSCP Advanced Practitioner (AP)
Will have a body of knowledge and skills in a particular specialist area above that expected of a senior HSCP and is regarded as local, national and international resource.	Will have significant clinical expertise in a defined area of work (e.g. imaging modality, disease, physiological systems, diagnoses, care and treatment etc.) and is regarded by peers as an expert in this field.
May have ready access to a more experienced practitioner advice.	Would be expected, as the expert in the field, to be available to less experienced staff and peers to offer support and advice in relation to their area of advanced practice.
Would be responsible for drafting and overseeing of the implementation of specialist work policies and protocols in their area of expertise.	Would be responsible for drafting and overseeing of the implementation of work policies and protocols in their area of expertise at organisational/regional/national level.
Would be expected to have postgraduate level qualification, e.g. postgraduate modules, a postgraduate certificate or diploma or have attended a number of short courses aimed at a well-defined area of specialist work.	Would be expected to have completed a relevant master's level 9 (or equivalent) education qualification, e.g. postgraduate modules, a postgraduate certificate or diploma or MSc/MA.
Responsible for a specialist aspect of service user care.	Responsible for the entire episode of service user's care within the scope of the advanced practice role including complex presentations.
Contributes to/leads audit and research projects in their area of specialism.	Leads research and audit projects.
Contributes to education and supervision within their speciality area for the multi-professional team. May be considered a specialist in the area at local/national/ international level.	Leads education in their area of expertise. Provides multi-professional AP CPD and supervision across all four pillars with relevant training. Contributes to education planning and development based on evolving population based health and social care needs

Governance

The Department of Health (2019) suggests that governance needs to focus on service user-centred care, safe and high quality care, broad-based education and regulation changes, a composite credentialing pathway, metrics and monitoring and increasing capability. "The vision set out for advanced practice highlights elements of the value of advanced practice, the ways in which it can contribute to safety, quality and effectiveness and the potential to support a "whole system" approach to healthcare" (Hanafin *et al.*, 2022, p. 52)

Good governance is essential in ensuring a consistent approach to realising the full potential of HSCP AP.

> The governance of advanced clinical practice roles is vital to their success. Good governance involves inclusive, participative decision making with clear lines of accountability and responsibility. Policies and processes need to be in place and must include the evaluation of effectiveness, impact, ongoing sustainability and responsiveness. Organisations must ensure that robust governance arrangements surrounding all types and levels of practice, are in place prior to the establishment of new roles, and these must be enhanced and strengthened for existing ones. (National Health Service England, 2017, p. 11).

Governance for these new roles are informed by policy and frameworks discussed in a *Report of Literature Review and Policy Analysis of Advanced Practice in The Health And Social Care Professions* (Hanafin *et al.*, 2022, p. 52)

These core elements of governance are:

- Comprehensive oversight of the system in which HSCP AP work considering all elements (Quality, Funding etc.),
- Works effectively and efficiently,
- Thorough but agile and encouraging innovation,
- Robust but resilient and consistently applied,
- Supports inclusive decision-making,
- Clear and transparent lines of accountability and responsibility,
- Clarity on objectives to be achieved and the service delivery,
- Considered and agreed processes and structures for establishing, implementation and evaluation of HSCP advanced practice roles at local level,
- Established governance structures are supported to be flexible but stable

Implementation of HSCP advanced practice will involve national level co-ordination and development of a suite of guidance, draft agreements and templates. These resources will be based on policy, and inform development of local and organisational level documents to standardise and ensure consistency in the deployment of these advanced practice roles.

Key components of these agreements include:

- Ensure local HSCP advanced practice policy, procedures protocols and guidelines are in place,
- Shared understanding regarding the HSCP advanced practitioner role,
- Clear line management and professional accountability,
- Role of Clinical indemnity Scheme and professional indemnity,
- Level of practice – assessed based on the four pillars as per the HSCP Advanced Practice definition, framework and supporting tools,
- Access to professional development supports and support in place for candidate/advanced HSCP practitioner including appropriate supervision,

- Description of the quality and risk management structures and processes in place to support HSCP candidate and HSCP advanced practitioner,
- Regular review including service user, audit, data, 360 feedback and nationally agreed competencies for candidate advanced HSCP practitioner and advanced HSCP practitioner,
- Commitment to engage with national data gathering and evaluation.

Key organisational supports include:

- local level policies and guidelines around a range of areas,
- clarity of roles and clear levels of responsibility (including scope),
- structures in place to manage workload issues,
- availability of administrative support,
- access to medical and other supports where required,
- Supports for candidate advanced HSCP practitioner.

The candidate advanced HSCP practitioner/advanced practitioner is responsible for their practice and must work within their scope of practice and be aware of limitations. Clear job descriptions will outline the individual candidate HSCP AP and HSCP AP role in detail and will including required evidence of the skills across the four pillars of advanced HSCP practice. The HSCP Advanced Practitioner will be on a salary commensurate with the relevant profession manager.

Employers' responsibilities include ensuring service user safety. Managerial responsibility for individual staff lies with the employer. Local policies, guidelines and agreements will describe the arrangements for governance and management of candidate advanced HSCP candidate and HSCP AP.

Regulation

CORU is the regulator of designated health and social care professions under the Health and Social Care Professionals Act 2005 (as amended). The "role of CORU is to protect the public by promoting high standards of professional conduct, education, training and competence through statutory registration of health and social care professionals". (CORU, 2021 p. 3). Any practicing health and social care professional using one of the titles regulated by CORU must be registered and ensured that they meet the requisite education standards, adhere to a Code of Professional Conduct and Ethics and complete Garda vetting.

This is an important aspect of progressing advanced practice and is an important consideration for policy development. Existing regulation under the Health and Social Care Professions Act (2005), does allow for advanced practice where designated professions 'must act within the limits of your knowledge, skills, competence and experience.' (Health and Social Care Professions Act, 2005, rev. 2021, p. 29). Regulation of the Health and Social Care Professions by the Health and Social Care Professionals Regulator is welcomed by the professions and service users as it provides national and independent assurance of appropriate standards of practice.

Table 3: Designated HSCP for CORU regulation

Currently regulated by CORU	Soon to be regulated by CORU
Dietitians	Clinical Biochemists
Dispensing Opticians	Counsellors
Medical Scientists	Orthoptists
Occupational Therapists	Psychologists
Optometrists	Psychotherapists
Physiotherapists	Social Care Workers
Physical Therapists	
Podiatrists	
Radiographers	
Radiation Therapists	
Social Workers	
Speech and Language Therapists	

The purpose of regulation is to improve performance and quality, to offer assurance that the minimum acceptable standards are attained and to provide accountability for performance and value for money (Sutherland & Leatherman, 2006). Regulation and quality improvement, a review of the evidence). Others include maintaining public confidence in the regulated professions as a function of regulation.

In the UK, the Professional Standards Authority's *Standards for Good Regulation* are guided by principles for good regulation, which says that "regulators should act in a way which is: proportionate, consistent, targeted, transparent, accountable and agile. (Professional Standards Authority, 2019, para. 2)

Key elements of regulation by CORU

- **A Code of Professional Conduct and Ethics** developed by the relevant registration board, which describes the **expected standards of performance** for the professional in their practice.
- Higher education institutions must meet **standards for qualifications** that enable HSCP to deliver safe and suitable care.
- A requirement for registrants to carry out **continuing professional development** to maintain, update and develop skills and knowledge.
- A publically accessible **register of professionals** who meet the specified standards on www.coru.ie.
- A process to address complaints and, if required, leading a **fitness to practise** hearing.

This is similar to other professional regulators e.g. Professional Standards Authority in the UK.

Legislation

A Health Research Board review (Coyle *et al.*, 2021) sets out the legislative context for HSCP practice in other jurisdictions (the United Kingdom, New Zealand, Australia, the Netherlands, Sweden and Denmark) but it provides limited information about the regulation of advanced practice. Restrictions in legislation governing the work of HSCPs identified in the report have been acknowledged.

Expanding the scope of practice of HSCP at clinical specialist and advanced level will involve meeting the requisite legal, professional and educational requirements e.g. for prescribing medications and referring for radiological procedures. HIQA is the competent and regulatory authority for service user radiation safety in public and private settings in Ireland and for safeguarding compliance by inspecting, monitoring and enforcing the regulations that apply to medical ionising radiation In Ireland. The Environment Protection Agency (EPA) is responsible for both authorisation of medical facilities and enforcement (monitors compliance with regulations and licence conditions) and for the regulation of radiation protection of workers and the general public.

