**Background**

Shortfalls in the NHS workforce and increasing demands on health in the UK, provided the original impetus for introducing the Advanced Clinical Practitioner role, utilising and expanding the skills of nurses and other healthcare practitioners, to expand their roles into areas traditionally confined to doctors. (Imison et al., 2016; NHS England, 2017).

The emphasis was on a generic higher level of expertise (rather than highly specialised expertise) so ACPs could care for patients as they presented, with a variety of undefined and undiagnosed conditions. In 2017, NHS England produced a document outlining a ‘Multi-professional framework for advanced clinical practice in England’ to set out an agreed definition for advanced clinical practice, encompassing ‘four pillars’ of capability (clinical practice, leadership and management, education and research) (NHS England, 2017). The aim of the framework was to ensure, ‘safety, quality and effectiveness’ (NHS England, 2017 p4).

The introduction of ACPs in emergency and critical care settings produced cost-savings, reduced length of stay, time to treatment and mortality rates, and improved patient satisfaction (Woo et al. 2007). Other research reported improved continuity of care, reduced delays in diagnosis and treatment, good patient satisfaction and positive effects for junior medical and nursing colleagues (Halliday et al 2018; McKeag & Fenton 2017; Pearce and Breen 2018; Williams 2017).

Confusion around titles which refer to advanced level practice and the distinction between ‘advanced’ and ‘extended roles’, is frequently addressed in the literature (Pearce & Breen 2018; Ormonde-Walshe 2001; Stasa et al 2014; Imison et al. 2016). The Nuffield Trust commissioned a report into reorganisation of NHS staff in 2016 which defined “extended roles” as where registered professionals take on tasks beyond their traditional scope of practice, but which do not require education to Master’s degree level, whilst “advanced roles”, require education to Master’s level or above (Imison et al., 2016). Implementation of this concept has however not been uniform.

There is a gap in the literature regarding how the roles are utilised in different settings and the barriers and facilitators to successful implementation.

**Study Aim**

The aim of our study was to examine the way in which ACP roles are being used in acute and primary settings in one region of England. Furthermore, to explore understanding of some of the facilitators and barriers to it.

**Methods**

Case study methodology was used (Baxter 2010). The boundary for our two cases was the context (GP practice or acute clinical trust) in which ACPs were employed. Each case was made up of a series of individual ‘units of analysis’.

We employed a qualitative, semi-structured interview approach, selecting in each unit of analysis an ACP, his or her line manager and, in some cases, a colleague. In addition four individuals with a strategic understanding of the roles were interviewed.

**Sample**

Four units of analysis from primary care and five from the acute care sector where selected. The sampling was purposive and aimed at maximum variation, by selecting settings from dispersed geographical areas within the region of interest, and drawing on cases where ACPs were being used in varied clinical settings and/or professional backgrounds (see Table 1). 22 participants were included.

**Data gathering**

Participants were interviewed in person or by telephone.

**Analysis**

Analysis of the transcripts was carried out using thematic analysis (Braun & Clark 2006).

# **Findings**

Insert Table 1 participants

The four over-arching themes emerging from the analysis of the transcripts, were ‘Purpose and Development of the ACP Role’, ‘ ‘Impact and Evaluation of ACP role’ , ‘Barriers and Facilitators of the role’, and ‘Governance’

Insert Table 2 – Themes and Sub-themes

## **Purpose & Development of Role**

#### **Medical shortages**

The primary driver for the roles in both acute and primary care contexts was service need due to a lack of medical professionals. The ACP role had evolved to meet the specific needs of the particular service area, resulting in variations between practice areas.

*“The driver … was the fact that we are struggling to meet demand … trying to supply appointments basically […] we have really struggled to fill the roles with GPs”* PC3b

**Enhanced, autonomous, decision-making**

A dominant theme from interviews was that the ACP role was not solely about undertaking advanced tasks, but clinical decision-making and an ability to deal with undifferentiated diagnoses in a holistic manner.

The majority of participants saw the ACP role as being broad and generalist, compared to specialist practitioners, who practiced in an advanced but highly discipline specific role. This said, in some ACP roles filled by Allied Health Professionals, a degree of specialism remained.

