Assessing the benefits of advanced clinical practice for key stakeholders

Vikki-Jo Scott

ABSTRACT

Background: Advanced clinical practice (ACP) roles, usually filled by nurses, have had positive effects on clinical effectiveness, including in patient satisfaction, but their benefits for other stakeholders (such as employers, health professionals, education providers and commissioners and professional/regulatory bodies) are less clear. Aim: This study aimed to identify UK research on the potential benefits of ACP and evaluate the evidence base for key stakeholders in this field. Method: A mixed-methods systematic literature review was carried out to inform a narrative interpretive synthesis. Findings: 44 papers of mixed quality were identified. Consensus was found regarding the definition of and barriers and facilitators to ACP. This role is split into substitution (e.g. of doctors) and supplementation (e.g. adding value) aspects, and the clinical practice element dominates. Training for the role varies, as do scope of practice and regulation. Conclusion: There are several barriers to the implementation of ACP and therefore the realisation of its benefits for key stakeholders. Areas requiring attention include training, support from others for role expansion and organisational issues.

Key words: Advanced clinical practice ■ Benefits ■ Literature review ■ Nurses

A number of professional bodies collaborated with Health Education England (HEE, 2017) seven years ago to create the *Multi-Professional Framework for Advanced Clinical Practice in England*. Drawing on research and related policy documents and collaboration with key stakeholders,this paper sets out the definition of advanced clinical practice (ACP), the scope of practice and practitioners this applies to and the standards and capabilities that are expected of health professionals in these roles. The introduction of this framework, along with additional funding released specifically for the support of ACP training, the development of the NHS People Plan and the approval of an apprenticeship route, have led to increased activity around ACP.

In 2020, a study by Lawler et al exposed the workforce experience of ACP since the introduction of the multiprofessional framework. The COVID-19 pandemic and recent industrial action have also sharply bought into focus the demands upon health services and those who work within them, including advanced clinical practitioners, the largest number of whom are nurses, who have often had to step up, be redeployed or work in different ways from before (HEE, 2020). This provides the context in which ACP has become an increasingly hot topic in healthcare career development and, potentially, a hot potato when it comes to decisions on regulation as well as access to and provision of ACP education, support, and development.

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As a result, the author undertook a systematic literature review to explore the evidence base for claims made regarding the beneficial impact of ACP for key stakeholders in this field and to discover where there are gaps in evidence for future research. The findings from this literature review influenced the author's subsequent research for her PhD and illuminate key topics for nurses to consider when working within the field of advanced practice.

The purpose of this review was not to assess the evidence base for clinical effectiveness of ACP or benefit to the patient.

Previous studies consistently note a positive impact of ACP on clinical effectiveness, including in patient satisfaction. (For example, see the SCAPE study conducted by Begley et al (2013), which was endorsed by the Nuffield Trust's independent review on advanced practice for the Nursing and Midwifery Council (NMC) (Palmer et al, 2023)). However, the potential benefits or positive impact of ACP for key stakeholders other than patients is less clear (i.e. employers, health professionals, education providers and commissioners and professional/regulatory bodies). This study therefore focused on identifying evidence of benefits of ACP for these key stakeholders.

Methodology

The discussion below is based upon the findings of a mixed-methods systematic literature review (*Table 1*), using the STARLITE (sampling strategy, type of study, approaches, range of years, limits, inclusion and exclusions, terms used, electronic sources) approach (Booth, 2006). Critical interpretive synthesis (Dixon-Woods et al, 2006) has been employed to draw narrative conclusions from appraisal of the evidence, synthesis of the data and interpretation of the key findings of the literature. The key findings and limitations were summarised from those identified by the author/s of each study. Recurrent themes were identified by re-reading the abstract, summary, findings, discussion and conclusion sections of each paper.

Results

The literature search identified 44 papers that fulfilled the criteria (*Figure 1*). The largest proportion of those excluded were omitted because they were not primary research or literature reviews (*n*=414). This highlights that a large amount of opinion, discussion or editorial-based discourse on ACP exists, and that practice, policy and theoretical literature dominate above primary research. The large number of papers that were excluded because they did not meet the ACP criteria confirms the much-cited issue that ACP definitions, scope and job titles used are multiple, variable and may be confusing (Leary et al, 2017).

