A cross-sectional, exploratory, mixed-method study examining Advanced Clinical Practitioners' expectations and experiences of their roles.

(Short Title)

What are Advanced Clinical Practitioners' expectations of the benefits in pursuing this role, and are these being realised?

Vikki-Jo Scott

A thesis submitted for the degree of PhD Health Studies

School of Health & Social Care

University of Essex

Date of submission for examination 18th March 2024

Re-written and re-submitted 15th November 2024

ABSTRACT

Aim

The aim of the research contained within this thesis was to understand the expectations Advanced Clinical Practitioners (ACPs) have regarding the role and to evaluate whether expectations are currently being realised. Previous research identified barriers which prevent the effective implementation of ACPs. To achieve objectives of health service reform, a better understanding of disparities between ACPs expectation and reality is needed for focused initiatives to be implemented.

Method

This cross-sectional study used a sequential, mixed method, exploratory design where themes were created from focus groups to construct a follow up questionnaire. UK participants were recruited via social media and ACP networks. Using maximum variation sampling, focus groups took place on-line and were studied via reflexive thematic analysis. The on-line follow up questionnaire collected both quantitative and qualitative data. Exploratory data and reflexive thematic analysis were employed to probe and visualise results, drawing findings together via narrative synthesis.

Results

Five themes were constructed from 17 participants over 3 focus group discussions: the need for 1) clinical/ non-clinical balance; 2) full use of knowledge, skills and experience; 3) leadership in quality improvement; 4) career progression; and 5) policy, vision, and structure to support effective implementation of the role.

The follow up questionnaire identified divergences in ACPs expectations and their lived experience of the role. Overall respondents (n= 230) did though believe their expectations are being met.

Recommendations

To achieve the expected growth of ACP, attention is needed on narrowing the gaps between the expectation and reality of working in this role. This requires ring fencing time for non-clinical activity, providing opportunities for leadership, better access to professional development, and clearer career planning. Initiatives to standardise ACP should be further embedded and measured for impact which will require further research, including gaining a clearer picture of the ACP community.

TABLE OF CONTENTS

Glossary

ACP – Advanced Clinical Practice or Advanced Clinical Practitioner. The literary context determines how this abbreviation is used. Further detail on this is provided in chapter 1.

AHP- Allied Health Professional. People who are regulated by the Health Care and Professional Council and registered to practice in a defined list of health professions. This includes Physiotherapists, Occupational Therapists, Paramedics, Radiographers etc.

CfAP- The Centre for Advancing Practice. This is a subsidiary body of NHS England (previously Health Education England which merged into NHS England in 2023) Further detail about their work can be found in chapter 1.

HCPC- The Health and Care Professional Council which is the PSRB/ regulatory body for allied health professionals.

MPF- The Multi-professional Framework for Advanced Clinical Practice in England.(Health Education England, 2017b)

NHS- National Health Service in the United Kingdom (UK)

NMC- The Nursing and Midwifery Council in the UK, which is the PSRB/ regulatory body for Registered Nurses, Midwives and Nursing Associates.

PCN- Primary Care Network. A group of GP practices that work together alongside community, mental health, social care, pharmacy, hospital and voluntary services to deliver a range of health care services within a particular geographical location.

PDR- Personal or Professional or Performance Development Review. Often otherwise known as an appraisal process in which (usually annually) performance against set objectives and planning for objectives to be achieved in the future are discussed and agreed between an employee and their line manager or designated appraiser.

PSRB- Used as an abbreviation to denote all organisations which are professional, statutory and, or regulatory bodies for health and social care, (e.g. including the NMC, and HCPC)

rTA- Reflexive thematic analysis, as defined by Braun and Clarke (Braun and Clarke, 2020)

tACP- Trainee Advanced Clinical Practitioner.

Trust- Many hospitals became established as ‘NHS foundation trusts’ since the Community Care Act in 1990. Health care workers will therefore commonly refer to their employing organisation in the NHS as a ‘trust’.

Author Details

This thesis has been written by Vikki-Jo Scott for her PhD in Health Studies undertaken at the University of Essex between January 2020 and March 2024. Vikki-Jo is a Senior Lecturer and former Dean of the School of Health & Social Care at the University of Essex. She is a Registered Nurse with specialist clinical experience in Critical Care Nursing. Vikki-Jo returned to working clinically in Critical Care during the peaks of the Covid-19 pandemic. She undertook this work alongside her PhD studies and her role as the programme lead for the Advanced Clinical Practice and other Masters programmes which include post-registration continuing professional development courses for registered health care professionals. Vikki-Jo has previously obtained a Masters in Learning and Teaching and is a Senior Fellow of Advance HE (previously known as the Higher Education Academy). Vikki-Jo embarked on her PhD to support the development of her academic career and to build her expertise, knowledge and feed her interest in the fast-emerging field of Advanced Clinical Practice. She has utilised her PhD studies to undertake in depth research in this field and to develop her knowledge, skills, and confidence in research skills, including research methodology, data collection, and analysis under the close and expert supervision from Professor Andrew Bateman and Dr Paul Freeman.

Acknowledgments

The author of this thesis would like to acknowledge and thank people who have most generously and perseveringly provided their support during the period of her PhD. This includes the aforementioned kind, thoughtful, and thought-provoking supervisors who gave me the right nudges when needed. Paul's support in guiding my ventures into quantitative research and editorial endeavours has been phenomenal. Andrew's encouragement to own my choices and go for it despite my rocky start with different supervisors has been fundamental to me continuing and completing my PhD. Dr Murray Griffin also helped rescue me at this crucial time when it looked like the opportunity to undertake my research and achieve my PhD dream had been whipped out from under my feet. I cannot thank them enough for putting their faith in me, picking me up and putting me back on the doctoral studies road. My thanks also extend to colleagues who have covered for me during my periods of study leave. External partners as well as my ACP students and research participants have also continued to provide a focus and drive to push forward with my research. I hope they are able to benefit from the new knowledge gained as a result. And last, but not least, I wish to thank my partner and my family. Andy has been unstinting in supporting me to keep going, giving me confidence, time, space and feeding my soul when needed. My sons have forever given me meaning and focus with their encouragement and positive attitude toward life; this has given me great comfort, motivation, and a solid anchor in some tough times. Going back to work clinically during the Covid-19 pandemic alongside completing my PhD and continuing my academic role has been no different. In completing this thesis, I hope I continue to provide my family with the same spirit of support and pride that they give to me every day.

COVID-19 Impact Statement

The period of my PhD studies overlapped with the Covid-19 pandemic having both positive and negative impact upon my PhD studies and research. I was awarded part-time study leave from my academic role during 2020-2022 which allowed me greater time and flexibility to adjust my study plans. With increased on-line working this gave me greater autonomy to manage my dual role as PhD student and academic.

As part of my request for study leave, I included a desire to spend some time in clinical practice in my former role as a critical care Nurse. When the pandemic hit, I therefore had more opportunity and demand than could ever have been anticipated to undertake this work. I can truthfully say that my time within critical care over this period was the most challenging and traumatic experience of my career and has exposed me to symptoms of Post-Traumatic Stress. However, it also allowed me to directly work alongside Advanced Clinical Practitioners and to understand better their role, what they can do, and how they have adapted in this momentous period of history. This undoubtably added to my insight, empathy, and drive to support development of ACP.

The University of Essex at this time took a risk averse approach where measures were put in place to avoid wherever possible in-person contact. This influenced to some extent the methods chosen for my research. In the literature review this meant that I relied upon sourcing publications via electronic databases and email communication. For later stages of my research, I was well aware of the ongoing impact the pandemic had on my chosen group of participants, meaning that on-line collection of data was the most practical and pragmatic approach to use to achieve the aims of the research. I therefore wish to acknowledge and highlight the impact that Covid-19 has had on my studies, my research, and the thesis produced as a result.

Publications

Publications, outputs, and conference presentations that have emanated from this PhD and my developing profile in the field of Advancing Practice research are:

1. What are advanced clinical practitioners' expectations of the benefits of pursuing the role, and are these being realised?' International Journal for Advancing Practice. Published October 2024 Volume 2, Number 4, pages 164-171
2. Written evidence submission to the Public Accounts Committee for the inquiry 'NHS England's modelling for the Long-Term Workforce Plan. Reference No. LTW0001. Published April 2024 Available at; https://committees.parliament.uk/work/8369/nhs-englands-modelling-for-the-longterm-workforce-plan/publications/
3. 'Assessing the benefits of Advanced Practice for key stakeholders.' British Journal of Nursing March 2024. Volume 33, No 6. DOI: 10.12968/bjon.2024.33.6.300
4. Continuing Professional Development, appraisal and revalidation' chapter in 'Acute, Emergency & Critical Care for the Advanced Practitioner' textbook. December 2023. Wiley Publishing. ISBN-978-1-119-90828-9
5. 'Professional Development and Transition' co-written chapter in 'The Advanced Clinical Practitioner: A Framework for Clinical Practice' textbook. September 2023. Wiley Publishing. ISBN-978-1-119-88203-9
6. 'Core Principles of Advanced Practice' co-written chapter in 'The Advanced Clinical Practitioner: A Framework for Clinical Practice' textbook. September 2023. Wiley Publishing. ISBN-978-1-119-88203-9

7. ‘Advanced Clinical Practitioners’ expectations of the benefits in pursuing this role, and whether these are being realised.’ International Journal for Advancing Practice. 1:13-13. 31 Jan 2023
8. ‘Improving Quality of Care.’ co-written chapter in ‘Advanced Clinical Practice at A Glance’ textbook. November 2022. Wiley Publishing. ISBN-978-1-119-83328-4
9. Editorial Comment: ‘Advanced Clinical Practice- Is it worth the bureaucracy?’ British Journal of Nursing, 30: 2, page 109. Published January 2021. DOI: 10.12968/bjon.2021.30.2.109
10. Written evidence submission to the Health and Social Care committee’s parliamentary inquiry on ‘Workforce: recruitment, training and retention in health and social care’. Reference No. RTR0001. Published 8th February 2022. Available at; https://committees.parliament.uk/publications/23246/documents/171671/default/

Contribution to policy consultations:

11. Member of the Council of Deans of Health Strategic Policy Group for Regulation since February 2024 and the Advanced Practice Impact Group since 14th July 2022 as a result of which I have represented the Council on the Nursing and Midwifery Council (NMC) Phase 2 Advanced Practice Review workstreams, and at the Steering Group for the NMC Advanced Practice Regulation Phase 2 (held 20th August 2024).

12. Contribution of findings from my PhD research to the call for evidence on a ‘Separate pay scale for Nursing’ February 2024 https://www.gov.uk/government/calls-for-evidence/separate-pay-spine-for-nursing

13. Contribution to the ‘Post-Registration consultation; Building on our ambitions for community and public health nursing.’ October 2021 Nursing and Midwifery Council.
14. Contribution of evidence to the project report ‘Busting Bureaucracy: Empowering frontline staff by reducing excess bureaucracy in the health and care system in England.’ Department of Health & Social Care. November 2020. https://www.gov.uk/government/consultations/reducing-bureaucracy-in-the-health-and-social-care-system-call-for-evidence/outcome/busting-bureaucracy-empowering-frontline-staff-by-reducing-excess-bureaucracy-in-the-health-and-care-system-in-england
15. Contribution to the paper ‘Analysis of the online workshop to consider the impact of Covid-19 and the implications for the future of advanced and consultant practice.’ October 2020 Health Education England. https://tinyurl.com/y48enxk3
16. Contribution as an expert to: Health and social care system and COVID-19: What are experts concerned about? 14 May 2020. Parliamentary Office for Science & Technology. https://post.parliament.uk/category/horizon-scanning/2020/

Conference/ webinar presentations

17. ‘“What are Advanced Clinical Practitioners expectations of the benefits in pursuing this role, and are these being realised? A mixed method study.” Abstract accepted for Oral Presentation at the International Council of Nursing: Nurse Practitioner/ Advanced Practice Nurse Network Conference (10th September) 2024
18. Presentation of the research “Advanced Clinical Practitioners’ expectations of the benefits in pursuing this role and whether these are being realised.”

a. Hertfordshire and West Essex ICB Research Forum, 24th July 2024
b. Suffolk and North East Essex Advanced Practice Forum, 18th July 2024
c. East of England Primary Care Advanced Practice Forum, 12th June 2024
d. Mid and South Essex ICB Advanced Practice Forum, 11th June 2024
e. Cambridge and Peterborough Advanced Practice Forum, 16th May 2024
f. Hertfordshire and West Essex Advanced Practice Forum, 10th April 2024
g. Essex Partnership University Trust Advanced Practice Conference, 12th March 2024

19. Chair of the 'Latest Advancements in Advanced Practice' webinar for the Council of Deans of Health Advanced Practice Impact Group. Held 5th March 2024
20. Presentation of the research "A cross-sectional, exploratory, mixed-method study examining Advanced Clinical Practitioners' expectations and experiences of their roles." School of Health & Social Care Staff-Student Research Conference, 17th June 2024 and University of Essex Health Research Group 13th February 2024.
21. Presentation of initial results from 'Advanced Clinical Practitioners expectations of the benefits in pursuing this role and whether these are being realised' Mid and South Essex Integrated Care System Advanced Practice Conference. 10th October 2023 (20 minute presentation).
22. Presentation of progress with the research 'Advanced Clinical Practitioners expectations of the benefits in pursuing this role and whether these are being realised' Suffolk and North Essex Integrated Care System Advanced Practice Conference. 30th June 2023 (30 minute presentation, followed by 10 minutes for questions).
23. Poster presentation of progress with the research 'Advanced Clinical Practitioners expectations of the benefits in pursuing this role and whether these

are being realised' School of Sport, Rehabilitation & Exercise Sciences (University of Essex) Annual Research Conference. 23rd June 2023

24. Presentation of progress with the research 'Advanced Clinical Practitioners expectations of the benefits in pursuing this role and whether these are being realised' School of Health & Social Care (University of Essex) Annual Staff-Student Research Conference. 5th June 2023 (10 minute presentation, followed by 5 minutes for questions).
25. 'Advanced Clinical Practitioners expectations of the benefits in pursuing this role and whether these are being realised' Poster presentation (with 10 min recorded audio) at 'Advancing Practice Conference 2022: Empowering People, Transforming Care.' Presented online November 2022. (This poster was voted the best by 3000 attendees out of 98 posters submitted with 28% of the total vote).
26. Protocol poster presentation: 'What are Advanced Clinical Practitioners expectations of the benefits in pursuing this role, and are they being realised?'. Association of Advanced Practice Educators-UK Annual Conference. Online June 2022
27. Protocol poster presentation: 'What are Advanced Clinical Practitioners expectations of the benefits in pursuing this role, and are they being realised?' Health Education England Centre for Advancing Practice 'Extraordinary People: Extraordinary Care' conference (on-line), November 2021
28. Presentation: 'Mixed Method Research- benefits and challenges'. Research, brew and discuss, University of Essex, November 2021
29. Poster Presentation: 'Advanced Clinical Practice- Is it worth it?' The Advanced Clinical Practitioners conference Sheffield, October 2021

30. Plenary Session: ‘The benefits of ‘Advanced Clinical Practice’ (ACP) training and education for key stakeholders. A systematic, mixed method, literature review’ Royal College of Nursing International Research conference (on-line), September 2021
31. Presentation: ‘What are the realistic expectations of pursuing an Advanced Clinical Practitioners role? (or…ACP-Is it worth it?) A Mixed Method Research Proposal (in development). HSC Annual Staff/Student Research e-conference 22nd June 2021
32. Presentation: ‘Advanced Clinical Practice- Is it worth it?’ University of Essex Newcomers presents webinar series 9th December 2020
33. Poster presentation: ‘What research has been conducted in UK settings with regard to the benefits of ‘Advanced Clinical Practice’ (ACP) Post-Graduate training and education for key stakeholders (or…ACP Is it Worth it?) A systematic literature review.’ School of Health & Social Care PGR Seminar series. 24th November 2020
34. Poster presentation: ‘What research has been conducted in UK settings with regard to the benefits of ‘Advanced Clinical Practice’ (ACP) Post-Graduate training and education for key stakeholders- A literature Review.’ Health Education England Centre for Advancing Practice ‘Taking Centre Stage conference (on-line), November 2020. (Gained award for being in the top 10 of posters presented at this conference).

CHAPTER 1- INTRODUCTION

INTRODUCTION

This thesis details my PhD research journey where I have chosen to focus on the topic of Advanced Clinical Practice (ACP). Advanced Clinical Practitioners are a group of health care professionals that are increasingly being used in the UK to deliver health services. The NHS Long term workforce plan, (NHS England, 2023b) has indicated an aspiration to massively increase the number of ACPs. They are seen as vital to reshaping services to meet population needs and to address staff shortages by recruiting and retaining highly experienced health care professionals in the NHS workforce. My research focuses on the experience of people working or training as Advanced Clinical Practitioners and whether their expectations for the role are being realised. This work is intended to examine and support the development of ACP.

HOW TO READ THIS THESIS

Each chapter will start with a short introduction of the content to be covered and will end with a brief summary of the key topics that have been addressed. Within the text you will find headings and sub-headings that have been listed in the 'Table of Contents' on pages 6-8. The reader can automatically be taken to each of these by clicking on the link in the Table of Contents (if reading this document electronically). You will also find that certain words, phrases, and reference to appendices have been underlined and created as hyperlinks so that the reader can click on these to automatically be directed to their location within the thesis.

The thesis will begin with clarification on definitions and key stakeholders followed by an overview of the ACP background and context. It will then detail the process undertaken and findings of a systematic literature review which has been used to hone

down the focus of the research which forms the subsequent chapters. The thesis will conclude with a discussion of recommendations, plans for future research and dissemination of the research undertaken within my PhD.

It should be noted that due to the positionality and philosophical underpinning of my research work and the methods I have chosen to use within my research, the author and primary investigator will be referred to in the first person.

DEFINITIONS OF ACP

At this point, it is worth defining further some of the terms used in relation to ACP as these can be numerous, variable and confusing, (Leary *et al.*, 2017). For the purposes of this thesis, the term ‘Advanced Clinical Practice’ includes reference to alternate nomenclature related to different professional groups (e.g. ‘Advanced Nursing Practice’). It also encompasses reference to the individuals that are undertaking the acts related to the practice itself (e.g. ‘Advanced Clinical Practitioner’). When referring to specific professional groups, such as ‘Nursing’ or ‘Physiotherapy’, it is important to note this refers only to those people in the UK that are allowed to use such restricted titles by the relevant regulatory body. For example, the definition of ‘nursing’ globally is far more diverse and encompasses people with different training and scope of practice. In some instances, more specific clinical contexts are included in reference to the broader term ‘ACP’, such as ‘Advanced Practice Nursing’. This specifically refers to ACP undertaken by a Nurse within the primary care GP surgery setting.

There is also some confusion regarding the use of the different spellings ‘practice’ and ‘practise’. Practice is a noun and is the act itself, whereas practise refers to the verb. Therefore, practise may be used to discuss how someone was practi**s**ing (learning, preparing) to work at an advanced level, whereas an Advanced Clinical Practitioner is employed to provide advanced clinical practi**c**e (specific clinical skills, knowledge, tasks) within a health care service.

Where reference is made to ACP in this thesis, it therefore encompasses all of the above. Where the abbreviated term of ‘ACP’ is used, the literary context in which it is being used determines if it relates to practice, or practitioner, or both.

SCOPE OF PRACTICE

Similarly, the scope of ACP is diverse and wide ranging. The inclusion and exclusion criteria used in the research presented in this thesis has been deliberately broad to reflect the diversity of the context of ACP and the key stakeholders that are potentially impacted by this.

In terms of the field in which ACP operates, this refers to health care in its broadest sense, including the provision of health care services in primary, secondary, private, independent, voluntary, and statutory settings. In the current context, the boundaries between these different settings have blurred. Individual organisations (e.g. hospital NHS trusts) may provide services in both primary and secondary care. They may also utilise some services provided on a private funding basis and commonly reach beyond the geographical boundary of the hospital site. With the development of Integrated Care Systems in the UK, there is expected to be an increase in such cross boundary working.

The starting point for this research was therefore to encircle all health care services as occur in the UK. The UK health system holds similarities but also distinct differences from other countries. There are common features internationally to the development and practice of ACP (e.g. performing a substitution or supplementation role). However, national policy, organisational structures, and local practice can be expected to influence how ACP operates within this context. The research reported in this thesis was therefore restricted to the UK.

KEY STAKEHOLDERS

Key stakeholders that fall under the remit of this research are:

- health professionals,
- employers,
- education providers and commissioners
- professional/ regulatory bodies.

Employers

Employers play a major role in supporting staff to undertake ACP development and can act as gatekeepers for people wanting to train or work as an ACP. ‘Employers’ is a broad term which has been used in this thesis to include all those organisations that issue and hold employment contracts for people delivering health care in the UK.

Health Professionals

The next key stakeholder to consider are the health professionals themselves that are either seeking to become recognised or employed as an ACP, or those that are currently working in roles and positions within UK health care settings that could be considered as ACP.

It should be acknowledged there are limitations in research that has focused on ACPs because of the difficulty of identifying who exactly is an ACP. In a Health Education England funded project in Wessex (unpublished 2019), they attempted to recruit people who were currently working as an ACP to support them in mapping against the MPF (Multi-professional Framework for Advanced Clinical Practice, Health Education England, 2017) and to provide a tailored education plan to address any gaps. This project found it was difficult to be confident that all those working within the scope of the study as ACPs had been appropriately identified. Some may not have considered themselves as ACP and so did not come forward. Some may have come forward but within the MPF definition were not operating fully in an ACP role. Because of the variety of terminology used in role or job titles and the paucity of clearly defined job descriptions, this makes capturing all ACPs in a particular setting difficult. My experience of working with employers and within ACP networks, continues to highlight the early stage that organisations are at in terms of accurately identifying people that are working at or being labelled as ACPs. Current research therefore includes a variety of definitions where people are classed as ACP. This has been considered carefully when drawing any conclusions in this thesis.

Education providers and education commissioners

Both the words ‘training’ and ‘education’ have been utilised to ensure all those on the spectrum of philosophy of education methodology are included. Some make distinct difference between the terms ‘training’ (i.e., acquisition of technical or kinetic skills) and ‘education’ (i.e., acquisition of knowledge and understanding) whilst others may argue you cannot separate the two. Both the words training and education have therefore been retained and are used interchangeably in the research.

The introduction of the Multi-Professional Framework for Advanced Clinical Practice in England or 'MPF' (Health Education England 2017) and ACP apprenticeship standards (Institute for Apprenticeships & Technical education, 2018) sets out the expectation that to provide full evidence of ACP, Masters level is required. This research therefore refers to those organisations that provide post-graduate education and training products as defined by the Framework for Higher Education Qualifications and regulated by the Office for Students in the UK. (Quality Assurance Agency, 2014).

An important distinction to make here is between post-graduate and post-qualification or post-registration training and education. Not all post-qualification/ post-registration training and education is at a Masters level. For Nurses and Paramedics, where up until relatively recently they were able to enter the professions without an Undergraduate degree qualification, they more commonly sought and undertook post-qualification/ post-registration education at undergraduate level. Consequently, there remains a significant portion of healthcare professionals in the UK who do not hold a degree, some of whom may be working at or employed in an ACP level position. All regulated health care professionals are expected to undertake Continuing Professional Development (CPD) that may include training and education. This would encompass a variety of activity such as in-house training, mandatory education activities, role shadowing, and conference, networking, seminar/ workshop attendance. These activities, whilst being legitimate post-qualification/ post-registration CPD, are not post-graduate or Masters level as described above and as expected under the national ACP framework. To ensure this research reflects the now current and widely accepted definition and expected educational standard for ACP, the type of training and education and how this fits with the current definition of ACP (i.e., post-graduate, post-registration, Masters level) has been recognised.

The funding and commissioning landscape for ACP has continued to shift overtime. Funding for ACP now often comes through the Centre for Advancing Practice (CfAP) to Integrated Care Systems (ICS), which cover a wider geographical area and range of organisations linked to healthcare provision (NHS England, 2021). Ring fencing of funds specifically for ACP training and education has also been a growing feature, particularly since the publication of the MPF. When referring to education commissioners in this research I am therefore including all those organisations and individuals that fund ACP training and education to health professionals and employers as described above.

Professional and regulatory bodies

Regulatory bodies set the requirements for entry into protected title professions (e.g., 'Nurse' or 'Occupational Therapist'). They also set the limits on scope of practice and the requirements to continue to hold a protected title (i.e., registration requirements such as accepted types, levels, and volume of CPD). Some professional groups will have both a professional and a regulatory body, one or both of which may set down the requirements for training and education. As an example, the UK Nursing & Midwifery Council regulate;

- the title of Registered Nurse (the NMC register),
- the requirements to remain as a registered nurse (through revalidation),
- the scope and expectations of practice as a Registered Nurse (through the code of conduct), and
- the education requirements for pre-registration training (to become a registered Nurse), and some post-registration extended roles (e.g., Prescribing).

For other professional groups (commonly termed AHPs), they will have a regulatory body (e.g., the Health & Care Professions Council) and Professional organisations (e.g., the Royal College of Occupational Therapists). To legally practice with a protected title, only the regulatory body requirements need to be fulfilled. However, it is expected and common practice that education programmes in these fields also meet the requirements of the professional body so that it carries both the regulatory validation and the professional body accreditation. Individuals in this instance are commonly both a registered practitioner with their regulatory body and an accredited practitioner with their professional body. For the purposes of this research, both regulatory and professional bodies are included (commonly referred to as PSRBs).

Service Users

It is significant to note that arguably the most important stakeholder in health care has been excluded from my research. The purpose of this research is not to assess the evidence base for clinical effectiveness of ACP or benefit to the service user or patients. This may seem perverse to exclude this group however from initial reading it was evident that studies consistently noted at least equivalent or a positive impact of ACP on clinical effectiveness. (For example, see the 'SCAPE' study conducted in Ireland by Begley *et al*, 2013). In a recent report commissioned by the Nursing and Midwifery council, Palmer, Julian and Vaughan (2023) further noted that

> *"The merits of advanced practice are not in doubt. Indeed, there is a substantial literature that demonstrates that it can support better delivery of services and improve a range of outcomes for people who use services".*

There is consequently a limited gap in knowledge or evidence here that needs to be addressed. The research undertaken and reported in this thesis therefore focuses on key stakeholders in ACP in UK settings, not including service users, patients or recipients of care, support, advice, or health interventions from ACPs.

SUMMARY

This introductory chapter was intended to provide a direction to the reader to help guide them through this thesis. It has also provided a definition for key terms and has scoped out the stakeholders that are referred to throughout the following text.

CHAPTER 2- CONTEXT

INTRODUCTION

This chapter will explore the historical background of ACP and will explore some of the recent debates, development of policy, governance and organisational structures within the UK to provide a contextual backdrop to the research presented within this thesis.

HISTORICAL BACKGROUND OF ACP

Advanced Clinical Practice begun to emerge in the Unites States from as far back as the 1960s (Dunn, 1997). Examples of developing trained health care professionals (usually nurses) to take on additional advanced tasks and skills or extended roles can now be found globally. Comparisons have been made between the UK trajectory and that in Europe and Australia, with recognition that different countries, and professions, specialties or particular health care services are at different stages of developing models of Advanced Clinical Practice. Maier *et al.* (2016) Pulcini *et al.* (2010) noted that, while advanced clinical practice roles have varied, initial development is typified by a need to reconfigure services to address unmet need. Common examples are substitution for a short supply of medical professionals, (for example as described by Coombes in 2008 in the confrontational piece named “Dr Nurse will see you now”) or to develop new ways of working such as the shift from emphasis on acute-in-hospital health services to delivery of primary, community-based health care. For example, the introduction of the ‘Affordable Care Act’ in the USA accelerated the use of Advanced Nurse Practitioners in community based, nurse-led clinics and public health initiatives (Cleveland, Motter and Smith, 2019).

For many years reference has been made to ‘Advanced Clinical Practice’ and ‘Advanced Clinical Practitioners’ and attempts have been made to control the use of this title by training or education providers, employers, or by health practitioners. In 2017, for the first time, a number of professional bodies collaborated with Health Education England (HEE) to create the MPF (Health Education England, 2017b). This framework sets out the definition of ACP, the scope of practice and practitioners this applies to, and the standards and capabilities that are expected in order for health care professionals practice under this title. Whilst this falls short of regulation of the title, it has now provided a benchmark by which education and training providers can badge their products as leading to advanced clinical practice, employers can use to select individuals to work in ACP roles or undertake ACP related tasks, and individuals can provide evidence against to support their credentials as an ACP. The introduction of this framework, alongside additional funding being released specifically for the support of ACP (Health Education England, 2019), as well as the development of the NHS people plan (NHS Improvement, 2020), and the approval of an Apprenticeship route for ACP (Institute for Apprenticeships and Technical Education, 2018), has led to an increase in activity around ACP.

In June 2020, HEE established the ‘Centre for Advancing Practice (CfAP) and issued a statement opening an invite to education providers to seek accreditation for ACP education programmes. The accreditation process is mapped against the MPF and is the closest England has got to establishing some form of ‘universal’ governance. Many education providers have mapped their programmes to the framework and promoted their courses as ‘ACP’, with some also developing new ACP apprenticeship programmes. It is anticipated that many HEIs (Higher Education Institutions) will now be working toward or have already gained CfAP accreditation. This provides a ‘badge’

of recognition for those that successfully complete eligible education programmes. Being that the accrediting body (the CfAP under HEE, which was subsumed into NHS England in 2023) is also the largest commissioner of ACP education in England, this may also provide a route for ACP titles to be more tightly controlled. The release of funding that has been tied to ‘ACP’ has led to an increase in enquiries to education providers about the opportunities for ACP training and education.

The CfAP expect employers to review staff that currently hold ACP roles or undertake ACP related tasks to ensure they meet the framework expectations and use this to develop workforce plans and shape their bids for ACP training budgets. Some employers have looked to create new ACP posts to provide further career routes and retention opportunities for their highly skilled staff and reconfigure or develop service provision in particular areas (NHS Improvement, 2020). However, currently there is no comprehensive route for those who already employ ACPs to check their credentials against the MPF as the accreditation route is only open to those commencing ACP education programmes since June 2020. Whilst the NMC have recently commenced work on introducing registration and regulation of Registered Nurses and Midwives working at Advanced Practice level, the HCPC has not, (Nursing and Midwifery Council, 2024; Health and Care Professions Council, 2024). Key research and reports undertaken on behalf of the NMC and HCPC, although coming to the same conclusions about the benefits of ACPs and the lack of evidence they create additional risk to the public, are taking different approaches regarding recognition and regulation of ACP (Hardy, 2021; Palmer, Julian and Vaughan, 2023). This creates a challenge for key stakeholders working within the field of ACP.

The introduction of education standards expected by the NMC would provide a way to standardise the entry routes into for ACP (for Nurses and Midwives). However this does not address standardisation of education routes for other professional groups, or for staff that are already working in these roles. HEIs can apply for CfAP accreditation of 'legacy' programmes. However, this relies on there being no substantial changes made to the programme since its introduction up until the point of accreditation. HEIs commonly review programmes on annual basis in line with market forces, feedback, and evaluation, and you would expect them to have changed their programmes since 2017 to more closely align to the MPF. For those that employ ACPs who have not followed a full or formal higher education route to gain their role, a supported e-portfolio route to gain recognition has been opened up by the CfAP. However, the number of places is restricted and has thus far only been open to people that have not completed a post-graduate ACP programme since 2017. It is also expected that this route for recognition will cease to be available by 2030.

Accreditation and recognition of ACPs through the CfAP is therefore patchy and in its infancy. Employers are consequently the current 'gatekeepers' to people accessing ACP roles and recognition of their ACP status. From my experience as a Nurse and health education provider, health care professionals working today are now expected to have longer working lives than ever before. The fragility of long-term careers in a particular service, field of practice, or employer, has increased with a higher pace of service reconfiguration, development of specialisms and creation of new roles within the field. This creates a perceived pressure on health professionals to ensure they have the 'right qualifications' to satisfy employers and to allow them to progress in their career or maintain job security.

SUMMARY

This chapter has explored the context in which the research presented in this thesis has been set whilst noting that ACP is a fast-evolving field of practice and policy. It also reflects the 'muddy waters' of the background to and current context of ACP where there is still a significant amount that is unknown, unclear, or variable in its approach to implementation. Endeavours have been made throughout my research and in writing up the thesis to capture and refer to the current context, whilst recognising this may not be reflective of ACP going forward as it continues to evolve. The discussion of 'context' contained within this chapter has therefore demonstrated that ACP is increasingly a 'hot topic' in healthcare career development and education, and potentially a 'hot potato' when it comes to decisions on regulation and provision of ACP education.