In the acute setting however, where ACPs were working more within a medical model of care, the broad nature of the role brought concern about deskilling, and loss of original discipline competence.

Additionally, in the primary care setting there was a degree of concern raised from medical colleagues about escalation of the roles and ACPs being expected to take on more and more complicated cases, with undifferentiated diagnoses, for which they may not be appropriately trained, or skilled.

*“I do get annoyed when they go, oh it’s ok for the nurses… to see minor illness … what is minor illness, what a patient tells you on the phone or tells the reception may or may not be minor illness.”* PC4b

Borne out of such concerns, high degrees of professional and personal accountability were viewed as essential characteristics of ACPs, in particular having the ability to understand their remit, limitations and scope of practice.

*“you have to be a very critical thinking reflective practitioner to be an ACP… you need to know your learning needs and … scope of practice.”* AT2a

**Job titles**  
There was consensus that the number of different job titles that existed was problematic in terms of role recognition and acceptance in the clinical setting because colleagues and patients alike did not always fully understand what the role was and its remit.

In the primary care setting, the title Advanced Nurse Practitioner (ANP) was more common than Advanced Clinical Practitioner (ACP).

**Professional roots**  
The importance of professional roots and remaining true to these, was a strong theme throughout.

*“I see it as a role as a mega-nurse, not a mini-medic.” PC1a*  
This was verified further, with observation that ACPs were complementing, not substituting medical roles. Whilst the ACP roles were introduced to overcome the shortage of doctors, what they actually brought not only filled this void, but exceeded it.

*“I don't see it as medical substitution. I see it as added value … a complementary service. We're not here to replace. We're here to complement and build the workforce. “ AT1a*

Medical colleagues in particular expressed the added value that they perceived ACPs provided, noting that often years of clinical experience in root professions, brought with it a unique skill set, including enhanced communication and clinical skills, over and above those of the medical equivalence they were often replacing.

#### **Extent of substitution for junior doctors**

In acute care, ACPs who were nurses by background were part of the junior doctors’ rotas, but were not yet rostered at night. ACPs working in therapy services were not part of this rota. Instead, their roles involved performing roles usually undertaken by consultants, rather than junior doctors, taking on many of the less complex cases to free consultant time.

## **Impact and Evaluation**

#### **Career progression and *Job satisfaction***

There was consensus from ACPs, managers and those with strategic oversight, that the ACP role supplied challenge and provided career progression for many, offering an alternative to management.

*“these roles offer fantastic workforce development opportunities... they deliver better care for patients and for organisations, offer an ability to retain workforce and to develop the workforce according to local need.”* SO3

All of the ACPs noted increased job satisfaction in this role.

**Service Improvement**Participants reported service improvement as a direct impact of having ACPs. ACPs reported that their dual approach (i.e. medical and nursing/therapy) to care was an advantage, in that what they provided was a ‘one stop shop’, resulting in patients seeing fewer professionals, shortening their length of stay, or wait time (depending on setting). Both medics and ACPs shared this consensus.

*“I think the patients really like them and we really like having them so yeah … it’s … very positive from our point of view.”* PC1b

**Teaching Role**

Teaching was a valued aspect of the ACP role. In the acute setting, ACPs were often responsible for induction and initial teaching of the junior doctors when they rotated. ACPs from both acute and primary care had participated in teaching at the local university.

***Familiarity with wards and departments***

In the acute setting, where junior doctors rotate through specialities, ACPs were present on wards in a permanent fashion. This meant ACPs were aware of systems, already had rapport with ward staff and were able to provide more efficient care for patients.

## **Facilitators and Barriers**

#### **Support of Colleagues**

Supportive colleagues (medical and peer), were a particularly important facilitator to success of the ACP role.

Furthermore, access to wider peer networks provided forums to share experiences, resources and to create learning and collaborative research opportunities, enhancing the role.

Clinical supervision was provided by medical colleagues and was an important aspect providing the ACPs with confidence in their role.

Some medical colleagues were uncertain about the introduction of ACPs, including their scope, competence and the impact on their own workloads, due to a lack of experience of seeing the roles at work. All medical colleagues who had worked with ACPs were extremely positive and could see the enormous benefits that it provided.