The Nursing and Midwifery Board (2019, p. 4) writes that "the prescriptive authority for nurses and midwives is founded on a dual framework of medicines legislation, and associated regulation and professional regulation" (in line with the Nurses and Midwives Act 2011).

Legislative changes are required to enable HSCP working at clinical specialist and advanced practice, to prescribe medications and to refer for radiological procedures. The Basic Safety Standards Directive (Euratom 2013/59) updated European wide radiation protection legislation which has been transposed into Irish legislation as SI 256, 2018 and SI 30, 2019 and importantly, Irish transposition (SI 256) incorporated two amendments (Regulation 4 & 5) which include **Radiographers and Radiation Therapists as both Referrers and Practitioners** within the Irish healthcare system.

In addition, as per the development of radiographers and radiation therapists and nurse/midwife prescribers, extensive supporting practice guidelines are required.

The legislative requirements/conditions for the prescribing of medicinal products by nurses and midwives are specified in Statutory Instruments and include:

- The Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations, 2007 (Statutory Instruments, (S.I.) No. 201 of 2007) and
- The Misuse of Drugs Regulations 2017 (S.I No. 173 of 2017) (this revokes the 2007 Misuse of Drugs (Amendment) Regulations).

Additional legislation relating to the prescribing of MDA-controlled drugs, is as detailed in the Misuse of Drugs Regulations, 2017 which stipulates conditions for Schedule 8 and restrictions for prescribing Schedule 4 and 5 MDAs.

Practice guidelines have been developed by the Nursing and Midwifery Board of Ireland and the legislative provisions are as follows:

- The nurse/midwife must be employed by a health service provider in a hospital, nursing home, clinic or other health service setting (including any case where the health service is provided in a private home).
- The medicinal product is one that would be given in the usual course of service provided in the health service setting in which the nurse/midwife is employed.
- The prescription is issued in the usual course of the provision of that health service.
- The NMBI registration number (also known as the Personal Identification Number (PIN)) must be stated on the prescription. S.I. No. 529 of 2018 provides for the additional authority for the registered nurse or midwife prescriber to prescribe Exempt Medicinal Products within their scope of practice. A number of conditions must be satisfied for this authority. Reference must be made to the individual legislation and regulation for full details.

Learning from the experience in the UK, informs the development of an agreed framework for regulation of HSCP advanced practice incorporating credentialing. The Centre for Advancing Practice, Health Education England defines a credential "as standardised, structured units of assessed learning that are designed to develop advanced-level practice capability in a particular area" (Health Education England, 2022, para. 3).

Providing assurance regarding HSCP engaged in extended and advanced practice requires collaboration between CORU, other relevant regulators, the Department of Health and the HSE the relevant HSCP professional bodies, higher education providers. Furthermore, robust governance arrangements must be in place at local and national level to support safe and effective practice for all HSCP.

Education Pathway and Credentialing

Health and social care professions are highly skilled with the majority requiring at a minimum level 8 National Framework Qualification or above to enter the profession. They are committed to developing how they work and increasing skill mix including advanced and specialist practice and working with assistants, as documented in their contributions to the development of *HSCP Deliver, A Strategic Guidance Framework for Health and Social Care Professionals 2021-2026, (*HSE, 2021). Not all HSCP can access postgraduate level qualifications and the majority self-fund post-graduate education programmes, many of which are required for service delivery.

Hanafin *et al.* (2022) underlines the importance of rigorous education and training to ensure safe and high quality advanced practice.

> *There has been a strong focus across jurisdictions in both peer-reviewed and grey literature in respect of the educational preparation, credentialing and competencies required for advanced practice. There are, however, differences according to jurisdiction, professional group and focus of the advanced practice service.* (Hanafin *et al.*, 2022 p. 64)
>
> and
>
> *It is evident that a formalised educational pathway, with a significant contribution from higher education as well as experiential learning is a commonly adopted approach to support advanced practice.* (Hanafin *et al.*, 2022, p. 58)

The education model for advanced practitioner and clinical specialist Health and Social Care Professions practice reflects the increasing demand for health and social care services, and changes in healthcare delivery with a focus on integrated care and expansion of community healthcare services. The aim of the model is to enable HSCP to work to the top of their licence and realise their full potential to enable timely access to health and social care services closer to home.

The education model encompasses an education and development pathway from graduate to advanced practitioner in the Health and Social Care Professions including completion of a recognised education programme for Advanced Practice at "a minimum NFQ level 9[6] award or equivalent, evidence of learning that encompasses the four pillars of: (i) clinical practice (ii) leadership and management (iii) education and facilitation of clinical learning and (iv) evidence, research and development; and leads to the demonstration of core capabilities and area-specific competence relevant to scope of practice and role", as described in the definition of Advanced Practice in HSCP.

In keeping with national and international trends in this area, the model not only supports competency development, but also development of capabilities which necessitates an understanding of the level of competence required and used in any situation. The practitioner may extend these limits as their competence increases and in response to the needs of the service users, always working within their scope of practice and regulatory framework.

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6 *This National Framework of Qualifications award/evidence of learning is additional to the recognised qualification necessary for entry to practice to the profession and specific to supporting achievement of the level of competence capability and education required for Advanced Practice in the relevant area.*

"*Capability also requires the practitioner to have the ability to extend these limits when required and flexibly to adapt to unfamiliar professional environments". (National Health Service England, 2017, p. 15)*

This approach allows candidate advanced HSCP practitioners to work and develop their skills in advanced practice as they progress through the education and development pathway to attain the requisite competencies and capabilities.

Ongoing close collaboration with the higher education institutions and a flexible approach is required to support specialist and advanced practice aligned with identified priority and evolving healthcare needs at national and local level. It is anticipated that some existing education modules and programmes may meet the needs for three of the four pillars of practice (that is leadership and management, education and facilitation of clinical learning, and evidence, research and development). In addition there will be a need to modify and/or develop new programmes and modules to meet the education needs of HSCP for clinical competency and capability development. Taking a population health and service needs informed approach will guide prioritisation of development of such programmes, which will be open to inter-professional learning where appropriate.

The HSCP advanced practice education programmes and modules are grounded in the four pillars of advanced practice and also include dedicated programmes for specific clinical tasks/functions, e.g. prescribing medications and requesting diagnostic tests requiring ionising radiation both of which are also applicable to HSCP working at clinical specialist level.

An important element in enabling HSCP advanced practice is a system of credentialing. Health Education England defines credentials as "standardised, structured units of assessed learning that are designed to develop advanced-level practice capability in a particular area".

Credentialing refers to "the formal process used to verify qualifications, experience, professional standing and other professional attributes for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments". (Australian Council for Safety and Quality in Healthcare, 2004, p. 3)

