

Qualitative study of perceptions of senior health service staff as to factors influencing the development of Advanced Clinical Practice roles in mental health services.

Abstract

Introduction

Advanced Clinical Practice (ACP) roles are increasingly being developed internationally. Identifying factors perceived as affecting the development of ACP can support effective implementation.

Aim

To understand the views of senior health service staff as to factors influencing the development of ACP roles in mental health services.

Method

Focus group and semi structured interviews. Participants were directors of nursing (n = 10) and other senior staff from roles important to workforce development (n =10).

Results

Content analysis suggested 7 categories: understanding the role and national guidelines, attitudes to the role, learning from implementing other roles, understanding pre-requisites for development, challenges, opportunities, and future support/actions.. Prerequisites for success would include early engagement with stakeholders. Medical attitudes towards ACP roles were perceived as generally more positive than previously.

Discussion

The study provides unique information regarding perspectives of senior staff regarding the implementation of ACP roles in mental health services. A wide range of mental health services were perceived as potentially benefiting from ACPs, with the importance of role clarity being highlighted and long-term developmental pathways for staff.

Implications for practice

Successful Implementation of ACP roles may require clear role definition, early engagement with stakeholders and processes to evaluate role outcomes.

Accessible summary

What is known on the subject?

- Advanced Clinical Practitioners (ACPs) are, typically, non-medical healthcare professionals, who possess advanced clinical skills, a master's level qualification and evidence of leadership, management and research abilities.
- Most ACPs are nurses and new ACP roles are increasingly being established around the world.
- The views of senior staff towards new mental health nursing roles in organisations is likely to influence their introduction and sustainability
- Research on mental health nursing ACP roles is sparse.

What the paper adds to existing knowledge

- The paper uniquely provides specific information as to factors perceived by senior staff as affecting the implementation of ACP roles in mental health services.
- A wide range of mental health services were perceived as potentially benefiting from ACPs
- Establishing role clarity for MHN ACPs is perceived as being as essential to successful introduction of the role, as has been found for other specialities

What are the implications for practice?

- Participants identified a need for early engagement with service users and professions about new ACP roles and for processes that can evaluate ACP roles once they established.
- Some mental health nurses may require long-term developmental pathways to help prepare them to take on a master's level course and then the ACP role.

Relevance statement

Advanced Clinical Practice (ACP) roles are increasingly being developed worldwide, based on post graduate level training, advanced clinical skills and, typically, a role in managing complex care. Nurses predominate in these roles. Mental health services have opportunity to introduce new skills and create new career pathways through the successful introduction of ACPs. New nursing roles in mental health services have previously experienced challenges and been implemented unevenly. This paper explores views of senior health staff, influential and/or experienced in the introduction of new roles, as to factors that may hinder or facilitate this process within mental health services.

Qualitative study of perceptions of senior health service staff as to factors influencing the development of Advanced Clinical Practice roles in mental health services.

Introduction

Advanced Clinical Practice (ACP) roles are increasing internationally (Pulcini et al 2010; Lowe et al 2012). 70 countries are reported as either have advanced practice nursing roles or are aiming to do so (ICN 2019).

The potential benefits of ACP roles for nurses (and other health professions) have been widely debated and the creation of such roles proposed as a solution to many healthcare challenges, particularly in primary care, health education and health promotion ((Bryant-Lukosius et al. 2004; Lowe et al 2012; Iglehart 2013). Systematic reviews of advanced practitioner treatment compared to medical treatment across a range of specialities have identified equivocal or improved clinical outcomes and patient satisfaction (Newhouse et al 2011; Donald et al 2013; Morilla-Herrera 2016), although confusion is common as to the terminology used to describe these advanced practice roles (Lowe et al 2012; Jokiniemi et al 2012).

Internationally, a systematic review of psychiatric advanced nursing practitioners identified 14 heterogeneous studies of psychiatric advanced nursing practitioners and concluded that such roles could achieve significant results in managing patients with depression and psychological stress, and in improving inpatient services (Fung et al 2014)

Until recently the ACP role in England has lacked consistency in scope of practice, training, and regulation (King et al 2017). However, in 2017 guidance was issued describing required competencies and training for England's National Health Service (NHS) (Health Education England 2017). ACP is defined as '...a level of practice characterised by a high degree of autonomy and complex decision making.' Stated prerequisites for the role are a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education, and research, as well as demonstration of core and area specific clinical competencies (HEE 2017).