CHAPTER 3- SYSTEMATIC LITERATURE REVIEW

INTRODUCTION

In this chapter the process and findings from a systematic literature review is presented. Exploration of the ACP context formed the basis for my search strategy for this review, including selection of databases, key terms, and inclusion and exclusion criteria. A specific aim of the systematic review is provided below that builds from discussion in the first two chapters of the background and context, scope, key stakeholders, and definitions used. Following this, the protocol used to structure the systematic review is detailed prior to presentation of the findings (to include critical evaluation of the quality of the literature returned), which will then inform a narrative synthesis. This chapter will conclude with identifying gaps in current research based upon the systematic review which have informed the remainder of this thesis.

AIM & RESEARCH QUESTIONS

An initial review of the current literature, including opinion pieces, key policy documents, editorials, and position statements from relevant stakeholders helped to identify the initial focus for this research. From exploring the context of ACP, I found that there are a significant number of claims made regarding the beneficial impact and value of Advanced Clinical Practice (ACP) and the increasing presence of Advanced Clinical Practitioners (ACPs) in healthcare settings. ACP is gaining increasing attention because of changes within the healthcare system and policy that guides healthcare services. However, a large proportion of the literature appeared to be policy, position statement or opinion based, with a significant number referring to each other rather than to, what appeared on the face of it, any empirical research.

The purpose of the systematic review was therefore determined to identify research conducted in UK settings with regard to ACP. The research questions derived from this purpose and aim were:

1. What empirical research is there regarding the benefits and impact of ACP?
2. Is there sufficient evidence of adequate rigour to support or refute claims of potential benefit of ACP?
3. What are the current gaps in evidence regarding the benefits and impact of ACP?

SEARCH PROTOCOL

The search protocol was developed using the STARLITE tool as a structure (Appendix 1) with reference to the PRISMA checklist (Page *et al.*, 2021). Booth (2006) noted that standards of reporting of search processes is an important and often neglected part of effective literature review, particularly where this includes qualitative or mixed method studies. Use of tools such as STARLITE is in keeping with the principles set down by Cochrane Library (2020) and the Campbell Foundation (2020) where a central requirement is for a clear protocol to be determined prior to the search taking place. This helps to clearly identify the aims, parameters, and the process that will be taken in the literature search. By clearly reporting the search protocol, this can then be used to assess its quality and whether a robust approach has been taken to effectively achieve the project's aims and can provide a sound basis for the conclusions drawn (Booth, 2006).

STARLITE- Sampling Strategy

Through using STARLITE to refine and provide a clear report of the literature search I first identified that this would be a mixed method systematic review (MMSR), the purpose of which was to capture the range of research based evidence available in this field. I have ascribed to the definition that in MMSR, *"the core intention is to combine quantitative and qualitative data (from primary studies) or integrate quantitative evidence and qualitative evidence to create a breadth and depth of understanding that can confirm or dispute evidence and ultimately answer the review question/s posed."* (Aromataris and Munn, 2020, p. section 8.1 para 3).

STARLITE- Types of Studies

The types of studies and methodology included in this review was left deliberately broad as the potential 'benefits' of ACP are likely to differ for different stakeholders. The 'potential benefits' could, for example, be quantity of income generated from providing ACP education, length of time to secure employment, or expressed feelings of increased job satisfaction of employees. How these different aspects are measured would require different methods and methodology which is why the 'types of study' selected allowed for a range of methods and methodology to be included.

As noted from initial review there is a large amount of practice, policy, and theoretical literature on ACP. However, these are designed to offer opinion or tend to refer to each other rather than provide pieces of primary research or literature review undertaken regarding ACP. Practice, policy, or theoretical literature, including editorials, guidance or policy documents, blogs, textbooks, commentaries and letters were therefore not included in the search.

Broader types of publication were specified as an exclusion criterion which prevented this from being a scoping review that would provide an overview of a topic rather than focusing on identifying and synthesizing evidence to answer specific questions.

STARLITE- Approaches to searching.

Electronic databases were selected from the range that were available to me to access. A descriptor of each database was examined to look for relevance to the subject area (health-based research) and types of publication (to include reference to primary research and literature review publications) before deciding which ones to include.

Once the papers were screened by reading the title and abstract from the chosen databases, the reference lists for papers included thus far in the literature review (i.e., had not met any of the exclusion criteria) were examined. Any papers in the reference lists that appeared to meet the scope of the literature review were obtained and included where they adhered to the inclusion/ exclusion criteria. These papers obtained via citation searching are listed on the PRISMA flow diagram as 'Identified of studies via other methods'. In Badampudi, Wohlin, and Petersen's research on citation searching (2015) they found that snowballing can be a more reliable method than database searching, as long as the 'start set' is suitable. By using a protocol driven database search to identify the 'start set' of papers, additional relevant literature was identified that adhered to the aim, inclusion, and exclusion criteria of this review.

Full text copies of all literature were obtained and examined before they were either included or excluded from the synthesis. Where full text was not immediately available from the database or by searching on Google, an inter-library loan was requested, or

the author was contacted to request a copy. Research Gate was used to e-mail requests directly to authors, as well as searching for contact details in papers or on google. Other methods such as browsing in libraries and discussion with colleagues (as suggested by Greenhalgh and Peacock, 2005) were difficult or impossible to achieve at the time the literature search was carried out due to the lockdowns that were implemented due to the Covid-19 pandemic. This meant I was reliant on accessing search tools and papers electronically only. My limited experience and undeveloped networks and social media presence in this field also restricted use of alternative approaches. However, this allowed for the search to be more reliable and repeatable as did not rely on personal contacts, 'lucky' breaks, or serendipitous finds.

STARLITE- Range of Years

No limits were placed on the range of years in which studies took place or were published. Although definition of ACP nationally has only been agreed in 2017, studies conducted prior to this and the context in which they took place have fed into this definition (HEE 2017). At the time the search took place, there was unlikely to be many studies conducted since the framework had been published and this would otherwise have excluded longitudinal studies, which may provide useful insight to this topic. Due to sporadic time being available to the author to undertake the search, it was conducted over a period of 3 months, 26th February 2020-18th May 2020, with alerts being placed on database searches where possible so that any potentially relevant material published in this time was not missed.

STARLITE- Limits

The scope of healthcare professions including how, why, where they practice and how this is organised, managed, and regulated in diverse health systems varies considerably across the globe. This makes the context in which research is conducted significant to the conclusions that can be drawn. The MPF (HEE 2017) applies to England only but has drawn upon the other 3 nations work in this area, which utilise similar structures and principles for ACP. The literature search therefore included all 4 nations of the United Kingdom. Where studies were 'international' in nature and included data from the UK or provided comparisons between the UK and other countries, these have been included. Where there was no mention of data being drawn from England or the UK, they were excluded.

STARLITE- Inclusion & exclusion criteria

The criteria used are provided in Appendix 1. These were chosen according to the aims of the study and from understanding the context in which this literature review takes place. 'UK' and 'primary research and literature review' were applied first as exclusions to restrict the search results. Some databases allowed this to be added as a filter once the search had been conducted, whilst for others this was used as an exclusion criterion when reviewing the title, abstract, or full text. Attention to whether a study was focused on measuring a 'clinical effectiveness' outcome was then also applied as a criteria. When determining whether to include or exclude papers returned in accordance with 'ACP' terminology, certain types of practice, practitioner, or types of training were identified as needing to be excluded. Determining these was an iterative process in which as papers were read, and specific exclusions were able to be identified to finesse the criteria of ACP or not ACP. These included:

ACP-Pre-registration or other types of training or education including doctorates.

Themes related to advancing practice, even at the stage of where someone is training to become a registered healthcare professional, were sometimes discussed. Healthcare profession training has varied over time and continues to vary today with some professions having a mixture of registrants with a diploma, degree, masters, doctorate, or none of these depending on when and where they qualified. In some studies, it was not clear at what education level the ACP research was related to. Where this was not specified and all other criteria were met, the paper was included. If there was reference to it being 'on the job' training, non-accredited, or any other level of education as defined by the Framework for Higher Education (e.g., degree, undergraduate, diploma, doctorate) it was excluded (Quality Assurance Agency, 2014).

'ACP' for this literature review related specifically to those individuals that have completed their pre-registration training (regardless of the academic level this was taken at) and are now able to practice in that profession (i.e., those registered with the NMC, GPhC, or HCPC).

ACP- Clinical specialties or specialist practice.

This terminology often overlaps or is used interchangeably with ACP. Studies were included where both specialist and advanced practice/ practitioners were included. If the study focused on a clinical specialty alone (e.g., oncology, emergency medicine) without reference to advanced practice or advanced practitioners within this, they were excluded.

If a study included only those who were working as clinical specialists but not as advanced practitioners (as defined by the HEE 2017 MPF), they were excluded. Examples include practice nurses, who may go on to be advanced primary care or advanced nurse practitioners but are not yet working in an advanced practice role. This exclusion criteria also encompassed studies that focused solely on non-medical prescribers or non-medical prescribing. Whilst non-medical prescribing forms part of the competencies expected in some professions to be an ACP, holding this qualification alone does not meet expectations of all four pillars of ACP.

ACP- Professional development or stages of career

In some studies, the sample focused on student nurses, student allied health professional, or trainees. Some studies also focused their sample on people that held specific job roles such as nurse consultants, hospital matrons, or ‘out of hours’ directors. Where these studies did not refer to advanced clinical practice within these roles (either explicitly stated or implied by reference to clinical, leadership, education, and research), they were excluded.

Duplicates

Once all databases had been searched, any duplicates were removed. When undertaking snowballing only those that had not already been identified through the search of databases were reviewed so that repeated duplicates were not included.

STARLITE- Terms used.

Two key concepts were extracted from the question this literature review was trying to answer: 'ACP' and 'Benefits'. These concepts were used to define the terms that would be used when applying the protocol to each database search. Every database has some variation in the way it allows you to search; the types of results you are likely to get can be limited by the terms used. Because of the difficulties noted previously regarding the large variety of terminology and titles used within ACP, when defining search terms attention was given to use of Boolean operators, truncation, and phrase searching. Prior to searching the databases, any guidance or instruction provided on their use was read (e.g., whether the use of Boolean operators, truncation or phrase searching was allowed or what form it took). From this 'best practice' for each database, a list of terms used, and the order in which they were applied, was recorded in the STARLITE report (appendix 1).

STARLITE- Electronic Sources

As noted above, due to the timing of the literature coinciding with the lockdown in England due to the Coronavirus pandemic, only electronic sources were accessed. Databases were accessed through the University library, and where needed Google, Research Gate, inter-library loan, and e-mail were utilised to retrieve the full text papers for review.

DATA EXTRACTION

As noted by Li, Higgins and Deeks (2019, p. section 5.4) *"Data collection for systematic reviews should be performed using structured data collection forms".* They say *"Because each review is different, data collection forms will vary across reviews";* this may necessitate the information being captured in more than one form. Key considerations in the design of the data extraction forms used for this literature review were that:

1. It should contain the information required to identify and easily locate the source document for future reference.
2. It should describe the methodology and scope of the paper to allow for this to be used for critical evaluation and analysis and synthesis of key findings.
3. It should provide a direct link to the research question and aims of the literature review.

The data extraction form was developed in two stages. The first was to capture the data that would allow for easy reference to the original source (i.e., Author, Title, Date, Location) as well as defining features of the article methodology (type of methodology employed, where specified the methods used, reported findings, and the sample or source, including size, location, population type). This information, which has been summarised in Table 3.2 (located on page 57), was commonly gleaned from the title and abstract. Further investigation was undertaken in the main text of publications where this was not already reported in the title or abstract.

The second stage, (presented in Appendix 2), was directed at capturing data to answer the research question posed (i.e., what is the evidence base for the benefits of ACP in the UK?). A column was used to record whether the literature review research question has been answered by this paper, with commentary to explain judgement made regarding this. The key findings were summarised from those identified by the author/s of each study, (normally contained within the 'results' or 'outcomes' sections). The limitations have also been extracted and are as stated by the author/s of each study, taking into account the methodology and sample used. The final column summarises whether the paper allows for any gaps in knowledge pertinent to the research question to be identified. A summary of the key findings as they relate to the aims and key concepts of the literature review from this second stage of data extraction can be found in Table 3.2.

CRITICAL EVALUATION OF THE LITERATURE

The data extracted, alongside re-reading of each article was used to inform the critical evaluation of each study. It should be noted that critical evaluation of the quality of the research presented in the papers has not been used in this literature review to provide a filter for inclusion or exclusion, as the purpose is to identify what evidence is present. The assessment of quality used in this literature review informed conclusions as to how extensive and sound the evidence base is for the benefits of ACP. When searching for an appropriate method to systematically evaluate the quality of the literature identified in the search it was important to choose one that would be appropriate for a variety of research methods used in the research papers.

The papers returned can be categorised broadly into 4 types of methodology:

i. Literature review (n=11)
ii. Quantitative (n=5)
iii. Qualitative (n=15)
iv. Mixed method (n=13)

As noted by Dyba, Dingsoyr and Hanssen (2007), effective critical evaluation will necessarily require attention to different aspects due to the different processes that are determined by each methodology. In quantitative research, the way in which validity and reliability are addressed will differ from that in a qualitative study; they are measuring or capturing different things and so use different tools and processes to achieve this. Critical evaluation therefore needs to recognise the significance of using one measure or tool compared to another. For this reason, critical evaluation tools, such as those produced by the Critical Appraisal Skills Programme (2020), ask for assessment on different aspects of the research based upon the method used. There have been tools (including by Critical Appraisal Skills Programme, 2020 and Joanna Briggs Institute 2017) that have been developed specifically for systematic literature review, and this includes literature reviews that encompass both quantitative and qualitative research papers.

The most commonly referred to critical evaluation tools are Cochrane (Cochrane Library, 2020), The Campbell Foundation (2020), or The Joanna Briggs Institute (Aromataris and Munn, 2020). Underpinning these tools are often a set of principles that should be used to design, structure and record the research undertaken. As example, these all refer to the need for a protocol or pre-prepared plan that is designed or selected and agreed prior to critical evaluation taking place. Examining where these

principles have been addressed within publications can therefore be used as a basis for evaluation. This allows for consistency in the way in which the evaluation is conducted and ensures that significant areas of ‘quality’ are identified. This may take the form of a tool to structure the critical evaluation, for example “AMSTAR 2” used for critical appraisal of systematic reviews (Shea *et al.*, 2017). In searching for possible critical evaluation tools to use, I first attempted to use CASP (Critical Appraisal Skills Programme, 2020). CASP covered many of the significant areas that would be expected in performing a critical evaluation. However, I found the format difficult to use, and the ‘Yes/No/Can’t Tell’ was not sophisticated enough to capture the variety seen in the papers (e.g., ‘Sometimes’ or ‘Mostly’ may have been more useful). Being able to tabulate and summarise across the set of papers from the individual CASP forms was also not facilitated by the format provided by CASP.

Dixon-Woods *et al.* (2006) discussed the merits or not of using quality as a filter when the objective is to provide interpretive synthesis of literature (as is the case here). In their study papers were prioritised that appeared to be relevant rather than met particular methodological hierarchies of evidence or standards. They coupled this with inclusion of judgements and interpretations of the credibility and contribution that the papers made and noted that use of a structured approach to quality assessment may not always be more effective than broader judgements. In circumstances where the purpose is not to use ‘quality’ as a filter, taking a more simplified (e.g., RAG rating) approach may be more appropriate. This can provide a snapshot of quality as one source of information to feed into an interpretive, narrative, synthesis of the research. This chimed well with the intentions and approach taken in this literature review.

I was also conscious that ‘vote counting’ or ‘mathematical averaging’ may not capture the complexity of the context sufficiently (Greenhalgh, Thorne and Malterud, 2018). The purpose here was not to perform a meta-analysis where the quality of each paper would need to be tested to see if the data could be aggregated and synthesised across papers (Verbeek, Ruotsalainen and Hoving, 2012). Having noted in the protocol that this was a mixed method systematic review, a meta-analysis would not be possible or appropriate.

When looking at Hawker *et al.* (2002) ‘Appraising the Evidence’, the tool they used appeared to be specifically designed for the purpose of Mixed Method Systematic Review. This allowed it to be used across the 4 different types of research that had been picked up in the search and provided trigger questions that encompassed the different research methodologies employed in these studies. Using a scoring system from graduated and categorised quality statements allowed me to tabulate the papers into RAG ratings. This allowed me to not get bogged down in trying to filter the evidence in fine grading of quality, nor attempt to use a meta-analysis approach to produce aggregated data, but to get a broad understanding of the quality of the evidence available.

I piloted using the Hawker et al tool on the first 3 papers. From this I established there were some elements that did not capture fully the significant assessments of quality needed for this review. For example, in assessing reliability, particularly for quantitative or literature review research, an evaluation is needed of whether sufficient information has been provided that would allow the study to be repeated. This was not clearly stated in the Hawker et al tool under the section they called ‘Method and Data’.

Heyvaert *et al.* (2013, p. 1) advised that critical appraisal is *"an essential step in the development of a methodologically sound review"* and that tools used to do this need to fit with the methodology being evaluated. Stern *et al.* (2020) noted that there is a paucity of tools specifically designed for MMSR. Commonly assessments are carried out using different tools for each type of methodology and then the results are attempted to be synthesised. This risks undermining the principle of mixed method research which acknowledges the value of combining a variety of sources of evidence to better understand the 'whole' picture. The decision was made therefore to adapt the Hawker tool. Using the insight from the guiding principles of critical evaluation (Cochrane Library, Campbell Collaboration and Joanna Briggs Institute, 2020), I identified areas within the Hawker tool that needed adjustment to capture the key areas of critical evaluation needed for my review. (In Appendix 3 you can see the track changes made to the Hawker tool). A table was created for recording the results for each paper, (Table A, Appendix 4), and for summarising the evaluation with an overarching commentary of 'strengths and weaknesses', (Table B, Appendix 5). This allowed, as suggested by Popay *et al.* (2006), use of the data gathered on the quality of evidence gleaned to feed into analysis of the current evidence base in ACP.

INTERPRETATIVE NARRATIVE SYNTHESIS

When deciding which approach to take in the analysis of findings of this systematic literature review, I revisited the aim. I was struck by a particular approach which appeared to reflect the aim and research questions well: interpretative narrative synthesis. Greenhalgh, Thorne and Malterud (2018, p. 2) noted the importance of *"meaningful synthesis of research evidence relevant to such complex situations".* To do this they noted that the reviewer must incorporate a broad range of sources of

knowledge. The diversity of study types included in this review requires and acknowledges a range of evidence available on the complex topic of ACP. Selecting an approach that lends itself to a particular methodology type or assumes a certain standard of evidence was not therefore appropriate (Dixon-Woods *et al.*, 2006)

Noblit and Hare (1988, p. 17) discussed inductive, integrative approaches (commonly where data is accumulated and aggregated) and how these can relate to an interpretive approach aimed at achieving synthesis from research. Rather than attempting to purely aggregate data, they proposed that an interpretative approach can provide and preserve multiple perspectives and the unique contexts in which the research was generated (meta-ethnography). However, this focuses on synthesis of only qualitative (ethnographic) research rather than mixed methodologies. This systematic literature review is not therefore taking a meta-analysis or a meta-ethnographic approach to data analysis. However, it does fit with Noblit and Hare's notion that *"interpretive explanations are narratives through which meanings of social phenomena are revealed"* and that this can help to represent the reality from a number of perspectives (Noblit and Hare, 1988, p. 18).

The literature in this review has deliberately not been filtered for quality or forward citation searching used to determine 'impact' prior to inclusion to capture the range of evidence that has been published. However, this means there is likely to be a mix of strengths and weaknesses in the evidence reviewed. This requires interpretation to include appraisal of evidence quality alongside consideration of the findings from the literature. Greenhalgh, Thorne and Malterud (2018, p. 3) noted that the goal of narrative review is to provide an authoritative argument based on *"informed wisdom that is convincing to an audience of fellow experts."* This requires that the resulting

review and its conclusions authentically represent the underpinning evidence. The aim of this systematic literature review was to identify a gap in current evidence as a rationale for a research proposal. The objective was therefore to identify a way for the literature review to represent the underpinning evidence and how this has been drawn together to develop an appropriate and worthwhile focus for further research in ACP.

Dixon-Woods *et al.* (2006) noted the difference between interpretative and inductive approaches to review. The latter requires that concepts (or themes) to be specified in advance and evidence then assessed as to whether the concept can be supported or refuted. An interpretative approach allows the concepts to be drawn from an examination of evidence. The critical interpretive synthesis approach as described by Dixon-Woods *et al*. reflects the one taken here, where the narrative conclusions were drawn from appraisal of the evidence, synthesis of the data, and interpretation of the key findings of the literature. The synthesis presented in the next section of this chapter therefore includes reference to;

1. data extracted from the evidence base

   (PRISMA and summary of papers presented on page 57, plus data extraction presented in appendix 3),

2. a critical appraisal of the evidence as a 'moderator variable'

   (RAG rating presented in table 3.2 on page 57, plus detail of appraisal provided in Tables A & B presented in appendices 4 and 5),

3. synthesis of the evidence base using thematic analysis including use of groupings, as described by (Popay *et al.* (2006, p. 17).

   (summarised later in this chapter in Table 3.3)

SYSTEMATIC LITERATURE REVIEW FINDINGS

TABLE 3.1 – PRISMA flow diagram

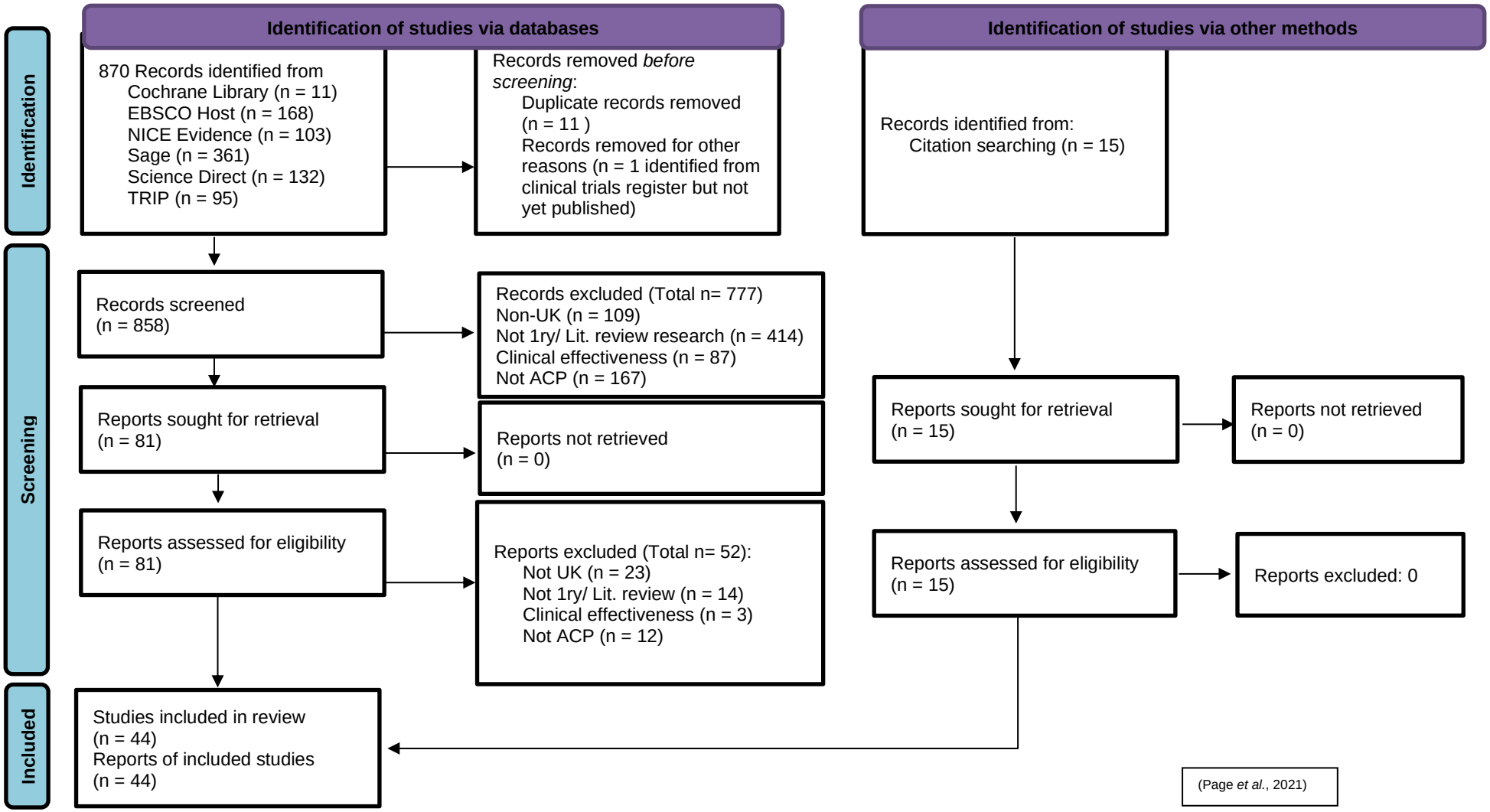


TABLE 3.2.- Summary of Papers

No.	Reference	Title	Methodology	Participants/ sources	Key findings reported re 'benefits' of 'ACP' and gaps in evidence base	Quality RAG rating
1	Bagley (2018) Nursing Standard; 32(26): 41-50.	Exploring emergency nurse practitioners' perceptions of their role.	Qualitative phenomenological study using semi-structured interviews	Emergency Nurse Practitioners (n=6)	There are several barriers but also opportunities for ACP including education and to enhance their scope of practice. Although it is not articulated what the benefits of these are for key stakeholders	
2	Barea (2020) Practice Nursing, 31(1): 31-36.	What is a Primary Care Advanced Practice Role in Cornwall?	Quantitative questionnaire	Primary Care practitioners practicing with an advanced title in Cornwall (n=34 respondents which was 60% of those invited)	Provides a picture of a subset of the ACP community and to what extent this aligns with agreed definition and benfits of ACP which could be evaluated in other ACP populations.	
3	Barratt (2010) Nurse Education in Practice, 10(3): 170-175.	A focus group study of the use of video-recorded simulated objective structured clinical examinations in nurse practitioner education.	Focus Group	ACP students in first semester of 2007-2008 cohort at a post-1992 London University. (n=16) 8 first year nurse practitioner students, 8 final year nurse practitioner students	Focuses on the effectiveness of one particular type of educational methodology. Further research needed to evaluate types of education methodology to be used in ACP education and what benefits this has for ACP in general.	
4	Bird and Kirshbaum (2005) Clinical Effectiveness	Towards a framework of advanced nursing practice	Literature review	Medline, CINAHL and Google Scholar databases (n=8 articles) focussing	Provides/ confirms a definition of and framework for ACP roles which may raise awareness of ACP and potential benefits it creates particularly within research nursing	

No.	Reference	Title	Methodology	Participants/ sources	Key findings reported re 'benefits' of 'ACP' and gaps in evidence base	Quality RAG rating
	in Nursing, 9, (3–4); 161-171	for the clinical research nurse in cancer care		on UK based clinical research nurses in cancer care	and cancer care, (but does not evaluate this directly)	
5	Carney (2016) Journal of Nurse Management, 24:105–14.	Regulation of advanced nurse practice: its existence and regulatory dimensions from an international perspective	Literature review	Scholarly nursing papers (n=510) published in CINAHL, PubMed and MEDLINE between 2002 and 2013 and websites (n=30). Materials were reviewed in relation to 19 countries: Australia, Canada, Denmark, Finland, France, Germany, Hong Kong, Ireland, Italy, Japan, Netherlands, New Zealand, Norway, Singapore, Spain, Sweden, Switzerland, United Kingdom and United States.	Provides an overview of the variety of regulation/ governance structures for ACP and suggests this is a barrier to effective implementation (and thereby achieving the benefits) of the role.	
6	Cooper, McDowell and Raeside (2019) British Journal of Nursing; 28	The similarities and differences between advanced nurse practitioners and clinical nurse specialists.	Literature Review	Search in CINAHL, Medline and Embase databases (n=12 articles). Range of titles used to capture different roles. Papers were	Comparison of CNS and ACP roles which feeds into a definition of ACP and explores its scope and potential beneficial impact for clinical outcomes, noting that variation exists.	

No.	Reference	Title	Methodology	Participants/ sources	Key findings reported re 'benefits' of 'ACP' and gaps in evidence base	Quality RAG rating
	(20): 1308-1314			international although all published in English language only.		
7	Currie *et al.* (2012) Nurse Education Today, 32(3): 267-272.	Participants' engagement with and reactions to the use of on-line action learning sets to support advanced nursing role development.	On-line survey and in-depth interview	ACP nursing students in Scotland from both urban and rural NHS boards(n=15)	Focuses on the effectiveness of one particular type of educational methodology. Further research needed to test effectiveness and potential benefit from using this (or other) educational methodology for ACPs.	
8	De Bont *et al.* (2016) BMC Health Services Research; 16: 1-14.	Reconfiguring health workforce: a case-based comparative study explaining the increasingly diverse professional roles in Europe.	Case studies (x16) including interviews (x160) and observations (600+ hours)	Physicians, nurses, health care professionals in new roles in health care clinics in 8 European countries	Notes significant variation of implementation of ACP raising the concept of and potential for further research on 'localisation' of the role which restricts scope of practice, autonomy and barriers/ facilitators to effective implementation and thereby benefits of role being achieved.	
9	Delamaire and Lafortune (2010) Organisation for Economic Co-operation and Development,	OECD Health Working Paper No. 54 Nurses In Advanced Roles: A Description and Evaluation of	Policy and data questionnaire, plus review of the literature.	Designated national experts in the participating countries (n=12) focusses on Nurses only, including CNS and ANP roles.	Collates the evidence of benefits ANPs have in terms of cost, patient outcomes, patient satisfaction, access to care and to some extent career prospects. Raises potential for further research on career routes and their impact on recruitment/ retention of Nurses. And clinical outcomes.	

No.	Reference	Title	Methodology	Participants/ sources	Key findings reported re 'benefits' of 'ACP' and gaps in evidence base	Quality RAG rating
	Health Working Paper No.54, 8th July 2010	Experiences In 12 Developed Countries				
10	Dowling *et al.* (2013) International Journal of Nursing Practice; 19: 131–140	Advanced practice nursing: A concept analysis	Rodgers's evolutionary method of concept analysis	Data sources included Medline, CINAHL, Applied Social Sciences Index and Abstracts (ASSIA), Cochrane Library, Science Direct, SCOPUS, Web of Science, Dissertation Abstracts and DARE as well as relevant nursing texts and professional organisation websites. n=184 papers from 'United Kingdom (UK)', 'United States (US)', 'Canada', 'Australia', 'New Zealand', 'Ireland' and 'Nordic States'.	Highlights the consensus around the definition of ACP whilst noting the variation in regulation/ governance, titles used and education preparation for the role. Makes a distinction between role extension and role expansion noting their impact on potential benefits/ negative outcomes but this would need to be researched further.	
11	Duffield *et al.* (2009) Collegian; 16(2): 55-62,	Advanced nursing practice: A global perspective,	Literature Review	CINAHL, Medline, and the Cochrane database of Systematic Reviews were searched from	Confirms the consensus around the definition of ACP whilst noting variation exists which could create a barrier to benefits of the role being achieved. Old,	

No.	Reference	Title	Methodology	Participants/ sources	Key findings reported re 'benefits' of 'ACP' and gaps in evidence base	Quality RAG rating
				1987 to 2008. Information was also obtained through government health and professional organisation websites (number of documents retrieved is not specified). Focuses on Nurses only in the UK, USA, Canada, New Zealand and Australia	limited scope of study that may need to be revisited for global and current context.	
12	Elliott *et al.* (2016) International Journal of Nursing Studies, 60: 24-45.	Barriers and enablers to advanced practitioners' ability to enact their leadership role: A scoping review.	Literature review	Databases PubMed, CINAHL, PsycINFO, ProQuest Dissertation and Theses, (n=34 papers). Papers reviewed were included from the United Kingdom, Ireland, Canada, United States, Australia, New Zealand, Taiwan and Northern Ireland	Identifies the potential benefits of ACP, particularly from a leadership perspective whilst also noting potential barriers to effective implementation of the role; presents opportunity to evaluate benefits/ barriers further.	