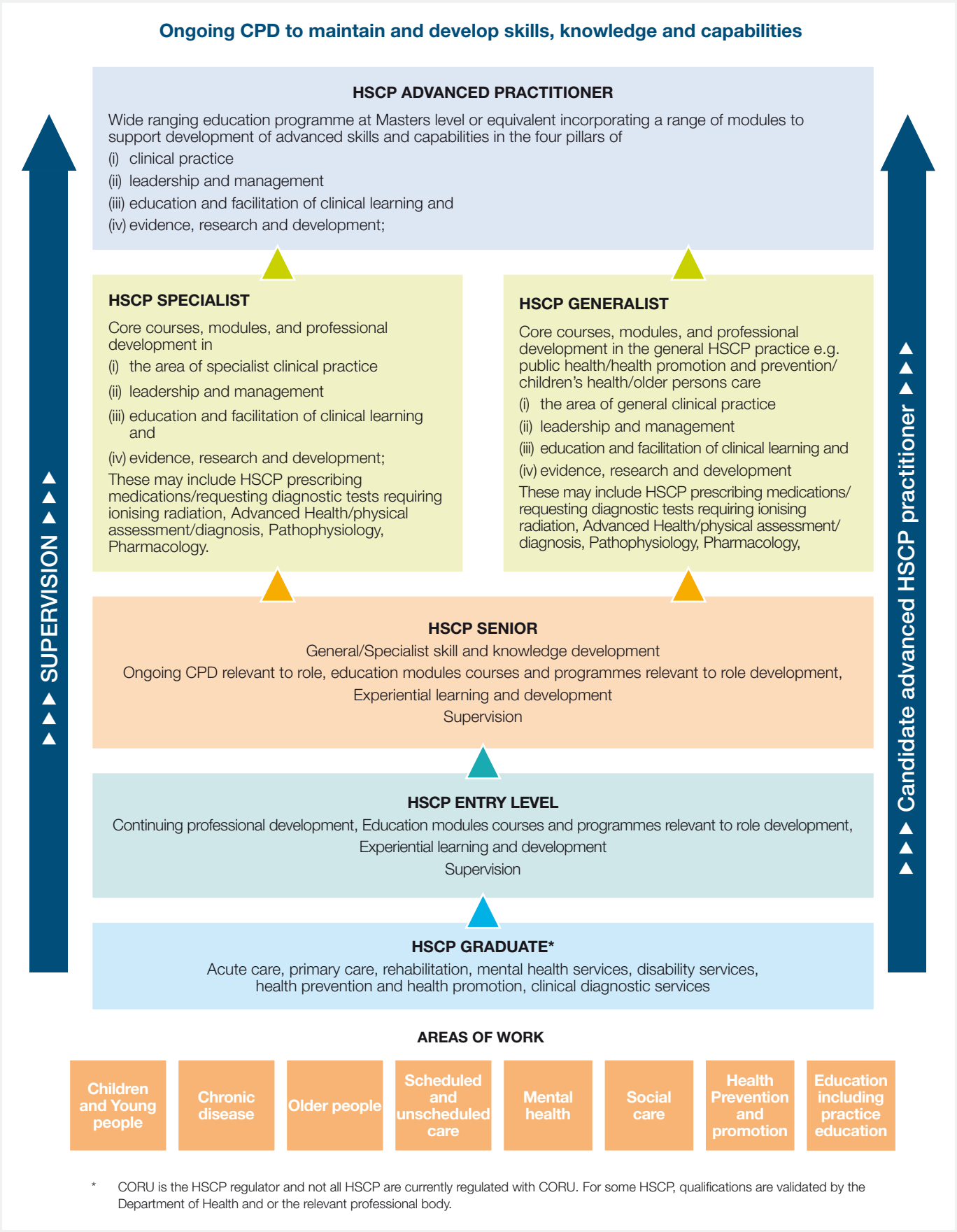
This approach is allows for a flexible and dynamic approach for HSCP to attain and demonstrate the necessary skills, knowledge and capabilities required for clinical specialist and advanced practice. Provision of appropriate level of supervision and support during competence and capability development is an essential element of the education pathway and requires clear guidelines for local implementation.

The three elements of the HSCP Advanced Practice Education Pathway are:

- Development of competence and capability,
- Clinical governance – supervision, performance review,
- Credentialing.

The development of the HSCP Advanced Practice Education Pathway is a separate but connected work stream which complements this framework, and describes in broad terms the educational requirements and how they can be achieved with input from HSCP colleagues in the higher education institutions.

Figure 2: Proposed Education and Development Pathway to Advanced Practice in HSCP



* CORU is the HSCP regulator and not all HSCP are currently regulated with CORU. For some HSCP, qualifications are validated by the Department of Health and or the relevant professional body.

Implementation of HSCP Advanced Practice

HSCP Advanced Practice Implementation

Implementation of HSCP Advanced Practice draws on the review and recommendations in the Report of Literature Review and Policy Analysis of Advanced Practice in the Health and Social Care Professions and the learning from the experience of HSCP colleagues and other professions both in Ireland and in other countries.

The approach to implementation of HSCP Advanced Practice

Context

Health and social care professions work across the domains of diagnostics, therapy and psycho-social care and in all health and social care settings. Demand for health care is increasing and access to senior clinical decision makers has been identified as a priority by senior health service managers.

Preliminary data from Census 2022 shows the population is **5,123,536 people**, an increase of **7.6%** compared the previous census**.** The 2016 census showed that life expectancy has risen, as result of successful management of several major conditions, meaning that there is greater demand for health and social care.

HSCP play a key role in delivering new service provision models for diagnosis, prevention and management of chronic disease and older persons care. HSCP are required to provide assessments and health and social care in Children's Disability Network teams. HSCP are essential in provision of rehabilitation, and service user centred psycho-social care.

The creation of community networks requires HSCP working in multidisciplinary teams, and new roles at clinical specialist and advanced levels to enhance senior clinical decision-making capacity. This will support the aim of care closer to home and preventable admission avoidance especially for older persons and those who are vulnerable. This can be achieved through agreed referral pathways utilising the full range of skills and capabilities of the multidisciplinary team (MDT) including HSCP. Timely access to diagnostics across primary secondary and tertiary care is key enabler to reduction in ED presentations and enabling scheduled care pathways.

The strategic goals and priorities in the *Children's Health Ireland – Statement of Strategy 2021-2025* includes a focus on timely access to child and adolescent services, innovation and workforce development.

Sharing the Vision, the most recent policy for mental health services references the requirement "for each team member to work to the maximum of their scope of practice, as well as to develop shared team competencies." (Department of Health, 2020, p. 45)

The National Cancer Control Programme is reliant on radiation therapists, medical physicists, psychologists, physiotherapists, social workers, biochemists, medical scientists, dietitians and many more to diagnose, monitor and safely deliver treatment and support to people with cancer.

Health and Social Care Professions have an important role in health promotion and health prevention e.g. prehabilitation, secondary prevention e.g. cardiac/respiratory rehabilitation programmes, falls prevention programmes, long COVID etc.

HSCP also support safe service user care through remote and onsite monitoring and providing diagnostic services in acute and primary care e.g. remote cardiac monitoring, community spirometry.

Implementation of Slaintecare calls for the necessary supports to enable "staff to work at the top of licence, maximise capacity of the workforce and facilitate better job satisfaction and graduate retention". (Department of Health, 2021, p. 40)

Implementation HSCP Advanced Practice

Implementation of HSCP Advance practice is policy driven, following agreed principles (TABLE 1) and focusing on prioritised service requirements, to augment service users' access to timely, appropriate and effective care, in the right place. The aim is to deliver the greatest possible impact for the people of Ireland and the health service. There will be a planned and phased approach with an initial proof of concept stage which will include independent evaluation. This approach will allow for incremental establishment of the necessary structures, resources, education programmes etc. and confidence before moving to the next phase.

Key Considerations for implementation

The Report of Literature Review and Policy Analysis of Advanced Practice in the Health and Social Care Professions (2022) pointed to five key areas of focus for implementation of advanced practice in the HSCP. These areas are understanding of advanced practice; governance; regulation; educational pathways; and workforce planning.

Understanding of Advanced Practice

In the previous chapters a clear and agreed definition of advanced practice including the four pillars of practice has been developed. This definition is expanded in the advanced practice competencies to ensure clarity on the level of practice. It is anticipated that this framework will be adapted by professions and/or groups of HSCP working in a particular area of practice with input from the National HSCP Office.

Governance

Policy will guide implementation of advanced practice in the Health and Social Care Professions. Clear lines of accountability and reporting at all levels will be articulated in supporting documents. A National Oversight Committee with Multi-stakeholder representation including Department of Health, HSE, Department of Further and Higher Education, Research, Innovation and Science, national clinical programmes and service users will be established to oversee the proof of concept phase and staged introduction of HSCP AP. A working group will develop clear guidelines for implementation at local level and template job specifications etc. will assist local services to plan for and implement HSCP AP. Similar to the process for advanced practice in Nursing and Midwifery, it is expected that the Drugs and Therapeutics committees will be the appropriate fora for governance of AP in HSCP in acute hospitals in the initial phase and that this will evolve as the new structures in community services and regional health areas are established.

Regulation and legislation

Only HSCP registered with CORU will be eligible for advanced practice roles. This will be reviewed on an ongoing basis. There will be close collaboration between the HSE National HSCP Office, the Department of Health including the Professional Regulation Unit, CORU, HSE HR (re eligibility criteria), HSCP HEI and the Professional Bodies in order to establish, monitor, review and update guidance, on advanced practice in HSCP to ensure effectiveness and safety.

Legislative changes will be required to enable HSCP clinical specialists, candidate advanced HSCP practitioners and advanced HSCP practitioners to expand their competencies to include prescribing medications and requesting diagnostic tests requiring ionising radiation as has been seen for nursing and midwifery as follows. See Regulation on page 22.