No research has been identified specifically related to this model of ACP carried out by mental health nurses, although there are descriptive studies regarding mental health nurse consultant roles, which share many role characteristics with ACPs (Brimblecombe et al 2019)

Aim

To understand the perceptions of senior clinical staff as to factors that may influence the development of effective ACP roles in mental health services.

The study area was an urban region with a population of 8.3 million; mental health services being provided by 10 NHS Trusts (service provider organisations).

Method

The approach was a qualitative methods service evaluation. Participants were sought from roles that were potentially influential as to decision making regarding implementing new workforce roles.

- i) A focus group with executive directors of nursing from mental health trusts to identify key issues for ACP development. Director of nursing are the board level leads for nursing workforce developments. A semi-structured interview schedule provided a loose framework with which to facilitate discussion (Appendix A). Issues not included in the interview schedule were discussed if participants felt they were relevant. The interview schedule was devised by the first author based on international literature concerning the development of ACP type roles.
- ii) Semi-structured individual interviews conducted face-to-face or by phone, with senior staff from two NHS trusts providing mental health services, whose position could be influential in the introduction of ACP roles. Participants were to include non-nursing professional leads and roles that led on aspects of workforce planning and development. The two trusts were identified through convenience sampling, utilising existing professional links. Suitable potential participants from each trust were identified by the trust's director of nursing in discussion with author one and were purposively chosen to ensure views from a range of roles and professions.
- iii) Additional semi-structured interviews were conducted with two other purposively selected individuals engaged in aspects of ACP development, a nursing professional organisational mental health lead and a higher education institution mental health ACP course lead.

Potential participants were contacted by email, explaining the purpose of the study and that participation was voluntary. Consent was received by invited individuals responding by email agreeing to participate. Further verbal explanation was made prior to interviews commencing.

The study took place between July and October 2019. This study was carried out as a service evaluation commissioned by Health Education England, seeking to generate information to improve specific regional services. NHS ethics clearance was therefore not required (Health Research Authority 2017). Data was anonymised.

Key issues arising in the nurse director focus group were recorded in contemporaneous handwritten notes made by Author 1. A written summary of key points was subsequently distributed to participants with a request for any corrections or amendments.

Semi-structured interviews were electronically recorded where feasible, otherwise contemporaneous handwritten notes were made. The author verbally summarised what had been said at points throughout the interviews, thus allowing participants to correct specific misunderstandings.

Author one, a mental health nurse, with experience of introducing new roles for mental health nurses, carried out the interviews and led the focus group.

Analysis

Qualitative data from the focus group and interviews were subject to content analysis, which is suitable for the simple reporting of common issues mentioned in data (Green & Thorogood 2004). This process classifies textual material, reducing it to more relevant, manageable bits of data and may include categories that are not mutually exclusive (Weber 1990).

Author one read and reread interview transcripts and notes to become familiarised with the data before open coding potential categories, i.e., groups of content that share a commonality (Krippendorff, 1980). Categories focused on issues noted as important by several or all participants, or where there were differences of opinion about a single issue. The initial open categories were reviewed again in relation to the entire data and to ensure that they were derived directly from the comments made by participants. Author two then reviewed the content analysis and interview transcripts separately and discussed any differences of view with author one, whereby the final coding was agreed.

Results

All requests for individuals to participate were consented to. Twenty individuals participated - 8 in the Focus Group, the remainder in individual interviews, or, in one case, a paired interview. The director of nursing focus group and 6 individual interviews were carried out face-to-face, the remainder by phone.

Participants comprised:

- 10 directors of nursing

- 3 senior staff development roles
- 2 senior medical leaders
- Senior operational manager
- Director of human resources
- Allied health professions lead
- University ACP course lead
- Professional organisation mental health lead

Participants were randomly allocated a participant number, to anonymously attribute quotes.

Seven categories highlighted as important to the development of ACP roles were identified through the process of content analysis. The categories identified were not discrete, in that some data could be in more than one category.