No.	Reference	Title	Methodology	Participants/ sources	Key findings reported re 'benefits' of 'ACP' and gaps in evidence base	Quality RAG rating
13	Endacott and Chaboyer (2006) Nursing in Critical Care, 11(2): 94-102.	The nursing role in ICU outreach: an international exploratory study.	Descriptive case study design using semi-structured interviews and job descriptions as sources of evidence	Australian ICU Liaison nurses (n=6) English ICU Consultant Nurses (n=4)	Provides confirmation of consensus around definition of ACP and identifies potential benefits and barriers to effective implementation of the role which have not been directly evaluated in this paper and could be compared where ACP roles do not currently exist.	
14	Gerrish *et al.* (2011) Journal of Advanced Nursing 67(5): 1079–1090.	Factors influencing the contribution of advanced practice nurses to promoting evidence-based practice among front-line nurses: findings from a cross-sectional survey	Cross-sectional survey	Advanced practice nurses (n-855) working in hospital/ primary care settings in England (n=87)	Provides a picture of ACPs and their interaction with EBP noting that policy was used more often than reference to primary research. Suggests potential for ACPs to be change agents and lead on using EBP for problem solving, although there are some barriers to this. Further research could focus on whether ACPs agree with this conclusion and that their confidence/ ability to use EBP and to influence policy etc builds over time.	
15	Gloster, Neville and Windle (2015) Nursing Management – UK, 21(10): 23-30.	Effects of advanced practitioners' learning in one hospital.	Programme evaluation using Kirkpatrick's model; includes questionnaire, measurement of outcome (increase in knowledge) from a portfolio of evidence (assignment outcomes, end of programme	Convenience sample, self-selecting- first to volunteer from the 2007-2012 graduates of the MSc Advanced Practice programme in Salford(n=15)	Provides a picture of ACP, noting significant variation although common themes to their experience. Some potential benefits of ACPs as viewed by others were reported although these were anecdotal so could be researched further.	

No.	Reference	Title	Methodology	Participants/ sources	Key findings reported re 'benefits' of 'ACP' and gaps in evidence base	Quality RAG rating
			questionnaire), interviews observation in practice, & assessment against KPIs.			
16	Heale and Rieck Buckley (2015) International Nursing Review 62: 421–429	An international perspective of advanced practice nursing regulation	On-line survey	National Nursing Associations and nursing health policy makers worldwide from June to December 2015 (n=36 responded from a possible 135. 6 provided incomplete data, and only 24 responded to all questions)	Provides a global overview/ context to ACP and the potential benefits and barriers to effective implementation (further research could evaluate this more directly).	
17	Hughes *et al.* (2017) International Journal of Clinical Pharmacy, 39(4): 960–968	Future enhanced clinical role of pharmacists in Emergency Departments in England: multi-site observational evaluation	Multi-site observation study	Patient attendance at Emergency Departments in England (n=400)	Provides evidence of ways in which ACPs can contribute to managing workload within the specific area of ED which could be tested in other specialities. Recommends the training that is needed- this could also be tested for success in achieving intended objectives.	
18	Hutchinson (2014) Nursing Research, 63(2):116-28.	Deriving Consensus on the Characteristics	A three-phase approach involved (a) systematic review of the	Manuscripts (n=50) met inclusion criteria and were retained for analysis.	Presents common features of ACP and adds to consensus regarding definition of ACP whilst also noting some variation.	

No.	Reference	Title	Methodology	Participants/ sources	Key findings reported re 'benefits' of 'ACP' and gaps in evidence base	Quality RAG rating
		of Advanced Practice Nursing	literature, (b) qualitative meta-summary of practice characteristics extracted from manuscripts (c) statistical analysis of domains across advanced practice categories.		Suggests benefits of the role but does not test this directly.	
19	Kaldan (2019) British medical Journal, 9(9); 1-5	Evidence characterising skills, competencies and policies in advanced practice critical care nursing in Europe: a scoping review protocol.	Five-stage scoping review methodology with a comprehensive systematic literature	Interdisciplinary databases (n=9) and grey literature for publications originating in European countries in 1992-2018. Focuses on critical care nurses only.	Adds to the consensus definition of ACP and proposes the benefits of the ACP role although does not examine the evidence base these conclusions have been drawn from.	
20	Lloyd Jones (2005) Journal of Advanced Nursing, 49(2):191-209.	Role development and effective practice in specialist and advanced practice roles in acute hospital settings: systematic	Systematic literature review	Papers identified (n=14) 'mostly' from the UK and they excluded Mental Health & Midwifery specialities	Provides a view on personal characteristics of ACP and the potential barriers and facilitators to effective implementation / achievement of benefits of the role although these are not measured directly.	

No.	Reference	Title	Methodology	Participants/ sources	Key findings reported re 'benefits' of 'ACP' and gaps in evidence base	Quality RAG rating
		review and meta-synthesis.				
21	Mackavey and Cron (2019) Nurse Education Today, 76: 85-88.	Innovative strategies: Increased engagement and synthesis in online advanced practice nursing education.	one-way analysis of variance to compare Health Education Systems Incorporated examination scores between semester cohorts of students, followed by a post hoc pairwise comparison	Students on a Family Nurse Practitioner program pre and post changes in curriculum redesign that introduced use of gamification. 522 test results over the period of the study with 87 of these post new curriculum.	Focuses on one type of education methodology and its potential to support ACP student development but does not evaluate how this may feed into benefits being generated from ACPs. Potential to extend this research to measure whether it enhances ACPs effectivity.	
22	Manley (1997) Journal of Clinical Nursing; 6 (3): 179–190.	A conceptual framework for advanced practice: an action research project operationalizing an advanced practitioner/consultant nurse role.	Action Research	An advanced practice/consultant nurse role in a Nursing Development Unit	Provides a roadmap/ conceptual framework for ACP which adds to the consensus regarding definition of ACP. The potential facilitators identified (particularly around education aspects of ACP) could be further researched to evaluate their impact on effective implementation of ACP roles.	
23	Mantzoukas (2007) Journal of Clinical Nursing; 16: 28–37	Review of advanced nursing practice: the international literature and developing the generic features	Systematic literature review	Database search of Ovid, CINAHL and Medline. Plus use of snowballing (n=46 papers). Only papers in the English language	Identifies the generic skills and attributes of ACPS which adds to the understanding/ definition of ACP. Further research could use this to develop education programmes for ACP or see if these are contained within current ACP training programmes.	

No.	Reference	Title	Methodology	Participants/ sources	Key findings reported re 'benefits' of 'ACP' and gaps in evidence base	Quality RAG rating
				were retrieved from USA, UK, Canada, Holland, Australia, Brazil and Ireland		
24	Marsden (2003) Journal of Advanced Nursing; 43(6): 595–605	Nurse practitioner practice and deployment: electronic mail Delphi study	Delphi study using e-mail	Key stakeholders (n=24) in NP practice, education and research and (non-governmental) policymaking	Explores the barriers and facilitators to effective implementation of the ACP role. Used 'key thinkers' as participants) not necessarily ACPs themselves). Could create potential for researching where facilitators exist if benefits of ACP are realised.	
25	Marsden (2013) Journal of Research in Nursing, 18(1): 7-18.	Advanced practice in ophthalmic nursing: A comparison of roles and the effects of policy on practice in the UK and New Zealand.	Mixed method questionnaire	National ophthalmic nursing conference ANP participants in UK (n=22) & New Zealand (n=17)	Discusses the evolution of the ACP in one speciality, noting the drivers that have influenced its development. Suggests lack of policy has aided its evolution which could be explored further to see if this enhances effectivity of the role in this or other specialities.	
26	McConnell (2013) International Emergency Nursing, 21(2): 76-83	Emergency nurse practitioners' perceptions of their role and scope of practice: Is it advanced practice?	Survey using questionnaires	All emergency nurse practitioners working in Accident and Emergency Departments and Minor Injury Units in a region in the UK (n=42)	Focuses primarily on the limiters to effective implementation of this role in one particular speciality taken from ACPs perspective. Could present opportunity to see if this is the same in other specialities and if this has an impact on benefits of the role (particularly for ACPs themselves).	

No.	Reference	Title	Methodology	Participants/ sources	Key findings reported re 'benefits' of 'ACP' and gaps in evidence base	Quality RAG rating
27	McDonnell (2012) Journal of Research in Nursing, 18(4); 368-383	The perceived impact of advanced practice nurses (APNs) on promoting evidence-based practice (EBP) amongst frontline nurses: findings from a collective case study	Collective instrumental case study	Extended case studies (n=5) and short case studies (n=18) in a range of hospital and primary care settings across seven Strategic Health Authorities in England	Looks at the impact of EBP for ACPs. It was found hard to measure but suggestions given of potential beneficial impact and confirms EBP as important in the definition of the ACP role. As this was an old study could be used to explore modern and multi-professional context of ACP.	
28	McDonnell (2015) Journal of Advanced Nursing, 71: 789–799	An evaluation of the implementation of advanced nurse practitioner (ANP) roles in an acute hospital setting.	Collective case study.	A district general hospital in England in 2011–2012. Interviews with strategic stakeholders (n = 13) were followed by three individual case studies including direct observation of practice and collection of documentation e.g. job descriptions.	Provides evidence of beneficial impact of the ACP role for patient outcomes and for others in the team. Highlights features that contribute to this. Could be used to research in other settings. Beneficial impact for the ACPs themselves not fully explored.	
29	McGee (1996) British Journal of Nursing, 13-26; 5(11): 682-686.	A Survey of Specialist and Advanced Nursing Practice in England.	Questionnaire	Chairman & Chief Nurse of NHS Trusts in England (n=371)	An old study which provides a picture of early development of the role and features of the CNS as opposed to ACP role. Notes variety of implementation. Could be used as a comparison for modern context. Benefits	

No.	Reference	Title	Methodology	Participants/ sources	Key findings reported re 'benefits' of 'ACP' and gaps in evidence base	Quality RAG rating
					suggested were not measured directly and respondents not ACPs themselves.	
30	Miller, Cox and Williams (2009) Institute for Employment Studies, Report 465.	Evaluation of Advanced Practitioner Roles	A review to identify appropriate measures to use in the evaluation; survey (n=2), and case studies (n=4)	Survey of sites at which Advanced Practitioners were employed and a similar survey of sites without these roles (n=13 respondents); and case studies (n=4) of implementation sites	Describes evolution and implementation of the ACP role (e.g. substitution v supplementation) noting the variety of practices which have potentially limited beneficial impact of the role. Provides evidence of cost-benefit analysis whilst more work on this needs to be done. Qualitative evaluation of benefits/ impact not included (e.g. staff morale).	
31	Pulcini *et al.* (2010) Journal of Nursing Scholarship, 42(1): 31–39.	An International Survey on Advanced Practice Nursing Education, Practice, and Regulation	Cross-sectional, descriptive Web-based survey preceded by pilot study	Key informants and active members of the Inter-national Nurse Practitioner-Advanced Practice Nursing Network of the Inter- national Council of Nurses. (n=174)	Adds to/ confirms the definition and key features of the ACP role internationally. Does not measure benefits directly and respondents may have skewed results where the majority were educators/ highly engaged at policy level. Could be repeated to capture modern context and expanded (e.g. used English language only) to get a broader picture.	
32	Read *et al.* (2001) Final Report King's Fund Nursing Developments Programme King's Fund	Exploring New Roles in Practice (ENRiP) Final Report	stage one – a mapping exercise to identify the range and purpose of new roles) stage two – a set of case studies stage three – a survey	Nurses and professions allied to medicine (PAMs) in a sample of acute Trusts throughout England (excluding maternity, community and psychiatric services) Stage 1 n= 5 Trusts	Adds confirmation to the volume and multivariate nature of ACP and how they have been established. Some potential 'clinical effectiveness' benefits of ACP implementation, are measured by self-report; could be revisited for modern context and more direct evaluation undertaken.	

No.	Reference	Title	Methodology	Participants/ sources	Key findings reported re 'benefits' of 'ACP' and gaps in evidence base	Quality RAG rating
				Stage 2 n=3 case studies, including 17 nursing roles and 15 PAMs Stage 3 survey sent to 782 potential participants with a 79% response rate.		
33	Roberts-Davis (1998) Accident & Emergency Nursing, 6(1): 36-40	Education. Realizing specialist and advanced nursing practice: a typology of innovative nursing roles.	Delphi technique, Literature review and Interview	Informants (n=49) Demography for literature review not provided.	Explores the context at that time regarding difference/ overlap between CNS and ANP roles and adds to the definition of ACP and the proposed benefits of the role although this was not measured directly in this paper.	
34	Rogers (2013) Nursing Standard, 27(36): 35-39.	An evaluation of therapeutic optimism in advanced nurse practitioner students.	Pre and post-test evaluation	3 cohorts of students of the ANP programme at University of Huddersfield 2009-2012. Pre-test n=65 respondents, post-test n=57	Suggests that ANP education can contribute to therapeutic optimism which may enhance mental health patient outcomes in primary care.	
35	Shearer D and Adams (2012) Nursing Standard, 26(21): 35-41.	Evaluating an advanced nursing practice course: student perceptions.	Descriptive qualitative study using a framework for thematic content analysis	ANP Masters students (n=10) at 1 English University	Focus on student ANP so not clear if benefits are sustained post-qualifying but some personal benefits (e.g. job satisfaction) were identified, as well as some barriers to effective implementation of the role.	

No.	Reference	Title	Methodology	Participants/ sources	Key findings reported re 'benefits' of 'ACP' and gaps in evidence base	Quality RAG rating
36	Smith and Hall (2003) Archives of Disease in Childhood, 88(5): 426-9	Developing a neonatal workforce: role evolution and retention of advanced neonatal nurse practitioners.	Semi-structured open-ended questionnaire	Advanced Neo-natal Practitioners (n=95, 83% response rate)	Identifies important barriers/ facilitators for key stakeholders regarding ACP, and potential benefits of the role (e.g. retention). Could be repeated for other specialities and current context.	
37	Taylor (2012) Joanna Briggs Institute Library of Systematic Review, 10:1-22	The Experience and Effectiveness of Nurse Practitioners in Orthopaedic Settings: A Comprehensive Systematic Review.	Systematic literature review. Use of JBI-MAStARI tool for quant analysis and JBI-QARI for qual and textual data extraction using JBI-NOTARI	Published studies and opinion papers up until 2012, 31 studies 19 quant, 11 text and opinion pieces and 1 qualitative thesis (unpublished). International databases plus specific sources from Australia (where this study was based).	For a specific speciality identifies barriers/ facilitators of the role and some potential benefits (particularly around patient outcomes) as well as some personal attributes that are a feature of ACP. Could be replicated for other specialities and current context.	
38	Tee, Jowett and Bechelet-Carter (2009) Nurse Education in Practice, 9(6): 377-382.	Evaluation study to ascertain the impact of the clinical academic coaching role for enhancing student learning experience within a clinical	Case study research design with a two-stage evaluation with analysis of structured questionnaires and interviews (x10)	MSc ACP students (n=35) and coaches (n= 15) in 2007 at a UK HEI. 35 questionnaires were returned, and 10 interviews were conducted.	Focus on one educational methodology (coaching) and the potential benefits it has for the ACP role (e.g. aiding transition into the role). Could be replicated with larger sample size and extended into a longitudinal study to see if benefits continue to have an impact.	

No.	Reference	Title	Methodology	Participants/ sources	Key findings reported re 'benefits' of 'ACP' and gaps in evidence base	Quality RAG rating
		masters education programme.				
39	Thompson *et al.* (2019) Journal of Health Organisation & Management,33(4): 443-459	Whole Systems Approach: Advanced Clinical Practitioner Development and Identity in Primary Care	Qualitative using online survey followed by interview and Braun & Clarke's 6 phase method for data analysis	22 staff working in primary care and perceived themselves to be ACPs in Northern England	States there are 5 factors that influence role identity and development of ACP and that expectations of ACPs are not currently being met (which could limit benefits of the role being achieved). Could be repeated with current ACP education/ governance context and to identify what could be focussed on to meet ACPs expectations.	
40	Tsiachristas *et al.* (2015) Health Policy, 119: 1176-1187	Costs and effects of new professional roles: Evidence from a literature review	Literature review Conducted in Western Europe, North America, New Zealand, or Australia papers written in English, German, French or Dutch language.	studies (n=41) of specialist nurses (SNs) and advanced nurse practitioners (ANPs) were selected for data extraction and analysis	Raises doubt over claims that ACP roles can create cost benefits but endorses that they can have an impact on service redesign and enhancing clinical effectiveness. Notes paucity of evidence re cost-benefit analysis.	
41	Williams (2017), Emergency Nurse, 25(4): 36-41	Advanced practitioners in emergency care: a literature review.	Literature Review. Demography stated as 'international' English language only.	n=4 papers	Provides a view on potential benefits, barriers and facilitators to the ACP role in this particular setting. The claim that this provides a career structure and route to recognition could be explored further as this is disputed in other papers.	
42	Williamson *et al.* (2006) Journal of Clinical Nursing, 15(9): 1091-1098.	Change on the horizon: issues and concerns of neophyte advanced health	Qualitative design: focus group interviews	ACP students (n=16) from 2 cohorts	Overall evidence of personal benefits from ACP training as well as identifying some barriers. This could be revisited to see if these continue further into the ACP career.	

No.	Reference	Title	Methodology	Participants/ sources	Key findings reported re 'benefits' of 'ACP' and gaps in evidence base	Quality RAG rating
		care practitioners.				
43	Wilson-Barnett *et al.* (2000) International Journal of Nursing Studies, 37(5): 389-400.	Recognising advancing nursing practice: evidence from two observational studies.	'reflective' observation	Nurses, midwives, health visitors (n=19)	Provides insight into the ACP role and particularly the clinical aspects and personal attributes that may be needed to gain benefit from the role. Further research could focus on the gap in evidence for non-clinical aspects of the role.	
44	Woods (1998) Intensive and Critical Care Nursing, 15: 308-317	Identifying the practice characteristics of advanced practitioners in acute and critical care settings.	Longitudinal, multiple case study. Interviews, observation of clinical practice and self-report role development diaries completed over their first 6 months as an ACP.	11 ANPs post completion of Masters in Health Studies working in acute and high dependency clinical settings over a 2 year period	Examines (from the ANPs own perspective) the scope and reality of the role (including barriers and facilitators to benefits being achieved). Notably the non-clinical aspects of the role are identified as significant, particularly where patients had high dependency/ acuity.	

A total of 841 papers were excluded from the initial search results (n=885). The largest proportion of these were excluded as they were not primary research or literature reviews (n=428). This reinforced the author's original hypothesis that there exists a large amount of opinion, discussion, or editorial based discourse on ACP and that practice, policy or theoretical literature dominates, with a much smaller amount being published that is primary research.

Papers that did not focus on the scope of ACP (as had been defined above and in the 'STARLITE' tool) contributed the next largest category for exclusion (n=167). These papers were excluded as they focused on:

- a particular clinical specialty (not the advanced practice that may be present within that specialty),
- other job roles or stages of career, such as pre-registration students, clinical educators, consultants, or clinical specialists.
- specific sub-types of professional training or enhanced or specialist practice which may form a clinical part of ACP but is not ACP in its entirety (e.g., endoscopy, primary care nursing, or non-medical prescribing).
- other types of training or education (e.g., pre-registration healthcare profession training rather than ACP, or not at Masters level),

There were relatively few articles that were excluded as 'not ACP' on the basis of not being at Masters level (n=11). This small number of exclusions may be because there is now consensus of Masters level training and education being part of the definition of ACP, with this being a common expectation globally.

The multi-professional framework for ACP (HEE 2017) and ACP apprenticeship standard have further reinforced the expectation that ACP training and education should be at a post-graduate level. Papers were included where the level of training or education was not exactly specified and so were presumed to encompass, at least in part, ACPs that had been trained at Masters level.

There is a question over what extent people currently working at an advanced practice level or employed in ACP roles have been trained to Masters level, and it could be expected that a significant proportion of 'legacy' ACPs may not have previously been required to or achieved this level of academic qualification. As the CfAP moves beyond the accreditation of ACP education programmes and opens up opportunities for existing ACPs that have not completed an accredited programme to receive recognition via the e-portfolio route, we may then be able to estimate the scale of ACPs that do not meet the Masters level criteria. Certainly recent funding arrangements to support ACP training and education has recognised this, as opportunities for use of Accreditation for Prior and Experiential Learning and 'top-up' courses for those that do not have a Masters have been made available (Health Education England, 2021c).

The large number of papers that were excluded due to not fitting the 'ACP' criteria, gave confirmation to the much cited issue of ACP, in that the definition, scope and titles used are multi-variate and may be confusing. As was utilised in this literature review, future research therefore needs to define carefully at the outset what is meant by ACP and what types of people, job roles, scope, and training/ education are encompassed by this definition.

After exclusion of ‘non-primary research/ literature review’ and ‘not ACP’, the third largest number of papers were excluded as they did not focus on or include the UK as the setting for the research (n=132). This does highlight that there is research that has been conducted globally in this field, some of which may be transferable to the UK context. The UK phenomenon of ACP could therefore be argued to be under-researched in comparison to the larger body of research available at an international level. A significant amount of research in this area was evident from the USA, which is often referenced as the potential country of origin for development of ACP.

Research that focused on measurements of clinical effectiveness were also excluded (n= 90). These often focused on measurements such as reduced waiting times, patient satisfaction scores, or comparisons of outcome between a Doctor and an ACP undertaking a particular aspect of clinical assessment or intervention. It highlighted (as anticipated) that a significant amount of research has been conducted in this area of measuring the benefits or impact of ACP with a consensus now being evident of how this compares to services or healthcare context where an ACP is not present.

The EBSCO Host database gleaned the largest number of papers, with papers identified through snowballing producing the next largest batch included in the final review. Not surprisingly the National Institute for Clinical Excellence Evidence database returned the smallest number of papers (n=1) due to its focus on producing policy documentation based on research that collects evidence on clinical interventions and effectiveness (clinical effectiveness being an exclusion criteria in this literature review). A relatively small number of duplicates (11) were removed, noting that when snowballing, only ‘new and as yet undiscovered’ papers that fitted the inclusion criteria were reviewed.

All papers identified through the above process were able to be viewed on-line and downloaded as full text, except one clinical trial which had been registered but not yet published and so was excluded from the review. Over half of those initially screened as meeting the inclusion criteria were ultimately excluded once review of the full text had taken place. As with initial screening, ‘not UK’ and ‘not literature review/primary research’ were common reasons for ultimately being excluded.

CRITICAL EVALUATION OF THE QUALITY OF THE RESEARCH

The methodology types were mixed with a range of quantitative, qualitative, literature review, and mixed method studies. Use of a quantitative method was the least frequent and no randomized controlled trials were found in this search. The quality varied across the range of methodologies; there was not a particular methodology that had a generally higher or lower quality than the others with strengths and weaknesses being found across the full the range of methodologies employed.

Use of a protocol or clear plan of how the research was conducted is a good example of the variety of quality of evidence available, regardless of the methodology. For most papers, some form of protocol was evidently in place to structure the design and process of the research undertaken. There are examples of clear protocols in place in literature review (e.g., Elliot *et al*, 2016), quantitative (e.g., Rogers *et al* 2013), qualitative (Tee *et al* 2019), and mixed method study types (Read *et al* 2001). These papers included description of not only how the research was conducted, but also how and why particular methods were chosen and developed prior to their implementation in the research in order to achieve the project aim.

There are also examples across all categories of methodology where the protocol has been poorly described (e.g., McGee *et al* 1996- mixed method; Dowling *et al* 2012- qualitative; Heale and Buckley 2015- quantitative; and Duffield *et al* 2009- literature review). Discussion of the rationale behind the methodological choices made was not always explored. Often this was discussed in an implicit rather than explicit way. This may lead to assumptions being made about why researchers chose one method over another, rather than providing assurance that the research design was the most effective way to achieve the aims of the research. As an example, in the Williams paper (2017), a literature review was chosen to establish the evidence for ACP roles in emergency care. There was an extensive background discussion, but it is not clear why a literature review was chosen over perhaps direct observation. The fact that only 4 papers were reviewed further questions whether the methodology was the right choice to achieve the aim. Explanation of the rationale behind the choices of method made (e.g., the databases accessed, the data extraction and analysis process used) may have added power to the somewhat weak evidence base upon which the conclusions and recommendations were then drawn.

The Titles, Abstract and Introduction sections were generally of high quality with good presentation of the background and context, including reference to other research or a literature review to help ‘set the scene’. There was a lack of use of defining clear research questions, although the aims or objective of the research were often more clearly stated and usually appeared to flow well from the discussion of the background or context in which the research was set. De Bont *et al.* (2016) is a good example where questions were clearly defined based upon the aims of the research and these were then returned to in presenting the results and discussing findings.

Clear presentation of how data collection or analysis within the research was conducted was sometimes lacking. Whilst this may be due to limited wordage being available in some publications, this meant having confidence that the findings and conclusions reflect the actual data collected in the research was not always easy to achieve. In the paper by Miller, Cox and Williams (2009), they carefully described the rationale and process behind developing the data collection tools, but did not then provide detail of how the data was analysed. This, combined with no reporting of the actual data gleaned, makes it more difficult to assess whether the findings accurately reflect the data. Discussion of potential bias and how this was attempted to be addressed also comes into play here; because the process of data analysis was not clearly presented, it was not always transparent that the process of data analysis had sufficiently protected against interpretation bias when presenting the results.

Overall, presentation of results performed better than in other areas of the papers; findings were often clearly presented and could be easily linked to the data gleaned from the research. Conclusions and discussion about the potential impact of the findings from the research was often good, with many highlighting areas that require further development or more research. Gerrish *et al.* (2011) was a useful example where data collected directly from the research was presented in tables and using quotes from participants alongside discussion of the findings, limitations, and implications for future practice, policy, or research. Conversely the paper by Roberts-Davis (1998) provided little connection between the data presented, and explanation of the findings or how the conclusions have therefore been drawn from the data collected.

Ethical considerations, including acknowledgement of potential bias in the research, stood out as the element that was performed worst. Most often, only the fact that ethical approval had been sought and gained was reported, rather than any further discussion of potential ethical issues the research may raise and how these were attempted to be addressed. For example, in the Currie *et al.* (2012) paper, it was noted that the research was based on 'ethical principles' and the project had been scrutinised by a committee; however, it also noted that participants were required to respond due to funding arrangements. Further discussion of how this may have affected participants' autonomy was therefore warranted as a significant 'ethical consideration'.

Acknowledgement of the limitations of the research was often where quality was most affected in critical evaluation. Limitations or confounding factors were either not discussed fully, or there was only occasional reference to how these had or could have been addressed or was taken account of when drawing conclusions. The paper by Gloster, Neville and Windle (2015) provides an example of this, where the limitations of the research were not acknowledged or explored. The recommendations for future development they provided also appears to sit separately from the results and does not include discussion of implications for future research. This has the effect of providing a limited evidence base upon which to support their recommendations.

Research found in this review tended to focus either on a small, specific sub-set of the ACP community, or attempted to get a more global picture of ACP that included the UK perspective. Even in the global-based research, where literature was drawn upon as part of the research, it was restricted to those published in the English language only (e.g., Pulcini, Jelic, Gul, and Loke, 2009). This will potentially have excluded capturing the diversity of ACP.

Bias in terms of selection of the sample was evident, where convenience appeared to be the dominant feature in 'choosing' the methodological approach. This influenced my ability to judge how representative the sample was of the general population that had been the focus of the study, particularly where the broader population had been poorly defined or described. As an example, Marsden, Shaw and Raynel (2010) attempted to establish a picture of ACP in Ophthalmic Nursing by using a voluntary questionnaire distributed at a national conference. The results were based on how people who answered the questionnaire viewed their role. Those privileged to attend a national conference may not be reflective of the broader population of Ophthalmic Nursing ACPs. In Marsden (2003), the researchers selected 'key thinkers', but did not adequately describe the criteria of what constitutes a 'key thinker'. They highlighted that this was done to prevent local issues dominating, however, there is a risk that this perpetuates bias and misses out on identifying patterns that occur at a local level that may be significant to the general population. The sample size (as in much of the research) was small and few details of the sample were given so it is difficult to tell if they were representative of the broader ACP population or a sub-section of it. This is a significant consideration in ACP research, where it is known that there is a diverse population, covering many different role titles, professional groups, levels of training and education, clinical specialties, and types of practice, which may include role substitution or provision of supplementary services.

Small sample size, or a sample that captures only one element of the broader ACP community, is a common feature with the research conducted thus far. This is acknowledged by some, including Tsiachristus *et al* (2015), when drawing conclusions or setting out the rationale for undertaking this research and Hutchinson (2014) who draws attention to it as a limitation of the research they conducted. Research such as

Barea's study of primary care advanced practice in Cornwall (2020), or Smith and Hall's research on a specific group of advanced neonatal nurse practitioners (2003), clearly specified the sample and noted the objective was to understand ACP in that particular context. Research such as Delamaire and Lafortune (2010) which attempts to capture a more general theme, concept, or experience may have external validity, but cannot assume the conclusions are applicable to all types, contexts, professional groups, or clinical specialties in ACP. The multi-factorial, and diverse nature of ACP, even within discrete areas of practice has been well established (e.g., McConnell *et al* 2013 who focused on Emergency Nurse Practitioners in Northern Ireland). This presents a challenge for understanding the significance of current evidence as well as planning any future research.

THEMATIC ANALYSIS

Popay *et al* (2006), suggests that thematic analysis can be vague or lack transparency. To overcome this, description of the way in which thematic analysis has been undertaken needs to clearly described and should be approached in a systematic way to organise themes found in the literature.

Popay *et al* (2006) noted that if identified 'a priori' this can introduce bias in the themes that are looked for and reported. More commonly thematic analysis is inductive. This is the approach that has been taken here; other than using the research question and objective of the literature review to record data from the papers, no themes were identified before the data were extracted and tabulated. Each paper was individually read and data were recorded at the time of reading under the headings set out overleaf and detailed in Appendix 3.

Table 3.3- Thematic Analysis Linked to Research Questions

Research Question	Thematic Analysis Headings
1. What empirical research is there regarding the benefits and impact of ACP?	**key findings** as described by the author of the paper
	assessment of whether the literature review **question was answered**
2. Is there sufficient evidence of adequate rigour to support or refute claims of potential benefit of ACP?	**limitations** as described by the author of the paper, or if absent as identified by the reader
3. What are the current gaps in evidence regarding the benefits and impact of ACP?	understanding of whether any **gaps** or focus for a PhD could be identified from this paper

Popay *et al.* (2006, p. 17) noted that revisiting the aim or review question to identify relevant groupings can be helpfully used to guide narrative synthesis in systematic reviews. In this review, the groupings from the review aim are the key stakeholders:

- Healthcare professionals.
- Education commissioners and providers.
- Employers.
- Professional/ regulatory bodies.

Inductive thematic analysis of the findings has therefore been grouped by recurrent themes and then also grouped according to the impact or relevance this may have for key stakeholders. (Addressing research question 1- What empirical research is there regarding the benefits and impact of ACP?). Building upon the critical evaluation, discussion of limitations will be referred to in discussion of themes in order to respond to research question 2 (is there sufficient evidence of adequate rigour to support or refute claims of potential benefit of ACP?). Gaps in current research (question 3) will then be explored and have been used as a precursor to designing further research (presented in the remaining chapters of this thesis).

RECURRENT THEMES

Table 3.4- Recurrent Themes (Literature Review)

No.	Summary description of theme	Papers in which this was identified as a theme
1.	Definition, nomenclature, scope of ACP	Bagley, Barea, Bird & Kirshbaum, Carney, Cooper et al, de Bont et al, Delamaire & Lafortune, Dowling et al, Duffield et al, Endacott & Chaboyer, Gerrish et al, Gloster et al, Heale & Buckley, Hutchinson et al, Jones, Manley, Mantzoukas & Watkinson, Marsden Shaw & Raynel, McConnell et al, McDonnell Gerrish et al, McDonnell Goodwin et al, McGee et al, Miller et al, Pulcini et al, Roberts-Davis et al, Read et al, Smith & Hall, Taylor et al, Wilson-Barnett et al, Woods
2.	Barriers/ facilitators of ACP	Bagley, Currie et al, de Bont et al, Delamaire & Lafortune, Duffield et al, Elliot et al, Endacott & Chaboyer, Gerrish et al, Gloster et al, Heale & Riech Buckley, Jones, Marsden Dolan & Holt, Marsden Shaw & Raynel, McConnell et al, McGee et al, Miller et al, Read et al, Smith & Hall, Taylor et al, Thompson et al, Williams, Williamson et al, Wilson-Barnett et al, Woods
3.	Education Pathways, Regulation & Methodologies	Bagley, Barea, Barratt, Cooper et al, Gerrish et al, Gloster et al, Heale & Riech Buckley, Hughes et al, Jones, Mackavey & Cron, McConnell et al, McDonnell Goodwin et al, Miller et al, Pulcini et al, Read et al, Rogers et al, Shearer & Adams, Smith & Hall, Tee et al, Thompson et al, Williamson et al, Wilson-Barnett et al
4.	Patient outcomes/ clinical effectiveness	Cooper et al, Delamaire & Lafortune, Dowling et al, Duffield et al, Hughes et al, McDonnell Gerrish et al, McDonnell Goodwin et al, McGee et al, Miller et al, Read et al, Taylor et al, Tsiachristas et al, Williams
5.	Cost analysis	Barea, Delamaire & Lafortune, Miller et al, Tsiachristas et al, Williams
6.	Domination of clinical practice	Elliot et al, Endacott & Chaboyer, Gloster et al, Jones, McConnell et al, Read et al, Wilson-Barnett et al, Woods
7.	Substitution/ Supplementation	De Bont et al, Delamaire & Lafortune, Dowling et al, Marsden Shaw & Raynel, McDonnell Goodwin et al, McGee et al, Miller et al, Read et al, Thompson et al

Definition, nomenclature, and scope of ACPs.