The quality of the research published varied; strengths and weaknesses were found across the full the range of methodologies employed. The rationale behind the methodological choices made and how this addressed the stated aim was not always explored. Often this was discussed in an implicit rather than explicit way without the use of a protocol or a clear plan of how the research would be conducted.

In the primary research identified, small sample size or a sample that captures only one particular element of the broader ACP community is common. Critical evaluation of the literature identified in this review suggests a cautious approach should be taken when selecting and relying upon existing research to establish the benefits of ACP.

Generalisation, replication or an attempt to apply findings to other subsections of the diverse ACP community from previous research should be done only through reference to studies that have specified a relevant aim and methodology and provide clear reporting of a research protocol.

The lack of longitudinal research found in this literature review, particularly since key developments in ACP have occurred, exposes opportunities for future research.

Key themes

Thirty out of the 44 papers included findings related to the definition of ACP, and the scope of the ACP role or practice. These papers noted the variability of ACP including a proliferation of nomenclature and titles used to describe ACP. There was agreement on the definition, conceptual models and features of ACP. These commonly reflect the four pillars, (research, education, leadership and management, and clinical practice), knowledge, skills and attributes (capabilities including education and experience) and context (workforce and

Table 1. Literature review according to STARLITE

Sampling strategy	Mixed-method systematic literature review	
Type of study	Primary research and literature review (not practice, policy or theoretical literature)	
Approaches to searching	Electronic database search and snowballing (reference lists from papers retrieved were checked for additional relevant research)	
Time span	No publication date limit was set. The search took place between 26 February 2020 and 18 May 2020	
Limits	UK healthcare systems only as structure, training and regulation vary considerably between countries	
Inclusion/exclusion criteria	Inclusion: UK primary research and literature reviews; ACP Exclusion: duplicates; not UK based; practice, policy or theoretical literature; not ACP; focused on clinical effectiveness, practice patterns or patient outcomes	■ International studies that included data from the UK or provided comparisons between the UK and other countries were included. ■ ACP was as defined by the *Multi-Professional Framework for Advanced Clinical Practice in England* (Health Education England, 2017), i.e. not preregistration, clinical specialties/specialist practice, professional development or stages of career, e.g. student nurses, allied health professionals, nurse consultants, clinical educators, practice nurses or non-medical prescribers ■ Where reference to ACP clinicians was made in addition to other healthcare workers, these papers were included
Terms used	■ advanc* ■ clinical and nurs* ■ practi*	■ Phrase searching to ensure articles where single words such as advanced, clinical or practice are used as part of a phrase were included (so, for example, advanced directives or clinical effectiveness would not be captured where they did not relate to the topic of this review) ■ OR used to broaden the search to capture as far as possible all relevant research ■ AND used to narrow the search to the two main concepts: ACP; and benefits
Databases	This review took place during national lockdown during the COVID-19 pandemic, when only electronic sources of information were available. These were: EBSCOHost research databases; the Cochrane Library; National Institute of Health and Care Excellence evidence search; TRIP; Science Direct (Elsevier Science); and SAGE journals	
ACP: advanced clinical practice		
Source: Booth (2006)		