1. Understanding of the role and framework

Most of the senior staff from trusts were not familiar with national guidance regarding ACPs, only two showing anything more than very vague knowledge. There was a general acknowledgement from participants that *'there is some confusion'* (P11) as to the exact requirements for the role. Where there was an absence of detailed understanding of ACP roles, participants thought of what seemed to them to be similar roles, as in *'I'm very familiar with the nurse consultant role, but in terms of the ACP role, not as familiar really.'* (P19)

ACPs were seen as having a *'quite broad scope of clinical role'* (P19) and would have *'..gone beyond the general nursing qualifications and are engaged in either prescribing or other similar level activity'* (P5). Most participants recognised that post graduate education would be a requirement. Individual characteristics were also suggested as requirements – *'.. being able to respond and also having a sort of clinical gravitas'* (P4) and that *'resilience is important'* (P7). It was important that it is *'... verifiable that the competencies are there, and they are clearly defined and clearly mapped against interventions.'* (P5)

Nurses, psychologists and Allied Health Professional (AHPs) were cited as potential candidates for AC roles, although some participants expressed surprise as to the range of professionals who could, theoretically, become ACPs; *'I hadn't realised it applies to any professional'* (P5). There were advantages identified from this, as *'not only would they have their newly acquired skill set as an ACP, but also all the skills that they bring with them by*

virtue of their professional background and that would bring with it a wealth of different experience.'(P18)

2. Attitudes towards the role

Attitudes towards ACPs and related roles were discussed at length in both the focus group and individual interviews. Most participants agreed that attitudes were changing overall, in that high-level clinical roles for non-medical professions were more accepted. Attitudes were characterised as broadly very positive, *'London wants it'* (P10) or, more cautiously *'... it's no longer an alien concept'* (P8). Professional boundaries were less rigid than in the past – *'we are far less defined around professions now'* (P5). However, enthusiasm for the role was perceived as not always being matched by consideration of practicalities - *'services are keen with new roles, but do not always understand the implications'* (P15). There was a context of various new roles having been introduced recently, with consequent pressures on trusts – *'we are always on shifting sands, with roles changing and new titles coming in'* (P15).

The attitudes of medical staff were deemed particularly important, in that a lack of their support could potentially damage the introduction of ACPs (see Themes 3 and 5, below). Most participants took the view that medical staff were *'generally more welcoming'* (P15) of new roles than in the past, possibly because of the shifting workforce picture, with shortages in many areas and specialities - *'Workforce issues have changed'* (P1). Individual examples were given of planned ACP type roles being warmly supported by senior medical staff, such as *'...it's been absolutely great, yes, which really surprised me! So yes, very positive'* (P19). Alternatively, a view was expressed that *'.... some [doctors] are on their high horses, but some aren't...'* (P4).

Participants also commented on attitudes of the public towards others carrying out work previously only done by doctors, as in *'I suppose the public also makes it more difficult sometimes, because there is this sense that "oh I want to see The Doctor because....."'*(P4). However, this issue should and could be tackled by providing information – *'..if I'm a patient and I'm receiving an intervention, I want to know the person who's carrying it out is competent and properly trained to do the job'* (P5).

Concern was expressed that some professionals, otherwise interested in ACP roles, could be put off by the generic title 'Advanced Clinical Practitioner' or if they felt that it was *'all about breeding generic practice'* (P18), especially if they believed that *'I'm a nurse first'* (P2).

Conversely, there was a view that many clinicians would welcome opportunities to become an ACP, that a lack of senior clinical roles is *'something people often bemoan, in terms of career*

development' (P18) and they '*...want promotion, but don't like the drudgery of management and love clinical work'* (P2).

3. Learning from current ACP and other new roles

With the current absence of formally defined ACP roles, previous experience of introducing other roles or skills sets, that shared common features with ACP practice, were discussed. A nurse was described who was '*...an incredible resource to us and left us ... with the state of physical health care in our service being of a higher quality than had been previously.'* (P5)

A participant had previously worked with an ACP type role, developed to provide an alternative to replace junior doctor out-of-hours cover in inpatient services (P10). This had been a financially driven development, but had not be sustained, partially because of the relatively high cost of employing the ACPs.

