

# An exploration of the role of advanced clinical practitioners in the East of England

Claire Hooks and Susan Walker

## ABSTRACT

Medical staff shortages in the UK have provided impetus for the introduction of advanced clinical practitioners (ACPs). This case study explored the views of 22 ACPs, managers and doctors in primary and acute settings in a region of England, to understand how the role is used, and barriers and facilitators to its success. ACP roles improved the quality of service provision, provided clinical career development and enhanced job satisfaction for staff and required autonomous clinical decision-making, with a high degree of self-awareness and individual accountability. Barriers included disparate pay-scales and funding, difficulty accessing continuing education and research, and lack of agreed role definition and title, due to a lack of standardised regulation and governance, and organisational barriers, including limited access to referral systems. Facilitators were supportive colleagues and opportunities for peer networking. Regulation of ACP roles is urgently needed, along with evaluation of the cost-effectiveness and patient experience of such roles.

**Key words:** Advanced nurse practitioner ■ Role ■ Barriers  
■ Facilitators ■ Acute settings ■ Primary settings

Shortfalls in the NHS workforce, and increasing demands on health in the UK, provided the original impetus for introducing the advanced clinical practitioner (ACP) role, which used and expanded the skills of nurses and other healthcare practitioners 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 that 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' that set out an agreed definition for advanced clinical practice, encompassing the '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).

The introduction of ACPs to emergency and critical care settings produced cost-savings, reduced length of stay, time to treatment, 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 (McKeag and Fenton, 2017; Williams, 2017; Halliday et al, 2018; Pearce and Breen, 2018).

Confusion around titles that refer to advanced level practice and the distinction between 'advanced' and 'extended roles', is frequently addressed in the literature (Ormonde-Walshe, 2001; Stasa et al, 2014; Imison et al, 2016; Pearce and Breen, 2018). In 2016, the Nuffield Trust commissioned a report into reorganisation of NHS staff that defined 'extended roles' as being those where registered professionals take on tasks beyond their traditional scope of practice, but which do not require master's degree level education, while '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 ACP roles are used in different settings and the barriers and facilitators to successful implementation.

## Study aim

The aim of the study was to examine the way in which the ACP role is used in acute and primary settings in one region of England and to understand its facilitators and barriers.

## Methods

Case study methodology was used (Baxter and Jack, 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, their

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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 were 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 (*Table 1*). Twenty-two 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 and Clark, 2006).

### Findings

The four overarching themes that emerged from the analysis of the transcripts were: purpose and development of the ACP role; impact and evaluation of the ACP role; barriers and facilitators of the role; and governance (*Table 2*).

### Purpose and development of role

#### Medical staff shortages

The primary driver for the roles in both acute and primary care contexts was service need owing 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 also involved 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 with specialist practitioners, who practised 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.

In the primary care setting, there was a degree of concern from medical colleagues about escalation of the roles and ACPs being expected to take on more complicated cases

**Table 1. Details of participants**

Setting	Role of ACP	AFC pay band	Other comments/time in role
PC1a	ANP, GP	8b	Nurse, 18 years in GP surgery. Has master's
PC1b	GP		GP, 10 years' experience
PC2a	ECP	7	Paramedic. No master's
PC2b	GP		GP, 30 years' experience in general practice
PC2c	ANP, GP practice	8	Nurse for 36 years, practice nurse for 30 years. No master's degree, but master's level study
PC3a	ECP nurse	7	Nurse, 7 years' experience. Working as ECP for service providing GP cover for home visits. No master's degree, but master's level study
PC3b	GP		GP, doctor for 17 years. 10 years' GP experience
PC4b	GP		GP, 10 years
AT1a	ACP (and ACP manager)	8b	Nurse, 16 years' experience in A&E, GP and acute medicine (AM). On doctors' rota. Has master's
AT1b	Medical consultant acute care		Acute care consultant
AT2a	ACP physiotherapist	7	Physiotherapist, 19 years' experience. Specialist respiratory lead for 15 years. Has master's
AT2b	Physio manager		Manager for therapy services. Physiotherapist by background, 30 years' experience
AT3a	ACP older people	8a	Nurse, 8 years' experience. Has master's
AT3b	OPM Consultant		Doctor, trust lead for frailty. Had consultant post for >10 years
AT4a	ACP radiographer	8b	Therapeutic radiographer for 15 years. Has master's
AT4b	Radiotherapy lead/HOD		Therapeutic radiographer, 14 years' experience
AT5a	ANNP	8a	Nurse, paediatrics for 16 years, neonates for 10 years. ANNP, 5 years. Has master's
AT5b	NNU manager		Nurse and midwife, manages NNU, line manages ANNPs
S01	Medical consultant A&E		Medical consultant, A&E
S02	Chief nurse		Nurse, >5 years as chief nurse, various trusts. Consultant nurse before this
S03	Medical director		Consultant radiologist by background
S04	Divisional director clinical support services		OT background, clinical director support services