Educational pathways

Building a sustainable education and development pathway to support HSCP advanced and clinical specialist skills that responds to the population health needs requires agility and a pragmatic, collaborative and inter-professional approach where appropriate and feasible. It is acknowledged, that of the four pillars of advanced practice, providing education pathways for discipline specific clinical skills may be a little more challenging. However both inter-professional modules and credentialing offer the opportunity to demonstrate attainment of required level of skill, competency and capability. The model will allow for recognition of

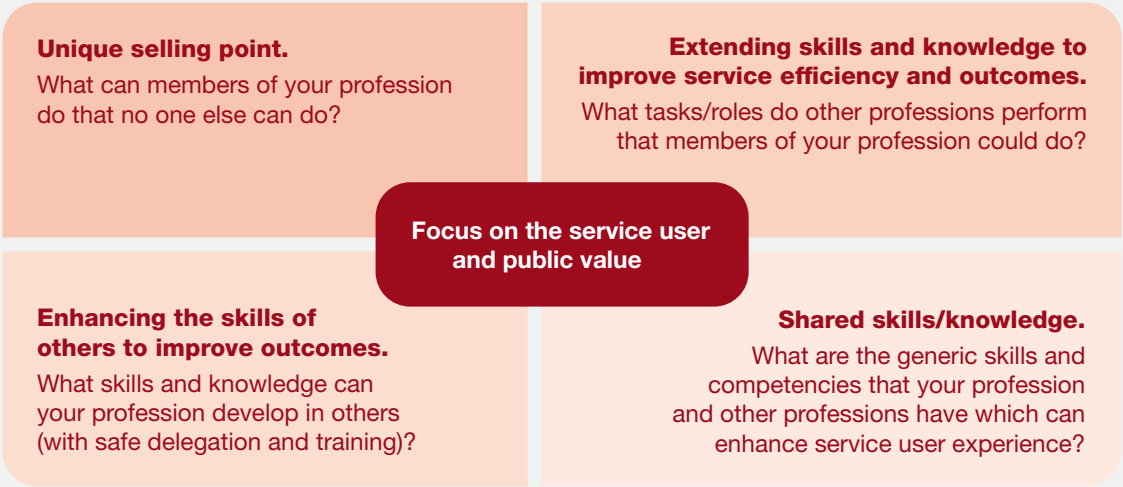
prior learning and experience with a minimum requirement of a NFQ level 9 Masters level qualification or equivalent. A dedicated programme of work will focus on the HSCP education pathway.

It is important for recruitment and retention of new entrants and for HSCP returning from abroad to see a clear career pathway to attaining and/or recognition of advanced practice.

Workforce planning

Meeting the healthcare requirements of the people of Ireland requires thorough workforce planning encompassing diagnostic, therapeutic and psycho-social domains. In *Allied Health Professions into Action, Using Allied Health Professionals to transform health, care and wellbeing. 2016/17 – 2020/21* (National Health Service England, 2017) referred to the unique selling point of HSCP as in what is the work that only HSCP can do, or extend skills and knowledge to do, and what skills and knowledge can HSCP help to develop in others or share with others. This was adapted with permission, by the National HSCP Lead in in development of *HSCP Deliver, A Strategic Guidance Framework for Health and Social Care Professions 2021 to 2026* (Health Service Executive, 2021) see below. This offers a blueprint for the future design of services in interdisciplinary teams where the ultimate goal is meeting the local and national population needs by optimising the skills and knowledge of the workforce.

Figure 3: Optimising the healthcare workforce



Source: Adapted from Allied Health Professions into Action[11], Using Allied Health Professionals to transform health, care and wellbeing. 2016/17 – 2020/21

HSCP have long identified the need for expanded opportunities in a clinical career pathway. At present many skilled HSCP are lost to clinical practice due to severely limited promotional opportunities other than in management roles. Recognition of advanced practice can only have a positive impact on recruitment and retention of HSCP, including those who are recognised as AP overseas.

Another important element of workforce planning is the need for succession planning with regard to clinical specialist and advanced practice. The National HSCP Office will continue to engage with HSE Strategic Workforce Planning and the Department of Health with respect to workforce planning for HSCP including specific planning for HSCP specialist and advanced practice.

Prioritised HSCP Candidate Advanced Practice for maximum impact

In addition to meeting regulatory and governance requirements, an agreed policy, creation of two new grade codes for Candidate Advanced HSCP practitioner and Advanced HSCP practitioner, a firm commitment to fund posts and support for education pathway and credentialing is required, initially on proof of concept basis in a number of key areas.

The HSE will lead development of a suite of supporting resources including guidance and templates, to standardise and support all aspects of this development.

As outlined above and in previous chapters, the establishment of structures at national and local level are required to oversee and support the proof of concept phase and beyond, which will be co-ordinated by the National HSCP Advanced Practice Oversight Group.

Phased introduction of advanced practice will allow for testing the model, embedding governance and reporting arrangements, ensuring sufficient support for supervision, and independent evaluation.

A key aspect of the evaluation of HSCP AP is impact on service user access and experience of health and social care and impact on the service in terms of access times/waiting lists and cost benefit analysis. This can then inform further phases of implementation of AP based on evolving key service priorities.

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Examples Advanced Practice in HSCP

Occupational Therapy (OT), Advanced Practitioner (AP) Clinic for Wait Listed Elective Orthopaedic and Plastics Service Users with Hand and Wrist (HAW) Pathology.



Defining the problem that HSCP advanced practice addresses

In 2017 a review of GP referred service users highlighted that **579 service users** were waitlisted between **12 to 36 months** for an appointment with the Orthopaedic Upper Limb Trauma Consultant, at St. James's Hospital. In 2018, the Occupational Therapy (OT) department at St James's Hospital (SJH) introduced a new triage and treat, waiting list initiative, to reduce the number of GP referrals wait listed for the consultant upper limb Orthopaedic and Plastic surgeons with hand and wrist pathology[7].

Two advanced practice Occupational Therapists (APOT's) practising as hand therapists (HT) were identified to deliver the service. All referrals were screened by the APOT/HT to identify those service users who met the inclusion criteria for the OT led triage and treat hand and wrist clinic. The inclusion criteria included conditions deemed suitable for use of non-surgical management in the first instance, supported by clinical evidence and agreed by both Orthopaedic and Plastics Consultants. The conditions identified as suitable for this initiative were Carpal Tunnel Syndrome (CTS),1st Carpometacarpal osteoarthritis (1st CMCJ OA), trigger digit, DeQuervain's, Cubital Tunnel (CT), Ganglions and unspecified hand and wrist conditions.

Funding was agreed to support 1 WTE APOT/HT for six months in October 2018 following a successful business case to National Treatment Purchase Fund (NTPF). The service is now in its 5th year with continued funding from NTPF.

Quality Improvement

Clinical pathways were developed for each of the conditions based on international research, best practice guidelines, and with agreement from the Plastics and Orthopaedic Consultants. The pathways provide consistency in practice for the assessment and treatment process between the APOT running the clinic and the Consultants who provide clinical governance. Screening assessments forms were also developed for each condition, thus providing consistency in subjective and objective clinical assessment and differential diagnosis.

The aims of the OT-led triage and treat HAW Clinic, were to

- Provide a streamlined service user pathway from point of referral to healthcare provider.
- Reduce *service user* wait times for assessment and intervention.
- Reduce the number of *GP referrals wait listed* for the consultant upper limb Orthopaedic and Plastic surgeons.
- *Improve service user experience and outcomes*.

7 aligned with HSE Strategy for the Design of Integrated Outpatient Services 2016-2020, (HSE, 2017), NTPF and the DOH's vision for change for outpatient service delivery Strategy for the Design of Integrated Outpatient Services 2016-2020, (HSE, 2017).

Evaluation

Between October 2018 and July 2022:

- **587** service users were triaged and treated at the OT-led hand and wrist clinic, with **405 (69%)** discharged without requiring consultant referral
- All new GP referrals to the AP OT clinic, with the specified hand and wrist pathology, were seen within four weeks of receipt of referral.
- Prospective service user satisfaction and data collection of service user outcomes is ongoing.
- Service evaluation and clinical outcomes and education regarding clinical assessment and differential diagnosis specific to each condition were shared with local, national and Internationally Occupational Therapists and Physiotherapists.
- The outcomes highlight the value of an APOT/hand therapist with the appropriate skill level in reducing hospital waiting lists for hand and wrist pathology.

Scope to spread

This service initiative has been presented internationally at the British Association of Hand Therapists Conference, London,(best poster 2020) nationally at the Irish Hand Surgery Society (best paper 2021), and most recently at the IFSSH, IFSHT & FESSH combined congress in London, 2022. It was also a finalist in the 2022 Health Service Excellence Awards, under the category, *Improving Patient Experience*.

The model of care, including treatment pathways and assessment forms has been shared and implemented by several acute hospitals throughout Ireland, including NI and the UK**.** The service has also evolved to include a the first APOT/hand therapy led injection clinic for trigger digit and De Quervain's in Ireland (2021) and an APOT/hand therapy led Mediracer clinic for nerve conduction studies (2021).