The directors of nursing reflected on working with non-medical consultant roles, such as nurse consultants, and considered them to be most successful when they had a very clear focus. Some had tended '*to drift into roles that maybe don't fully reflect the clinical aspects of being an ACP'* (P15). It was suggested that nurse consultant role implementation was particularly unsuccessful where '*..it was not a strategic development'* (P17), i.e. not supported in organisational plans.

Implementing non-medical prescribing as an advanced practice skill also suggested the need for organisation level planning, '*..we've trained people in the past and then haven't actually used those skills. It's been pointless.....'* (P19). The recent introduction of nursing associates to services (NMC 2018) had showed the importance of good communication as to the purpose of a new role - '*Not just around informing staff about the changes and the new roles, but also our patient groups. Are they understanding the difference?'* (P11).

4. Pre-requisites for development

Participants identified several conditions that needed to be in place to allow for successful implementation of new ACP roles. Trusts must know '*what is needed'* (P9), to have spent time '*.... just identifying the need to begin with identifying the problem'* (P5). Early communication was vital within organisations, all directors of nursing agreed that implementation must be framed in a positive way, '*we have got to get the messaging right'* (P1). It was important to avoid negative framing, '*we aren't training you to fill gaps in other professions, this is a unique professional role'* (P7) and that '*this brings a real opportunity to properly improve and provide the best possible care.'*(P9)

There had to be enough staff suitable to become ACPs. All participants believed that there were some current staff who could progress into ACP training and take on the role quickly.

I could identify people right now who are in relatively junior positions, who I would say “that person would be great in one of those roles.” Give them the right training and whatever and experience. (P4)

However, a common caveat was the numbers of such individuals was not high; *‘[We are] not tripping over nurses ready to train to be an ACP’ (P15)* (see Theme 5 below). Plans to support staff through ACP training were also required, as potential ACPs *‘need to have a massive amount of support from their organisation’ (P7)*.

5. Challenges

As above, most participants stated that a lack of clear plans for the creation and use of ACP roles was problematic. Training of ACPs had sometime begun in a haphazard manner - *‘... 3 people currently in training, but what are we doing with them? No planning!’ (P8)*. Furthermore, having suitable candidates to become ACPs was limited by *‘a large gap in clinical and educational preparation to enable nurses to be ready to complete a master’s ACP course’ (P13)*.

Identifying funding for ACP posts was also challenging in that other clinical posts might have to be lost to free up required finances (P1). Access to suitable mentorship and supervision for ACPs could be difficult (P11), but this issue was seen as resolvable (P8). Use of peer group supervision was as one answer to this challenge (P20). Medical staff would play a role, although caution was expressed due to past experiences of there being *‘...issues re: medical sign up’ (P10)*.

The nature of the ACP training was cited as potentially challenging in that academic requirements may be too high for some practitioners with no recent academic experience (P7) and that the course might be too focused on physical health care, rather than on mental health (P18), often lacking specific psychological treatment skills training (P20).

6. Opportunities for the role

Participants perceived many opportunities for the creation of effective ACP roles, for both nurses and AHPs. A recent increase in the number of pharmacists attending the ACP course was also noted (P7).

Suggestions as to particularly useful areas of practice for ACPs included crisis/home treatment (P19), substance misuse (P5), Asperger’s Syndrome (P20) and community older people’s (P11) services and working as Approved/Responsible Clinicians under the Mental Health Act (P8). A participant described how ACP roles could save time for service users/patients, as

they would not need to be *'seeing a junior doctor, consultant and a care coordinator for a review and having as many as three appointments'* (P9).

Suggestions were made that some geographical areas or sub-specialities may have a greater need for ACP roles, (P1; P10). In one trust, the acute mental health pathway was noted as being somewhere where:

... we struggle with recruitment and medical practitioners So that would be good, to strengthen the clinical leadership there (P19)

Shortages of medical staff were cited as providing opportunities (P12) : *'... medics are leaving to retirement – it provides gaps to fill ...'* (P2), however, there was some caution around how this issue should be framed and communicated (as in Theme 4 above).

It was suggested that the development of ACP roles could be useful in providing a more appealing career structure (P10), as in theme 2 above,

7. Future support and actions

In the context of little pre-existing knowledge regarding the current national guidance regarding ACP roles amongst the staff interviewed, it was viewed as important that there was more active communication with trusts in the future regarding this guidance, *'repetitive communications'* (P2) on this issue were essential.