30 out of the 44 papers included findings related to the definition of ACP, nomenclature used when referring to ACP roles and titles, and the scope of the ACP role or practice. All noted that there continues to be a proliferation of nomenclature/ titles used to describe ACP and ACP roles. However, what emerges is a broad consensus on the definition, conceptual models, and features of Advanced Clinical Practice across different professional, clinical speciality, health service and geographical contexts.

The definitions of ACP commonly reflect the 4 pillars (Research, Education, Leadership, and Clinical Practice), knowledge, skills and attributes (expected capabilities including education and experience), and context (exploring the ACP workforce, governance, and accountability) as set out in the MPF (HEE 2017). Some alternative conceptual models are presented, including Hutchinson (2014) meta-summary of ACP characteristics which identified 7 Practice Domains and 19 associated categories of activity. This provides a 'finer-grading' of the definition and scope of ACP, which reflects the existing '4 pillar' framework but also draws particular attention to aspects such as the administration features of the role that may not be as overtly described elsewhere. Other models proposed include some variation from the more simplified '4 pillars' framework which could be seen as a set of tasks to 'tick off' to fit the definition of an ACP. For example, Manley (1997) argued for a model that recognises the integrated sub-roles, skills and processes, contextual pre-requisites, and outcomes of ACP. Dowling *et al.* (2013) noted the significance of autonomy and clinical expertise as central attributes. Roberts-Davis (1998) proposed a continuum of predominately clinical orientation to predominately managerial orientation for innovative nursing roles, with ACPs working at some point on this continuum.

Some papers focus on developing a snapshot of the current status of ACP (e.g. the McGee et al 1996 survey in England, the 2010 Pulcini *et al* international survey, or the Read *et al* 2001 study exploring new roles in practice). These tended to only provide a picture of ACP within a sub-set under the broader definition of ACP by focussing on either:

- **a particular profession:** e.g., Hughes *et al.* (2017) who focused on pharmacist ACPs, or Wilson-Barnett *et al.* (2000) study of advanced nursing practice.

- **a geographical area or particular service:** e.g., Barea's (2020) review of Primary Care Advanced Practice Role in Cornwall, Thompson *et al.'s* (2019) study on Primary Care in the North of England, Satu Gloster *et al*. (2015) who focused on ACPs within one particular hospital, or McDonell *et al*., (2014) who focused on 1 acute hospital in the North of England.
- **a clinical specialty:** e.g., Emergency care in Bagley, (2018), Williams, (2017), and McConnell *et al*. (2013), Acute/ High-Dependency/ Critical Care reviewed by Woods, (1998), Kaldan *et al,* (2019), and Endacott and Chaboyer, (2006), or Bird and Kirshbaum, (2005) who focus on cancer care, Smith and Hall (2003) focused on neonatal, Wilson-Barnett *et al*. (2000) who concentrated on medicine, surgical, and orthopaedics, Taylor and Strauchowicz, (2012) who focused on orthopaedics, and Marsden *et al*., (2013) who focused on ophthalmic nursing.
- **one of the 4 pillars of ACP:** e.g., Gerrish *et al*. 2011 and McDonnell *et al*. 2012 who focused on Evidence Based Practice, which falls under the 'Research' pillar of the ACP framework,

The scope of ACPs varies, as highlighted by De Bont *et al.* (2016), Duffield *et al.* (2009), Heale and Rieck Buckley (2015), Lloyd Jones (2005), Pulcini *et al.* (2010), and Delamaire and Lafortune (2010). This is influenced by several factors including the original purpose for developing the role, regulation boundaries on scope, education preparation, organisational context in which the ACP operates, origins or purpose of the role, and personal attributes of role holders. The impact of these various factors leads to 'localisation' of the role, which then impacts on the 'professional jurisdiction' and scope of practice in which ACPs operate (De Bont *et al.*, 2016).

Regulation, accreditation, and professional recognition practices reflect the broader finding referred to in many of these papers; that there is not standardisation or consistency internationally of ACP scope of practice (Carney, 2016, Cooper *et al.* 2019, Delamaire and Lafortune, 2010, Pulcini *et al*. 2010). The introduction of non-medical prescribing has been highlighted as a type of regulation that has changed the autonomy, scope, and value of ACP in the UK, and exists as a barrier for some professions wanting to practice fully as ACP who do not currently hold this authority (Lloyd Jones, 2005). Some propose that regulation may facilitate standardisation and this may help with clarity of role, recognition, and valuing of specific roles and titles (Heale and Rieck Buckley, 2015, Marsden *et al.* 2003). However, there is insufficient longitudinal evidence that directly assesses whether regulation is a barrier or facilitator of ACP, or what types or degrees of regulation may be more or less effective.

The international comparative studies (e.g., Pulcini *et al*. 2010 and Delamaire and Lafortune 2010) highlighted that despite the varied definitions, nomenclature, scope and regulation globally, ACP continues to be increasing and developing in a range of healthcare settings.

Barriers/ facilitators of ACP

Over half of the papers included findings related to the identification of barriers or facilitators of implementing effective advanced clinical practice or advanced clinical practitioner roles, which influences the impact they can achieve. As noted above, several of the papers focussed research on a specific context (e.g., specialty, geographic area, or professional group), however, the results identified potential barriers/ facilitators that could be applied in other contexts where ACP occurs or where it is being developed and introduced.

There is broad consensus on the barriers and facilitators that by their presence/ absence affect full realisation of the potential benefits of ACPs, effective implementation, or measurable positive impact on outcomes. The range and currency of many of the papers appears to also provide consensus that despite knowing about the barriers to effective implementation of ACP, they are still prevalent, and the facilitators are often not considered when planning development of an ACP role, (e.g. Miller *et al.* 2009, Thompson *et al.* 2019). Bagley (2018), Delamaire and Lafortune (2010), Thompson *et al.* (2019) and Elliott *et al.* (2016) attempted to categorise the barriers and facilitators, which fit under the themes below:

- Access to training and education.
- Support from others for role expansion.
- Organisational structure, policy, and protocols.

Access to training & education

Duffield *et al.* (2009) highlighted the 'ad-hoc' way in which ACP roles have developed and this has created a "confusing overlap" in many areas. They emphasised the NMC allows nurses who want to assume additional clinical tasks or alter the nature of service provision can do so as long as they attain the appropriate education or training, but 'appropriate' has not been more clearly defined. They claim that a lack of consistency in education has hindered efforts to make full use of ACPs in healthcare. Heale and Rieck Buckley (2015), Lloyd Jones (2005), Miller, Cox and Williams (2009), Read *et al.* (2001), Thompson *et al.* (2019) and Delamaire and Lafortune (2010) also note sufficient availability of appropriate inter-professional and financially viable education and training is needed to provide the skills necessary to fill ACP posts. Without this, it acts as a barrier to development and implementation of effective ACPs.

Inadequate protected time for education has been commonly identified and often related to one of the other major findings of this review; that clinical practice dominates the role and the time allocated to duties/ tasks within this role (e.g., Llyod Jones 2015, McConnell *et al.* 2013 or Read *et al.* 2001). It was often reported that clinical demands took priority and that opportunities for development and education were missed if a clinical task was needed. In Currie *et al.* (2012) and Williamson *et al.* (2006), it was noted that the "pressures of time" restricted the participants' ability to effectively engage in aspects of their CPD education.

Support from others for role expansion.

In Delamaire and Lafortune (2010), Bagley (2018), De Bont *et al.* (2016), Elliott *et al.* (2016), Heale and Rieck Buckley (2015), and Williams (2017) studies, medical staff were the major professional group that had a significant impact on the development, implementation, level of autonomy, management and operation of the ACP role. Miller, Cox and Williams (2009) talked of the need to 'win round' physicians if the role was to be considered as a worthwhile endeavour by removing anxiety of ACPs 'taking over' and undermining their role. By assuaging colleagues' concerns this can enhance the prospect of attracting the funding and managerial or organisational structures to facilitate the role. Elliott *et al.* (2016) and Lloyd Jones (2005) found that 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. Where support from colleagues was not in place, ACPs often found they were unable to operate the full extent of the role and utilise the knowledge, experience, and skills they had gained. Significantly, McConnell (2013) correlated this with a lack of engagement in managerial or leadership functions of the role, including development of policy.

De Bont *et al.* (2016) and Thompson *et al.* (2019) discussed how the perception and understanding of the role, particularly by physicians and employers, had a major influence on how, what, and where ACP roles were developed. They identified this as a reflection of the 'localisation' of ACP, which as noted above has an impact on the definition, nomenclature, and scope of ACPs. They emphasised this occurred even in situations where specific policy or protocols were in place to ensure consistency. Personal relationships can be key to perception and understanding and may require a long time to build up; 'trust' is required between professions to allow the sharing, re-allocation or shaping of healthcare services, roles, and tasks. The personal relationships and attributes of the ACP therefore may have an impact here, with perceptions of ACPs that hold desirable attributes, such as confidence being more likely to gain trust (Jones 2005). The reliance on support from others makes the ACP role precarious as it requires professional relationships built up over time; if a supportive member of staff leaves, the ACP role may not be able to continue to develop or operate as it had done before (Miller, Cox and Williams, 2009).

Organisational structure, policy and protocols

Lloyd Jones (2005) and De Bont *et al.* (2016) noted that familiarity within an organisation and 'localisation' extends even in situations where national, professional, or organisational level policy is in place and that local arrangements may restrict ACPs from undertaking their full range of the role and the skills they hold. This includes protocols that define the path of clinical intervention, including what tasks are undertaken by whom (e.g., McConnell *et al*. 2013). De Bont *et al.* (2016, p. 8) noted that *"The differences in tasks and responsibilities, the organisational embeddedness of practitioners, and the situatedness of the work, limit further development of extended professional roles, and may even lock professionals into their work place. "*

The impetus for the development of the role is seen as significant in providing the organisational structure in which ACPs operate and, as Thompson *et al.* (2019) highlighted, when ACPs have been bought in to 'fill the gaps', this can impact the scope of their role. De Bont *et al.* (2016, p. 11) identified an example where advances in medical knowledge, clinical interventions, and technological advancement, especially in management of chronic illness, creates a need for roles that organise the various aspects of care required in this complex context. They described how ACPs as a 'generic' rather than a specialist role can *"fill up the space between the specialised practitioners, guiding the patient through the treatment trajectory".* In this organisational structure, the ACP can therefore be seen as adding value in terms of promoting continuity of care through complex systems, services, and disease trajectories. In the Delamaire and Lafortune (2010) international study, they pointed to funding mechanisms that support particular organisational structures (such as group GP practices), which may then provide an impetus (or disincentive) to support the ACP role.

On a more functional level, Elliott *et al.* (2016) and Read *et al.* (2001) noted that lack of access to administrative support, funding, and resources for data management affected the fulfilment of the role, particularly leadership aspects. Elliott *et al.* (2016) and Read *et al.* (2001) also pointed to a lack of authority and position within an organisation because they often sit outside of traditional hierarchical and committee structures, which impedes their influence on strategic decision making, including funding.

As new or developing roles in these contexts, Lloyd Jones (2005), Thompson *et al.* (2019), Wilson-Barnett *et al.* (2000) and Miller, Cox and Williams (2009) highlighted the need for clear communication of role definitions, job descriptions, and boundaries to reach consensus on expectations and facilitate transition into ACP roles. The lack of clear agreement and communication of the career pathway for ACPs within the current or traditional organisational structure was noted by Thompson *et al.* (2019) and Miller, Cox and Williams (2009) as a potential barrier, with the risk that it is seen as a 'dead end job' or a 'career cul-de-sac' (Smith and Hall (2003). The lack of engagement with or opportunity for non-clinical aspects of the role (leadership, education, research) may reinforce this, with few options for these health professionals in an organisation to progress in a clinically dominated career.

Education pathways, regulation, and education methodologies

15 of the 26 papers that included education as a theme, noted there are a variety of education pathways that ACPs have taken to be working in their current role, including formal, UG, PG, and Doctoral study and 'non-formal' training. As noted above, this is identified as a potential barrier to effective implementation of ACP, creating confusion and an unclear career pathway. This is linked by some to lack of regulation structures (e.g., Barea, 2020, Carney, 2015, Lloyd Jones, 2005). However, there is limited research on different types of regulation and its impact on ACP other than by Carney (2016) and Heale and Rieck Buckley (2015). The work by Heale and Riech Buckley was, however, based upon a survey of a subset of organisations linked to a nursing only organisation in some countries. Both Carney's and Heale and Riech Buckley's work is restricted to publications in English language only and presents what regulation is present but does not measure which may be more or less effective.

Evidence has not been established that one form of education and training better equips the ACP for their role. It is proposed, however, that the form of training and education undertaken by ACPs may have an influence on their ability to provide, and support others in providing, evidence-based practice (Manley, 1997; McDonnell, 2012; Gerrish *et al.*, 2011), critical thinking, decision making and professional identity (Thompson *et al.*, 2019), and leadership (Elliott *et al.*, 2016). In Miller et al's 2009 study, they highlighted the effectiveness of some types of ACP training, recommending that use of distance learning and alternative forms of delivery and funding should be investigated further as current options can be costly, inconvenient, and not sustainable. Some other types of education methods within ACP training programmes have been tested for their effectivity on achieving their stated aims or purpose:

- simulated video OSCEs (Barratt, 2010),
- coaching (Tee, Jowett and Bechelet-Carter, 2009),
- gamification (Mackavey and Cron, 2019),
- mental health/ therapeutic optimism training (Rogers, 2013),
- action learning sets, appraisal, clinical supervision and competence portfolios (Gloster, Neville and Windle, 2015).

In all but the study on use of Action Learning Sets, these were seen as useful and effective education strategies for ACP. Evidence though is limited in these studies in terms of measuring long-term outcomes.

The participants in the Thompson *et al.* (2019) study also highlighted the varying quality of ACP training and education programmes, particularly in relation to their relevance to specific fields of clinical practice. Hughes *et al.* (2017) included Training Needs Analysis where 4 themes were identified as needed to carry out the ACP role;

- clinical examination and assessment,
- diagnostic skills,
- medical management and treatment, and
- specialist training course components (e.g., radiology or minor injuries).

Whilst the Hughes *et al.* (2017) study focussed on assessing if ACPs could effectively manage a clinical case load within an emergency department, it is interesting to note that other aspects of training such as leadership, policy development, research and evidence based practice were not identified as significant or valued by ACPs. This is contrary to the stance of requiring a Masters level qualification noted by many of the papers and one that does not align to the MPF (Thompson *et al.*, 2019), which necessarily entails training in a broader range of knowledge and skills than being focussed purely on clinical practice. There is a self-reported perception that certain types of training/ education preparation (Masters study) provides personal benefits including opportunities for service improvement (Williamson *et al.*, 2006) and that it enhances confidence, autonomy, and external authority (Shearer D and Adams, 2012; Wilson-Barnett *et al.*, 2000). There is broad consensus that ACP preparation should be at Masters level, with the Pulcini *et al.* (2010) international study noting that 90% countries delivered ACP programmes at Masters level and 50% of countries identify this as the most prevalent credential required to practice as an ACP. However, there is recognition that in the UK a number of routes continue to exist (Barea, 2020).

Patient outcomes, clinical effectiveness

Whilst this was specifically excluded from the search criteria, the research often measured this as part of a broader focus. All papers identified under this theme confirmed that ACPs in a range of contexts have been shown to have at least similar, if not better outcomes in terms of clinical effectiveness when compared to other professions or types of service such as reducing waiting times, improved access to services, continuity of care, treatment management, and patient satisfaction. For example, McDonnell (2015) reported a perceived positive impact on patient experience, enhanced continuity of care from admission to discharge, improved patient safety, and the reassurance, confidence, and patient dignity that is provided by ACPs to those under their care.

The limitations of the research noted by the authors of these papers does though draw attention to any conclusions being drawn beyond the specific context in which these outcomes and measures have been evaluated. An example of this is Hughes *et al.* (2017). They proposed that 36% of cases could have been managed effectively by an ACP, with positive impact on case management, in particular clinical specialties. However, the research focused on a particular profession, within a particular speciality, in one hospital during a specific time period, so it is limited in offering external validity. Delamaire and Lafortune (2010) also noted that few studies have been undertaken longitudinally, with many stopping at pilot stage. This misses opportunity to assess impact on patient care outcomes, such as the trajectory of chronic disease over a longer period of time.

Dowling *et al.* (2013) and Delamaire and Lafortune (2010) noted that it is difficult to separate out the unique contribution that ACPs have made to these outcomes as they are often operating within multi-professional teams or as part of a complex set of services where other changes or developments have been made at the same time. Dowling *et al.* (2013, p. 135) referred to this in saying *"patient care provided by advanced practice nurses is often 'invisible'"* and that the role tends to have indirect rather than a direct effect on patient outcomes. For example, McDonnell *et al.* (2012) found that ACPs improve the care provided by front-line nurses. In addition, Miller, Cox and Williams (2009) drew attention to examples of where the impact of ACPs on patient outcomes and clinical effectiveness measures appeared to have been affected by the presence/ absence of barriers/ facilitators of ACP noted above. 'True' measures of impact on clinical effectiveness are therefore likely to be highly context specific and obscured by other factors. This, combined with the absence of formal structured and consistent audit and longitudinal measurement of outcomes of ACP (as described by Miller, Cox and Williams 2009), makes the evidence of clinical effectiveness of ACP context specific rather than holding robust external validity.

Cost Analysis

Relatively few of the 44 papers contribute evidence to cost analysis of ACP. Miller, Cox and Williams (2009) highlight that data required to undertake this kind of exercise has not been collected or retained. Delamaire and Lafortune (2010) provided the most comprehensive report of research conducted in relation to cost analysis. Their study is though restricted to Nursing and is now 13 years old when significant developments in ACP have occurred. Contemporary information on how this relates to the broad range of professions undertaking ACP is therefore lacking.

Duffield *et al.* (2009, p. 9) made the bold statement that *"it has been well established that care provided by APNs results in greater improvements in outcomes for patients, and also greater cost savings".* However, this statement is referenced from one piece of research conducted in 1995. The Tsiachristas *et al.* (2015) study reflects a more balanced picture in that they found an equal number of studies that had lower, the same, and higher costs and this was matched with reduced, the same, and improved clinical outcomes.

Delamaire and Lafortune (2010) noted that where the ACP role is used as a substitution for others (as described by Williams 2017), it has been shown to be equivalent to or produce a reduction in costs, although commonly the full costs have not been included such as costs of education. Where ACPs are used to provide a supplementary or 'adding value' service, costs are shown to increase, but again commonly the long-term costs have not been fully evaluated such as effects on preventing future hospitalisation or enhancing continuity of care. However, this broad conclusion relies on several factors which may tip the scale of cost evaluation for substitution as opposed supplementation roles either way. For example, ACPs may be paid less than doctors (depending on their grade) but may also provide an 'added value' service which allows them to spend a greater amount of time with patients. This may require supervision from doctors and, over time, it may cost the equivalent or more than the 'standard', time-restricted, service that would have been delivered if ACPs had not replaced doctors in this part of the clinical pathway. A number of papers highlight that grading, salary scales, and remuneration of ACPs varies considerably. For example, Barea's 2020 study of primary care ACPs in Cornwall found their pay varied between £15-£31 per hour.

Barea's study also showed no clear correlation between the pay awarded and the career pathway, training, or education route ACPs had followed to be in their current role. Barea highlighted that this group of ACPs commonly sit outside of the 'Agenda for Change' pay banding, which was bought in to provide consistency of pay for similar roles, work, and responsibilities of healthcare staff. The variety in salaries, combined with variety of education routes and thereby costs to supply training and education to ACPs, makes drawing any broad conclusions about cost of ACP in the UK difficult. It would of course also be perverse to want cost reduction to be the only or primary outcome measure in health care, where positive clinical outcomes are the more desirable, standard, and required outcome measure that is expected.

Domination of clinical practice

Whilst there is a consensus that ACP reflects the 4 pillars, it is clear that in practice the 'clinical' element dominates in terms of priority given, workload allocation, or the value it is held in. The Wilson-Barnett *et al.* (2000) observational study provides some evidence for the other 3 pillars being part of the role of ACP in the reality of practice, but these are seen, prioritised, and valued to a lesser degree. They noted that the focus on clinical practice is seen as a motivational factor for why practitioners choose to undertake this role as they want to remain to be seen as clinicians and be responsible for delivering clinical activity.

The extent to which dominance of clinical practice occurs is affected by known barriers. For example, Elliott *et al.* (2016) noted that 'large clinical caseload' was the most frequently reported barrier. Read *et al.* (2001) and Elliott *et al.* (2016) found that increasing clinical caseloads impacted on the time available and opportunities for ACPs to research, take on leadership activities, engage in networking, or move

forward with practice development. This resulted in a lack of visibility of ACPs (in this case nurses) as leaders. Gerrish *et al.* (2011) noted that the heavy workload was cited by a quarter of their participants as the reason they did not have the time to keep up to date with research. Lloyd Jones' (2005) work echoes the finding that clinical workload takes priority over other parts of the role. This included opportunity for undertaking continuing professional development and that research had to be undertaken outside of work time, which may cause stress and potential burnout.

Lloyd Jones (2005) mainly found evidence that focussed on clinical nurse specialists, who may overlap with ACP but also may have a distinctly different role to them. However, the Read *et al.* (2001) work on a variety of innovative roles, including ACPs, also noted the potential for personal detriment due to excessive clinical workloads, which further compromises the ability to undertake other aspects of the role (e.g., training, audit, research). In their study, over 75% reported working in excess of their contracted hours.

Perhaps more startling is the McConnell (2013) study, which found Emergency Nurse Practitioners (a sub set of ACPs) estimated >80% of their time was spent on the clinical aspects of their role with only 2.5% and 2.6% being spent on leadership and research. In addition, none of the participants reported *"involvement in any organisational decision-making, legislative or policy making activities"* (McConnell, 2013, p. 79). This is also seen in Woods (1998) work where the acuity of the patient correlates with the amount of time spent on clinical activities, so ACPs working in acute, emergency, critical care, or high dependency settings may experience the dominance of clinical practice to a greater extent than other ACPs.

Endacott and Chaboyer (2006) described a subset of ACPs, the Intensive Care Outreach nurse. The focus on clinical practice is more nuanced here with confirmation that much of the activity is in response to acute clinical need and staff shortages, but that, where possible, the emphasis is on supporting, educating and enabling other staff to undertake the direct patient care activities, such as taking blood gases or inserting cannulas. This is echoed by Read *et al.* (2001) who noted that in future developments of such roles, if they were allowed to draw back from clinical activities, the teaching and management aspects of the role would likely be developed further. It is therefore hard to see how the participants in these studies are fulfilling the '4 pillars' scope of the ACP role, particularly around expectations of leadership and service improvement at an organisational level.

Substitution/ supplementation

A major feature found in the literature regarding the definition, nomenclature, and scope of ACP is whether the role is a substitution or a supplementation. Dowling *et al.* (2013) categorised this as role extension (substitution) or role expansion (supplementation). Substitution is where ACPs are either employed to take on the work normally or previously performed by others (e.g., junior doctors) thus *"freeing them up to concentrate on other elements of care"* (McDonnell, 2015, p. 794). Supplementation is where ACPs hold their own case load within a service which may previously have not existed or was fragmented across a number of services or role holders (e.g., outreach). Substitution/ supplementation is a common feature in terms of the impetus for development and thereby the definition and scope that is afforded to ACPs.

Delamaire and Lafortune (2010), Dowling *et al.* (2013), (Marsden, 2013), Thompson et al (2019) and McGee (1996) all noted that a main impetus for development of ACP roles had been due to a shortage of doctors or where policy change, such as the imposition of a restriction on junior doctors hours or a requirement to reduce waiting lists (Miller, Cox and Williams, 2009; Read *et al.*, 2001), has affected the supply of medical professionals. A significant number of ACP roles, at least in their development and early stages of implementation, were therefore aimed at substitution.

Interestingly, McDonnell (2015) pointed to evidence that whilst the impetus may be to address the shortage of doctors, due to the reluctance of medical staff to accept that ACPs had the skills to cover them (a commonly identified barrier to ACP), there had actually been no reduction in the number of medical posts. Recently, the use of ACPs to substitute for medical colleagues has been given further attention as they have been used to cover for colleagues during periods of industrial action. Marsden (2013) and Delamaire and Lafortune's (2010) research appears to demonstrate that whilst substitution creates an impetus for creating ACP roles, once in place ACPs are then well placed to develop supplementary services and drive the evolution of these roles. These new services are aimed at promoting high quality care or responding to changing demands on healthcare systems, and filling gaps in services (rather than staffing) that need filling. Read *et al.* (2001) described this as a type of re-engineering that shifts the focus to patient centred care, using case management and multi-disciplinary approaches.

Delamaire and Lafortune (2010) drew 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 they are able to operate as autonomous practitioners. The extent of autonomy further influences how much they draw, to a lesser or greater extent, on their own professional background, theoretical frameworks, knowledge and skills rather than purely using the 'medical model'. This will therefore have an impact on the extent to which re-engineering involving radical ideas about changing professional roles can take place (Read *et al.*, 2001).

De Bont *et al.* (2016) described how the local relationships, practice, attitudes, and policies plays a crucial role of reallocation of tasks (i.e., in substitution roles). Their case studies reveal that *"legally assigned clinical activities sometimes cannot be carried out due to restrictive local arrangements"* and this can lead to ACPs not being able to practice their full scope of competence (De Bont *et al.*, 2016, p. 8). Thompson *et al.* (2019) supported this view in noting that where ACPs were bought in to 'fill GP gaps' their scope of practice became limited to clinical tasks. This can impact on costs, and the measurable outcomes achieved by ACPs (Delamiare and Lafortune, 2010).

De Bont *et al.* (2016) related substitution/ supplementation to specialisation and generalisation. Tasks previously undertaken by others that are reallocated, i.e., substitution roles, commonly develop in clinical sub specialities (e.g., diabetes, cardiology, or oncology). However, the examples they provided may be considered to be more fitting with clinical specialist roles (e.g., the haemodynamic technician or a radiography assistant). They described generalist roles as those that involve organisation and integration across different clinical specialities or groups of health professionals (e.g., doctors and nurses). They said that *"professionals in organising*

roles work independently of physicians as they run the services on their own" (De Bont *et al.*, 2016, p. 9). This description appears to fit well with 'supplementation' roles, where new services are developed to provide additional or different healthcare provision or are expected to add value by co-ordinating care across services to enhance continuity and effectivity.

Where substitution is in place, the literature points to this leading to fragmentation of care (Dowling *et al.*, 2013), lack of clarity around extent of permitted autonomy in the role and lines of responsibility (Thompson *et al.*, 2019), and that it can trigger others feeling disempowered or may result in loss of skills of those substituted over time (McGee, 1996; McDonnell, 2012). From this viewpoint, one could argue that substitution roles are not well placed to facilitate the full remit of ACP, which requires that they include, but also go beyond, operation of specialist clinical tasks.

THEMES IDENTIFIED ACCORDING TO KEY STAKEHOLDER GROUPS

Health Professionals (including ACPs or potential ACPs)

For health professionals, there was little of the research that was specifically focused on measuring an outcome for them. The research consistently confirmed the large amount of variability and diversity within ACP (e.g., Thompson *et al*. 2019). This made measuring or drawing any conclusions regarding the personal benefits or outcomes for health professionals difficult. There was variation in pay, grading, titles, and training, education, and career pathways to become, be recognised, and allowed to practice as an ACP. There are diverse contexts in which ACPs practice, and different degrees to which ACPs are able to operate in arenas beside clinical practice, such as strategic leadership, operational management, and research development.

As noted above regarding definitions, nomenclature, and the scope of ACP, several authors identified the inconsistent and confusing picture of ACP. For example, Barea's (2020) research found that pay could not be linked to length of time in the role, training/ education qualifications, or level of experience This 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.

There was a paucity of evidence gathered longitudinally, and none that directly tracked or measured outcomes that may be relevant to healthcare professionals such as career development, job satisfaction, and retention in the role. Shearer and Adam's (2012) research measured perceptions of the role including personal benefits, which they identified as improved clinical assessment skills, increased confidence, increased autonomy, and education. Their research was conducted with trainee ACPs. The outcomes reported were therefore only measured up until the point participants were nearing the end of their training, not as they entered the ACP workforce or continued in the reality of working in that role. Longer term measurement of whether their expectations and hopes for the role had been realised, were not therefore measured.

Smith and Hall (2003) noted an 86% retention in the role of an Advanced Neonatal Nurse Practitioner in the 10 years since a group of students undertook their training at one University. 68% were working in the same place that they were employed in when they first finished their training, but 58% of these said they would consider moving away. Barea (2020) measured length of service as an ACP (ranging from an average of 3 years up to 20 years), but this was also a 'snapshot' in a sub-section of the ACP community (geographically, professionally, and by focusing on one clinical specialty). In other papers, retention was not directly measured.

Retention in the same job, organisation, or locality may or may not be perceived as important to the ACP, where career development, financial security, flexibility in working patterns, or opportunities to enhance the quality of care may be more significant to them personally. Other benefits or outcome measures of job satisfaction (e.g. stress, burnout and sickness levels, quality of life, financial security or stability and work productivity) were not directly measured in any of the papers and these perceived benefits mostly relied on reports from people other than ACPs.

The research conducted by McDonnell (2015) identified perceived positive impacts that ACPs have on others, including quality of working life, workload, and distribution of work. Williamson *et al*. (2006) and Wilson-Barnett *et al*. (2000) highlighted that many had chosen this career pathway as they wanted to remain working in the clinical arena, where other options to do this may not be available. Williams (2017) also repeated the belief that ACP can offer an enhanced career structure and enhanced recognition as a profession. The participants in the Williamson *et al.* (2006) study believed that ACP training would lead to a better paid and more interesting job that allows them to have greater involvement in improving services for patients.

However, several studies pointed to the burden of workload for ACPs and how this may create negative effects for the individual ACP, including burnout and restrictions in their ability to practice the full scope of ACP, which limited their autonomy. Typical of the barriers which may create stress and frustration for ACPs in attempting to operate their role effectively is the Wilson-Barnett *et al.* (2000) observational research study of ACPs. In this paper it was noted that *"Almost all the participants had encountered resentment from at least some colleagues";* a potentially significant stressor for people in these roles (Wilson-Barnett *et al.*, 2000, p. 397).

Miller, Cox and Williams (2009), Thompson *et al.* (2019), and Marsden (2013) noted that there were few opportunities for continuing professional development and career planning for ACPs. The Thompson *et al.* (2019) research noted that formalised Masters level training that was aligned to the MPF (HEE 2017) was perceived by ACPs as making a positive change to their skills and professional identity. However, they also noted the varying quality and relevance of ACP training and that access to this is also variable, which may restrict expansion of the ACP workforce and leave ACPs unprepared for the demands of the role.

The Williams (2017), Wilson-Barnett *et al.* (2000), and Williamson *et al*. (2006) research could point to potential benefit for ACPs in that it offers evidence of a clinically focused career pathway that is seemingly not otherwise available. However, this research is limited as Williams (2017) relied on one paper conducted in 2006 in one clinical specialty, and the Williamson *et al.* research was also conducted in 2006 on first year ACP students, so this suggests that perceived benefits have not been fully tested over a significant period of time.

Post-Graduate Training and Education Commissioners & Providers

Consistently in the papers that address ACP training and education (listed in Table 3), it is noted there is considerable variation in the types, volume, and delivery model. It is understandable therefore that commissioners want to know the ‘best’ of the variety that is on offer to know which training and education provision to support. There is increasing attention on the development of this workforce and significant amounts of funding ring-fenced for ACP training.

The Thompson *et al.* (2019) study is the most recent which includes reference to contemporary developments in this field (i.e., the introduction of the MPF by HEE in 2017). This study, along with other research that collected data across different countries (e.g., Pulcini *et al.* 2009) and sub-sections of ACP (e.g. Wilson-Barnett *et al*. 2000), highlighted that Masters level education is the most commonly expected level of education for ACP. This in effect has made Masters level study an industry standard, which, with the advent of the MPF and ACP apprenticeships at level 7, confirms the place of a Masters in ACP as a key gateway into this profession. However, it is also noted that ACP has often developed in different or 'ad hoc' ways, commonly to fill gaps in services, and so the development trajectory tends to be localised (e.g., Duffield *et al*. 2009, Thompson *et al*. 2019). In addition, the multi-professional nature of ACP means that different professions will have had different routes of education prior to reaching the stage of considering or taking on the role of ACP. For example, Nurses and Paramedics have been required to train to a degree level at pre-registration more recently than some of those in the Allied Health Professions (e.g., Occupational Therapist or Physiotherapists). As a result, there is significant variation in the current ACP workforce in terms of the training and education they have received to date and are likely to have access to in the future (Barea, 2020). This makes achieving a universal standard of all ACPs holding Masters level qualifications difficult and presents a challenge for those that are seeking to introduce regulation and recognition at a national level. For example, the CfAP initiative to create a badge of recognition for ACPs or the Nursing and Midwifery Council's efforts to move towards introducing regulation, (2023).