HSE SPARKS community innovation funding was awarded in **January 2023** providing an opportunity to trial an integrated model of care between SJH and primary care for GP referred service users with hand and wrist pathology. Building on the experience of the last four years, an APOT from St James's Hospital will deliver this integrated model of care for service users with hand and wrist pathology in a primary care setting whilst providing a training opportunity for a primary care senior OT to work alongside the APOT.

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Advanced Practice Radiographer – Ultrasound Reporting Pilot 2023

In line with the Labour Court Recommendation LCR20232 of February 2012, a national review of Radiography Services was initiated. The purpose of the review was to ascertain the effects and challenges arising from the implementation of the Labour Court recommendation. The Working Group issued its' final report in January 2020 which sets out its recommendations.

One of the primary recommendations is to establish the role of Advanced Radiographer Practitioner in Ireland. The Implementation Oversight Group seeks to formally pilot and evaluate the introduction of Advanced Practice Radiographer Sonographers to report on Ultrasound scans commencing in early 2023 with the aim of selecting 10 WTE Radiographer Sonographers to participate. The pilot will run for 6 months and will be reviewed by an external expert from UK.

Any recommendations will be submitted to Department of Health for consideration. Subject to the outcome and recommendations of pilot evaluation, any future recruitment of Advanced Practitioner roles would be through open competition and in line with HSCP Advanced Practice Framework (Health Service Executive, 2022).

Specialist Perinatal Medical Scientist



Defining the problem that HSCP advanced practice addresses

There is a severe national shortage of Perinatal Pathologists in Ireland, leading to a lack of access to specialist Perinatal Pathology services. This has left many parents without access to specialist perinatal post mortems upon the death of a baby. The provision of a perinatal autopsy provides important information for service user counselling and recurrence risks in a significant proportion of cases of both intrauterine or postnatal deaths, and terminations for prenatally diagnosed abnormalities. Furthermore adequate audit of the quality of antenatal care and prenatal diagnosis can only be achieved by the provision of high quality perinatal post mortem services.

Quality Improvement

A service model was developed in Cork University Hospital (CUH) involving transfer of many of the functions of the Perinatal Pathologist to the Specialist Perinatal Medical Scientist (SPMS). This included the development of a training programme for medical scientists in perinatal post-mortems from 12 weeks gestation. The establishment perinatal of the histodissection service required development of a suite of updated standardised post mortem information leaflets and consent documentation which was distributed to all units served by the unit at CUH.

Since 2012 there has been an increase of 178% in perinatal autopsies due to the availability of this high quality service in CUH. SPMSs are members of the CUMH Bereavement Committee and are involved in the continual improvement of the care of pregnancy loss service users including implementation of the *HSE National Standards for Bereavement Care following Pregnancy Loss and Perinatal Death*, completion of training days, courses, attendance at conferences, and involvement in TEARDROP workshops, perinatal research and clinical audits. All documentation related to SOPs, training and competency for medical scientist to train in perinatal histodissection and post mortem autopsies within the department, were developed by the SPMS.

Evaluation

The SPMS can perform both consented and coronial post mortems under clinical supervision and has been trained to reconstruct the body after the post mortem.

- The SPMS has performed or assisted in over 420 post-mortems under clinical supervision and has complied and participated in MDTs.
- Responsible for gross examination and processing of placentas and products of conception from first trimester miscarriage including cases of suspected gestational trophoblastic disease.
- The SPMS provides Placental Histodissection training to both NCHD's and Medical Scientists.
- The SPMS is a member of the late miscarriage and stillbirth CUMH committee, which oversees many aspects of the hospital's approach to pregnancy loss
- The SPMS leads audit of aspects of perinatal pathology practice.
- The SPMS is involved in the development of relevant special techniques or tests (e.g. Development of CISH for triploidy detection)

Scope to spread

The service aims to ensure that all couples at all sites who experience pregnancy loss beyond 12 weeks have equal access to a high quality perinatal post mortem investigation. The role of the SPMS is key to the expansion of services. This is a model that could be expanded to other sites with appropriate training, education and experience.

Contact

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Publications/Abstracts/Posters

- Review of post mortem quality for foetuses under 50g confirms value of investigations at extremes of foetal size – 2019 NIHS Research Bulletin
- Audit of post mortem quality for fetuses under 50g confirms value of investigations at extremes of fetal size – Poster Presentation ISA Cork 2017
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- Pathology Information Workshop for Advocacy & Support Groups ISA Cork Survey 2017
- Pathology Department Placental report Survey 2017

Physiotherapy led clinic using injection of Botulinum Toxin clinic for spasticity management.



Defining the problem that HSCP advanced practice addresses

Botulinum toxin is safe & effective method of managing spasticity but in Ireland there is

- a shortage of medically qualified injectors: The majority of injections carried out at consultant grade
- Increasing number of referrals and extended wait times: physiotherapists working at advanced practice level provide additional capacity to review new service users in consultant clinics.
- Limited access to assessment & rehabilitation

Best practice guidelines advocate that botulinum toxin injection must be part of a rehabilitation programme to achieve an optimal clinical effect & promote the administration of Botulinum toxin by appropriately qualified health professionals (RCP Guidelines 2018). In the UK it is established practice that advanced practice physiotherapists to administer botulinum toxin.

Quality Improvement

Service users with complex spasticity needs had limited access to botulinum toxin prior to 2011. One consultant neurophysiologist provided the service as a small component of their caseload, with no MDT input and no capacity for comprehensive spasticity assessment or evaluation of the outcome. It was recognised that the addition of a physiotherapist working in an advanced practice role would provide additional capacity for injection, expertise in the assessment of spasticity and the objective evaluation of Botulinum toxin as an intervention, and bridge the gap with international best practice guidelines.

As a result, the physiotherapy team set about engaging stakeholders, negotiating for resources, putting governance structures and policies in place and developed Irelands first *Physiotherapy led Botulinum toxin injection therapy clinic*. Two clinical specialist physiotherapists were trained in injection therapy in Plymouth University in the UK and a monthly spasticity clinic was developed.

The clinic provides:

- Improved access: The physiotherapists working in an advanced practice role have established a monthly botulinum toxin clinic which provides capacity for 8 service users including comprehensive assessment and evaluation of outcome. The current wait time for this clinic is 5 months. Prior to this, the service was provided on an ad hoc basis.
- Quality and Safety: Clinical specialist physiotherapist working in an advanced practice capacity have been delivering this service since 2012 and there has been no complaints, no adverse effects or no incidents reported. Published research (Ashford *et al.* 2018) demonstrated that clinical outcomes and safety were comparable between physiotherapy and rehabilitation medicine Injectors.
- Cost Effectiveness. Enhanced evaluation of outcome of Botulinum toxin injections resulted in improved discharges and reduction in medication costs – estimated medication cost saving per annum €22,790 (10 service users pre-assessed and not requiring commencement of Botulinum toxin treatment for 1 year).

Evaluation

- Service audit was completed using a published process of care tool (Allison and Knapp 2012) and changes made post audit ensuring greater than 75% adherence to key standards.
- Evaluation of Quality of Life: -8% change in mean total EQ-5D-5L score was reported by 18 service users post treatment in physiotherapy led clinic.
- This service was a finalist in the 2018 National HSCP Innovation Awards and received a highly commended award.
- Research outputs were presented at the Irish Institute of Clinical Neuroscience 2019, The Irish Society of Chartered Physiotherapist Study Day 2018 and The National HSCP study day 2018.

Scope to spread

There are currently 10 clinical specialist physiotherapists administering injections of botulinum toxin in Ireland. Two of whom, provided supervision for the practical training component of the Masters Programme in Beaumont Hospital, as they did not have a suitable experienced medical consultant in their own hospital. A national special interest group of injectors was established and in 2022 shared resources for standard operating procedures and policies to reduce the work-load for those considering developing an injection service were developed. A profile of national injectors is underway to establish current resources used, governance structures in place, and the gaps in the services nationally. A plan to develop and present a national study day in June 2023 is underway. The model of care is at its infancy in Ireland compared to the UK where HSCP working in an advanced practice role are providing injection services in acute hospital care, rehabilitation facilities, community outreach and nursing home outreach.

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Dietetic service to service users referred through an Integrated Interdisciplinary Irritable Bowel Syndrome (IBS) Care pathway in St James's Hospital.