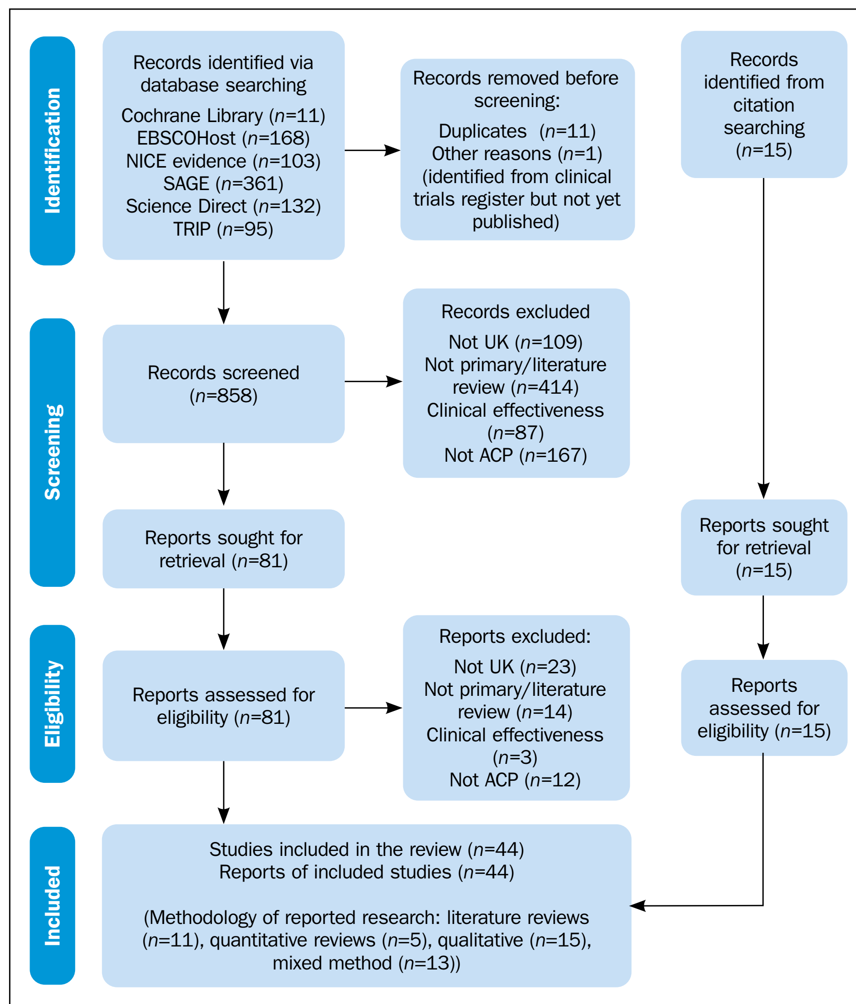

Figure 1. PRISMA flow diagram (adapted from Moher et al (2009))
ACP: advanced clinical practice; NICE: National Institute for Health and Care Excellence

governance and accountability) as set out in the *Multi-Professional Framework for Advanced Clinical Practice* in England (HEE, 2017). This was found in different professional, clinical speciality, health service and geographical contexts, although research that focused on or included professions other than nursing was rare.

Despite the time that has elapsed since many of these papers were published, current regulation, accreditation and professional recognition practices reflect the broader findings of many studies. For example, there has not been standardisation or consistency in the UK or, indeed, internationally of ACP (Delamaire and Lafortune, 2010; Pulcini et al, 2010; Carney, 2016; Cooper et al, 2019). This has led to 'localisation' of ACP, which then impacts on the 'professional jurisdiction' and scope of practice and therefore the benefits of ACP (de Bont et al, 2016).

Pulcini et al's (2010) international study noted that 90% of countries delivered ACP programmes at master's level and, in 50% of them, it was the most prevalent credential required to practice as an ACP clinician. There is recognition that in the UK a number of ACP training, education or development routes exist (Barea, 2020). ACP clinicians have taken a variety of education pathways to their current roles, including formal and informal training as well as undergraduate, postgraduate and doctoral study. This creates confusion and lack of a clear career pathway for ACPs and their employers (Jones, 2005; Miller et al, 2009; Thompson et al, 2019), with the risk that it is seen as a 'career cul-de-sac' (Smith and Hall, 2003).

There is a self-reported perception that master's-level study provides personal benefits including opportunities for service improvement (Williamson et al, 2006) and that it enhances confidence, autonomy and external authority (Wilson-Barnett et al, 2000; Shearer and Adams, 2012). Some types of education methods in ACP training programmes have been tested for their effectiveness although evaluation of their long-term outcomes and their application to contemporary ACP contexts is limited.

Some evidence has also been collected on how training or education can influence the ability to provide and support others in giving evidence-based practice (Manley, 1997; Gerrish et al, 2011; McDonnell et al, 2012), critical thinking, decision-making and professional identity (Thompson et al, 2019) and leadership (Elliot et al, 2016).

Papers identified in this literature review commonly discussed barriers or facilitators to enabling the potential benefits of ACP. These can be summarised as:

- Access to training and education: inadequate protected time for education, availability of relevant and financially viable education opportunities and the ad-hoc development of ACP roles leading to various types of training being offered and accessed
- Support from others for role expansion: needing to 'win round' other staff (particularly doctors and managers), to reduce anxiety and conflict regarding role overlap and to gain potent advocacy for the role to operate at its full scope. This leads to a reliance on building personal relationships and localisation of the role, which makes it precarious. The presence of a role model, mentor or support from senior managers combined with opportunities to receive feedback or engage with a peer network were powerful enablers of the role
- Organisational structure, policy and protocols: a lack of resources, authority and position within organisational hierarchical structures to influence strategic decision making. Clear communication, consensus and funding mechanisms are needed to support the development of the role, including use of local protocols that give permissions to practice, even where national, professional or organisational policy exists.