Some specific methodologies used within ACP training have been researched and there is some evidence to encourage their use in future education programmes designed for ACPs. For example:

- creating networking opportunities (Shearer D and Adams, 2012)
- research skills to facilitate evidence-based practice (Gerrish *et al.*, 2011)
- use of coaching (Tee, Jowett and Bechelet-Carter, 2009)
- mentorship, support and supervision (Thompson *et al.*, 2019)
- use of gamification (Mackavey and Cron, 2019)
- pre-recorded simulation OSCEs (Barratt, 2010).

However, these are small scale, one-off, pieces of research conducted with a sub-set of the ACP student community, the effects of which have not been measured longitudinally. Education commissioners and providers of ACP education and training programmes should therefore look to pilot and research further into these 'tried and tested' methodologies in a variety of contexts and continue to seek evidence for other approaches to support the development of ACPs.

It is evident from this research and more recent policy (NHS England, 2023b) that ACP is seen as a growth area which will require increased successful opportunities for training and education to be provided if the workforce demands and potential benefits of ACP are to be realised (Read *et al*. 2001). There were no papers that specifically focused on directly evaluating training and education for ACPs once they are in the role, and the evidence points to this being patchy in access, quality, and relevance to practice (Thompson *et al*. 2019), and that the level and content of training opportunities are under-developed (Smith and Hall, 2003). Marsden *et al*. (2010) provided an example of this within ophthalmic ACP, where training in this specialty at ACP level varied considerably.

Time release away from clinical activity was seen as a major barrier to ACPs being able to engage in development activities. The challenge for commissioners is therefore to find a way to support the 'whole costs' or needs for ACPs to engage effectively in training and education (e.g., through the provision of backfill for ACPs to undertake training, as suggested by Thompson *et al.* 2019). Education providers will also need to consider how they support effective learning when conflicting pressures on the ACPs time are likely to impact their ability to dedicate time to study and engage with learning activities. The Miller, Cox and Williams (2009) evaluation study particularly noted that alternative approaches of delivery (e.g., on-line and use of generic elements of training to create economies of scale) need to be considered both in terms of ACPs being time poor but also in relation to pursuit of containing costs of education when the demands are likely to continue to grow. Delamaire and Lafortune (2010) supported this view, noting that cost analysis of ACPs to date does not include the costs of training and education, which have not been documented.

Health Care Professional and Regulatory Bodies

For regulators there is reference in the majority of the research regarding inconsistency and variation in ACP, which some say is due at least in part to a lack of regulation through standardisation of education, pay, grading, job descriptions, and legislature that determines the scope of roles (e.g., Llyod Jones, 2005). Only three papers specifically focus on regulation (Carney, 2016; Pulcini *et al.*, 2010; Heale and Rieck Buckley, 2015). Rather than provide evidence of whether a specific type of regulation is more or less beneficial to the development of ACP, these papers reinforced the knowledge that it varies and that different sub-sections of ACP are at different stages of the development of regulation. Heale and Rieck Buckley (2015)

proposed that in countries where there is less developed regulation, the presence of barriers to effective implementation of ACP are higher, however, the data to corroborate this statement is not presented in the research; only data that confirms that variation exists was presented. Conversely, Delamaire and Lafortune (2010) pointed to the lack of regulation in the UK as removing a potential barrier to adapt the scope of practice to enable these roles. However again, this was not directly measured in this research, and they also highlighted the lack of research that has evaluated the measurable outcomes from implementing new models of health service delivery, such as introduction of ACPs.

There appears to be a consensus that regulation may be a way to reduce variation and confusion over career pathways for ACPs (Duffield *et al.*, 2009). There is though also recognition (Barea, 2020) that because of the diversity of contexts, professional backgrounds, and clinical specialties in which ACPs work, consistent regulation is difficult to achieve. Read *et al*. (2001) noted that thus far existing regulatory bodies appear to have rejected the idea of adding a new level or type of regulation for their ACP members because of the belief that their regulation already covers practitioners to develop along a continuum, including advanced practice. Whilst this paper is over 2 decades old, and there have been some changes in national policy and regulation of health care professions, the most recent paper (written by Barea 2020), highlighted that there continues to be no national regulation of ACP and the somewhat newer introduction of ‘credentialling’ as an attempt toward standardisation, remains patchy. There is no evidence from this review which proves regulation provides additional risks or benefits to protecting the public, which is, of course, the raison d’etre of regulatory bodies.

Employers of ACPs

As noted for the other key stakeholders addressed in this review, the variation of ACP also creates a potential issue for employers. There is not a singular consistent 'ACP' package that could be bought off the shelf. When designing or developing health services, the nebulous context of ACP will need further refinement to understand if employment of an ACP will 'fit the bill' of what is needed for that service, and if it fits within a coordinated workforce plan (Read *et al.*, 2001; Marsden, 2003). Lloyd Jones (2005), Wilson-Barnett *et al.* (2000), and Thompson *et al.* (2019) noted role ambiguity, which can be exhibited in poorly defined job descriptions and lack of standardisation against definitions. Within the context of lack of regulation (as noted by Carney, 2016; Pulcini *et al.*, 2010; Heale and Rieck Buckley, 2015) and confusing landscape of career pathways (Thompson *et al.*, 2019; Smith and Hall, 2003) this places the burden on the employer to shape the scope of practice, pay, grade, outcome measures, training, education, support, and development of ACPs in their organisation.

The localisation or 'situatedness' of ACP (De Bont *et al*. 2016) places a demand on employers to understand the particular context in which ACPs can or do operate and the impact this may have on others around them. This may be positive, such as the work of Gerrish *et al.* (2011) and McConnell (2013) on the beneficial impact of ACPs on front-line nurses in facilitating evidence based practice, or negative such as McGee *et al.* 1996 and Read *et al*. 2001 (''Compliment or Compete"), who reported negative attitudes from other staff that ACPs were threatening their scope of practice and retention of knowledge or skills.

The work by Delamaire and Lafortune (2010) noted that the full costs of ACP have not been measured comprehensively. This is both in substitution roles (where it is assumed costs may be reduced) or supplementation roles (where it is assumed they provide a 'value added' service where costs may be more). Employers need therefore to be clear about the purpose of the role, so that they can ensure the full assessment of the costs are taken into account when designing, implementing, and evaluating the role (Miller, Cox and Williams, 2009; Tsiachristas *et al.*, 2015).

The variation of training and education further makes evaluation of costs difficult and presents a dilemma for employers in deciding how best to provide continuing professional development support for ACPs, (which Miller, Cox and Williams, 2009; Smith and Hall, 2003; Marsden, 2003; Thompson *et al.*, 2019 found to be lacking). Some methodologies such as mentoring, coaching, and supervision have been found to be effective in supporting trainee ACPs development (Thompson *et al*. 2019), and these could be provided in the workplace, education settings, or both.

For employers that 'sign up' to the multi-professional definition of ACP, which, as noted above, broadly has reached a consensus that fits with the MPF, there are very few examples where evidence has been collected on non-nurses in these roles. Hughes *et al.* (2017) gave one example where this has been directly measured for a non-nursing profession. Further examples of this type of study or where research is not directed at one professional sub-group of ACPs is warranted.

A major barrier to the effective implementation of ACP, engagement with education, and a common characteristic of ACP is the dominance of clinical practice over the other 3 pillars of ACP: leadership & management, education and research (Elliot *et al*. 2016, Read *et al*. 2001 and Gerrish *et al*.2011). For employers that are wanting and

expecting ACPs to contribute to these aspects of managing and delivering a health service this creates a challenge. Elliot *et al.* (2016) highlighted that for this to change, greater presence of ACPs on committees and organisational structures at a leadership level are required to be facilitated and 'built in' to the role from its inception. Consideration of reporting structures within the organisation, and basic resources to facilitate the role (e.g., administration support) is also needed. As Read *et al*. (2001) and McConnell *et al*. (2013) highlighted, the demands of clinical practice can also have an impact on ACPs perception of job satisfaction and potential stress and burnout.

Delamaire and Lafortune (2010) also noted that the measurement of outcomes for ACPs is often lacking and, as experienced by Miller, Cox and Williams (2009), gathering data on this is difficult as the information is not collected, or has not been collected in a consistent, comprehensive way. For employers this makes proposing implementation of ACPs or defending their use difficult. Outcome measures that align with the employers' strategic objectives, targets measured through audit, and values that the organisation aligns itself with, therefore need to be further developed and implemented. This may include measures of clinical effectiveness, although these have more frequently been measured and appear to have established that ACPs in a number of contexts can perform at least to an equivalent level to other professions in this respect (e.g., Tsiachristas *et al*. 2015). Other measurements such as job satisfaction, retention of the workforce, and flexibility of ACPs to adapt to service need, do not currently have the evidence available to provide a definitive argument either way that ACPs are meeting the employer's expectations. These have further been emphasised in the more recently published research by Drennan *et al.* (2021).

LIMITATIONS OF THE LITERATURE REVIEW

It should be remembered that whilst no date limit was placed on the search criteria, this systematic literature review has taken place at a certain moment in time. As noted in the introduction, ACP is currently getting increasing attention and there are several new initiatives, policy changes, journals, and conferences, and thereby new research and knowledge that is likely to emerge. Since starting the process of the review, the 'Centre for Advancing Practice' (CfAP) has been established by Health Education England (now coming under NHS England). The process for national accreditation of ACP Masters programmes has begun. This has been followed by a process for existing ACPs or those not following an accredited education pathway to seek recognition through the Centre as an ACP through the supported e-portfolio route. The impact of this on the UK ACP context and many of the issues highlighted in the literature review is therefore yet to emerge, be published, and to be evaluated.

The methods used within the systematic literature will in itself have created a limitation to the findings from this research. These have been noted within 'STARLITE', (e.g., the inclusion/ exclusion criteria and search terms used). Choices were made regarding the databases selected for this research and the snowballing, data extraction, and thematic synthesis were conducted by the researcher alone, without moderation or validation by others. By choosing to not use quality as a filter for inclusion, not conducting forward citation searching, and including literature reviews alongside primary research this may have led to including papers and placing emphasis on their findings that may have been excluded in more restrictive reviews. However, this has allowed a broad range of evidence to be captured and over emphaisisng themes from poor quality research has been avoided by ensuring weaknesses in all papers have

been noted in critical evaluation of previous research. To avoid ‘double counting’ the themes generated were not just from literature review papers but were also present in other primary research papers that had not been cited elsewhere. The themes therefore can stand on their own as key aspects elicited from primary research.

Whilst a protocol has been used to guide this process throughout, and ongoing development of the research has been discussed in supervision, the choices made presents an opportunity for researcher bias to emerge. The use of narrative, interpretive synthesis as a methodology has been criticised for its propensity for bias. As noted by (Noblit and Hare, 1988, p. 25) *“The analyst is always translating studies into his own world view.”* I have attempted to guard against this by using existing tools to structure and record the findings and by using inductive methods for identifying themes, rather than determining them from my own ‘world view’ from the outset.

The impetus for this research was to establish what evidence exists and for this to drive the framing of a research proposal. The development of ACP roles has been shown to most often be a pragmatic response to a problem; to fill a gap or to develop a service to meet a need. Taking a pragmatic approach therefore appears fitting when studying ACP. As a personal tutor and programme lead on CPD programmes in a School of Health and Social Care at a University, I chose this topic to study through pragmatism; the results will aid in a practical way my role in providing career development advice to students, alumni, and potential students. This exposes the author’s bias but also underpins the pragmatic stance taken in this research. In exposing and reflecting upon my potential bias for the choices made in this research, I was keen to ensure that the literature review design developed from a constructivist viewpoint that believes there is no single reality and that reality needs to be interpreted.

The evidence from the systematic literature review has shown that the reality of ACP is changing over time, and that it is localised and context specific. To understand ACP, it therefore needs to be constructed from multiple realities (i.e., the key stakeholders), each of which will hold a view. This approach aligns itself to critical realism, in that there is a current 'true' picture of ACP, but it is recognised that because the context keeps changing, and research methods are on a continuum of quality, we can only try to get as close as possible to discovering this reality. It could be argued that more attention should have been paid to certain viewpoints in this review (e.g., higher quality primary research) over others (e.g. papers with limited impact discovered through forward citation searching) as they may have more power in the reality of shaping the ACP context or practice. However, the axiology of this research is that it values the diversity of viewpoints as each have an influence on the reality of ACP as experienced by its stakeholders.

Whilst attempting to capture a diverse range of research and viewpoints of ACP, as with all literature reviews, I acknowledge that the findings are limited by the scope and quality of the current literature sources available, retrieved, and selected. The literature commonly only captures a subset of ACP and tends to use small sample sizes that are limited in their ability to be representative of the diverse community of ACP. There is a large amount of opinion or discussion-based research which relies on report from people other than ACPs themselves. Longitudinal data collection that provides measurable outcomes of the benefits or risks of ACP is limited in the literature found in this review. There was also a dearth of evidence relating to ACPs not coming from a Nursing background (AHPs). Attempts have been made to expose these limitations throughout the analysis and discussion of this review, including the gaps in knowledge that have been identified as a result.

SUMMARY- GAPS IN KNOWLEDGE

From examining the above findings from this review, there are a number of areas that lack robust evidence and could warrant further research. By thinking about the implications for each of the key stakeholders, four areas were identified as gaps in current knowledge and evidence. These are:

a) What are the measurable successful outcomes from implementation of ACPs for employers (beyond clinical effectiveness), such as full cost analysis and addressing workforce needs.
b) What are the 'best' delivery models, types, and education methodologies for training, educating and developing ACPs?
c) What is the impact of regulation mechanisms on facilitating effective implementation and development of ACP?
d) What are the expectations of personal benefits for health care professionals in becoming an ACP and are these being realised?

These are all areas that are worthy of further investigation based upon my literature review. However, it would not be feasible to attempt to address them all in research that can be effectively designed and managed within the confines of the expected period of my PhD studies. I therefore took time to reflect on the findings and to horizon scan for further insights to help decide which direction to next take in my research.

Following completion of the literature review, alerts were set up to highlight any new publications that addressed the search criteria. The alert highlighted a review published by Abu-Qamar *et al.* (2020) which examined whether Post-Graduate (PG) Nursing qualifications (such as a Masters in ACP) had affected employment

opportunities and job satisfaction. In one piece of evidence, they found 50% nurses had been promoted since receiving a PG qualification. However, this study was conducted only up until 1996. Abu-Qamar *et al.* also noted the majority of respondents who had received a promotion were working in the education sector. There were studies that Abu-Qamar *et al*. found that reported an increase in job satisfaction though why people perceived they had increased job satisfaction was not explored and so could not be attributed to holding a PG qualification. The Abu-Qamar *et al*. study illuminated the following gaps in evidence which chime with and add to the findings in my literature review:

1. Previous studies encompass various types of education; in the Abu-Qamar *et al*. study it included those who had undertaken doctoral qualifications, which are more akin to Consultant or Manager roles in the UK than ACPs.
2. Abu-Qamar *et al.* (2020) noted that post-graduate education is perceived to be a driving factor in career development and stated *"empirical evidence is required to examine the extent to which post-graduate qualifications enhance career opportunities and job satisfaction."* A focus on the impact of PG Advanced Clinical Practice education on the personal benefits for ACPs has not been studied.
3. Previous evidence may now be outdated and does not reflect the current context. This is particularly since recent developments that have been made since the MPF, NHS People (NHS Improvement, 2020) and NHS Long-term workforce plans (NHS England, 2023b) have been published, and ACP apprenticeships, accreditation, and credentialing has come into play.

4. The Abu-Qamar *et al.* study focused on PG Nursing education and did not include AHPs. It included a broad range of roles within Nursing, including Nursing educators, rather than focusing only on ACPs.

Following completion of the literature review, a new article was also published that focussed on Allied Health Professions (Stewart-Lord *et al.*, 2020). The authors utilised a survey, followed by semi-structured interviews of Allied Health Professional ACPs working in North Central and East London region. The findings of this research echoed what had been found in the literature review, again highlighting the diversity and barriers to effective implementation of ACP. They identified that teamworking, collaboration, and being recognised as ACPs was very important to this group. They also noted significant variation in terms of confidence in the role; lower levels of confidence were particularly apparent in the research domain. This research again highlighted the difficulty of measuring outcomes, although the respondents reported perceived benefits to patient care and cost effectiveness of the role.

In 2020, a report was published from an on-line workshop held in 2018 that focused on collecting views on Advanced Clinical Practice (Health Education England, 2017a). The on-line workshop aimed to develop a *"deeper understanding of how advanced practice currently operates and to generate ideas for further enhancements, mitigation of risks and ideas for innovation."* (Health Education England, 2017a, p. 9). There was a paucity of evidence in the literature review that gathered evidence directly from ACPs, whereas this research was dominated by responses from registered health care professionals, although it was skewed toward those working in acute NHS Trusts and particularly nurses who were already working as ACPs. The report from the on-line workshop picked up on many of the themes identified in my systematic literature

review including benefits to patient care from the development of advanced practice, workforce implications, and assurance mechanisms for ACP roles. In the 'other ideas' section taken from crowd-sourcing, it noted that *"concern was expressed that a degree of certainty was needed about the future of advanced clinical practitioners if professionals were to invest their time in developing their skills and qualifications and if employers were to provide their investment and planning."* (Health Education England, 2017a, p. 7). This presents a key challenge for ACP research, policy, and governance going forward.

These three more current pieces of evidence not previously captured in my literature review failed to provide evidence to support the view that there are personal benefits for ACPs themselves. Instead, they again highlighted the barriers that ACPs face. This includes obstacles to career development, autonomy to utilise their full scope of practice knowledge and skills, as well as variation in the way ACP roles are operated. I therefore resolved for this to be the focus for my future research.

CONCLUSION

This systematic literature review has taken a narrative interpretive synthesis approach to reach its conclusions. The gaps in knowledge highlighted above are not therefore exhaustive. The high degree of localisation and context bound conclusions from existing research reflects that the experience of ACP is diverse and therefore further research should take account of this in its scope, methodology, and recommendations. By distilling the findings and using the key stakeholders as points of reference some over-arching challenges and potential focus for future research can be identified.

From reflection on more recent evidence, reflection on my own experience within the world of delivering ACP education, combined with the results of the systematic literature review I carried out, it appears that little has changed in terms of barriers to effective implementation of ACP. These are areas that need further investigation and development if there is to be a solid evidence base for key stakeholders and particularly ACPs themselves, to be assured that pursuing ACP is worth it. This conclusion has informed the next stage of my PhD, namely development of the research project which is discussed in the next chapter.

CHAPTER 4 – METHODOLOGY

INTRODUCTION

In this chapter the research design for the chosen project will be set out including details of the sample, data collection, and data analysis methods. The quality measures that were employed to address 'trustworthiness' of the research methods used will be discussed. It will begin with exploration of the approach taken to reflexivity and the researcher's role and positionality in this research. It will then explore the philosophical approach that underpins this research and supports the rationale for using a mixed methods design.

REFLEXIVITY AND POSITIONALITY OF THE RESEARCHER

The evidence from the systematic literature review in chapter 3 showed that the reality of ACP is changing over time, and that it is localised and context specific. To comprehend ACP it therefore needs to be understood from multiple realities (i.e., a diversity of ACPs, each of which will hold a view of the reality of ACP). The axiology of this research is that it values the diversity of viewpoints of ACPs and aims to give voice to their experiences. It takes an emic approach to capture the 'insider's view', drawing upon the perspective from within the ACP culture in which this study is situated.

The research undertaken for this thesis began at a time when some major events were happening in the world, including the rise of the Black Lives Matter movement and increasing cries of 'fake news' regarding the coronavirus pandemic. These drew attention to the significance of ensuring a diversity of perspectives is recognised and taken account of when reaching an understanding of the truth, and the potential negative consequences when this is not addressed.

The emic approach used in this study therefore focuses on the members of the culture being studied and notes that the 'truth' or meaning is relative to the perceptions and beliefs of the persons holding them, including the researcher themselves. It recognises the significance that local culture can play and the influence that myself as a researcher imbued in the world of ACP and the local East of England culture of delivery of ACP education will have had on the methodology choices made and thereby the inferences that are drawn from this research.

In previously published research there have been suggestions made of potential beneficial expectations and aspirations for ACPs (e.g., pay, increased professional autonomy, or the desire to be retained in a clinical role). However, these commonly have not been established from asking ACPs directly and we know that there is great diversity and localisation of ACP. The ACP role is continuing to evolve and therefore research in this field should recognise that it reflects the state of ACP at a specific time and in a particular context. When collecting data, recognition therefore needs to be clearly given to the context bound nature of the data produced. This should include direct data drawn from participants such as the transcript of words used, but also recognition of the environment, interaction, and context in which this occurred, including the (emic) positionality of the researcher in the research process.

Reflexivity has been established as *"one of the ways qualitative researchers should ensure rigor and quality in their work; it is the gold standard for determining trustworthiness"* (Dodgson, 2019, p. 220). A reflective diary has been kept throughout the research process, including in the final stages of the study, to achieve meta inference and create a weaving, narrative analysis.

The reflective diary has been combined with use of 'thick description' as *"an interpretive approach to understanding the many layers of what is going on in the social world"*, (Mills 2010, page 4). Thick description has aided capturing the environment, interactions, and context of the research. The reflective diary and thick description have been used to provide contextual understanding of the potentially significant influences (including my own) that were noted as expressed by participants. This is in keeping with the recommendations of Braun and Clarke (2019); utilising and exposing the influence the researcher's own perspective has on the results is necessary to ensure the quality or trustworthiness of the research. Tashakkori, Burke Johnson and Teddlie (2021) further emphasised the importance of providing assurance of the trustworthiness when undertaking mixed method research. Key to this is being diligent in design and operation of the research, but also in how this is openly and honestly reported with reference to potential bias and limitations.

In contextualising this research, I therefore draw attention to the fact that I am a cisgender, divorced, white woman with 2 male children in their early 20s. I live and have worked throughout my career in the East of England. I am a registered Nurse with a clinical background in critical care which I returned to work in during the period of this research due to the Covid-19 pandemic. This exposed me directly to working with health care professionals in a clinical context, including ACPs. At the same time as commencing my PhD I moved from holding a Dean of School role in the School of Health and Social care to focussing on developing, delivering, and leading the Masters programmes that serve Post-Registration health care professions. This included reviewing the MSc programmes to align them to the apprenticeship and MPF standards for ACP and gaining CfAP accreditation for them in 2023.

Through my academic role I engage in many ACP networks and committees at a local, regional, and national level. During the period of this research, I have worked as an external examiner for another University delivering ACP programmes. I am also a reviewer for CfAP accreditation, including for pilot of the supported e-portfolio for ACPs without an accredited Masters. From the list of publications presented at the start of this thesis, the reader can see that I have had a wide range of experience in engaging with and contributing to policy, governance, and the evidence-base for ACP.

It is clear therefore that I am coming from an 'insider view' in undertaking this research whilst not having practised as an ACP directly. The reflective diary, thick description and ISSM-COREQ checklist (Appendix 6) developed from Tong, Sainsbury and Craig (2007) has been used to ensure this is captured, including recognition of potential researcher influence within the findings that are generated. NVivo has been utilised to store 'sources' (documents and information), 'code' extracts from sources, and organise into 'nodes' (themes). Each phase of the research was held as a 'case' and the reflective diary and thick description was utilised to provide case classification. Whilst using these tools to systematically organise, record, and provide rigour to the research process undertaken in this study they deliberately do not conceal the influence of reflexivity and my positionality in this research.

THEORETICAL AND PHILOSOPHICAL APPROACH

The cross-sectional, mixed method, research study presented in this thesis fits within the pragmatic research paradigm. As a precursor to determining which methods to use a 'Paradigm Contrast Table' (Appendix 7) was employed to identify the alignment of this research to "five points of view", or commonly named research paradigms (Tashakkori, Burke Johnson and Teddlie, 2021).

The research presented in this thesis most often fits within the pragmatic paradigm, with a leaning toward constructivism and transformativism. To some degrees it could fit within all the major paradigms. Pragmatists believe not only is there not one single reality, some of which are objective and some subjective, but that reality is constantly renegotiated, debated, and interpreted (Shannon-Baker, 2016). Pragmatists therefore believe that the current reality is best studied using a method that can solve the research problem. It rejects the either/or choices associated with the paradigm wars and advocates for selection from the range of research methods to best answer the question posed (Johnson and Onwuegbuzie, 2004). The pragmatic approach could therefore be seen as wanting to use the best tool to get to the truth. However, this research also takes a critical realist approach which acknowledges that our understanding of 'truth' is fallible.

Critical realism as originally described by Bhaskar (2008) distinguishes between the 'real world' and what is observable. It notes that the real world cannot be directly observed. Instead, our knowledge comes from our own perspectives and experiences through what can be observed. *"The tides would still turn and metals conduct electricity in the way that they do, without a Newton or a Drude to produce our knowledge of them."* (Bhaskar, 2008, page 12). It separates ontology and epistemology into what we say is real (ontology) and what we can know and understand about reality (epistemology), noting that one can exist without the other. When trying to understand reality, we are therefore looking at the observable events or entities that occur as a result of reality, rather than reality itself.

A critical realist perspective also notes the transitory nature of knowledge, in that it can change over time. Whilst we can improve our understanding, pursuit of 'perfect knowledge' as may be a feature in positivist research is unrealistic (Haigh *et al.*, 2019). Nevertheless, we can and therefore should choose the most plausible method of inquiry to improve our knowledge of the real world. This could also be argued to encourage taking a pragmatic approach where selection of research methods is guided by the task at hand rather a pre-determined ideology.

Whilst pragmatic, this transitory, flexible approach potentially opens up the opportunity for accusations of subjectivity. Critical realists would argue however that this is the only defendable position to hold, notwithstanding the attempt in research to ensure rigour is consistently pursued throughout the process. Taking a critical realist approach means that the choice of research method should therefore be based upon capturing the structures, mechanisms, perspectives, and experiences from reality to the best of our ability. As McEvoy and Richards (2016) noted, the goal of critical realists is to develop deeper levels of explanation and understanding and the choice of research methods to achieve this should be dictated by the nature of the research problem at that time.

Through exploring the theoretical and philosophical approaches that underpin research, it highlighted to me that this study is in keeping with the view of several authors and theorists of mixed method research (MMR); that paradigms may be more part of a continua rather than dichotomies that force an either/ or choice, (Johnson and Onwuegbuzie 2004). By operating in the 'middle ground' of this continuum the pragmatist can select parts of multiple paradigms and research methods to achieve the objectives of a particular research study.

For critical realists and pragmatists, the research question is therefore central to selection of the methodology. Some questions are best answered using quantitative research, and others using qualitative research; there are also questions that require a holistic approach and benefit from use of mixed methodology. No one methodology is viewed as superior to the other, except in how effectively it answers the question; this is the “compatibility thesis” described by Howe 1998 and cited by Tashakkori *et al.* (2021, page 18).

RESEARCH QUESTION

The research question identified to take forward from the systematic literature review completed in chapter 2 was:

What are Advanced Clinical Practitioners expectations of the benefits in pursuing this role, and are they being realised?

This is addressed by asking:

1. What are the expectations ACPs have regarding the personal benefits of their role?
2. Do ACPs believe these are currently being achieved?
3. What factors appear associated with whether or not expectations are achieved?

Whilst noting the ‘fluidity’ of mixed method research, Brown *et al.* (2015) emphasised the importance of justifying the selection of MMR instead of a single qualitative or quantitative approach by examining the aim and purpose of the intended research. They gave one reason for use of MMR is in situations where the aim is to provide an account of both the nature and magnitude of a phenomenon.

A single method in this research would not adequately capture both the expectations (the nature) and whether they are being realised (the magnitude) in ACP (the phenomenon being studied). A combination of methods was needed to address these aims and thus a mixed method research design was chosen.

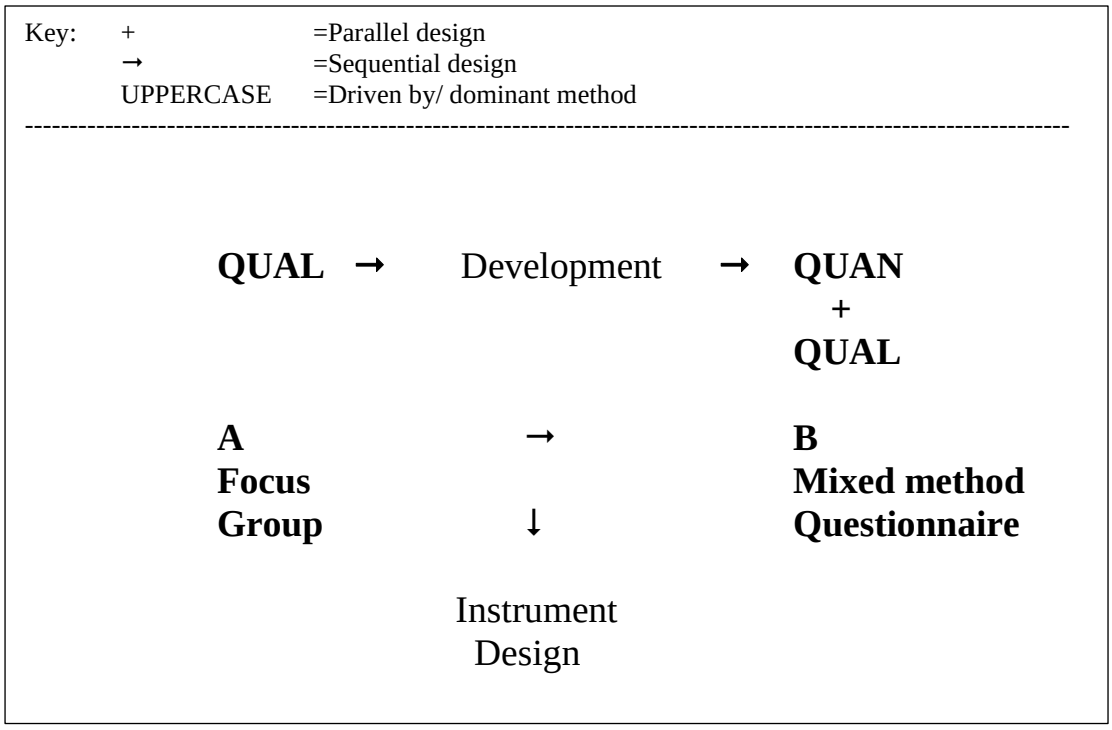
MIXED METHOD RESEARCH (MMR) DESIGN

Creswell and Plano Clark (2017) provided 4 overarching designs for MMR: triangulation, embedded, explanatory, or exploratory. These designs include use of quantitative followed by qualitative methods or vice versa and are categorised further into specific models within each design. Johnson and Onwuegbuzie (2004) noted the possibility of taking more of a 'mix and match' approach to ensure the research design components offer the best chance of answering the research questions. Teddlie and Tashakkori (2012) described this as 'methodological eclecticism', where the researcher selects from the research toolbox the best techniques to address the question posed. Using Creswell and Plano Clark's classifications of mixed methods designs (2017), the research undertaken and reported in this thesis aligns most closely to an exploratory design with use of an instrument developmental model.

Exploratory research designs use a sequential approach due to the need to develop and test a measurement instrument or identify important variables when the variables are unknown. It can be used "to explore a phenomenon and then test its prevalence" (Creswell and Plano Clark, 2017, page 75). The research is split into sequential phases that follow an inductive-deductive-inductive cycle. The purpose for using MMR design within the pragmatic paradigm for this research was 'development' as it sought to use the results from one method (i.e., focus groups) to develop or inform the other methods used (i.e., the follow-up questionnaire) (Schoonenboom and Johnson, 2017).

Teddlie and Tashakkori (2012) described this as a contemporary characteristic of MMR in which an iterative, cyclical approach to achieve the aim of the research is used and can be described as use of 'abductive logic'. This is in keeping with the pragmatic, exploratory approach, which requires that the results from one phase build and inform the next phase. Once the expectations of ACPs are understood within a particular context (using focus groups) an instrument (follow-up questionnaire) will then be developed to test the prevalence of these variables (i.e., have the ACP's expectations been realised). Morse's 1991 notation of MMR (cited by Schoonenboom and Johnson (2017) allows for a shorthand to present the research design including the dominance of methods and order (parallel or sequential) in which phases of the research take place.

Figure 4.1 - MMR design notation



In summary, the qualitative method of using a focus group has been used to answer the question:

1. “What are the expectations of ACPs regarding their role?”

The results from the focus group have been analysed in the development phase of the research to design a questionnaire that further focuses on answering:

2. Do ACPs believe these are currently being achieved?
3. What factors appear associated with whether or not expectations are achieved?