**Continuing education and research**  
Difficulties accessing continuing education and undertaking research (one of the pillars of advanced practice), were reported as barriers to fulfilling the ACP role. This was due to a lack of time for these activities.

*“education beyond initial registration can be difficult to access and difficult to get time for. One of the key pillars of Advanced Practice is research. Getting involved in research, as an ACP, is incredibly difficult.”* AT1a

**Institutional barriers**   
ACPs reported many institutional barriers to their carrying out their role, e.g. difficulty ordering tests, making referrals, prescribing and access to medical IT systems. These were most acute when the roles were first introduced, but decreased over time, with improved understanding of the role, and support from the medical team.

The exception to this remained the issuing of death certificates and Med3 (Fitness to work) forms, the issuing of which is legally restricted to medical practitioners. This was reported as a problem, particularly in primary care, where ACPs were being used to attend home visits.

**Funding barriers and Pay scales**  
Lack of clarity over which budget (i.e. nursing/allied health or medical) should be used to fund ACP roles caused difficulty in the acute sector. In none of the acute settings did the ACP pay come from the medical training budget (deanery), despite ACPs substituting for junior doctors.

Differing salaries and pay banding for ACPs meant there was not always equal pay for an equal role.

#### **Dual roles**

All of the ACPs in the acute setting reported that the dual roles of clinical and management responsibilities were problematic. Most had designated days for their clinical work, but reported that the boundaries were blurred and they spent time undertaking management tasks, at the expense of building upon the other pillars of advanced practice, particularly continuing education and undertaking research.

*“The clinics are clearly set … it’s my other time that should be … my research, my development kind of time, that’s what gets eaten up and that’s what then turns into the day to day PDP’s, the line management, the staff management, health and wellbeing.”* AT4a

***Line management and appraisal***

As a consequence of not being funded from medical budgets, none of the ACPs in acute care were line managed by the medical team. Whilst this was seen as beneficial in terms of line management’s understanding of professional governing body requirements, (e.g. revalidation), line managers did not always fully understand the nuances of the ACP role either, and were not best placed to appraise performance.

**Prescribing**

Where practitioners were unable to prescribe, as a result of restrictions on their profession, this was reported as a barrier to performing the role.

## **Governance**

#### **Professional regulation**

ACPs and medical colleagues felt that specific regulation of advanced practice roles was needed, along with standardised job descriptions, levels of practice and expectations in order to ensure public safety.

Ideas for addressing this included a central register of ACPs, held by an umbrella organisation, e.g. Advanced Practice Academy, or alternatively professional governing bodies, such as NMC, having a place on the register to acknowledge acquisition of advanced practice standards.

Participants in the study suggested that registration as an advanced clinical practitioner should be subject to revalidation, to ensure currency of practice. All agreed the importance of clinical competency, accompanied by continued appraisal, for ensuring patient safety. Most of the participants could see a place for accreditation frameworks to ensure competency in specialist areas, but many felt that these encouraged a task-based approach to advanced roles, which may limit ACP roles.

**Transferability of roles**Lack of defined roles and standardised credentials was reported to cause difficulty when advertising and employing practitioners as ACPs.

*“when we were considering employment of an ANP … a lot of the CVs … didn’t [meet the criteria], the qualifications weren’t very standardised … people came from very different backgrounds and then almost all called themselves an ANP.”* PC1b

In primary care, ACPs with nursing backgrounds reported developing into their role over time, starting their career as a practice nurse, with the incremental development of further skills and training, eventually becoming independent practitioners. This caused marked variation in scope of practice, which had often become bespoke to an individual medical practice. A consequence was reduced transferability of the ACP into other employment settings. Many of the participants in the acute settings however, had core elements of transferability between specialities which included; advanced clinical reasoning and judgement, potential for leadership and research, service improvement and innovation. These common components are aligned to the four pillars of advanced practice.

***Education Variation***

Participants recognised variation in education leading to acquisition of advanced skills qualifications. They supported standardisation of postgraduate advanced practice education qualifications. However, whilst some of the ACPs in primary settings had undertaken Master’s level study, many did not have a full Master’s degree, and there was concern that their extensive experience might not be recognised in such a system.