Defining the problem that HSCP advanced practice addresses

Irritable Bowel Syndrome (IBS) is a chronic, relapsing, often life-long functional gut disorder, causing sleep disturbance, anxiety and lethargy, work absence, avoidance of stressful or social situations, and a significant reduction in quality of life. Approximately 40% of all visits to gastroenterologists are due to IBS with global prevalence is 11.2% (5-20%). People with IBS commonly have multiple invasive endoscopic and radiological investigations despite negative findings. This leads to extensive waiting lists and possible delays in the diagnosis of malignant and serious conditions. On 27th October 2022, there were 76,910 adults waiting for an endoscopy. Over 50% of service users seen for day case and outpatient diagnostic endoscopies have functional gut disorders such as IBS.

Quality Improvement

The aim of the Integrated IBS Care-pathway was to provide timely access to specialist evidence-based dietetic care, increase service user wellbeing and satisfaction and contribute to addressing the national endoscopic waiting lists.

The National Institute of Clinical Excellence (NICE), the American College of Gastroenterology (ACG) and the British Society of Gastroenterology (BSG) all endorse a positive diagnosis strategy rather than a diagnosis by exclusion. These guidelines use algorithms and a number of blood and stool tests to diagnose and manage IBS without endoscopic or radiological assessments and a focus on dietary education and intervention strategies.

Collaboration between the clinical nutrition department, the consultant gastroenterologist and the business and finance departments, delivered a highly successful pilot project and the development of the interdisciplinary, integrated IBS care pathway. Between Sept 2018 and May 2019, all referrals received for endoscopy were triaged by the gastroenterology medical teams. Service users meeting specific criteria were diagnosed with IBS and referred for dietetic assessment and intervention.

Endoscopy waiting lists were reduced with possible avoidance of delayed diagnosis. The pilot enabled a permanent dedicated clinical specialist dietetic service for service users referred through the IBS care-pathway. Service users are seen within 2 weeks of referral and a pathway has been developed to refer back to gastroenterology for 'non-responders'. A hospital guideline has been developed to guide practice and educate staff involved and inter-professional learning is facilitated by educational sessions with medical and with nursing colleagues.

Evaluation

- In the pilot 72.5% of all service users triaged were diagnosed with IBS and referred for dietetic management.
- Since 2018, 450 service users were referred by the gastroenterology team through the IBS Care-pathway, 87% of whom completed dietary intervention.
- As a direct result of the IBS Care-Pathway 540 endoscopies were made available, potentially reducing delays in the diagnosis of malignant and other conditions. There were 1116 service users on the endoscopy waiting list in St James's Hospital (June 30th 2022), down from 1668 in Jan 2021.

- 86% of whom were discharged without endoscopic investigation or follow-up in the medical gastroenterology OPD and reported satisfaction with their gut symptom control. 14% were referred back for medical assessment and management.
- Direct savings of €400,000 (based on HSE ABF Guide 2021) were achieved and unmeasurable in terms of histopathology, outpatient appointments, radiological tests, laboratory costs, etc.
- The Clinical Specialist Dietitian critically evaluates, applies and seeks to advance the best available evidence for dietary management of IBS through audit, reviews and presentations at journal clubs in the hospital, conferences and publications.
- A tele-health service was introduced in 2020/2021, in response to COVID 19. Service user feedback showed 100% were satisfied or very satisfied and reported improved efficiency, convenience and access to care.

Scope to spread

This pathway has been proven to reduce endoscopy waiting lists, reduce healthcare costs and improve service user outcomes by providing timely access to scheduled care. Service users are enabled to self-manage their condition. Individualised treatment plans are developed using advanced and highly flexible expert skill set, adapting to meet needs of service users with different symptom presentation, educational backgrounds and abilities to follow complex dietary programmes. A high level of training and skills development in the area of behavioural change and motivational interviewing underpins the approach. Training in Low FODMAP[8] diet enables diagnosis of food intolerance such as lactose or fructose intolerance, appropriate dietary advice and long-term dietary management. Complex decision-making informs either discharge to the general practitioner without further medical follow-up in the hospital, or referral back to medical gastroenterology.

The pathway has been shared at local and national level (e.g. oral presentation at the National HSCP Office conference in Feb 2019 and links with the HSE NCP Gastroenterology and Hepatology). The template has been used to establish a similar service in other centres many others in the planning stage. With appropriate planning, training, resources and support, roll out in primary care may be realised in the future.

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Publications/Abstracts/Posters

HSPC Unscheduled Care Conference booklet in Nov 2019

Highly commended poster presented at the INDI research symposium in 2020

Oral presentation at IRSPEN national conference in April 2021

8 Fermentable Oligosaccharides, Disaccharides, Monosaccharides, and Polyols.

Pathfinder: Occupational Therapist/ Physiotherapist responding to 999 calls from older people, alongside an Advanced Paramedic – Multidisciplinary Team Example



Defining the problem that HSCP advanced practice addresses

Traditionally in Ireland all 999 callers are transported to the Emergency Department (ED). Pathfinder aims to treat 999 callers in their own home rather than in ED. Older people can be vulnerable to adverse outcomes due to overcrowding and prolonged length of stay in ED. At the time of the 999 call the Occupational Therapist (OT)/Physiotherapist (PT), in collaboration with the Advanced Paramedic (AP), must recommend the service user goes to ED or stays at home. The therapist also complete follow up visits consisting of rehab, case management and equipment provision. The OT/PT is required to act with a high degree of autonomy with complex cases, in a team which draws staff from two organisations.

Quality Improvement

In 2017 the OT department in Beaumont Hospital approached the National Ambulance Service to begin exploring how a joint service for older people might work. Throughout the following months an OT, PT and paramedic spent time together learning about each other's organisation and skill set. This progressed to a joint management forum being established. The Pathfinder OT and PT are members of the clinical team who sits on this forum.

Pathfinder ran a two-month trial in 2019 to help develop the service. It has been running full time since May 2020. The team consists of Occupational Therapists, Physiotherapists and Advanced Paramedics. It has been funded permanently by the Department of Health.

Evaluation

In 2021 two thirds of all Pathfinder service users were treated at home rather than in ED. The average age of service users was 81 years old and the average Clinical Frailty score was 6 (moderately frail). Ninety-nine percent of all non-transported service users remained at home at 24 hours and 89% at day seven. Further outcomes and service description is available in research published by the team, Bernard et al, 2021[1] and O'Brien et al, 2022[2]. The team are currently publishing a thematic analysis of service user feedback and will also soon be beginning an economic evaluation in collaboration with a health economist.

Scope to spread

Eight further Pathfinder teams, collaborations between the NAS and eight other hospitals, have been funded in Ireland by the Department of Health. Recruitment is currently ongoing and some of these teams will be operational in 2022. Throughout 2021/22 the Pathfinder OT/PT has presented to senior management at these eight hospitals and facilitated shadowing opportunities for therapists recruited to other Pathfinder sites.

The lead OT/PT posts within this service is currently at Clinical specialist grade and should be at AP level, in line with similar services in the UK.

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Advanced Practitioner SABR Radiation Therapist (AP-SABR/SRS-RT)



Defining the problem that HSCP advanced practice addresses

In specialist areas such as Stereotactic Radiosurgery (SRS) and Stereotactic Ablative Radiotherapy (SABR) there is an increased workload for both radiation oncologists and radiation therapists. St. Luke's Radiation Oncology Network (SLRON) introduced the frameless SRS programme in 2013 and the lung SABR programme in 2015. The service has grown substantially and now approximately 250 and 300 service users avail of the SRS and SABR service respectively annually. SRS and SABR involves the delivery of extremely ablative doses of radiation to the cranial or lung target. These techniques are often used as a substitute for surgical intervention in service users who are deemed unfit or are at high risk of surgical morbidity, for example, service users with early-stage lung cancer. SABR and SRS treatment planning and delivery are complex multi-step processes. As a result, these processes are resource intensive, requiring multiple professionals at multiple steps.

Quality Improvement

A dedicated SABR/SRS Advanced Practitioner Radiation Therapist (AP-SABR/SRS-RT) practice at an expert level providing a comprehensive radiation therapist led service for service users undergoing stereotactic radiotherapy. They are responsible for receiving new service user referrals, attending multidisciplinary meetings, providing advice information and support, obtaining informed consent, and identifying, interpreting and defining treatment planning volumes. They lead treatment and make clinical decisions based on image guided radiotherapy (IGRT). This streamlines the pathway for service users and delivers efficient and effective evidence-based care. This reduces the need for consultant radiation oncologist attendance at the treatment unit and reduces the burden on multiple professionals within the multi-disciplinary team. This redefinition of roles is not to replace medical colleagues but a means of reviewing and reconsidering who provides what service, to enhance efficiency and effectiveness within the pathway.