Several participants considered that the most important change needed was a change of attitude to workforce design in their trusts, where they should be *'.. challenging ourselves to think completely differently. "Why do we need that? What can we do differently?"'* (P19) and *'I really think with blue sky thinking we could turn it on its head'* (P11)

Both the director of nursing group and several other interviewees discussed the balance to be maintained in workforce planning between local ownership (geographically or by speciality/service line) and the advantages of adopting a whole trust approach. There was a tendency in some trusts for service areas to *'go off in tangents'* and *"we do different things in different service lines' ... rather than thinking programmatically'* (P15), making overall management of workforce development challenging. It was suggested that there should be a process of local identification of a problem and then having a trust structure and framework within which to address the problem (P5). Another expressed the view that *'I think there needs to be both.... have a trust wide approach to things but being able to innovate within the service line'* (P19). There was general agreement that to get workforce planning to the right place *'will need some infrastructure'* (P20), which was lacking currently.

The need to develop staff in a planned, long term fashion was recognized by most participants, *'..to develop staff towards being at a point where they can access and successfully complete the course.'*(P7). For some promising individuals, it could be better to take an iterative approach to development, for example, by gradually expanding the scope of their role, with relevant training attached, as *'you can overwhelm people by putting them into a completely new space'* (P20). It was suggested that different professions might have different needs, for example *'..to have something bespoke for mental health AHPs, who might be aspiring to an ACP route, but would need something in between'* (P18).

Comments were made that trusts could use role models to encourage ACP development, in addition to supporting long term development opportunities - *'We need to progress specific postsit's more tangible'*(P16). Opportunities should be used to share good practice and case studies, *'a lot of people will see things and say, 'why aren't we doing that?''*(P2). Such discussions could happen between trusts, as well as internally – *'discussing challenges and possible solutions would be good'* (P2)

The idea of having evaluation built into the process of creating new ACP roles was widely supported, *'... it would be understanding exactly what would we be expecting to see from these individuals and having some form of framework to actively evaluate this'*(P9). This should include *'focus groups and work with patients and staff about how they feel that role is working'* (P11). Quantitative measures could include waiting times, length of stay and incidents relating to physical health (P18), with a caveat that if there are very small numbers of ACPs, using such measures might be unrealistic.

Discussion

This study provides unique information as to how issues concerning ACP development are perceived by a sample of senior staff within one major speciality area, mental health. General enthusiasm for the potential of ACPs to improve services was expressed, although in the context of low levels of understanding regarding the national guidance for ACPs. Priority actions to support new ACP roles included ensuring appropriate educational and experiential pathways are available to develop staff for the roles and to ensure that the function and aim of ACP roles was clearly defined and well understood by both staff and service users. These findings, although not designed to be generalisable, do echo many of those from international literature and provide information that may usefully inform discussions about developing ACP roles, both generally and, specifically, in mental health settings.

The interviewer (author 1) was from a mental health nursing background, including senior management and professional leadership roles. This was known to the participants, which

could potentially have enhanced their willingness to openly discuss issues with someone with similar experiences or, alternatively, have constrained them if they considered that their views might be judged. Author one attempted to avoid the latter by emphasising the wish to hear all perspectives when introducing the focus group and at the beginning of each interview.

The need for reflexivity in terms of personal interpretation of data was addressed by checking assumed meaning of participant comments with participants, either during interviews and additionally, with the Focus Group, sharing a written summary of key points with participants for any correction. Author 2 provided an independent view of the content analysis, to decrease the impact of unconscious personal bias, whilst acknowledging that this would also be a subjective view.

Although participants came from 9 of the 10 mental health providing trusts within the region there was little knowledge of national guidance regarding ACP roles (HEE 2017). International studies suggest that a lack of detailed understanding as to requirements for ACPs and a lack of role clarity is often as a major challenge to the development of similar roles (Lowe et al 2012; Jokiniemi et al 2012). A study of mental health nurse consultants, who share many characteristics with ACPs, also identified similar issues (Brimblecombe et al 2019).

Typically, participants shared a common understanding of prerequisites for successfully introducing ACPs, e.g., active board level support, clear information as to the nature and requirements of the role, engagement with staff to produce a shared vision, careful assessment of need and finding good candidates for such roles, although many of these features were not yet in place in trusts.