The follow-up questionnaire is mixed method using both quantitative and qualitative oriented items to ensure that the themes identified in the focus group can be adequately captured. Through use of a focus group and questionnaire, qualitative and quantitative data collection and analysis, the over-arching question of the research that explores both the nature and magnitude of the ACP phenomenon has been addressed. McLeod (2019) described qualitative research as concerned with understanding from the informant’s perspective and that it assumes a negotiated reality. This description fits well with the aims and the researcher’s positionality within an emic approach for this research and explains why a qualitative methodology is more dominant within the research design used. Further detail of the methods employed in this research will now be discussed.

FOCUS GROUP

Focus Group Rationale

Breen (2006) highlighted the importance of starting by asking oneself 'what do I ultimately expect to get out of this research' to ensure the selection of focus groups as a data collection method is appropriate. Allen (2017, para 1) said that *"the focus group is a qualitative research methodology employed to gain rich insight into attitudes and behaviours."* Kitzinger (1995, page 299) noted that "*The method is particularly useful for exploring people's knowledge and experiences".* The aim of this research is to establish what ACPs expect to gain from the role. By drawing upon their collective knowledge and experience of the expectations they have for this role it will inform the collection of data to establish if those expectations are being achieved.

Kitzinger (1995) described focus groups as a form of group interview. By conducting a 'group interview' this can reduce the time it takes for data collection and may reduce the vast quantity of data that is normally produced in comparison to one-to-one interviews. Kitzinger also noted that focus groups can help people to explore and clarify their views through use of a range of communication methods (e.g., case examples, anecdotes, personal accounts) often in context specific ways, such as use of own vocabulary and pursuing particular priorities. She suggested this provides an advantage over one-to-one interviews where responses to direct questions rather than the more flowing form of group interaction can reveal *"dimensions of understanding that often remain untapped by more conventional data collection techniques"* (Kitzinger, 1995 page 299-300).

The main objective of focus groups is not to reach consensus among participants or to engage in debate, but to gain perspectives on a particular topic by capitalising on the discussion generated by participants drawn from their own experience, genuine beliefs, and feelings (Allen, 2017). This fits well with the stated axiology of this research which comes from a desire to give voice to the participants. It uses an emic epistemological approach which focuses on the members of the culture being studied (i.e., ACPs) and notes that the 'truth' or meaning is relative to the perceptions and beliefs of the persons holding them. This is reflective of the relativist ontological perspective which accepts there can be multiple 'truths' which are subjective and embedded in a context which can evolve and change.

Whilst the entire research sits within a cyclical use of abductive logic, the focus group phase of the research is inductive. The aim is to develop understanding of the expectations of ACPs rather than testing an existing theory of the benefits of ACP, which from previous research conducted in this field primarily comes from stakeholders other than ACPs themselves. The use of a focus group within this exploratory, sequential, mixed method design enables the use of a pragmatic paradigm to underpin the research: this method will work best in the first phase of the research to establish expectations, to then inform the development of the second phase. It reflects the instrumental developmental model as described by Creswell and Plano Clark, (2017, page 75) *"to explore a phenomenon and then test its prevalence*".

Focus Group Sampling Strategy

Probability sampling is aimed at achieving selection of a sample that is representative of the population that is the focus of the research. It does this by providing equal access to all members of the population to be included. However, previous research in the field of ACP has shown that nurses tend to be overrepresented, particularly when probability sampling has been used. For example, in the literature review only 9 of the 44 papers included non-nurses in their sample and the online workshop held by Health Education England in 2020, as well as the Lawler et al 2020 study, was dominated by nurses as participants. From previous research conducted in this field we also know there are a variety range of titles used which can lead to over-emphasis on some ACPs within the diverse community and will miss out capturing others.

The use of maximum-variation for purposive sampling attempts to capture the most diverse range of participants from the population. By presuming that different participants will *"illuminate different aspects of a phenomenon"* this type of sampling allows for development of a more holistic understanding of the topic being studied and arrive at a *"line of argument"* or central themes to pursue (Benoot, Hannes and Bilsen, 2016, pages 5-6). This part of the research was aimed at identifying key themes in answering question 1: What are ACP's expectations of the benefits regarding their role? The focus group participants became key informants to help the researcher to select and clarify central themes by exposing their relevance and meaningfulness through group discussion. In this research, purposive sampling has therefore been used for participant selection for the focus groups. A diverse, maximum variation, subset of the ACP population that was drawn from a nationally distributed recruitment questionnaire were selected as focus group participants.

Recruitment to the study

To ensure a diverse a cohort of participants for this research, the invitation to participate was publicised using a wide range of Advanced Practice forums on social media.

Table 4.1 - Sources for recruitment.

Facebook	Twitter	Other Forums
Advanced Clinical Practitioner Forum (5.9k members)	@acp4n (ACPAN : A multiprofessional for Advanced Clinical Practice).	AAPE UK members list- the invitation was distributed to the membership list following an approved request being made to the AAPE secretary.
	@ot_acp (ACP Occupational Therapists)	
Advanced Clinical Practice Forum (3.1k members)	@APPN (AP Physiotherapy Network)	
	@AAPEUK (Association of Advanced Practice Educators)	Use of the 'News Forum' on the Advanced Clinical Practice Moodle page at the University of Essex
ANP Credentialling (2.2k members)	@RespiratoryACPs	Snowballing
	@AcpPodiatrists	
Advanced Practice in Secondary Care (1k members)	@EoEaccp (East of England Advanced Critical Care Practitioner Network)	All social media posts asked people to distribute the invitation to their contacts/ networks.
	@RCNANPForum (Royal College of Nursing Advanced Nurse Practitioner Forum)	
Advanced Practice UK (8.1k members)		All participants were asked to distribute the invitation to their contacts of any other ACPs or staff that are in training or seeking to become trained as an ACP within their department or service
Advanced Practitioners (247 members)	@TheACPforum (AP Forum in Primary care in Bristol, North Somerset and South Gloucestershire)	
	@AccpWessex (Wessex based Advanced Critical Care Practitioner forum	

The invitation to participate (see Appendix 8) asked individuals to return, by use of a 'one-click survey', an expression of interest to participate in the research. It stated that by returning this expression of interest they were not bound into participating in the research, but that further information about the research will then be shown on screen along with a consent form for them to complete if they wish to proceed to participate (Appendix 9). By completing the on-line consent form, participants were then re-directed to the recruitment questionnaire (Appendix 10).

There are no nationally and publicly available verifiable figures of how many ACPs there are currently working in England. As noted in previous research, identification of ACPs is fraught with difficulties regarding the variation of role titles being used (Leary *et al.*, 2017). The regional faculty of the CfAP in the East of England conducted a 'deep dive' to better establish the number of ACPs in the region. Here they arrived at a figure of >1573, noting that this is estimate which is likely not to have captured everyone and may include people in job roles with Advanced Practice (or similar) in the title but who do not meet the criteria within the MPF (Health Education England, 2021b). At the time of recruitment to this study, the other 6 regions had not collected or published this data. Assuming there was no significant regional variation in the estimated number of ACPs, this gave an estimated figure of 11,000 ACPs in England. For a representative sample of the general ACP population to draw upon for maximum variation focus groups a target figure for sample size of the recruitment questionnaire was set at between 300-375. This was calculated using a confidence interval of 95% and 5% margin of error taking account of both the estimated East of England regional number (1573) and the national number (11,000). Ultimately, 291 participants responded to the recruitment questionnaire. Whilst this fell slightly short of target recruitment set, a number of factors have been considered that affected this.

The recruitment questionnaire was sent out during a time when health services were still addressing the effects of the Covid-19 pandemic. This may have meant that some ACPs were not engaging with work or their social media or networks at this time due to trauma from working in a frontline role, their own isolation and ill heath from Covid-19, increased workload pressures, or redeployment away from their normal ACP role or work. In addition, not all ACPs will have been connected to the social media outlets or networks utilised for recruitment to this study.

As noted above, there is ambiguity regarding the number of ACPs, with this data not having been collected or published at the time of the recruitment to this study. Since the recruitment questionnaire was issued, there have been structures and governance put in place with many organisations and regions now establishing Advanced Practice forums. It has been evident from my experience of sitting on these groups in the East of England that as employers have been sifting through staff to identify their population of ACPs many people may have 'Advanced' or similar in their job title, but do not meet the definition of an ACP as set down by HEE. This suggests a previous over-estimation of people working as ACPs (as defined by HEE). As will become evident from the results of this study in later sections of this thesis, there is great diversity of how ACP roles and training programmes have been implemented and are being used. This means some areas have more established and larger numbers of ACPs than others. The assumption that all 7 regions may have had similar numbers of ACPs may therefore have resulted in a miscalculated estimation of the total ACP population.

Whilst consideration of the above factors suggests there may be fewer ACPs than were first estimated, the total population size of ACPs has not been fully established and may not have fully taken account of trainee ACPs. By increasing the margin of error to 6% in the sample size calculation this results in a target of 229-261 participants which is line with the number recruited to this study. Increasing the margin of error reflects my revised confidence in light of the unknown total population size. With this adjustment it is acknowledged that the accuracy of whether the recruitment questionnaire represents the full ACP/ tACP population is reduced. This does however reflect the ACP context; the literature review found this community to be evolving and diverse with limited national and longitudinal research having been undertaken to date to understand the current features of the ACP population.

The inclusion and exclusion criteria detailed in Table 4.2 overleaf was used to identify from the recruitment questionnaire eligible participants for the research. The inclusion and exclusion criteria were set to address the aims and reflect the current ACP context of this research. No data was retained for those that did not consent to participate or for those that were not eligible to participate according to the inclusion/ exclusion criteria. The recruitment questionnaire design drew upon externally validated questionnaire formats from other ACP research (Health Education England, 2021b). This provided a well-established frame of reference to check against inclusion and exclusion criteria and would be familiar to participants answering this questionnaire.

Table 4.2- Inclusion/ Exclusion criteria

INCLUSION CRITERIA		**Notes** **If people meet 1 OR MORE of the inclusion criteria below, they are eligible to participate in the research, UNLESS they fulfil ANY of the exclusion criteria below.**
1	In a role/ job title identified by the participant's employer as being an 'Advanced Clinical Practitioner'	It is recognised that there a number of different titles and terminology to describe these roles; these are likely to be specific to the employer, clinical speciality, or professional group.
2	In a role/ job title identified by the participant's employer as being on a training/ education programme to become an 'Advanced Clinical Practitioner'	
3	In a role/ job title that fits the description as being an 'Advanced Clinical Practitioner' according to the 'Multi-Professional Framework for Advanced Clinical Practice in England'.	It is recognised that not all employers currently recognise or employ people within the description as set out in the 'Multi-Professional Framework for Advanced Clinical Practice in England', with some who DO fit the description NOT holding an 'Advanced Clinical Practitioner' job title, and some who DO NOT fit this description BEING GIVEN the 'Advanced Clinical Practitioner' job title. The description will be included in the invitation noting that whether or not they hold a job title of Advanced Clinical Practitioner (or similar title) if they fit with this description, they are eligible to participate. Questions within the recruitment questionnaire will provide confirmation of this.
4	In a role/ job title that fits the description as being on a training/ education programme to become an 'Advanced Clinical Practitioner' according to the 'Multi-Professional Framework for Advanced Clinical Practice in England'.	
EXCLUSION CRITERIA		**Notes** **People that meet ANY of the exclusion criteria below will be excluded from participating in the research**
1	Not currently employed within an ACP or ACP trainee role.	Participants must hold an employment contract, whether this be on a fixed-term, casual, consultancy or part or full-time or permanent basis. Questions within the recruitment questionnaire will provide confirmation of the type of contract and role held and whether it meets the inclusion criteria.
2	Currently suspended, excluded from practising as an ACP or undergoing investigation for Fitness to Practise	Participants will be asked to confirm that they are not currently suspended from their Advanced Clinical Practitioner role and that they are not currently under investigation for Fitness to Practise by their employer or regulatory body, (e.g. NMC/ HCPC/ GPhC).
3	Not willing to participate in this research, which includes completion of on-line surveys and a potential invitation to participate in a focus group	Reference will be made to the participant information sheet which they will need to agree they have read before being asked to consent to participate in the research. Only those that do consent will be able to access the recruitment questionnaire. No data will be held for those that do not consent.

The recruitment questionnaire generated data regarding the ACP population. The data were recorded using categories so that a maximum-variation sample could be identified for the focus groups. The categories included job title, professional background, length of time in the role, pay scale, location, field speciality. In addition, it asked participants to identify what training or education they have had to date that has led them into holding or pursuing an ACP role as it has been identified this is a key factor in the experience and career trajectory in ACP (Lawler, Maclaine and Leary, 2020). From analysis of this data the range of 'types' of values or attributes of respondents in each category were able to be identified (e.g. the pay scale ranged from 0 [not in the NHS pay banding] to 9 with the majority being paid at bands 7 and 8). The range for each category provided a framework to structure maximum variation selection for the focus groups.

Respondents to the recruitment questionnaire were asked to provide a contact email (held separately from the results), if they would be willing to participate in the focus group. Following contact via email, all those that consented to participate in the focus groups were mapped to the categories as described above and invited to complete a Doodle poll to identify their availability to attend a focus group at a particular time and date. To facilitate discussion and allow a range of views and experiences to be heard, the aim was to hold at least 3 focus groups with 5-8 participants each, with each focus group comprising of a diverse group of ACPs. Membership for each of the focus groups was cross-checked to ensure there were a range of participants selected from each category to achieve maximum variation. This was achieved and further detail is discussed in the focus group results chapter.

Focus Group Data Generation

The three focus groups held were semi-structured with use of a topic guide (Appendix 11) and conducted via Zoom. The topic guide included a set of trigger questions to ensure the research question *"What are the expectations of benefits ACPs have regarding their role?"* could be answered by the focus group method. Using the guidance provided by Allen (2017), I devised the trigger questions to move through engagement, onto exploration, into probing, and then finally to exit questions.

Participant information, guidance on using zoom which the participants may have had varying exposure to using previously, etiquette regarding protecting anonymity, raising hands to speak, muting, recording, and using the chat box was provided in advance of the meetings (Appendix 12). The focus group began with an introduction to ensure participants were aware of the aim, purpose, and how the research would be conducted and disseminated, as well as reminding them of the support systems that are available to them should this raise any questions, issues, or concerns, before checking their consent to participate. The trigger questions that followed explored the research question and concluded with a process for summing up and member-checking the key themes that had arisen through the focus group discussion. Birt *et al.*, (2016) noted how member-checking can be useful to limit the imposition of personal beliefs and interests and minimise researcher bias when the researcher is both the data collector and analyst. Whilst it is acknowledged researcher influence cannot be excluded, this technique has been used to ensure the key themes reflect those identified by the ACP participants.

A potential difficulty in focus groups is that ‘groupthink’ may develop where a prevailing opinion is hard to counteract by others in a group setting. A one-to-one interview may feel a less threatening environment and is less likely to have perceived repercussions after the interview has ended for ongoing relationships with other participants (Sim and Waterfield, 2019). Careful attention was therefore paid to ensuring all participants were encouraged to speak to openly convey their own knowledge and experience; whether or not this was contrary to others in the group. Strategies utilised included providing information in the introduction of how data will be used and noting that the responsibility of the moderator was to:

- encourage (to gain multiple perspectives and persuade all to participate),
- probe (to get detail and provide explanation where needed) and to
- facilitate (responding to the group, including participation from all).

Liamputtong (2011) described the moderator role as a navigator to encourage exploration but also to ensure the participants stay on the right track, answering the research question and achieving the aim of the research. Fern (2001) noted the background and ‘desirable characteristics’ needed for the moderator to be effective. These include being able to relate to the group with similarity between the participants and moderator being an important characteristic to avoid discussion that stays at the surface level of description rather than deeper exploration of a topic. My recent experience of working in critical care in which ACPs commonly operate allowed me to ‘blend in’ more than a moderator with no clinical experience would have. For example,, participants frequently used abbreviations for their role, speciality, or common clinical interventions. My clinical experience meant that the flow of discussion in the focus groups was not disrupted by having to stop discussion to ask for explanations.

Focus Group Analysis

As this research utilised a sequential design, periods of data analysis were required throughout the research so that the findings generated could inform the next phase of the research. The focus groups generated qualitative data for thematic analysis (TA) from which a questionnaire would be developed for use in the second phase of the research. In deciding the thematic analysis method used in this phase of the research a number of options were considered.

Grounded Theory (GT) uses a 'bottom up' approach, with 'emergence' of codes from the participants and the data they produce being a key feature. An 'Informed GT' approach could have been adopted for this study noting that use of an emic approach would have an impact on the themes that are chosen. Whilst admittedly Braun and Clarke (2020) were promoting their own version of (reflexive) thematic analysis, they highlight that GT can be "overly complex" which may not fit well where there are time constraints or lack of research experience. Timonen, Foley and Conlon (2018) concurred that time allowance can restrict effective use of GT. They also noted that theoretical sampling is core to GT to ensure as far as possible a comprehensive theory is generated; this is the primary purpose of GT although not always possible to achieve. In this research, once maximum variation sampling was used to capture a diversity of views on the expectations of ACPs, the aim was NOT to undertake repetitive time-consuming ways to keep honing down to a more focused level to provide a comprehensive and detailed theory. Instead, key themes identified from the focus groups were used to evaluate whether these are a feature of the broader ACP population's experience of the role. This made use of GT questionable as an appropriate method of analysis in this research.

In Interpretative Phenomenological Analysis (IPA) ‘the data’ is expected to come from a homogenous group of individual accounts of experiences, whereas in this research the aim is to get a diverse group of ACPs to identify the themes that they believe are significant for this group. Normally the analysis within IPA comes from close examination of the data once it has been collected, for example coding of transcripts from interviews (Smith, Flowers and Larkin, 2009, pages 3-4). Here, member-checking was utilised by the primary researcher as moderator within the summing up stage of the focus groups to identify themes for analysis rather than these being derived post-hoc, once the data was collected.

The reflexive TA approach (rTA) described by Braun and Clarke (2020) is designed to be flexible and able to be used effectively for a range of epistemological, ontological, and paradigmatic approaches. This fitted well with the researcher’s theoretical underpinning where ‘methodological eclecticism’ has been embraced to utilise the best techniques to address the question posed. Braun and Clarke’s 6 phase method of rTA emphasises that this is not a linear process where you move from one phase to the next to reach the nirvana of analysis. Each phase is a set of principles to be applied and reported upon to ensure effective rTA is undertaken and can be discussed to assure trustworthiness of the research. This approach allows for weaving back and forth between the phases, including reference to relevant contextual information and recognition of the positionality and active choices the researcher has made to provide meta-inference. The rTA method fitted well with the theoretical stance underpinning this research and the choices the researcher has made, including use of a reflexive diary, thick description, member-checking and the researcher as moderator for the focus group. For this reason, the 6-phase method of rTA as described by Braun and Clarke (2020) was selected for analysis of the focus groups in this research.

Table 4.3 - Braun and Clarke's 6 Phases of Reflexive Thematic Analysis

Phase	Description (taken from https://www.psych.auckland.ac.nz/en/about/thematic-analysis.html)	Application in this research
1.Familiarisation with the data.	This phase involves reading and re-reading the data, to become immersed and intimately familiar with its content	Researcher acts as moderator in the focus group. Zoom recording re-played and transcript amended for accuracy. Transcripts are stored as **files** in NVivo and shared with participants
2.Coding	This phase involves generating succinct labels (codes!) that identify important features of the data that might be relevant to answering the research question. It involves coding the entire dataset, and after that, collating all the codes and all relevant data extracts, together for later stages of analysis.	Zoom transcript read with notes made against each section as each label is identified. Labels and each relevant extract from the source (the transcript) are organised on NVivo as a '**context code'**.
3.Generating initial themes	This phase involves examining the codes and collated data to identify significant broader patterns of meaning (potential themes). It then involves collating data relevant to each candidate theme, so that you can work with the data and review the viability of each candidate theme.	Context codes are reviewed to identify patterns and these are organised into themes as **'top-level codes'** and **'child codes'** on NVivo. Potential themes and broader patterns of meaning are discussed as part of the research supervision, returning to re-reading transcripts, familiarisation and coding where needed.
4.Reviewing themes	This phase involves checking the candidate themes against the dataset, to determine that they tell a convincing story of the data, and one that answers the research question. In this phase, themes are typically refined, which sometimes involves them being split, combined, or discarded. In our TA approach, themes are defined as pattern of shared meaning underpinned by a central concept or idea.	Codes (context, top-level, and child) reviewed and checked against the research question 'What are the expectations of ACPs regarding their role?'. Also checked against the key themes as identified by participants within the summing up section of the focus groups, splitting, refining, combining, adding, or discarding as appropriate to tell a convincing story.
5.Defining and naming themes	This phase involves developing a detailed analysis of each theme, working out the scope and focus of each theme, determining the 'story' of each. It also involves deciding on an informative name for each theme.	Top-level codes are examined and extracts from the reflective diary and thick description are used to provide a more detailed description with reference to any contextual considerations, (including use of the 'context codes'), returning to the previous phases as needed. The names for key themes (top-level codes) are decided on this basis.
6.Writing up	This final phase involves weaving together the analytic narrative and data extracts and contextualising the analysis in relation to existing literature.	The themes which encompass context codes, top-level codes, and child codes are presented as stories in the findings section of the thesis followed by weaving in the discussion section to provide meta-inference. The CoReQ checklist (appendix 7) is used to ensure robust reporting of the process followed is openly available to the reader.

In the data familiarisation stage of rTA I had the benefit of being involved in the data generation through the role of focus group moderator. I could therefore review the automatically generated transcript to check for accuracy, making corrections where needed based upon what was heard at the time of the focus groups alongside re-playing the recording. Mistakes in zoom transcripts are commonly due to misspelling words because of the way in which they were vocalised or due to background noise (Zoom Help Centre 2021). The focus group recording was therefore used to confirm the transcript generated and NVivo was used to store the 'file' (zoom recording). A corrected transcript of the focus group was analysed using the recursive (back and forth) rTA method, to create core categories to answer the research question. These are referred to as 'codes' in NVivo and excerpts from the transcripts were filtered into 'context', 'top level' and 'child' codes for further analysis to create the 'stories' as described in rTA to explore and illustrate the themes. Throughout the focus group analysis, notes were made drawing from the reflective diary and thick description of the process undertaken. This provides clear anchoring of the findings to the context in which data was collected and analysed, allowing transparency of the choices made when identifying the themes from the focus group.

INSTRUMENT DESIGN

Questionnaire Rationale

Zhou (2019) noted the importance of instrument validation analysis throughout the process of development, not just once an instrument has been chosen. This includes ensuring the items included in the instrument developed will answer the research question being posed. The instrument that was designed in this phase of the research needed to facilitate answering the following research questions:

- Do participants believe the expectations of being an ACP are currently being achieved?
- What factors appear associated with whether or not expectations are achieved?

The design of an instrument in this phase of the research therefore addressed the 'magnitude' or 'prevalence', where the focus group has been used to explore the 'nature' or 'phenomenon' regarding expectations of the ACP role, whilst noting that the results from the instrument designed might also help to illustrate the nature of ACP in its current context. The decision to use a questionnaire to answer the study aims was based upon the advantages it has over other methods and it's fit with this phase of the research, which focussed upon capturing the reality of the experience of ACPs. Mathers, Fox and Hunn (2007, page 5) noted that survey designs, which include use of questionnaires, "*are particularly useful for non-experimental descriptive designs that seek to describe reality*". They highlighted 5 main advantages to using this design which have been considered overleaf and applied for this study:

1. **Validity**. The aim of this part of the study is to capture ACPs account of their experiences in the role. The follow up questionnaire was designed to reflect the themes identified in the focus group and answer the research questions posed (i.e., taking note of construct, content, and face validity). Through consideration of internal validity in the questionnaire design, inference can be made as to whether the expectations of ACPs (as identified in the focus group) are being realised by utilising the reports of the ACPs themselves.
2. **Efficiency**. A questionnaire has an advantage over other types of method, such as interview or observational studies, where due to limits of time and resources accessing, collecting, and analysing data from a large population would not be feasible. From the recruitment questionnaire undertaken there were 272 consented ACPs identified. It would not have been feasible to conduct individual interviews, observational studies or use other methods for this number of people within the time and resources available for this PhD thesis. Michaelidou and Dibb (2006) noted the benefits of on-line questionnaires as low costs for distribution and data collection, the immediacy of distribution and return of data, and ease of use for researchers and participants.
3. **Coverage of geographically spread participants**. The ACPs in this population are widely spread in different geographical areas of the country. As ACPs all work in clinical areas where services operate 24 hours a day, 7 days a week and all year around, finding a time and location for synchronous collection of data across this population would not be possible. Use of an on-line questionnaire allowed participants to provide data at a time of their choosing, without the requirement for them or the researcher to be in a specific location at a particular time.

4. **Ethical advantages**. All research methods require consideration of how the protection of respondents is addressed. This includes offering a level of anonymity to participants to build confidence that they can provide open and honest data without the risk of individual repercussions from participation. By utilising a questionnaire method, identifying features of the respondents can be excluded during data collection and assurance can therefore be given that their anonymity will be protected. Participants can as a result be encouraged to be honest in their answers which provide a direct account of their own experience of working as an ACP. Use of a questionnaire also removes the risk of exposing participants to interventions that would not occur “in the real world”, such as may happen in random controlled trials or observational studies. Instead, collection of data is from participants report of their own current normal working practices (Mathers, Fox and Hunn, 2007).
5. **Flexibility**. There are different types of questions that can be asked in questionnaires to collect both quantitative and qualitative data. This fits well with MMR and its use within a pragmatic paradigm. (Tashakkori, Burke Johnson and Teddlie, 2021). The combination of open and closed questions within the questionnaire, alongside the use of focus groups to inform the questionnaire design allowed the research questions to be answered and salient conclusions and recommendations to be made.

Reliability & Validity

Careful design of the questionnaires used in this research includes consideration of strategies to enhance reliability and validity. For example, inter-rater reliability has not been addressed as the data in this research has been collected and analysed by a single researcher for her PhD studies (albeit with guidance and support through reflection and supervision). However, by applying a single questionnaire to a larger population of ACPs than could be accessed through other research methods, consistency in data generation could be achieved.

Whilst not seeking to test a hypothesis or establish causal relationships in this research as would be expected for internal validity of experimental data, the questions asked were designed to reliably evaluate the magnitude or prevalence of whether ACPs expectations have been achieved. In addressing consistent questioning to a diverse sample of ACPs, the intention is to draw conclusions about this population's experiences of working as an ACP. However, this research acknowledges the diverse context and time bound nature of ACP; it cannot be assumed that if the same 'test' was used at a later date or with a different sample group of ACPs the results would be the same. A test-retest has therefore not been included in the research reported in this thesis as a measure of reliability. A longer-term objective (beyond the scope of this PhD) is to undertake longitudinal research which uses the same methods to see if any changes have occurred over time (and evolution of the ACP population in the UK) in the gap/s between expectations and reality of working in Advanced Practice.

Population validity as a measure of external validity is of course dependent upon response rate and how representative the respondents are of the whole population. Reference to response rates and characteristics of the respondents have therefore been explicitly reported in the results chapter of this thesis. The potential for generalisation of the results of this research has also been explored in chapter 8. This includes how the particular features of participants in this research relates to the inferences and recommendations that have been drawn from this research.

Having chosen questionnaire as the most appropriate method to answer the research questions, the themes identified from the focus group were used to search for relevant validated questionnaires. The 're-purposing' of existing, previously validated, questionnaires may not be possible to retain effective content validity in a new or differently orientated piece of research. However, use of a previously validated questionnaire can reduce the time needed to develop a new instrument and enhance the possibility for replication in other contexts. The range of themes generated from the focus groups were not able to be identified in a single validated questionnaire. There may have been a range of previously validated questionnaires that could have been used to cover each of the themes (e.g., QoWL: research based organisational scales and surveys (Quality of Working Life, 2019). However, combination of these into one questionnaire would have made the follow-up questionnaire too lengthy and risk a higher rate of non or partially completed questionnaires. Combination of previously validated questionnaires to be used for a different purpose than they were originally intended for may also risk their integrity and validity. A new questionnaire therefore needed to be designed to appropriately reflect the themes identified.

The validity of the instrument developed in this study has been evaluated taking note of the principles as described by Zhou (2019) before selecting it for use. Whilst Zhou's work referred to development of 'scales' normally associated with purely quantitative survey tools, this provides a useful structure for the broader remit of questionnaire development and validation. Zhou described a 5-step process:

1) qualitative exploration and validation
2) conversion of data to questionnaire items
3) checking content-based validity
4) administering the questionnaire
5) examining construct-based validity through quantitative validation.

After which, the questionnaire is revised and then reviewed, repeatedly returning to stage 3 of the process where needed.

In step 1 of the process Zhou, (page 43), noted that *"The central phenomenon of the qualitative study should be defined the same as the scale construct, and all research questions should relate to it."* In this study the qualitative focus group was used to explore the central phenomenon (the expectations of ACPs) and this provided the structure for the follow up questionnaire. Member checking was used within the focus group to provide validation of the key themes around which the questions in the follow up questionnaire were constructed. The reflective diary and thick description were utilised to explore and reflect the impact of contextual influences within the key themes identified. This was used as part of rTA to undertake 'qualitative validation' (step 1) and facilitate the 'mixing' phase and validation (steps 2 & 3) where qualitative data was converted to scale items, and content validity was the primary focus.

The reflective diary used included notes from supervision meetings undertaken during the PhD. This has allowed for ‘debriefing’ as described by Zhou (2019) in the ‘mixing validation’ of step 3 where the developed questionnaire was discussed to explore the relationship between the items included and the underlying construct. By utilising a logic flow diagram within supervision, (Appendix 13), it assisted in revisiting the central phenomenon to provide a cross reference for the scale construction (the questions being set within the follow up questionnaire).

In steps 4 and 5, administering the questionnaire and examining construct-based validity, item response theory (IRT) and the use of confirmation factor analysis (CFA) were considered. IRT has been described as a synonym for, or relying upon examination of, latent traits (Kline, 2020; Yang and Kao, 2014) which describes how an observable characteristic can affect how a person will answer a question about something that cannot be directly observed. It refers to use of mathematical processes to assess the propensity of a participant to answer a question in a particular way. By understanding the characteristics of the population responding to the questionnaire, this can be used as a predictor for results and can provide assurance that a set of questions focussed on one construct are reliable in their measurement. For example, you could have a set of questions that ask about job satisfaction. Using IRT you could identify that people that are extraverts always respond more positively to these questions. The application of latent traits/ IRT in this study would have required a far longer questionnaire to include a set of questions for each child code as well as consideration of the persistent personality characteristics of the ACP population being surveyed.

Whilst it would be interesting to carry out research to understand better the personality traits of ACPs and what may influence their expectations or interpretation of experience of the role, this study was not focussed on this aspect. Emphasis was placed on the constructivist and critical realist perspective being utilised for this research, where it is accepted that there is not a single 'truth', that it is fallible, and can be understood from a variety of perspectives. The research here was aimed at 'giving voice' to ACPs where previous research has primarily focussed on other ACP stakeholders' perspective on the reality of working as an ACP. As already noted in the systematic literature review the characteristics of the ACP population has not been established; rather we know that the ACP population is diverse and evolving. Current 'sifting' of staff is occurring to confirm identification of those that meet the consensus definition of ACP (as set out in the MPF); the boundaries of the ACP population (and thereby their characteristics) has therefore not yet been established or contained. The use of IRT was therefore not incorporated to this research.

CFA is also an approach whereby mathematical modelling is used. It is purposively used to construct an instrument to test a hypothesis and therefore relies on having background knowledge to develop a hypothesis to then test it. In CFA, observed variables (measurable data) and latent traits are utilised to establish factor loading. Factor loading describes how closely an observed variable corresponds with a latent variable to enable testing of a hypothesis regarding how one may impact or influence the other. However, this approach would fit better with potential future research rather than the focus for this current study as the latent variables for ACPs are not yet known and a hypothesis based upon the experience of ACPs has not yet been established.

In addressing Zhou's steps 4 and 5 for development and validation (administering the questionnaire and examining construct-based validity through quantitative validation) a pilot study as an alternative method to IRT and CFA was therefore employed alongside review of reliability and validity through supervision to explore different data analysis methods and approaches for this study.

Pilot Study

The pilot study utilised academic colleagues and regional contacts that I am connected with through my role as an ACP educational programme lead. As the follow up questionnaire was undertaken through use of an on-line platform, the pilot testing process was used to identify and address any technical issues and to check the questions asked. As noted by Toepoel in Fielding et al (2016), it is important to recognise that the questionnaire seen by the respondent may not be exactly as intended by the researcher due to different operating systems, screen sizes etc.

The 'pilot ACPs' undertook a 'dummy run' (or beta-testing) of the questionnaire to check access to, presentation of, and transition from question to question, and to ensure my ability to access and analyse the results worked effectively. The pilot study information was collated, discussed in supervision, and used to revise the questionnaire where needed. Via this process it was confirmed that the questionnaire would normally require no more than 30 minutes to complete, and that the questionnaire flowed as expected, displaying questions accurately and providing an appropriate range of options for response.