Evaluation

A dedicated AP-SABR/SRS RT Radiation Therapist means the number of treatment appointments are much less constrained by radiation oncologist availability as radiation therapists are on site 5 days a week. This increases service user appointment flexibility and the ability to treat more service users on the same day.

A pilot program conducted in SLRON demonstrated for service users requiring lung SABR treatment:

- A reduction in appointment time for non-first fraction SABR service users from 60 minutes to 45 minutes (25% improvement) was achieved.
- This increased treatment capacity provided more timely access to radiotherapy service users and increased throughput.
- Service user experience improved due to reduction in the time spent in an uncomfortable position.
- The increased capacity has resulted in additional cost benefits as many of these service users would otherwise have been funded by the HSE to attend a private hospital for treatment.

This single centre pilot study evidence is promising, and it is further strengthened by widespread international evidence where reduction in service user wait times, (Holt *et al.*, 2017) increase in service user throughput, and time savings can all be attributed to AP RTT roles. (Hartnett *et al.*, 2014) (Hartnett *et al.*, 2018)

Scope to spread

The AP-SABR/SRS-RT role could be replicated to provide similar benefits to other tumour sites using increasingly complex planning and delivery techniques e.g. breast cancer

Sites treated with SABR are expanding e.g. the introduction of the abdominal SABR programme in SLRON in 2021. The leadership, educational, research pillars of the AP SABR RT will further expand the service available to service users.

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Speech & Language Therapist Led clinic for voice and swallowing difficulties



Defining the problem that HSCP advanced practice addresses

Waiting lists for Otolaryngologists – Ear Nose and Throat Surgeons (ORL-HNS) are among the highest in Ireland which affects wait times for complex/high priority service users. Traditionally, new referrals for dysphonia were first seen by ORL-HNS with onward referral to Speech & Language Therapy (SLT) for assessment, diagnosis, and management. This has led to long waiting times for service users to access both ENT and SLT, duplication of assessment/care and unnecessary reviews.

In the new process GP referrals to hospital are triaged by ORL-HNS consultants. Appropriate referrals with suspected voice or swallowing difficulties of medium and low priority/ risk are directed to Specialist Speech and Language Therapist (SLT) clinic. On completion of assessment and any required treatment, service users are discharged back to GP and to primary care SLT as indicated.

Quality Improvement

This example of advanced practice improves timeliness of service users access to the right service at the right time, be it ENT or SLT, improves ENT capacity to see high priority referrals/complex urgent cases, and enhances service user experience. Service users receive specialist care from the SLT – those who can manage their needs most appropriately. Advanced training in the area of nasoendoscopy is required with the SLT achieving defined competency in the clinical area. The SLT-led clinic runs 'in parallel' to a designated ENT clinic, which facilitates ease of service user transfer to the medical team should it be required. The Clinical Specialist SLT completes the voice and/or dysphagia assessment including case history taking and endoscopy, a management plan is decided jointly with ENT, with all follow up and correspondence completed by SLT. Research has shown that joint voice clinics run by a specialist SLT avoid repetition of clinical assessment, resulting in better planning of service user management and early initiation of treatment (Vaghela *et al.*, 2005).

Based on evidence from similar services within the UK and Australia (Carding, 2001, Seabrook *et al.* 2018; Schwarz *et al.* 2021), it is expected that approximately 74-81% of service users referred to this service would have their needs met by the SLT clinic, without further specialist ENT input. Following a period of training and set up, the first parallel voice clinic was held in Beaumont in October 2019. This clinic is one of the first of its kind in Ireland.

Evaluation

Pilot projects of a parallel SLT/ORL-HNS clinic have been completed in Beaumont and Tallaght Hospital. Data from these clinics demonstrated the benefits with approximately 80% of service users managed by the advanced practice SLT led clinic and SLT alone with no further ENT input required, this is in keeping with international evidence. The advanced practitioner SLT can manage the service users in the SLT-led clinic and provides specialist assessment and management to each service user in relation to their voice/swallowing disorder. These clinics result in reduced numbers on ENT waitlists, reduced service user wait time (seen by SLT within 2-3 weeks, versus 1-3 years ENT waitlist), and high levels of service user satisfaction. The advanced practice assessment and endoscopy competencies and training of these SLTs allows them to offer leadership and training to other SLTs working with voice disorders in other parts of the service.

Data from Beaumont and Tallaght hospitals on their pilots to date:

	Beaumont Hospital	Tallaght University Hospital
Referrals to SLT led clinic	434	448
Number of service users seen	345	346
Managed by SLT with no ENT input required	85%	72%
Required ENT management	15%	28%

Scope to spread

This clinic model is aligned to the Otolaryngology Head and Neck Surgery Model of Care (RCSI 2019) and is recommended for all level 4 hospitals. Consideration should be given to including these SLT led clinics in model 3 hospitals as required with a hub and spoke model in place to support specific clinical needs of people attending ENT services. The service in Beaumont Hospital shows this hub and spoke model in practice as service users from ENT consultants who work in both Beaumont hospital and Drogheda Hospital, triage referrals from Drogheda to the Beaumont hospital SLT led clinic.

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Specialist Addiction Social Worker in Perinatal Medical Social Work



Defining the problem that HSCP advanced practice addresses

Addiction in pregnancy is one of the most critical areas where social work input is required. It involves complex case planning and leadership within the MDT. Service users with addictions require an enhanced Social Work service to meet the multitude of psychosocial needs while balancing child protection obligations.

Advanced skills, knowledge and training in the area of addiction and its impacts are required to provide an enhanced service to these vulnerable women, who often present with co-morbidities and have complex psychosocial needs often resulting in difficulty in engaging with the hospital. The Specialist Medical Social Worker provides a comprehensive assessment and psychosocial interventions with a broad range of supports.

The Specialist Medical Social Worker must be adequately skilled to determine the levels and intensity of the intervention required based on the complexity and presenting co-morbidities, especially given it is a voluntary service with often involuntary service users. The role requires leadership within the MDT case management and facilitates clinical learning among the MDT whom are heavily guided by the Specialist Medical Social Worker. Postgraduate training opportunities include a certificate/diploma/masters in addiction studies.

Quality Improvement

In light of the complex nature of work involved in working with addiction in pregnancy, a decision was made to have a Specialist Social Worker working specifically with these service users. The social worker had a special interest in the area of addiction in pregnancy and completed postgraduate training in the area. Since its inception, the specialist role has continued to grow and develop to meet the changing needs of these complex women alongside the needs of the hospital.

The Addiction Social Worker takes a lead role in relation to child protection issues and concerns, acting as the point of contact between Tusla and the MDT. The addiction social worker coordinates and facilitates the discharge of babies where there are concerns in relation to substance use or addiction issues.

With regard to education, the Addiction Social Worker is a resource not only to the Medical Social Work Team, but also to the wider hospital staff and beyond. The role includes provision of training to MDT colleagues, to the Centre for Midwifery Education, as well as to third level graduate and postgraduate programmes.

The Addiction Social Worker continues to upskill and learn, completing further study in areas relating to addiction and issues facing the service users they work with. The Addiction Social Worker also contributes to future learning, for example completing a multidisciplinary and interagency research study (awaiting publication). The Addiction Social Worker continues to review and update departmental practice guidelines. Alongside this, the Addiction Social Worker also has ongoing involvement in a peer network along the Dublin Maternity Hospitals.

Evaluation

As part of further quality improvement and to evaluate the service, the addiction social worker keeps a record of statistics and there is scope for clinical audits as part of the ongoing evaluation, as well as reviewing datasets and engaging in research. Feedback from key stakeholders is also crucial in evaluating the service and adapting as necessary.

Scope to spread

Specialist Social Workers in the area of addiction are only available in the three Dublin Maternity Hospitals. Given the ongoing issue of substance misuse in other urban and rural areas there is great need make this service available in all maternity networks/19 maternity units in a similar way to the intended role out of the Drug and Alcohol Liaison Clinical Midwifery Specialists posts in maternity units outside of Dublin.

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Intraoperative Neurophysiological Monitoring



Defining the problem that HSCP advanced practice addresses

Intraoperative Neurophysiological Monitoring (IOM) is a complex service provided by clinical physiologists in neurophysiology. It is a service provided to service users undergoing neurosurgical and orthopaedic procedures that carry risk of iatrogenic neurological injury, with a primary goal of identifying areas of functional neurological tissue and preventing post-operative deficits that may lead to paralysis. This is an important service offered in-house at Beaumont Hospital, with trained senior physiologist being fundamental to the service.