The clinical practice element of the role was consistently found to dominate, which in itself created a barrier to allow the full scope of the role (encompassing education, leadership, and research) to be realised. Jones (2005) suggests this may have a potential negative impact on ACPs in terms of stress and burnout, although direct evaluation or measurement of this was not contained in his or more recent research.

Typically, ACP roles have historically developed to provide either substitution or supplementation (Dowling et al, 2013). Where ACPs substitute for other professions (typically doctors), this has been shown to have a negative impact on the autonomy and realisation of the full scope of the role, although it can

potentially reduce costs of service provision (Thompson et al, 2019). For those who provide supplementary or value-added services, they are more diverse, have more wide-ranging positive impacts (including reducing waiting times or co-ordinating services over a continuum of care), but this may increase costs. (de Bont et al, 2016).

Delamaire and Lafortune (2010) draw attention to hierarchical and non-hierarchical forms of ACP where the degrees to which ACPs are substituting and are supervised by doctors may have an impact on the extent to which they are able to operate as autonomous practitioners, which Mantzoukas and Watkinson (2007) and Hutchinson et al (2014) saw as an overarching attribute of ACP. The extent of autonomy further influences how much they draw, to a lesser or greater extent, upon their own professional (e.g. nursing) background, theoretical frameworks, knowledge and skills rather than purely using the medical model.

Several articles noted that a main impetus for the development of ACP roles has been a shortage of doctors. A significant number of ACP roles, at least in their early stages of implementation, have therefore been aimed at substitution. Marsden et al (2013) and Delamaire and Lafortune's (2010) research appears to demonstrate that, while substitution creates an impetus for creating ACP roles, once in place these practitioners are in a position to develop supplementary services and drive evolution of these roles. Read et al (2001) described this as a type of re-engineering that shifts the focus to patient-centred care, using case management and multidisciplinary approaches.

The data on the full costs and outcome measures of ACPs are sparse, often missing costs of education or collection of longitudinal data on outcome measures. A number of papers highlight that the grading, salary scales and remuneration of ACPs have varied considerably, and this potentially remains true today. This, combined with the variety of education routes (and therefore costs to support development of ACPs), makes drawing any broad conclusions about the cost benefits of ACP in the UK difficult.

Discussion and recommendations

The aim of this study was to identify from existing research the evidence of benefits of ACP for key stakeholders. However, the research consistently confirmed the large amount of variability and diversity within ACP. Several authors identified the diverse nature of ACP, which makes it difficult to offer any definitive benefits of pursuing an ACP career for health professionals, as this career is likely to be significantly influenced by local factors.

Read et al (2001) and McConnell et al (2013) also highlighted that the demands of clinical practice can impact on ACP clinicians' perception of job satisfaction and may create stress and burnout.

Recommendation: role development

Further development and research on advanced practice roles are needed, especially if the ambitions of the NHS Long Term Workforce Plan to expand the number of ACPs are to be realised (NHS England, 2023).

The types, relevance and quality of ACP training and ongoing education have been and continue to be variable, although master's level training has been broadly accepted as the industry standard. ACP has often developed in different or ad-hoc ways, commonly to fill gaps in services, so development trajectories tends to be localised.

Recommendation: training and education

Nurses need to understand localised opportunities and seek out a range of ways to support their development as ACPs to master's level.

Not being allowed time away from clinical activity was seen as a major barrier to ACPs being able to engage in development activities and this continues to dominate above the other three pillars of ACP: leadership and management; education; and research (Lawler et al, 2020). The challenge for employers and education commissioners is therefore to find a way to support the whole costs and needs of ACPs so they can engage effectively in training and education. For employers that want ACPs to add value to managing and delivering a health service (rather than just substitute for staff shortages), this creates a problem. Elliot et al (2016) highlight that, if this to change, ACP staff need a greater presence on committees and at leadership levels, and these need to be facilitated and built in to the role from its inception, along with access to basic resources to bolster the role (e.g. administrative support).

Recommendation: policy development and regulation

Nurses working at advanced practice level need to actively engage with reporting, organisational and policy development structures within their workplace. Consideration needs to be given to how to manage conflicting pressures on advanced clinical practitioners' time (noting these are likely to impact on the ability to dedicate time to development, leadership and management, education and research).