ACP=advanced clinical practitioner; ANNP=advanced neonatal nurse practitioner; AT=acute trust; A&E=accident and emergency; ECP=emergency care practitioner; HOD=head of department; NNU=neonatal unit; OT=occupational therapist; PC=primary care; SO=strategic oversight

Table 2. Themes and subthemes	
Themes	Subthemes
Role purpose	How it is being used
	What the role should be
	Title of role
	Origin or development of role
	Generalist vs specialist
	Transferability of skills
Role impact and evaluation	On ACP in terms of development
	Report of patient perspective
	Medical opinion on role
	Colleague opinion on role
	No hard data
Role barriers and facilitators	Pay
	Line management complexity
	IT systems
	Dual role: management and clinical
	Lack of understanding of role
	Time for education and research
	Referral barriers
	Death certificates/sick certificates
	Supportive colleagues
	Good practice examples
Role regulation	Professional regulation
	Accreditation frameworks
	Governance and line management
	Indemnity and insurance
	Clinical supervision

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 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 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 observations that ACPs were complementing, not substituting medical roles. Although 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 years of clinical experience in root professions brought unique skill sets, 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 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 (ie 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 the 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 specialties, 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 for the 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 important for 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 carrying out their role, for example difficulty ordering tests, making referrals, prescribing and accessing 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 was the issuance of death certificates and Med3 (fitness to work) forms, 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 (ie 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 blurred boundaries with the time spent undertaking management tasks, at the expense of building on 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 personal development plans, the line management, the staff management, health and wellbeing.'**

*AT4a*

### Line management and appraisal

As a consequence of not being funded from medical budgets, no ACPs in acute care were line managed by the medical team. Although this was seen as beneficial in terms of line managers' understanding of professional governing body requirements, (eg 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



## KEY POINTS

- Advance clinical practice 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

job descriptions, levels of practice and expectations, to ensure public safety.

Ideas for addressing this included a central register of ACPs held by an umbrella organisation (eg Advanced Practice Academy) or, alternatively, professional governing bodies, such as the Nursing and Midwifery Council (NMC), and 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. Most started their career as a practice nurse, undergoing further training and developing skills, to eventually become independent practitioners. This caused marked variation in scope of practice, which was often bespoke to an individual medical practice. A consequence of this was reduced transferability of the ACP into other employment settings. However, many of the participants in acute settings

had core elements of transferability between specialities that 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, although 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 (McKeag and Fenton, 2017; Williams, 2017; Pearce and Breen, 2018; Halliday et al, 2018). Our participants also emphasised the increased job satisfaction and career development that being an ACP provided, and suggested that this increased workforce retention.

Although all ACPs were introduced to fill medical shortfalls in line with the literature, the study found that what ACPs provided went beyond replacing medical colleagues. Instead, they brought experience 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’.

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

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

Few ACPs were able to address the research activity requirement of the four pillars of advanced practice (NHS England, 2017), 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 the right to refer and appropriate access to medical ‘systems’ had to be overcome to allow ACPs to widen their roles and practices. The essential facilitators for the success of roles in both primary and acute settings, were the support of medical colleagues and management and networking opportunities with other ACPs.

## CPD reflective questions

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

## Limitations

This study was a snapshot 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 the medical workforce; however, ACPs agreed that their role went beyond simply undertaking expanded tasks, and was based on enhanced, holistic and autonomous clinical decision-making. Both ACPs and managers reported that ACPs improved the quality and timeliness of service provision and they were well accepted by patients.

For experienced staff, becoming an ACP provided career development and the role added to job satisfaction. Difficulty accessing continuing education and research because of service demands and lack of funding was reported. Many ACPs were, however, able to undertake teaching roles. Lack of clarity over pay-scales, and the source of funding for ACP roles, caused difficulty, especially in the acute care sector. **BJN**

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# Fundamental Aspects of Infection Prevention and Control

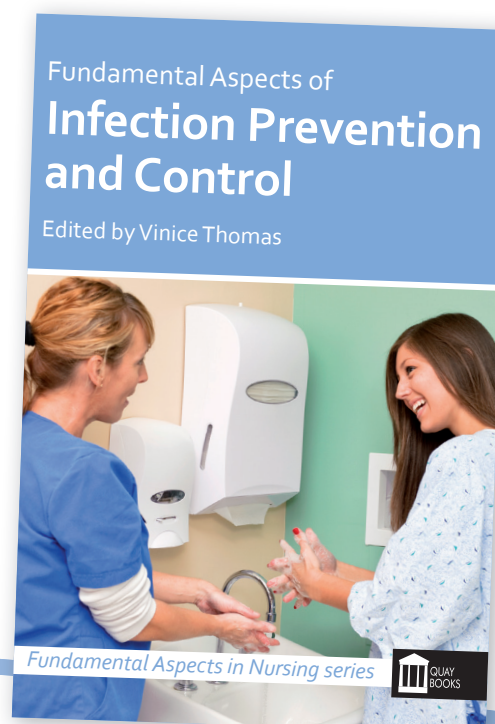
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