Centres in the UK and America have well established services for IOM, with certain surgical procedures requiring IOM as a standard of care. An example includes scoliosis correction surgery where there is a high risk of postoperative deficit.

There are currently two hospitals in the Republic of Ireland that provide an in-house IOM service – Beaumont Hospital and Cork University Hospital. Other hospitals that require IOM for particular surgical cases must contract a private IOM service at an additional cost as well as the case needing to be scheduled for when monitoring service is available e.g. Temple street. The specialist nature of this role is due to the knowledge required, the risks the test carries and the invasive nature of the monitoring. The IOM service encompasses techniques that assess the function of the brain, brainstem, spinal cord, cranial nerves and peripheral nerves during surgery. The physiologist is required to act with a high level of autonomy to minimise surgical risks of neurological injury.

Quality improvement

IOM meets the criteria of advanced clinical practice due to the high degree of autonomy and complex decision making required for neurodiagnostic investigations. This is due to the level of complexity of the service performed, the responsibility of staff involved as well as the extensive self-directed learning required to achieve a level of knowledge that greatly succeeds the entry level required for the profession. Physiologists must complete comprehensive clinical training to be competent in this area of neurophysiology. With neuromonitoring being implemented in Beaumont Hospital as a departmental service, service users who undergo surgeries with risks of iatrogenic neurological injuries have a better chance of completing surgery without an avoidable neurological deficit.

Since the establishment of the in-house service 2013 and initiative to train senior physiologist staff in the area of IOM under the guidance of a consultant neurophysiologist, there has been an increase in the number of cases monitored from 48 per year in 2016, to 90 in 2018. In 2021 there was a decrease in cases to 76 due to reduced bed capacity as a result of Covid19 pandemic. However the numbers of cases continue to grow in 2022.

With physiologists in Beaumont becoming specialised in this area, there are more opportunities for surgeons to avail of this service. This improves the quality of care given to service users as it maximises the surgeon's ability for more extensive resections during tumour removal surgery, which may prolong service user survival. Having experienced physiologist staff available to perform IOM means the consultant can carry out remote monitoring of certain cases, freeing up their time to take on more complex cases. It also helps free up time for Consultant clinics.

Evaluation

During IOM cases of functional mapping, areas of eloquent cortex and executive function have been identified and preserved post-operatively. In Beaumont over the last 7 years, eloquent neural tissue has been successfully identified during 443 cases of service users undergoing neurosurgical procedures, which has provided beneficial information to the service user's neurosurgeon. This is an average of 62 cases per year. IOM cases performed in Beaumont Hospital have also detected monitoring deterioration due to malpositioning of service users in their theatre beds; providing opportunities to prevent peripheral neuropathies. The decreased adverse events during surgery as a result of IOM help to enable reduced Hospital stays.

As the majority of intraoperative monitoring cases at Beaumont Hospital are Neurosurgical, a literature review was performed for the evaluation of the utility of IOM orthopaedic procedures. Studies of the incidence of motor deficit or paraplegia post-surgery in scoliosis have been identified without IOM to between 3.7% (Epstein, 1995) and 6.9% (Meyer, 1988). The incidence is notably less with monitoring, at 0.5% (Nuwer, 1995). In a retrospective study of 102 consecutive adults who underwent spinal deformity corrective surgery, multimodality IOM provided useful neurophysiological data with overall sensitivity of 100% and specificity of 84.3% (Quraishi, 2009).

Scope to spread

The new CHI is expected to develop an in-house IOM service as it will be the national centre for paediatric neurosurgery. Therefore there is need for this area of advanced practice to be introduced in Neurophysiology departments of paediatric Hospitals. A particular tumour that is most common to present in paediatrics is a posterior fossa tumour. Removal of a tumour in this area holds significant risk for neurological injury, and this test should therefore be accessible for all surgeries of this type.

Developing advanced practice posts in IOM could enable in-house services to be stablished in other major Hospitals where staff are contracted privately for neuromonitoring service at an additional expense.

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Total Contact Casting for the foot and lower limb





Defining the problem that HSCP advanced practice addresses

Diabetic foot disease is one of the most common, serious, feared and costly complications of diabetes, with limb loss and ulceration one of the most devastating complications for service users, and their families (Hurley *et al.*, 2013). In Ireland, an individual with diabetes is 22 times more likely to undergo a non-traumatic amputation than an individual without diabetes (Buckley *et al.*, 2012). In addition, research has demonstrated the economic impact of diabetic foot disease and estimated that it accounts for almost 0.6% of health service expenditure (Kerr, Rayman, & Jeffcoate, 2014). The diabetic foot with active foot disease (Charcot and ulceration) can require pressure relief and offloading. This service was not previously offered to service users and resulted in service users being offered limited offloading strategies as a treatment option, longer healing times for ulcerations, and limited offloading options for the Charcot foot.

Quality Improvement

Total contact casting is cost efficient treatment option for offloading the complex diabetic foot is provided by a highly trained podiatrist within appropriate governance structures. This is a specific casting technique that is used to heal diabetic foot ulcerations and to protect the foot during the early vulnerable phases of Charcot fracture dislocations. By distributing weight along the entire plantar aspect (sole) of the foot, the cast maintains contact with the entire plantar surface of the foot and lower leg and immobilises surrounding joints and soft tissue while allowing the service users to remain ambulatory. In line with international best practice (IWGDF 2019) total contact casting, an advanced practice for the podiatry profession is the gold standard for offloading the diabetic foot.

In 2018 the podiatrists working within the diabetic foot team at University Hospital Limerick highlighted the need to provide casting as a treatment option to offload the complex diabetic foot, they worked in the diabetic foot clinic, where 70-80% of the clinical caseload with active foot disease required offloading. They completed and presented their business case to the orthopaedic consultant and endocrinologist. The podiatrists trained in this advance practice in the UK and here in Ireland. In collaboration with the orthopaedic consultant, consultant endocrinologist and line management, the appropriate governance structures were established. These structures were developed in line with the Model of Care for the Diabetic Foot 2011 and reviewed and adapted in line with the redesigned and redeveloped Model of Care for the Diabetic Foot 2021. This states the highly complex active foot, is the responsibility of the acute multidisciplinary diabetic foot team which is led by the podiatrist.

Since 2019 podiatry members of the multidisciplinary diabetic foot team are providing total contact casting. This advanced practice was originally offered in the University Hospital Limerick, and primarily provided for people with diabetes with active foot disease. The service progressed and developed and is now located in Croom orthopaedic hospital.

Due demand for this service a new business case was developed, accepted and resourced, with the result, a dedicated WTE clinical specialist orthopaedic podiatrist is employed since 2021 to lead and develop the service working directly with the orthopaedic consultant in the orthopaedic team.

This service provides advanced specialist input into the service user's journey providing the right care in the right place by the right professional to assist wound healing, reduce further foot deterioration (bony and soft tissue), and reduce amputation or further amputation. Service users can be assessed, diagnosed and provided with total contact casting, which evidence shows provides a cost effective and underutilised treatment option for offloading the foot, (Sibbald et all 2019).

Evaluation

The service has been evaluated – audited, and is in line with the Model of Care for the Diabetic Foot 2021 providing a timely direct pathway to offloading modalities (casting) and orthopaedic consultation for the active diabetic foot. This example of integrated working, aligns with the principles of Slaintecare, provides a seamless service user pathway for active foot disease requiring and suitable for casting, and releases clinical support for the orthopaedic consultant time and his team, including a reduction in waiting list numbers. The appointment of a clinical specialist podiatrist for advanced practice in orthopaedics enables more formal evaluation of the service with a focus on demonstrating impact in the following outcome measures: reduction of ulcer healing times, admission avoidance, reduction orthopaedic consultation appointments, and service user reported outcomes and feedback. The orthopaedic team, staff and senior podiatrists are being supported and trained in this advanced practice technique.

Scope to spread

The practice is fully supported by the orthopaedic consultant and this podiatric advanced practice is continuing to expand to support the orthopaedic service, assist service development, reduce waiting lists and improve the care of the service user with lower limb conditions and reduce costs.

In line with the Model of Care for the Diabetic Foot 2021, expansion of this practice is planned to provide specialist podiatric assessment and treatment of the complex foot requiring and suitable for offloading for service users attending with wounds on the foot and lower limb with associated impact on podiatry, vascular, orthopaedic waiting lists and advanced nurse practitioner tissue viability, clinics.

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