It is important to note here that the pilot test was not aimed at collecting further information on the expectations of ACPs or adapting the questionnaire to meet with the key themes or perceptions of the pilot ACPs. The themes used for designing the questionnaire had been drawn from the focus groups. In summing up the focus group discussions the aim was to member check the themes highlighted had resonance with the participants experience and should be taken forward as a basis for designing the follow up questionnaire. Birt *et al.* (2016) emphasises the need to disclose the intended purpose for use of member checking to ensure claims about credibility and validity fit with the epistemological stance and design of the research. The aim of my research is to reflect the expectations of the participants rather than more broadly from the ACP population. The pilot ACPs were not therefore asked to generate their own themes or add to those already identified to be used for the questionnaire. This recognises and reinforces the findings of the literature review; that ACP is diverse, localised, and context-bound and that it is important to understand the experience of ACP from their own viewpoint.

The pilot ACPs were provided with the key themes that had been identified and were asked ‘Do you believe that the questionnaire captured the key themes identified by the focus group ACPs’. They were asked for any further comments that they believed the researcher should consider in revising the questionnaire before it was sent out to the purposive sample participants. One pilot ACP noted that she found the questions regarding the presence and effectiveness of the ACP lead for their organisation difficult to answer as she was the ACP lead in her organisation! A further option with skip logic was therefore added to FQ29 so participants could select the option that they are the ACP lead and then move directly onto question FQ31. Otherwise, the pilot ACPs all felt the themes had been addressed in the questions set.

The pilot ACPs responses, plus 60 random responses (generated by Qualtrics) were used to run a dummy analysis, using a pre-planned schema (Appendix 14). The free text comments provided by the pilot ACPs provided reassurance that responses to the open (qualitative) questions would work well with rTA. Using the pilot data, visualisations and descriptive analysis, including identification of areas for 'deep dive' exploration using 'breakout by' reports in Qualtrics, were able to be tested.

Follow-up questionnaire Design

The approaches described above attempted to enhance reliability and validity by reflecting on the process as described by Zhou (2019). This process seeks to address construct-based validity; namely are the questions measuring what they should be measuring. The goal here was for the follow-up questionnaire to answer whether the experience to date of this set of ACPs match up with the expectations of the role.

In keeping with the pragmatic, exploratory approach, the specific questions within the follow up questionnaire (Appendix 15) were not determined in advance of the focus group but were decided by what would best reflect the themes identified within the focus group discussions and subsequent analysis. This means that some follow up questionnaire items were best suited to an open question that could be qualitatively analysed and for others it was more appropriate to use a closed question and quantitative analysis. In addition, a mixture of nominal, ordinal and ratio questions have been used to ensure they fit with the information being sought for analysis of a key theme. For example, the questions that explore the themes from the focus group were primarily ordinal to provide a rank of the extent to which ACPs have experienced a particular aspect of the role (e.g., use of the full knowledge, skills and experience).

Table 4.4 Follow-up questionnaire overview

Question Set	Question Topic	Question Type
Q1-7	Consent	Binary (yes or no) Not included in data analysis
QA-C	Contact details for report of results	Binary (x1) and descriptive (x2) Not included in data analysis
Q1-13B	Demographic/ Context	Nominal (x5), ratio (x3), binary (x2), descriptive (x1), ordinal (x2)
FQ1-4	Theme- Clinical	Ordinal (x2), interval (x1). Descriptive (x1 open question analysed using rTA)
FQ5-11	Theme- Full KSE	Ordinal (x3), interval (x1), nominal (x1), rank (x1). Descriptive (x1 open question analysed using rTA)
FQ12-17	Theme- Leadership in QI	Ordinal (x3), interval (x2). Descriptive (x1 open question analysed using rTA)
FQ18-27	Theme- Career Progression	Ordinal (x6), interval (x2). Descriptive (x2 open questions analysed using rTA)
FQ28-39	Theme- Policy, vision, structure	Ordinal (x8), binary (x1) interval (x2). Descriptive (x1 open question analysed using rTA)
FQ40	Summary question	Interval (x1)
FQ41	Any other comments?	Descriptive (x1 open question analysed using rTA)
Total number of questions = 64		

Noting the rationale for not determining questions in advance of the focus group to ensure the integrity of the research methodology was upheld, the follow-up questionnaire had though always been expected to repeat the (closed) questions from the recruitment questionnaire (i.e., collection of demographic data, job title, grade etc). The inclusion of these closed questions at the start of the follow up questionnaire was determined in advance of any themes being established from the focus group as a necessary part of whatever questionnaire was developed. This allowed descriptive analysis of the respondents' demographic data and exploration of potential related factors for each theme.

An open question for each theme was included to capture experiences participants felt were relevant and had not been addressed by other areas of the questionnaire. This offered a further opportunity to ‘give voice’ to the participants, noting that the research recognises the diversity of ACP perspectives and experiences and the ‘situatedness’ in which they operate.

Lavrakas (2008b) noted that the order in which the questions are presented can influence the answers respondents give. He suggested that commonly this starts with general or neutral questions to build rapport and gain respondents confidence. In the follow-up questionnaire, easy to answer demographic questions were placed at the beginning. Following ‘easy to start with’ questions, it should then move to questions that may require greater effort to answer or are more complex. This is where the themed questions were placed and where respondents were asked to provide a view on their experience and perspective of the ACP role. Taking this suggested approach to sequencing questions illustrates the concept of ‘satisficing’ (as initially described by Herbert A. Simon in 1957 cited in Oxford Reference 2021). Satisficing is described as where people will expend the least amount of effort required to meet a threshold of acceptability for the desired outcome, including responding to a questionnaire. The satisficing concept suggests why, despite the many different options available to buy a particular item, we tend to return to a familiar store where the prices are broadly acceptable rather than look in all the different shops to find the best price before purchasing. This also illustrates why people might not respond or only partially respond to a questionnaire. Participants may give up halfway through a questionnaire as it is taking up too much effort to find and enter the answers that best fits with their opinion or experience, or they always choose the neutral ‘neither agree or disagree’ if given this option.

Krosnick, Narayan and Smith (1996) further described ‘optimising’ which is the cognitive processes and actions respondents undertake to provide high-quality data, noting that satisficing may compromise one or more of these processes. Lavrakas (2008c) describes how the 4 steps of optimising can be addressed to enhance respondents answering questions in the most optimal way. These have been considered to move towards the aim of ‘strong satisficing’ where respondents move swiftly through the cognitive processes required in responding to a questionnaire as the answers that fit with their world view can be easily identified and answered, thus avoiding exhaustion or providing inconclusive or ‘wrong’ answers.

1. **Interpreting the meaning of the question.** This requires that questions are clear and understandable to the reader. It includes using one question only to address a single concept, avoiding jargon, abbreviations, and colloquialisms, understanding the reading level that can be expected of participants, avoiding double or reversed negatives, and providing a clarification or definition where this may be needed (Fink, 1995). An example of this is in Q11B where it is defined what is meant by ‘ACP’ for the purpose of this questionnaire.
2. **Retrieving relevant information from memory.** Clues should be given as to how respondents can access relevant memories (e.g., FQ9 suggests respondents think back to their most recent appraisal, personal development review or revalidation). The questionnaire and information provided to participants was designed to emphasise that they were being asked about their own personal experience thus far of working or training as an ACP. They were not being asked more generally about ACP. This makes it easier for participants to find a point of reference from their own memory of experience to answer the question (Fink, 1995).

3. **Integrate the information into a summary judgement.** Use of summated rating scales can facilitate the cognitive process of forming a summary judgement. In Likert scales, descriptive text should be used to present a stimulus statement expressing an attitude or opinion (e.g., in FQ2 different options on the scale were provided with a stimulus statement such as “Sometimes- my role sometimes involves clinical work but on an infrequent basis (e.g. not every week ”). This aids respondents to arrive at a judgement by providing a specific frame of reference in which to reflect their experience of ACP (Spector, 1992)
4. **Map judgement onto the response options offered.** A sufficient and balanced (but not overwhelming) range of options to choose from should be given to accurately reflect a respondent’s summary judgement. A question that asks for a binary response may appear simpler for the respondent. However, they can be unreliable as the response may change over time depending on the context or specificity of the question, and may not accurately reflect the strength of feeling a respondent may have. (Spector, 1992).

Use of a summated rating scale which has an appropriate set of response options, and allows a range of options for the respondent to choose from that most closely reflects their experience, can therefore support participants to map their judgement to the response options on offer (Fink, 1995). In mapping judgements effectively in a questionnaire, the way in which the options are presented needs to be clear. This includes use of consecutive integers (e.g. 1,2,3,4) to reinforce the choice that is being made across the scale of options given and allow for quantitative analysis (i.e., the higher/ lower the number the extent to which the statement is agreed with can be reported and analysed further, as in FQ3).

A maximum of 5 choices were given in the majority of questions used. Endorsement (agree/ disagree), frequency (mostly/ never), or comparison (more/ less) type questions were used to fit with the topic of the question asked. The number of choices offered were restricted to not be too overwhelming, take too long to read and decide which best fitted, whilst offering a range of options to choose from. This included an option of 'not had enough experience to say' to give those recently in ACP roles a summary judgement that would fit with their experience so far and not forcing them to choose yes or no.

Some intensity (mild/ severe) and influence (big/ small) questions offered a sliding scale to choose from with integers of 0 to 10, 0 to 100, or -5 to +5. A percentage 0-100 integer was used for FQ37 where participants were being asked about the extent to which a feature was occurring. By representing this as a percentage it gave a larger range to choose from, recognising from the literature review there may be significant variation, whilst not giving an overwhelming number of points on the scale to sift through. These were highlighted in 10% intervals although they could select any number in between these intervals. The integers were chosen to be familiar frames of reference to choose from. For example, often health care staff use scales of 0-10 in clinical practice to ask patients to rate their pain or experience. The number and type of integers offered were also chosen to fit with the question and what is already known in the ACP context. For example, in Q8B integers of 0-9 were given to reflect the range of pay used within the NHS (qualified staff are paid from band 5-9), with the option of 0 for those that are not on the NHS pay bands. In the demographic questions an option of 0-11 was given in QB13, and 0-21 in Q4B. These wider ranges were to allow for people who had extensive experience in their profession or role to signify this, whilst not presenting all with a very large range of options to sift through and choose from.

Jupp (2008) noted that in using summated rating scales in questionnaires the underlying construct must be quantifiable but also it must be ensured that items within the scale do not have a correct answer. These two concepts may seem at odds with each other as quantitative research is best suited to finding a single answer that can be objectively measured; either the answer is right or wrong. However, the principle was applied here by only asking questions where the respondent can provide an answer that they believe to be true. By asking questions to respondents that drew upon their personal experience of working or training as an ACP, and not their opinion broadly of whether they think x or y is true of ACP more generally, this allowed the reality of working as an ACP to be quantified. It purposively did not force the respondent to think there was only one correct answer. This returns to the emic principles underlying this research, which was to give voice to ACPs from their personal experience of the reality of working in this field. For example, in FQ8 it asks "Thinking about a typical day at work…?"

Consideration also needed to be given as to whether a neutral or nonresponse option was provided (e.g., 'neither agree or disagree' or 'don't know'), or respondents were only given a forced choice (e.g., strongly agree, agree, disagree, strongly disagree). The advantage of eliminating a neutral option is that it increases the number of responses that can be used for analysis and inference. However, by not offering this option it may encourage respondents to answer in a way that does not reflect their true feeling or opinion, which may be ambiguous or apathetic. (Lavrakas, 2008a). Questions were therefore carefully constructed to ensure that the answer could reflect their experience and where necessary provide an option of 'not had enough experience to say' (e.g.FQ28).

There was effort made in framing the questions to provide options for respondents to relay a positive or negative experience as in the focus group it was clear this had been variable. Where -5 to +5 ranges were given as options to choose from, this was used to emphasise to respondents that they were signifying a negative or positive experience with the central point (0) offering a neutral or 'about right' option. For example, in FQ21 this reflected their experience of work-life balance.

Finally, in constructing the questionnaire, whilst addressing ethical principles of conducting research, it was important to re-iterate to participants what the next steps were, how their data would be used, and provide sources for support they could access if this raised any questions or concerns for them. This is discussed in more detail in the 'ethical considerations' section to be found later in this chapter.

Follow-up Questionnaire Sampling Strategy

One of the well-known disadvantages of questionnaires is the higher risk of non-response and broad acceptance that 100% response rate is an unrealistic aspiration. A number of authors have identified strategies to enhance response rates, including use of internet surveys (Dillman, Smyth and Christian, 2014) which has been employed for this questionnaire. Due to the time elapsed from the recruitment to the follow up questionnaire, some people that initially responded may have moved into other roles, or now be unavailable or unwilling to participate. The contact list generated from the initial recruitment questionnaire was consequently employed to directly recruit to the follow-up questionnaire to maximise the response rate.

Attention was also given to ensure potential participants were clear of what the possible benefits and risks were so they could trust that the rewards for completing the questionnaire would outweigh the costs. This included consideration of what to include in the advert for participation (Appendix 8) and participant information given prior to the questionnaire being completed (Appendix 12). This identified the benefits as well as the strategies that have been put in place to protect participants. Besides addressing best practice in attending to ethical principles of research, provision of this information was used to encourage participants to feel safe to respond to the call to participate in this research.

The target figure for respondents to the follow-up questionnaire was set at between 229-261 with a confidence interval of 95% and margin of error set at 6% to allow me to gather data from a sufficiently diverse group of ACPs to share their experience of the role. As with the recruitment questionnaire, the calculation was derived from both the 'known' East of England regional number (1573) (Health Education England, 2021b) and the estimated national number (11,000). Similar issues persisted as have been described for the initial recruitment questionnaire where the total ACP population number of 11,000 may have been an over or under estimation. The potentially modest target number set at 229-261 recognised that the health care context at the time of recruitment to this phase of the research continued to create pressures on the ACP workforce. This was compounded by increasing waiting lists (British Medical Association, 2023), industrial action (NHS Employers, 2023a), and increasing numbers of staff leaving, (Rolewicz, Palmer and Lobont, 2022). As I had achieved a sample size of 291 earlier in the research and this had returned data from a diverse group of ACPs, I was though confident 229-261 was a realistic and appropriate number to aim for to achieve the purpose of this phase of the research.

By setting this target figure it allowed me to monitor response rate with a view to sending out reminder messages on social media if needed. By the end of the first week of recruitment I had received over 100 responses which I posted on social media as an encouragement to keep recruiting. The number then steadily rose where I gave a 'final call' after 4 weeks to give a buffer zone of around 30 participants for any responses that would need to be removed due to the inclusion or exclusion criteria (provided in Table 4.2).The participants for the follow up questionnaire were recruited in the same way as in the initial recruitment questionnaire (Table 4.1). By advertising the follow-up questionnaire to the same community that was accessed as previously this continued to allow a diverse range of ACPs to respond, noting that the expectations of the role have been identified through focus groups taken from this community of ACP/tACPs.

The closed questions regarding demographic data, job title, grade etc allowed for inference to be made about the diversity of the participants that responded. Unlike in the focus group where maximum-variation sampling was used to ensure as far as possible a diversity of participants was included, this was harder to control within use of purposive sampling using the larger population of ACPs/ trainee ACPs. Clear reporting of the characteristics declared by participants in these closed questions has allowed for discussion of any considerations and limitations that should be taken into account with regard to the findings. For example, that the respondents to the questionnaire were predominately working in primary care settings where career trajectory may differ from those working in other fields of health care, or that it was dominated by respondents that are new to their ACP role and so may not yet have had time to fully experience the expected benefits of taking on an ACP role.

A total number of those that responded to the follow-up questionnaire was compared to the estimation of the total potential ACP/ tACP population within England. This was used as a measure of internal validity, so that any conclusions drawn regarding whether expectations are being realised, or factors are identified that may be associated with realisation of ACPs expectations can be placed in context. This allows for limitations of the research based upon sample recruitment to be discussed in chapter 7.

Follow-up Questionnaire Data Collection

The internet survey platform chosen to distribute and collect data was Qualtrics. This was chosen because of:

- Ease of use in displaying the chosen question design, and in generating reports and visualisations of data for analysis.
- Flexibility to use a range of question and response types (i.e., open, closed, Likert etc)
- Cost to the researcher (Qualtrics is free to access for university staff)
- Able to be displayed to participants through a number of formats and internet browsers (e.g., Apple/ PC, desktop, laptop, tablets or smartphones) so they were not prevented or discouraged from participating based on the access they have to computer hard/ software.

A Gantt chart (Appendix 16) was utilised to plan and track the data collection, to allow for sufficient time to distribute the questionnaire, participants to respond and data to be collected, and follow up to be undertaken where needed.

Follow-up Questionnaire Analysis

Exploratory Data Analysis (EDA) is a method which is used to identify possible relationships between variables by seeking to identify patterns and trends. Since the seminal work undertaken by Tukey in 1977 it has become viewed as an essential first step in data analysis (Komorowski *et al.*, 2016) with Chatfield (1986) suggesting that it should be renamed as 'initial examination of data'.

EDA commonly uses visualisations to facilitate comprehension of patterns that have been found in the data. Tufte (2021) notes that often the most effective, simplest, and powerful way to explore, describe, and summarise a set of numbers is to use data graphics or pictures of those numbers. Considering one of the key objectives of this research is to generate new knowledge of the ACP role to influence policy and practice, selecting the most effective data analysis and presentation method to aid key stakeholders learning was a significant consideration. In the work by Mangold *et al.* (2018) they build on Kolb's theory (1984) by suggesting professional development can be enhanced by determining preferred learning style to aid knowledge acquisition and retention. Their research found that Nurses tended to prefer visual learning and concluded that use of a variety of formats for learning activity, including visualisations, is recommended. Whilst not all key stakeholders for this research are Nurses, a large proportion are as this is the largest group of professionals working in this sector. Use of visualisation of the data from this research therefore was deemed necessary to achieve the research objectives in the most effective and appropriate way as possible.

The EDA approach adopts the underlying assumption that the more you know about the data the more effectively you can use data to develop, test, and refine theory. In this research, by knowing more about the ACP perspective through exploring the data

they have provided, key features of the ACP experience and subsequent interventions to address gaps between expectation and reality could be developed and tested. For example, the study may find that ACPs do not have enough time for non-clinical activity as they would expect. Further studies that draw upon the data from this research could explore whether by introducing ring fenced non-clinical activity in their rota, this enhances ACPs satisfaction and increases the number of ACPs that are recruited or retained in the role.

Hartwig and Dearling (1979) discussed EDA as a mindset rather than a specific mathematical model or equation, which relies on having an attitude of open mindedness. The EDA 'mindset' emphasises that there should be scepticism toward just relying on statistical data alone and acknowledges that even statistical techniques may have hidden assumptions about the data. Braun and Clarke also lay emphasis on rate being an attitude or approach rather than a linear process (Braun and Clarke, 2022, p. 76). rTA encourages back and forth analysis of the data and openness about the choices made and conclusions drawn as a result. Both EDA and rTA therefore encourages flexibility to consider different theory and allows for innovation to consider things from a different perspective. This is very much in keeping with the theoretical and mixed method approach taken in this research and is why rTA and EDA using visualisations were chosen for analysis of the follow up questionnaire data.

A schema for the types of analyses (including rTA for free text questions) and visualisations to be used for each question was determined in advance of the data collection (Appendix 14). As noted in the pilot study, an automated set of responses was used to test whether the chosen visualisation and analysis would work effectively.

The analysis schema was further refined during the process of writing up the research to select the presentation of data that best represented the patterns found. The bar set was that the analysis method chosen needed to answer the research questions and present them in a way that could be used for the intended audience, as described in the logic flow diagram (Appendix 13) The aim posed by this research is to build a picture of the ACP population's experience of the role; the emphasis has therefore been placed on employing descriptive statistics.

Selected questions from the follow-up questionnaire were chosen to identify if there appeared to be factors related with whether expectations are being realised. The selected questions to examine for 'deep dive' exploration using EDA are highlighted in orange and listed in Appendix 14. One follow-up question was identified for each theme from the focus groups to be explored alongside patterns in the data from the demographic background questions. The 'deep dive' questions were chosen as they use a factor that could be changed in the organisational structure of an ACP role (e.g., whether it includes non-clinical time). This is opposed to responses that can be more influenced by perception of the individual ACP (e.g., feeling valued) which would require further investigation to understand aspects that feed into this perception, and interventions that can effectively change this (e.g., personality traits or characteristics which might influence whether someone is more likely to feel valued).

In deciding whether to apply further statistical tests to the selected 'deep dive' questions it is noted that parametric tests would not have been appropriate to establish statistical significance as the questions asked/ responses given were not collecting continuous interval data but were more often ordinal or nominal data; the data would therefore not conform to the common assumptions of parametric tests (Pett, 2016, pp.

2-3). In all but the ‘generalist versus specialist’ question examined using EDA, ordinal data across more than one categorical variable had been collected. This made them potentially suitable for non-parametric tests (one that does not make assumptions about the data where one or more of the common statistical assumptions have been violated), (Bevans, 2023). However, I considered three potential reasons for not conducting these tests to be relevant for my research:

Firstly, when utilising statistical inference tests, it is expected that a hypothesis is stated so that it can be tested, (MacInnes, 2022, pp. 8-9). In this study the aim is to describe and represent patterns in the data, to explore and build a picture of the ACPs experience of the role; a hypothesis has not been generated and is not being tested in this research. I was conscious to carry through my critical realist perspective in my data analysis; I am accepting the truth reported by the participants of their experience rather than hypothesising or testing why this may be so within the bounds of this current study. Whilst the results of this research may provide data to develop hypothesis (e.g. ACPs are more likely to stay working in the health service if they are given opportunities to lead on quality improvement), the testing of such hypothesis would require further research. As an example, determining cause and effect through inferential statistical testing in this study would particularly not have been appropriate. Due to the study design, assumptions cannot and have not been made that one variable (e.g. pay) causes another variable (e.g. acting as a consistent and coherent presence within a team). The purpose of the current study is to provide a portrait of the current experiences of ACPs from their own perspective recognising that this is likely to be diverse and in a population that has not yet been fully defined.

My second consideration was that I have chosen to look at five of the follow up questions against 11 of the background or demographic questions. In selecting, albeit a limited number of questions to explore for ‘deep dive’ exploration, I was aware of the complexity this would create. Having undertaken simple visualisations using the ‘breakout by’ function in Qualtrics on the pilot study data I noted these were sufficient to identify where there were unusual patterns of frequencies of the whole group as compared to sub-sets of demographic groups of respondents. By revisiting my logic flow diagram and running a dummy analysis of the follow up questionnaire the visualisation method of EDA was determined to be sufficient to achieve my aim.

Finally, in deciding the analytical approach to use I have been conscious of my intended audience for the outcome of this research (namely the key stakeholders; health care professionals, employers, education providers and commissioners, and professional/ regulatory bodies). Each question identified for further exploration has been chosen to ensure it fits with my objectives of my research; to influence policy or interventions to address gaps between expectation and reality. In the work by Nash, Trott and Allen (2022) they note the power of using visualisation of data to capture policy makers attention, to convey key messages convincingly and to facilitate a swift, collaborative, and evidence based decision making process through enhancing data literacy or understanding. The visualisations used and analysis undertaken using EDA have been selected to achieve the intended impacts, as set out in the logic flow diagram in Appendix 13. For example, it may be the case that certain groups of ACPs are more or less likely to experience quality assurance of their role through mapping to the MPF. Knowing this could help employers to target those groups where this has been reported as happening less frequently, and those ACPs who are less likely to be quality assured could be advised to actively seek this out.

It is recognised therefore that whilst this study has generated data that creates the potential for further analysis and research, a pragmatic, critical realist approach has led to the choice to only utilise rTA alongside descriptive statistics and visualisations within an EDA approach to reach the point where a narrative synthesis could be produced. The utilisation of EDA and rTA in analysing data from the follow up questionnaire was not a linear process. It necessitated circling back throughout data analysis and the write up stages to check that the research questions were addressed and the narrative generated could be used to achieve the research objectives. Both, Braun and Clarke (2023), and Nash, Trott and Allen (2022) emphasise the need to be deliberative and open in the choices that have been made when using rTA and visualisation of data. This was supported by taking a reflexive approach using diary notes, supervision, and experimentation to check in against the data analysis schema and logic flow diagram and strive to achieve the best presentation of the research process and results. The approach taken to selection and implementation of data analysis, data collection and recruitment in this research has therefore attempted to remain anchored by the aim, philosophical and theoretical underpinning as well as methodological best practice.

ETHICAL CONSIDERATIONS & APPROVAL

In considering ethical dilemmas and risks created by undertaking this research a detailed outline proposal was drafted and reviewed through supervision before submitting it to the ERAMS (Ethics Review and Management System) portal at the University of Essex for approval. In advance of submitting the research to ERAMS, the NHS Research Ethics Committee Health Research Authority (Health Research Authority, 2023c) decision tool was utilised to determine if any additional approval

would be required. Using this tool, it was determined that this study is classed as research but does not require NHS Research Ethics Committee review for sites in England. ERAMS approval was granted and the research was allowed to proceed. The ERAMS authorised identification number for this research is ETH2122-1092, which was issued on the 23rd May 2022 (Appendix 17).

A key factor in determining the need for NHS ethical approval was the source of recruitment for participants. As this research was not reliant upon recruitment through a Participant Identification Centre (PIC) based in the NHS, instead using social media and other networks, additional HRA approval was not required. There were both advantages and disadvantages to this approach. Potentially this may have negatively affected the sample size, where using a PIC would have allowed for more targeted and locally supported recruitment. A more open recruitment may also have resulted in more people participating who believe they are ACPs but have not been verified as such. Conversely, by recruiting in this way it allowed for a broader, diverse mix of people (e.g. not just nurses who have dominated in other ACP research) to have the opportunity to participate, without the risk that they may have felt obliged to do so if an invitation had come through their employer.

Participant recruitment using methods that could be broadly accessed by a range of people was important not just for the integrity of the research and its potential impact, but also in consideration of ethical principles in research. This takes note of and assessment of the benefits and risks of the research (Health Research Authority, 2023b), and application of the ‘justice’ principle in research ethics derived from the Belmont Report where participants should stand a reasonable chance of benefitting from the outcomes of the research (Beauchamp and Childress, 2019).

It could be argued that by using social media and established networks this restricted access and potential benefit for those ACPs that do not use social media (at least not for their work or professional role or networking purposes) or are not connected into these networks. This may have resulted in disproportionally attracting ACPs that are already well connected and highly engaged in broader networking, where others in the ACP population do not operate in this realm but are just as worthy to participate and benefit from the research. However, within the restricted time limits, resources for the PhD, and connections known to me, this was the best approach to provide as open as possible access to participating in the study.

In the process of recruiting to the study it was important to ensure that potential participants had enough information in a format that could be easily accessed and understood so that they could make an informed choice to consent to participate. The participant information (Appendices 9 and 12) needed to emphasise, with candour, what the potential risks and benefits to participants would be in taking part in the study. In deciding how to relay this to potential participants, the potential beneficial impacts were considered, and a risk assessment tool was utilised. The risk assessment considered social, legal, reputational, safeguarding, health and safety risks, and potential for economic harm. Only potential and health and safety (namely activity) hazards were found to be relevant (University of Essex, 2023b). Through consideration of the risk assessment the participant information was devised and reviewed through supervision, including examination of the process, feedback and results from the pilot study.

The potential benefit to participants was noted as opportunity for enhancing understanding of their role, which may feed into support and development provided by their organisation. Whilst this may have been presented as an attractive opportunity for potential participants, there was also a risk that the clinical demands of their work may conflict with the demands of the research. This may have led to participants feeling conflicted in taking time to participate in the research or could have contributed to them feeling exhausted by adding more tasks to their already burdened workload. A standardised set of questions for obtaining consent as recommended by the University of Essex research governance team was utilised (University of Essex, 2023a) alongside strategies to manage risk wherever possible. Participants time spent on this research was minimised by using electronic asynchronous methods of communication where possible. This also addressed the potential effects of an ongoing pandemic where use of face-to-face interaction needed to be minimised for the protection of researchers and participants safety. As previously noted, the focus group was conducted via ‘zoom’ with guidance on using this platform provided in advance of the meetings. Time was given at the start of each group to remind participants what they could expect, how the focus group will work, and allow for any questions to be asked. A set time limit of 90 minutes was used so that participants did not become exhausted or start to disengage in the discussion. As the primary researcher for this study I took on the role of moderator for the focus group and utilised this role to obtain the data needed for the research whilst being aware of the need to contain the discussion to within the time limits, drawing it to an earlier close if there were signs of exhaustion or distress.

A further risk identified was the potential for the research to evoke concern or distress by asking participants to reflect upon their work and career. In an effort to address non-maleficence, sources for additional support should participants require it during the course of this research was repeatedly provided within the participation information sheet and consent forms. This was given alongside advice of when, how, and potential reasons why participants may want or need to access these services. This included providing direct reference to the counselling and health and wellbeing service that is provided anonymously and freely to all health care staff as well as links to independent on-line websites, forums, and sources participants could approach for career advice.

By utilising on-line questionnaires and anonymisation of focus group transcripts, this allowed for assurance to be given regarding protection of anonymity. It could not be identified who had or had not participated in the research. This may have encouraged participation, however, the participant information and consent process also needed to highlight there was no requirement to take part. Not using employers to recruit also aided the autonomy of potential participants to decide whether to consent to the study. No pressure or incentives were given to avoid people feeling obliged to take part, other than the potential altruistic benefits that are intended for the broader ACP community.

Each participant following consent was assigned an anonymous identifier, which thereafter was the method by which participants data was recorded, analysed, and reported. Personal contact name details, where provided by respondents, were held separately from the data for analysis. It was clearly stated that contact details would only be used for recruitment to the follow up questionnaire and to provide updates on the research where participants had consented to receive this information. The list of personal details and consent form files was stored in an encrypted file. It will be held

for 10 years on a ‘Box’ file (this being the cloud platform that is approved for use within the University). No data was retained for those that did not consent to participate. Access to the files on Qualtrics is through individual log in; only the Chief Investigator (me) and my research supervisors were given access to these files. Three people made contact after completing the recruitment questionnaire asking to withdraw from the research and not to be contacted further. Their data was duly removed prior to analysis and their contact details removed from the list for further follow up.

As a Registered Nurse, I have also been conscious throughout the design and implementation of this research of the expectations placed on me through the Code of Professional Conduct (The Nursing and Midwifery Council, 2023). These principles guide my practice in all spheres of my work and have been applied in this research. This includes the need to;

- act in the best interests of people at all times,
- respect people’s right to privacy and confidentiality,
- be aware of, and reduce as far as possible, any potential for harm associated with your practice,
- keep clear and accurate records relevant to your practice (which includes the need to ‘collect, treat and store all data and research findings appropriately’.

In review of the design and implementation of this research, I have believe this has adhered to the ‘best practice’ and ‘Principles and hallmarks of people-centred clinical research’ guidance, (Health Research Authority, 2023a) and this will continue to be carried through in subsequent reporting and dissemination of the research.

CHAPTER SUMMARY

In this chapter the methodology and methods chosen to be employed in this research have been described with exploration of the rationale and justification for the choices made. Principles and tools that have been applied to ensure rigour in the research undertaken have been discussed. The process by which this research has been implemented has been set out and the ethical considerations and approval gained have been reported.

CHAPTER 5- FOCUS GROUP RESULTS

INTRODUCTION

In this chapter the findings from the focus groups will be presented and will guide the reader through the themes that were identified through the rTA process. Prior to this the results that were generated from the recruitment questionnaire will be stated as these were used to undertake maximum variation sampling to constitute the focus group membership.

RECRUITMENT QUESTIONNAIRE

The recruitment questionnaire was utilised to initially advertise the research and gather a group of potential participants for maximum variation sampling for the focus groups. The consent form and recruitment survey (Appendices 9 & 10) were open from 30th May to 15th July 2022. A total of 291 people opened the consent form and 219 completed the recruitment questionnaire. Response quality was rated as 99% by Qualtrics with only two noted as potential minor risk, but on viewing these responses they met requirements. There were no duplicate responses. Three respondents replied that they were currently suspended or excluded from practicing as a health care professional or currently under investigation. These respondents will have been directed to the end of the survey with no responses being collected for other questions. Not all questions were answered by all the respondents.

- There was a geographical spread of respondents, with all regions being represented. South Central (n=7) had the lowest number of respondents, and North West (n=33) the highest.
- A range of specialties were represented, although none were in ‘Acute Medical (paediatric)’, ‘Midwifery’, ‘Neonatal’, or ‘Radiology’. The largest proportion

identified themselves as working in Primary Care (37%, n=74), with the second largest being ‘other’ (20%, n= 40).