Challenges to introducing effective ACP roles were identified from previous and current experiences. These were largely practical issues related to workforce planning and workforce development processes, resource issues and concerns about dealing with sensitive staff issues such as grading. The number of processes to manage does suggest a significant demand on trust time is required, including workforce planning, human resources, professional leadership and educational lead time, as well as a high level of commitment to be able to work through such a range of challenges.

Many participants commented that the attitudes of stakeholders towards ACP can influence the creation and sustainability of the role. Much of discussion focused on medical attitudes. There has been a history of medical objections to new roles for other professions, for example non-medical prescribing (British Medical Journal 2005) and non-medical responsible clinician roles under mental health law (Oates et al 2018). However, most participants noted a warmer

attitude toward new advanced non-medical roles than in the past. Even when there were negative attitudes, these were perceived as coming from a minority of medical staff. As elsewhere, such as in the United States (Drew et al 2009), shortages of medical staff were noted as providing some opportunity for ACP roles to be created.

The issue of the generic title of ACP, proved to be a complex one, with there being support for the idea that old role barriers should break down, but some participants were uncomfortable at any loss of professional identity or they were worried that potential ACPs may have such a concern.

In the absence of having little experience of working with established ACPs, participants were able to reflect on other relatively new roles in mental health services and suggest possible learning for ACP introduction from them. In this context the importance of clear role definition was again emphasised, as well as the perils inherent in not having organisational wide plans for implementing a new role.

The most striking characteristic of suggestions as to which clinical areas would benefit most from, or be most suitable for, ACP roles was the diffuse nature of answers received. Very few clinical areas were cited more than once. This may be an artefact of no detailed work yet having taken place in trusts on this issue yet, or that the ACP role is not understood clearly enough to make judgements accurately, or that the role offers such wide possibilities that it is understandable that such diffuse examples are given. Opportunities to develop higher level clinical roles in a broad range of professions, reflect legal changes opening up other opportunities such as non-medical prescribing, for example for pharmacists (Waddell et al 2016), as well as for nurses.

It is notable that patterns of deployment in mental health services of other relatively new roles, such as nurse consultants and nonmedical prescribers, and of advanced nurse practitioners in the United States, show marked variation in numbers between geographical area or between organisations (Drew et al 2017; Brimblecombe et al 2019; Dobel-Ober and Brimblecombe 2016). It is too early to understand whether this will be the case in English mental health services with ACPs, although wide variation may be more likely in the context of limited robust, speciality specific evidence regarding clinical and cost effectiveness. There is, also, as yet a dearth of evidence as to attitudes towards ACP roles within different clinical specialities from patients/service users and front-line clinical staff. The attitudes of service users/patients were speculated upon by participants but there was little concern that this would be a barrier, with various previous medical activities already being provided by nurses and other disciplines.

Limitations

The focus of the study was on the views of senior staff, and those of actual ACPs and service users was not included. These are important, but yet to be explored.

The limited number of participants in a qualitative study, such as this, will not generate widely generalizable data, although comparing local findings with international data provides an opportunity to identify common issues or exceptions. Amongst the participants there was a range of senior trust roles and the influential role of director of nursing was well represented, however, the professional background of participants was skewed towards nursing. The perceptions of participants were perceptions only and thus based on their experience and understandings, rather than any objective measures.

Ideally, all interviews would have been face-to-face and recorded fully and transcribed. However, time schedules, and availability and preferences of participants meant that this was not possible in many cases.

Implications for practice

The issues identified by participants in this study echoed many of those from recent research undertaken in the UK and internationally and indicate that mental health services may experience some of the same challenges in introducing ACP roles as have other services, especially those arising from lack of role clarity. This study specifically describes actions that are perceived as supporting the successful introduction of ACP roles in mental health services, including active engagement of both clinical professions and service user/patient representatives regarding new roles to increase understanding and acceptance of the role, ensuring that the rationale for ACP roles is clearly explained and the role tightly defined. Developing standardised approaches to evaluate the effectiveness of ACP posts in different settings and employment contexts will demonstrate commitment to evidence based workforce redesign and allow for modification of roles based on measured outcomes.

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