**Discussion**

This study highlighted improvements in patient care and positive effects for junior medical and nursing colleagues, which concurred with previous evaluations (Halliday et al 2018; McKeag & Fenton 2017; Pearce and Breen 2018; Williams 2017). Our participants also emphasised increased job satisfaction and career development that becoming an ACP provided, and suggested that this increased workforce retention.

Whilst all ACPs were introduced to fill medical shortfalls, in line with the literature, the study found that what ACPs actually provided went beyond replacing medical colleagues, instead, bringing experienced and diverse skill sets, enhancing the provision of medical teams. On the whole ACPs were highly valued for their contribution to medical workload by medical colleagues and where there was hesitance this was due to unfamiliarity, or concerns about ACPs being ‘taken advantage of’.

Our findings indicated that in the acute sector the division between nurse (or allied health) specialists, who focus on a specific client group, and more generalist ACPs is not always clear cut (Pearce & Breen 2018) and that this contributed to varying levels of role acceptance amongst colleagues. In line with previous research, variation in role title, remit and a lack of regulation exacerbated this.

Most ACPs welcomed a universal education, training and credentialing process for ACPs so that employers would know what lay behind the title of Advanced Clinical Practitioner, and employment mobility would improve. There was a strong sense that more formal regulation of advanced practice was needed. However there were concerns expressed about too rigid or prescriptive a credentialing process, which may disadvantage some ACPs already in post.

Of the four pillars of advanced practice (NHS England 2017) only a minority of ACPs were able to address the requirement for research activity, and many job descriptions prioritised clinical care, to the detriment of the other three pillars (education, leadership and research), suggesting a need for rebalancing.

Structural and institutional barriers, such as right to refer and appropriate access to medical ‘systems’ had to be overcome to allow ACPs to widen their roles and practices. Further, what was essential to the success of roles in both primary and acute settings, was the support of medical colleagues and management and networking opportunities with other ACPs.

**Limitations**

This study was a snap-shot of the roles of ACPs in a small number of specific settings, in a limited geographical area.

**Conclusions**

* All ACP roles had been developed to fill gaps in medical workforce.
* Both ACPs and managers reported that ACPs improved the quality and timeliness of service provision, and was well accepted by patients.
* The opportunity to become an ACP provided career development for experienced staff, and added to job satisfaction.
* ACPs agreed that their role went beyond simply undertaking expanded tasks, and was based on enhanced, holistic and autonomous clinical decision-making.
* Lack of clarity over pay-scales, and the source of funding for ACP roles, caused difficulty, especially in the acute care sector.
* ACPs reported difficulty accessing continuing education and research, because of the service demands and lack of funding. However many were able to undertake teaching roles.
* There was agreement that Advanced Clinical Practice and the title of ACP needed to be better regulated to ensure that those using the title had the proper skills and education. Formal registration, along with revalidation, was preferred. There was a lack of agreement about which body should hold the register.

**Recommendations**

1. Standardised education for ACPs, clarity and transparency over skills proficiency, and a universally recognised credentialing process is needed. This should contain flexibility, so that ACPs working in different clinical settings are not required to undertake training in redundant skills sets.

2. Regulation, either via professional bodies, NMC, HCPC, GPhC etc., or with an over-arching body such as an Academy of Advanced Practitioners should be introduced.

3. Agreement at leadership level, especially in the acute care sector, about where ACPs sit in terms of line management, appraisal, and funding for ongoing education is desirable.

4. Nationally or regionally agreed pay-scale parity should be introduced.

5. Multi-disciplinary peer support for ACPs, in the form of local or regional advanced practice forums, working groups and social media groups, to reduce isolation, enhance professional identity and encourage the sharing of best practice should be enabled.

**Key Points**

* ACP involvement enhances care provision, bringing diversity and root professional skills to supplement/complement the skills of the medical team.
* Regulation of Advanced Clinical Practice is urgently needed
* ACPs are highly valued by medical colleagues
* ACP introduction facilitates clinical career progression and supports workforce retention

**Reflective Questions**

1. How is, or where could, advanced practice be utilised in your clinical setting?
2. What do you see as the potential barriers and facilitators to the success of advanced practice in your own setting?
3. What steps might you need to take to develop into an advanced clinical practice role?

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