There appears to be agreement that regulation may be a way to reduce variation and confusion over career pathways for advanced clinical practitioners. Heale and Rieck Buckley (2015) posit that in countries where regulation is less developed, the barriers to this are greater; however, the data to corroborate this statement are not published in their study and only data that confirm that variation exists are presented. Conversely, Delamaire and Lafortune (2010) point to the lack of regulation in the UK; in the absence of regulation, ACP roles and scope of practice can be adapted more flexibly at a local level to meet population and service needs. However, again, this was not directly measured in this research.

This literature review highlights that there is insufficient longitudinal evidence that directly assesses whether regulation is a barrier or facilitator specifically of ACP, or what types and degrees of regulation may be more or less effective in realising the benefits of ACP.

The recent review undertaken for the NMC seems to show there is a shift towards a position where introduction of regulation is likely. As endorsed by Palmer et al (2023), further research that focuses particularly on the impact of changes to regulation or standardisation may provide

evidence to support or reject changes to the regulation of ACP within nursing.

Recommendation: role definitions

Nurses should keep abreast of any potential changes to regulation and look to future-proof as far as possible their credentials to be recognised as working at an advanced level of practice.

Regarding designing or developing health services, ACP roles require further refinement to understand whether employing an ACP clinician will benefit and fit the bill of what is needed for that service, and if it slots within a coordinated workforce plan. Jones (2005), Wilson-Barnett (2000) and Thompson et al (2019) noted role ambiguity, which can be exhibited in poorly defined job descriptions and a lack of standardisation against definitions.

The continued lack of regulation, poor evidence of evaluating the full costs of ACP roles and the confusing context of career pathways place a burden on employers to shape the scope of practice, pay, grade, outcome measures, training, education, support and development of ACPs in their organisations. The 'situatedness' of ACP (de Bont et al, 2016) places a demand on employers to understand the particular context in which advanced clinical practitioners can or do operate, their personal traits and skills, and the impact this may have on others around them.

Recommendation: need for dialogue

Open and honest discussion should take place between nurses and their employers to understand the expectations of the ACP role in their localised context.

Limitations

The review was conducted by an individual researcher and the findings are limited by the quality of the current literature available, retrieved and selected at that time. While no date limits were placed on the search to ensure that any relevant insights could be gained from longitudinal research and the historical context of ACP, the current context may differ from the previously less evolved nature of this field of healthcare. However, this research has highlighted areas of consensus.

Longitudinal evidence is lacking and research tends to be based on a subset of the diverse ACP population; caution should therefore be exercised when generalising to different specialties, geographical locations, healthcare services or professions.

Conclusion

When this systematic review took place (February-May 2020), ACP was attracting increased attention and it continues to do so.

ACP varies and has a high degree of localisation, and clinical practice dominates other aspects of the role.

There are barriers to effective implementation of ACP and therefore to realising its benefits. Repeated calls have been made for standardised education and career development pathways, with the diversity of the role creating a burden on employers to ensure it provides its anticipated benefits.

The outcomes of employing ACP clinicians need to be more robustly collected, including longitudinal research, and should reflect the diverse and evolving work by ACP practitioners.

There are areas of consensus where further research is not recommended at this time. However, research on ACP is insufficient except in discrete, specialised and localised studies.

More research is needed to identify the potential personal benefits for ACP clinicians in following this career if the ambitions of the NHS Long Term Workforce Plan (NHS England, 2023) are to be realised. **BJN**

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KEY POINTS

- There is broad consensus on the definition of advanced clinical practice (ACP) but titles, scope, pay, regulation, training and education vary
- Barriers to effective ACP are well known, albeit commonplace, and include that clinical practice dominates within ACP roles
- There is limited empirical evidence that evaluates the impact of the ACP role on staff in these posts (e.g. career development, autonomy and job satisfaction), which needs to be considered locally if practitioners are to recognise if it is the career path for them
- ACP development can be split into substitution (e.g. replacement doctor) or supplementation (value added) roles, which affect the scope of practice afforded in these positions

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CPD reflective questions

- What are the key themes regarding advanced clinical practice (ACP), according to the evidence?
- How does this relate to your experience of ACP?
- If you were establishing or stepping into an ACP role for the first time, what are the main issues you would need to consider to ensure it was effective?