- 78% (n=160) were nurses and 21% (n= 42) AHPs, (1%, n= 3 replied ‘other’).
- The largest single group of respondents had been working in their registered profession for greater than 20 years (n= 75). Only 20% (n= 40) had been registered in their profession for 10 years or less, meaning that the majority have had significant experience in their professional field of practice when working as an ACP.
- Three quarters of respondents (n= 143) had been in their role for 1-5 years with a cluster of people that had been in their role for greater than 10 years, (n= 15)
- The largest number of respondents (unsurprisingly) reported their job title as Advanced Clinical Practitioner/ ACP (n= 61) or Trainee ACP/ Advanced Clinical Practitioner (n= 48), followed by Advanced Nurse Practitioner/ ANP (n= 43). There were a group that had a specialist field identified in their title (e.g., paramedic practitioner, paediatric practitioner critical care, or outreach practitioner). A smaller number identified themselves as Nurse specialists (n=5) and consultants (n= 3). There were a range of other titles that did not contain the above, such as ‘Clinical Lead’, ‘Review Radiographer’, ‘Community Matron’ or Primary Care paramedic’. From the titles given it would be difficult to tell if these do fit the description of ACP. There were a small number (n= 10) of job titles where a level of seniority within ACP had been identified (e.g., Junior, Senior, or Lead ACP).
- The largest group of participants had a pay band of 8, with the next largest group being 7, (86%, n= 170 were being paid at band 7 or 8). A small number

(n= 11) were being paid at other pay bands, and fifteen (7.6%) identified they were not on the NHS pay banding.

- 97% (n= 192) of respondents said that their job role fitted, or partially fitted, the description of ACP as defined by the MPF. 74% (n= 146) believed it mapped fully to the MPF, although 38% (n = 75) of these had not undergone formal mapping. Only 3% (n= 6) said it did not match this description; these respondents at this point will have been directed to the end of the survey with no other data being collected.
- Eighty-nine (45%) respondents noted that they were currently on a training or development programme to become an ACP, with the largest proportion of these (48% n=43) being in their final year of study.

In the question regarding what training/ formal education participants had successfully completed to date, respondents could give more than one answer.

- Fifty-three respondents (16%) identified they were currently in a trainee role.
- 41% (n= 141) had achieved an academic qualification in ACP (30%, n= 103 to Masters level, 11%, n= 38 at PG Dip or PG Cert level). Only one respondent noted they had not received any training or formal education.
- 23% (n= 79) said they had received on the job training.
- Only 4% (n=15) had undertaken a credentialling programme.

MAXIMUM VARIATION SAMPLING

The results from the recruitment questionnaire demonstrated that there was a diverse population of ACPs that responded. Maximum variation sampling from the recruitment questionnaire data allowed for this diversity to be reflected in the selection of participants for the next stage of the research: the focus groups. The information participants had provided in the recruitment questionnaire was utilised to select people to invite to a focus group. 17 people participated in the focus groups. The characteristics of each participant, as declared by themselves in the recruitment questionnaire, was logged in the maximum variation table overleaf once they had consented to and participated in a focus group.

Equal amounts for each of the categories and types taken from the recruitment questionnaire data could not be achieved due to the diversity of ACP and some trends nationally. For example, from analysis of the recruitment questionnaire data, it was noted there are more Nurses than AHPs, some geographical areas have more ACP roles than others, and typically ACPs are paid at band 7 or 8. However, representation from a variety of ACPs was ensured so that in each focus group, and in the total number of focus group participants, there was a diverse group of ACPs, (i.e., each focus group had a mixture of Nurses and AHPs from a range of geographical areas, specialities, training backgrounds and length of time in the role).

Table 5.1 Maximum variation sampling data

CATEGORY	PROFESSION		REGION		SPECIALITY		BAND		LENGTH OF TIME SINCE QUALIFIED (IN YEARS)		LENGTH OF TIME WORKING AS AN ACP (IN YEARS)		TRAINING/ EDUCATION (NB more than 1 answer could be selected)	
TYPES	Nurse/NMC	10	South West	6	Other	8	0	1	20+	5	0 (trainee)	3	On the job training	3
			London	2	Acute Medical (adult)	1	6	2	15-20	4	1	3	PG Cert/ Dip ACP	2
			North West	4	Acute Mental Health	1					2	5	Individual modules	4
	AHP/ HCPC	7	West Midlands	2	Long term conditions	1	7	10	10-14	4	3	1	MSC ACP	8
					Community Mental Health	1					4	2	Credentialling	2
			Northern & Yorkshire	1	Emergency Department	2			5-9	3	5	1	Trainee ACP role	10
	Other	0			Primary Care	1	8	4			6	0		
					Radiotherapy	1			<5	1	7	1	ACP trained to MSc level but not currently in ACP role	2
			North East	2	Acute Paediatric	1					8	1		

The focus groups were held over a period of 7 weeks (12th August, 31st August, 28th September 2022). They were all held during 'office hours' (FG1 at 2-3.00, FG2 at 4-5.00, FG 3 at 11-12.30) although other times and days were offered. All but one participant appeared to be in a room on their own, although they were using headphones to listen and speak through. I found it increasingly difficult to gather together enough participants but found by sending out the meeting invite this prompted people to confirm their availability to attend. For the last focus group, I sent out the zoom meeting invite to all that had consented to participate. There were 6 participants in the first 2 groups, and 5 in the last, which met the threshold expected.

At the start of the focus group, I asked each of the participants to introduce themselves and why they had decided to pursue ACP. This proved to be a productive question as it gave each participant a defined time slot with permission and encouragement to talk, giving further detail of their background and experience of ACP to date. By allowing this time for each person to speak it signalled a valuing of their experience and provided context to the points they later made in the focus group discussion. I found this question highlighted the diversity of perspectives, as well as some similarities. For example, two participants knew each other and worked in the same organisation but came from different viewpoints and stages in their ACP career. This allowed a range of experience to be aired and group discussion was facilitated through curiosity of participants to hear and understand ACP from different perspectives. National data for ACP/tACP that meets the definition set out in the MPF was not available at the time of undertaking this research. By reviewing the focus group videos, transcripts and maximum variation sampling I concluded that I had engaged participants in the focus groups from a range of backgrounds that reflected the diversity of the ACP/tACP population who had responded to the recruitment questionnaire.

FOCUS GROUP THEMATIC ANALYSIS

When undertaking rTA of the focus groups, I certainly found myself using the back and forth, recursive approach rather than a sequential linear method for analysing the data (Braun and Clarke, 2022). This led to extensive exploration of the transcripts and personal challenge of the assumptions and conclusions that I was drawing from the data. I utilised my reflective diary alongside the '6 phases' structure to note down my thoughts, the process undertaken, and conclusions drawn. From this I was able to code, generate, review, define, and name themes. Stories that explore the themes identified are provided below. These were gradually formed using the transcripts and thick description as anchor points to ensure I was not veering away from the 'truth' that was being presented by the participants' perspectives of their experience.

Context codes

Phases 2 & 4 of rTA (Braun and Clarke, 2022, p. 35) notes that you should check codes against the research question to evaluate their fit. When starting to undertake coding I realised I had jumped into identifying themes without first recognising important features of the data. This included where the themes were being prompted from, the basis or background to the themes, and how these related to the research questions being posed. This led to the creation of 'Context Codes'.

A. Why they had got into ACP (driving forces)
B. Experience of the role to date
C. Key features of ACP (perceived or actual)
D. If only… (beliefs of factors that could make the ACP role more/less effective or attractive and hopes/ expectations for the future

The context codes acted as a checkpoint for where the themes had evolved from in terms of the perspective on experience the participants had provided. For example, why is this theme significant in terms of ACPs expectation of the role, was it identified by the participants as a 'driving force' or a 'if only…'? The context codes also helped in creating the stories for each of the themes.

When discussing development of codes with my supervisors as to how they related to the research question posed, this prompted me to again consider whether I was just focussing on the benefits of ACP. The answer was 'yes'. An intended impact for this research is to better enhance the experience of ACPs to allow for increased recruitment and retention by decreasing the mismatch between expectation and reality. The purpose of undertaking the focus groups was to give voice to participants and capture their experience and expectations regarding the role.

In the sequential design of this mixed method research the purpose of capturing this data was also to inform the design of a questionnaire. The aim in designing the follow-up questionnaire was to find where there may be a mismatch or explanation for a difference between beneficial expectations (as identified by focus group participants) and reality. The context codes reflected both positive and negative experiences and perceptions the participants had about the expectations of the role. In the design of the follow up questionnaire, it was therefore important to allow for both positive and negative responses and experiences to be captured. In identification of the context codes and their influence on the themes identified from the focus group, I therefore note that both positive and negative experiences and perceptions have been acknowledged and these have been reflected in the stories of the themes provided below. Five themes were identified:

Table 5.2 – Focus group themes and codes

Themes (top level codes)	Sub-themes (child codes)
Clinical	Clinical/ patient facing Non-clinical activity
Full knowledge, skills, experience	Specialist KSE tapestry Autonomy Professional development
Leadership/QI	Problem solving Consistent and coherent presence Patient safety and experience
Career Progression	Financial Valuing Job satisfaction
Policy, Vision, Structure	Quality assurance Buy in & support Continually evolve Local factors Long term investment

Clinical

In the systematic literature review, 'clinical practice' topics dominated over other aspects that are expected as features of and responsibilities within Advanced Clinical Practice, namely 'the four pillars' (Health Education England, 2017b). It is not surprising therefore that this was reflected in the focus group discussions regarding the participants' experience of the role and what they expected from it.

The word 'clinical' is commonly used by health care practitioners interchangeably with other words and phrases to describe activity that is based in a setting where health services are provided (e.g., in a hospital, clinic, or GP practice), and where there is direct contact between the health professional and people accessing services to address a health need. The focus when using the word 'clinical' colloquially is on physical interaction between a health professional and the person accessing the service in which they work, and within services where the people accessing them are commonly referred to as 'patients'. However, this may also include non-physical interaction (e.g., a telephone or video consultation). In mental health and learning

disability services commonly people accessing these services are also referred to by other nomenclature such as ‘clients’ or ‘service users’. In determining the remit of this theme, it therefore encompasses aspects of the discussion that related to settings used for health service provision, and to people that are accessing these services.

Being ‘by the patient’ in their role was discussed as a driving force for being an ACP.

> *“I wanted to be, you know, be near the patient.” (FG2C)*

> *“I find that it can bring a connection, and better understanding of where the patient's coming from.” (FG3C)*

Participants relayed a wide range of clinical activity they were directly involved in as an ACP. This included undertaking tasks which involved patient facing activity such as undertaking physical assessment and diagnostic procedures, providing treatments or health care therapies, and providing information, support, and advice to patients.

> *“We think it's just a chest infection, and half an hour later that patient has been assessed, diagnosed, treatment is on board, and then I’ll pick them up if there is frailty syndromes, then I can initiate a comprehensive geriatric assessment.” (FG2B)*

When discussing their role and driving forces for coming into or staying in the ACP role participants referred to being able to ‘remain clinical’ as fundamental to these decisions. Participants talked about experiences where they had actively sought out the role as a way of continuing to be involved in this activity where other career options had either been experienced or were potentially open to them but had been rejected because they were not ‘clinical’.

> *"I got a job as a matron, and the job description was given to me as very clinical, and it was very operational, so I did that for a couple years and was really actually unhappy and I wasn't getting the job satisfaction……I mean really, I think, from a personal perspective, I really enjoy clinical work, so I wouldn't want to go back through that operational role, I've been there, done that." (FG1E)*

Conversely, there were also instances where ACP was discussed as a route to diversify their work, to include activity other than it being purely a clinical role where the focus may also be on the other pillars of ACP (education, research, leadership).

Diversification of types of work activity was viewed by participants as a positive aspect of ACP and a way in which they could be encouraged to be retained within a health service. Participants relayed how this provided a career option where it was perceived that a purely clinical role may become boring, less satisfying, or overly taxing (physically or mentally) within a long career. There was an expectation that 'non-clinical' aspects also need to be encompassed within their ACP role.

> *"I think, you know, the clinical aspect is just a tiny bit of the things that really interest me long-term." (FG3D)*

In discussing different aspects of their work, participants noted that the right balance needs to be found across the 4 pillars of ACP. What the 'right balance' is has not been defined by this group of ACPs or more generally in ACP literature or UK policy to date, despite acknowledgement that the 'non-clinical' pillars are often neglected (Fothergill *et al.*, 2022). Getting the balance right is an expectation that can have an impact on the driving forces to come into and stay in the ACP role.

"Now I'm so glad that I did do it, because to see that four pillars, and how you can spread your role and not just go in every day and do a clinical role. I don't think I would still be working there now, if I didn't have the opportunities that I have as an ACP." (FG3B)

Full knowledge, skills, and experience

Participants talked about where the ACP role works well it allows them to fully utilise or draw together their previously accumulated knowledge, skills, and experience (KSE).

As noted from the recruitment questionnaire results, there are a range of professional and specialist backgrounds in the ACP community and the majority have had many years working in health care since qualifying in their profession. One participant also noted that before moving into training and working as a health care professional they had pursued an alternative career which provided valuable skills and knowledge. The range and type of KSE ACPs possess is commonly extensive but not homogenous. Participants recognised the positive benefit that can be gained by having people with a variety of experience and expertise in ACP roles.

"Put my previous skills, you know, some of the leadership, I have done in the past.... Colleagues encouraged that out of me because they see your leadership role as being a key part of advanced clinical practice…. so they encourage them, all of us who are from diverse backgrounds….. to draw on our previous experience to enhance the teams a whole." (FG1A)

"We have a huge pool of very talented and diverse and highly skilled clinicians from different backgrounds. They can bring different things to the patient's journey." (FG2B)

Participants also talked about previous KSE gained as an aspirational goal or vision for the role ('if only…'), where ACPs currently do not feel these were being recognised or utilised as effectively as it could. Participants linked this to a general lack of understanding amongst colleagues about the role and the underutilisation of the full range of activity that ACPs can contribute to.

"some people feel that when they have these ACP roles it's almost as if their past experience didn't really matter." (FG1C)

"You know I've gone on to this ACP route and it's like it it's forgotten that you've done that in the past, and you almost, people don't know that you can bring those skills, people don't know as FG1A said you've done project management before and service improvement it's almost like you're put in a box sometimes. And people don't recognise. And as much as you try and get yourself out there..... I think there's just still a huge amount of scope of what people can do." (FG1B)

Training to become a registered health care professional, whilst to some extent specialised with a unique body of KSE developed relevant for each profession, is generic in that it prepares people for practice in a wide range of settings. Health care staff in the UK are only allowed to work within a restricted scope of practice before they will need to undertake additional training. Most health care staff choose to train in a specific profession to extend their scope of practice and to attain seniority in the

hierarchy or pay structure. The majority of these professions are only accessible through regulated routes of training, and the professional title can only be used by those registered with a regulatory body (e.g., the Nursing and Midwifery Council for Registered Nurses, and the Health and Care Professions Council for Physiotherapists, Paramedics, Occupational Therapists etc). Once qualified, health care professionals choose to work in particular jobs which may specialise in particular medically diagnosed conditions (e.g., rheumatology, oncology), or parts of the patient journey through the health care system (e.g., rehabilitation, emergency care, or community care). Each of these specialisms requires development of a range of KSE that builds upon the more generic 'profession specific' KSE to address the particular needs of the patient group. When introducing themselves, the participant ACPs therefore noted their profession and specialist background as a way of identifying their KSE.

> *"I spent three years working as an alcohol specialist within the hospital." (FG1A)*

> *"I got this job as a, as a peritoneal clinical nurse specialist." (FG2C)*

> *"I'm a specialist physio by background, working in community respiratory services." (FG2E)*

Often participants discussed Advanced Practice KSE in the context of building upon their specialist background in either a particular profession or distinct field of practice or service.

> *"I think, by the time you get to be a specialist therapist or specialist nurse you already have a very solid foundation knowledge base and just what you want to do is kind of like build up on it." (FG1F)*

> *"I'd got a band seven post, and I was like what, what makes me different from a six to a seven. What makes me a clinical specialist physio. Actually for me, experience was something, but also starting to build on those skills and what I can do." (FG2A)*

This provides a picture of ACPs where a tapestry of KSE is utilised to inform their practice. 'Tapestry' has been defined as "a piece of cloth with a pattern or picture that is created by sewing or weaving different coloured threads onto a special type of strong cloth" Cambridge Dictionary (2023). In the UK the word 'tapestry' is used as a synonym for 'needlepoint' where stitching is discontinuously used to build up patterns and colours over the framework of a strong canvas mesh. On the front of the canvas the intended pattern or picture is revealed, whilst on the back you can see the messy, different coloured threads that have been used to create the desired image.

Image 5.1- ACP Tapestry

(Original tapestry created by Vikki-Jo Scott 2023)

These definitions of 'tapestry' reminded me of what participants were saying about their variety of KSE gained over time (different coloured threads) that are woven onto the strong structure of their professional background and training (strong cloth). This results in some aspects of their KSE being hidden (messy warp threads and the supporting structure of the strong cloth that signifies their previous professional

training and experience) but are vital to the integrity and beauty of the piece of textile art presented (the health service, or interventions ACPs provide). It may not be obvious what the professional background or previous roles or training route that an ACP has taken to get to this point are, but they provide the framework upon which they can apply with confidence the KSE they possess to a diversity of situations.

> *"I want to keep my physio roots. I know when I'm qualified, I'll be an ACP, but I want to make sure I keep that sort of core of my assessment." (FG2A)*

> *"I find that the skills that I use are very much comparable. Certainly, in terms of clinical management of patients, subtle changes, but also an enormous amount of ethical decision making about escalation of care and decisions around end of life, care and I need to draw on my previous experience that I've had to carry that out." (FG1B)*

When discussing KSE participants therefore strayed into the 'generalist/ specialist' debate (Timmons *et al.*, 2023). There were examples where ACP was seen as being a generalist role where practitioners primarily use a set of 'core' or generic KSE that can be applied in a range of situations. This is appealing in some settings such as emergency medicine or primary care where ACPs will be confronted with a wide range of patients and disease presentations. 'Generalist' settings were noted as often being where ACPs have been longer established, but where they also tended to favour people with certain professional backgrounds (e.g., nurses rather than those with an Allied Health Professional background). Alternatively, ACP was described as an opportunity to provide patients with access to a specialist service drawing upon advanced KSE built up over time in a particular field. Here ACPs are referred to and utilised specifically for their specialist KSE.

However, there was no resounding resolution to whether ACP should be generalist or specialist, with both positives and negatives being relayed in the discussion. Indeed, some services that could be classed as 'generalist' (e.g., the emergency department) were also viewed as a specialist field of practice in its own right where a distinct set of KSE is needed to operate effectively in this environment. For example, you cannot assume that an emergency medicine advanced practitioner transplanted into specialist clinic for people with dementia could perform with the same level of competence and confidence, or vice versa. The discussion therefore often circled round to noting that ACPs do have a tapestry of KSE generalist and specialist, bound by previous experience and professional training. Where the role ideally works best, a diverse range of KSE are recognised, developed, and utilised to fit with the patient needs and service in which they are working.

> *"You will have core ACP competencies and your general ACP competencies, and then you have your speciality on top, and that's the key difference between yourself and another band seven or a specialist on band seven……And then you got your speciality, and you're sort of, is specific to your service." (FG2B)*

> *"I think the ACP is a core sort of um, the core underpinning. And then you can build on that experience. It can be fluid. You could move into another area and, like a nurse, moves into another area. Then you need to learn that that sort of extra specialty sort of branch to that to the ACP in that area. Rather than starting again from scratch." (FG2F)*

ACP was therefore noted as offering health professionals the opportunity to advance their KSE by extending their scope of practice and building upon the experience and training they have received to date. Through the development or advancement of their

KSE, this allows ACPs to become someone that others can refer to and utilise for advice to enhance their own practice or development.

> *"I would be happy to say like FG1A to become an expert within my clinical area. (FG1E)*

> *"I just want to be really good at acute medicine, you know really, really good at some diagnostics, a font of all knowledge. You know the person, one of the people that the foundation year doctors will kind of come to ask questions and that's, that's my sort of personal vision for my role." (FG1A)*

> *"I do often have a lot of my colleagues ask me a lot of questions about physical health problems that perhaps that they don't know, so they do come to me about that, so that's obviously really positive for me." (FG1C)*

It was through being able to demonstrate and utilise their KSE that ACPs believed they are seen as a trusted source of information or skill. Trust then extended into being given the authority to independently carry through tasks or make decisions without further approval from others, commonly medical colleagues. Autonomy over decision making was consistently viewed as a positive attribute that ACPs were seeking to enhance patient care and to gain greater control over their work.

> *"I've really enjoyed the autonomy I've got….It's an incredibly autonomous role…. So it's a lot of responsibility, high level accountability and yeah and I'm very happy." (FG1B)*

“Having my own clinic, running my own clinic…gives me this, you know, information to be able to increase my knowledge. To be able to… care for patients, to be able to make decisions. “ (FG2C)

“We have regular meetings with all of the senior leaders now, and it's not just kind of us being told what to do. We have a say in how we work.” (FG3B)

Participants noted frustrations where they were not being awarded with as much autonomy as they would wish. This was seen as an underutilisation of the full KSE they have gained as an ACP. This view is supported by the systematic review undertaken by Lockwood *et al.* (2022) in which it was reported that Advanced Nurse Practitioners experience underutilisation of autonomy in clinical practice settings, which limits the beneficial impact they can make to service delivery.

FG3E: “A typical example of that would be, yesterday I was sat with one of the doctors explaining to them that Pregabalin is a controlled drug. I had to then explain to them how to write up a controlled drug, as in general, you know how you do that. Then the principle behind Pregabalin, weaning dose, how you write that up, what's it for. Yeah, and I can't do it.”

Moderator: “and by that time you could have put your signature on the end and given it?”

FG3E: “Yes, exactly.”

Participants noted the opportunities and challenges that developing their KSE and working as an ACP presents. Taking on an ACP role challenged them to learn new KSE where opportunities for new learning were limited in their previous role. From the

experience the participants relayed, the ACP role had provided an impetus and structure for their professional development.

> *"I'm really glad I did, because it has really pushed me and it's been it's just been such a learning curve, I've really enjoyed it." (FG1C)*

> *"I realised, just found myself, that I'm now having to look up my patients, or, you know, run a clinic, and… make consultations, which all this when new to me a few years ago. So I needed that boost, I needed that knowledge and skills to be able to deal with that, and to make all those decisions." (FG2C)*

In developing their own KSE and the trust to practise autonomously, participants noted how this can also feed into the professional development of others.

> *"I applied for the masters, graduated in 2018, and found it did make a massive difference in terms of what I was then able to do. I could support my colleagues better with prescribing queries, and we were starting to make things more efficient." (FG2E)*

> *"I guess everything was driven by the consultant team, and now it's not really. It's driven by…We, we we're part of that, and we kind of help some of the juniors do that a bit more as well, and we also deliver lots of teaching and things in the department. So it's about bringing quality to everything rather than just to our personal development." (FG3B)*

> *"I was making a sort of role model for others that are more junior to me to come up behind me and succeed in an advanced practice." (FG2F)*

The development, sharing, full recognition, and autonomous utilisation of a diverse range of knowledge, skills and experience was a common feature in the focus group discussions.

Leadership in quality improvement

The term ‘Quality Improvement’ encompasses a number of different activities and foci that are driven by an attitude of constant change within health care which has at its centre the shared purpose to achieve benefits for patients, as seen in the NHS England ‘Change Model’ (2018). There have been various bodies within recent history in the NHS with a focus on quality, most recently with ‘NHS Improvement’ merging with NHS England, which has also just taken over the responsibilities of Health Education England. The functions of quality monitoring, driving forward change, and workforce training and development have therefore become increasingly entwined. The NHS People Plan (2020) noted that the ACP role is key to the objective of transforming services in ‘growing for the future’. The evolution and implementation of the role also reflects the expectations for ‘new ways of working and delivering care’.

The focus group discussions, not surprisingly therefore, noted that leadership in quality improvement encompassed how they develop services, enhance clinical practice, promote collaborative working, engage in staff development, and through these activities how they achieve benefits for patients. There was a close link made in discussions between ‘full KSE’ and how this provides the right environment for leadership in quality improvement.

> *“And to me that that's really important, because when you're looking at the service provision that you're giving to your patients, when you're working at that*

level, you really are face on with the difficulties that primary care are facing, the ED [emergency department] *is facing, the discharge to assess are facing. And actually, when you've got very senior clinicians that have a huge amount of experience and clinical skills and advanced clinical skills to go with it. You can be quite instrumental in facilitating and making that service better, I think." (FG2B)*

"I think it just allows you to….. you could see where the gaps were, and that was one of the opportunities then to start to develop more sort of ANP [Advanced Nurse Practitioner] *led stuff…because I could see where the gaps were, and where we could fill those and improve things." (FG2D).*

Participants often talked about 'frustrations' they had experienced in the service or role in which they were working. They reported seeing ACP as a way to address those frustrations by leading on quality improvement projects to problem solve. In defining Advanced Practice, Health Education England (2017b) noted it is expected ACPs are trained and assessed to Masters level qualifications, and from the systematic literature review undertaken there was general consensus on this internationally. In the Framework for Higher Education Qualifications, (Quality Assurance Agency, 2014) it notes that holders of Masters (level 7) qualifications typically 'demonstrate self-direction and originality in tackling and solving problems, and act autonomously in planning and implementing tasks at a professional or equivalent level'. The focus on problem-solving by participants is reflective therefore of the educational level they are expected to be working at, and from the discussion of their experience it provides reassurance that ACPs are thinking and operating at this level.

"When I started to look at like ACP training it came from an area of frustration, we didn't have consistent medical cover on the Ward. I work on a stroke rehab ward and district Community work as well. So the frustration bit was always about medical assessment about prescribing….So I basically just wanted to see what else I could do to kind of lesser, reduce the frustrations that the team were feeling." (FG1F)

In dealing with frustrations through problem solving, participants referred to situations where ACPs had been added into a service, or where activity had been shifted to ACPs so the service could be reshaped to make it more effective. This chimes with the substitution/ supplementation debate found in my systematic review regarding the evolution of ACP roles and how they are used (Dowling *et al.*, 2013).

"I'm sure you can all agree, we really save faffing around and running around and trying to find a doctor to do very, very simple tasks, sometimes even prescriptions. And it's definitely in my department, (which is an outpatient department), definitely made things a lot smoother, less waiting for patients as well." (FG3A)

"I mean we have a fantastic team around us, but actually we could be leading this Ward and possibly more effectively with a greater emphasis on service improvement." (FG1B)

"There's a real kind of sort of niche there to be able to provide a different kind of service over seven days and things…and to pull together from acute oncology, palliative care, all of those kind of oncology things that could sit together, and provide a better sort of service for the patients." (FG2D)

A common thread in terms of problem solving, quality improvement, and making things more efficient, was in relation to how ACPs could provide a consistent and coherent presence in a service. This allows for their KSE to be utilised and retained in a particular service where other health care professionals or parts of the service rotate in and out or are intermittently accessed by patients. This provides a more joined up interaction for patients where different tasks, processes, or interventions can be bought together in a seamless journey or episode of care.

> *"I think they get more continuity of care. I think one of the issues with a lot of patients is that every time they come to clinic they may see a different doctor." (FG2D)*

> *"I think for me, a lot of this comes around being that constant in the department. You know it's a big emergency department, and we have a really high turnover of junior doctors. They only have four, or if we are lucky six on placement with us and I think what you find is that the ACP team have is this constant. We know the policies. We know the procedures, and really enhance the overall delivery of care." (FG3B)*

> *"It's really to be beneficial….. this knowledge will stay within your department. It won't go anywhere." (FG3E)*

Participants correlated the consistent and coherent presence that ACPs bring to a service with the patient experience being enhanced and safety maintained. In Gulliford, Naithani and Morgan's (2006) examination of the concept of 'continuity of care' they discussed how this can be thought about from two perspectives. The first is the idealised view patients have of an ongoing relationship with a health care

professional. Where this is achieved it leads to increased patient satisfaction; if nothing else, due to the patient not having to repeat information or keep retelling their story, which can be traumatising. The second perspective concerns health care professionals who are working in a system where due to the increasing complexity and co-morbidities, patients commonly interact with multiple parts of the health service. Health care providers therefore aspire to seamless transition of information and ongoing care or health care interventions from one service to another to maximise positive patient outcomes. This is often done through case management or multi-professional team approaches to minimise the risk that information gets missed or an aspect of need is overlooked due to patients interacting with services in a fragmented, sporadic way.

Having a consistent and coherent presence in a team emphasises the contribution that ACPs believe they can make to the quality of health care provision, both from a patient satisfaction and patient outcome perspective. By taking a lead in their service to focus on benefits for patients they believe they provide a link between and within health care services.

> *"I found over the years of working community that I was recommending inhalers, medications, antibiotics, admission prevention, early support to discharge, making those recommendations to GPs. And what was the point? Because it was a letter. It was just a whole trail of inefficiency. I felt that I could do my patients more service if I was the one to be able to do all that for them, give them a script and walk them through their admission prevention journey a bit better." (FG2E)*

> *"We've been very lucky that we are supported, within the organisation to be able to deliver that kind of care because then it's very palpable the difference that we are making." (FG2B)*

The leadership in quality improvement theme often came from discussion of a driving force for people to move into ACP. Quality improvement is an area of activity the participants were actively seeking out and is a key expectation they have for the role. Participants believed that through leading on quality improvement initiatives they can problem solve and make a difference to patient experience, manage risk and safety more effectively, and enhance patient outcomes. This in turn was a key part of them feeling fulfilled in the work they were doing and why they had chosen to pursue this role.

Career progression

When talking about the ACP role in terms of 'driving forces', as well as relaying their own experiences, participants emphasised the potential, aspirational, or actual incentives and opportunities the role can offer for career progression.

There was an expectation that the opportunities the role offered should be in tune with their level of experience (KSE) and the level of responsibility they were undertaking in relation to the activity they were involved with. As noted within the themes above, this includes highly skilled clinical practice, the 'palpable difference' ACPs believe they are making to patient outcomes, and experience through leadership in quality improvement. Participants expected that the opportunities offered in ACP roles should therefore include career progression in terms of being facilitated to change their scope of practice and range of activities or services they were involved in.

"I moved into advance practice quite early on well on the pathway, towards, cause… I found my scope of practice very limited… and for me I needed a bit more." (FG3C)

This included examples of taking on new job roles which involved different types of activity or responsibility (e.g., providing education to other staff or seeing patients from assessment through to intervention and discharge), or working in different contexts (e.g., not being solely based in a hospital setting but providing services that straddle community and in-patient settings). The concept of 'portfolio careers' is significant here, where a person may be employed in more than one job role where different aspects may be emphasised to different degrees in each role, or where they hold separate contracts held by different employers.

"When I first started the training…. what I had in mind was very naïve. Where I wanted to be, my vision was maybe a little bit more tunnelled. And the training has been really useful at like opening up loads of different opportunities, possibilities that I could go down." (FG1F)

Career progression opportunities were also discussed in relation to how training to be or taking on an ACP role was seen as offering a route to move further up the hierarchy.

"I mean I'm not kind of one for sort of climbing the ladder. But I just kind of just wanted something, something more. And it was, it was now or never kind of thing. So it was an opportunity." (FG2D)

Despite calls for reform, and significant restructuring of health services in the UK, there remains a dominant hierarchical social construct in health organisations and amongst health care professions. In this stratified system, different levels in the hierarchy hold

greater or lesser access to resources and power for decision making. In Lewis' (2022) article, it was discussed how ACPs have been injected into this hierarchical structure and how, despite significant changes to health care occupations (particularly nursing), the power differential is still prevalent, with the medical profession continuing to wield the largest influence over who does what. 'Knowledge is power', (as described by Lewis), is often seen as a way to circumvent or reinforce hierarchical structures. The controversial view that ACPs are significantly aligned to medical knowledge (Arslanian-Engoren *et al.*, 2005; Nadaf, 2018; Timmons *et al.*, 2023) perhaps reinforces the assumption and ambition that developing this knowledge will facilitate moving up the hierarchy of power and influence. It is certainly acknowledged that some types of knowledge and experience are valued more than others. For example, O'Shea, Boaz and Chambers (2019) concluded that patient and public involvement remains undervalued in the hierarchy of power in health service decision making bodies.

Whether or not it is due to alignment to traditionally valued knowledge, some participants relayed the experience that, at least in some areas, taking on the ACP role had given them the opportunity to change their position in the hierarchy and gain greater knowledge, control, power, or influence.

> [From a trainee ACP] *"In a way it's it's, kind of….from where I am right now…I can't move up, you know, the ladder really, unless I actually develop myself to move up to the next level." (FG2C)*

> *"You know it was kind of mind-blowing to have that, to you know going from a, I guess, I don't want to say a lowly nurse, but you know that kinda, that just cog in the wheel kind of thing, to actually be someone that can make a change in in*

things. And I don't know. Had we not changed the setup and introduced advanced practice, then I would not have been able to do that, or at least not have the same clout as I've got now to do it." (FG3B)

Conversely, the ACP role was also noted as not currently offering the opportunities for career progression some participants would have expected. The lack of opportunity to progress beyond their current status, and thereby scope of practice, power, or influence, in the hierarchy was seen as a disincentive for going into and/ or staying in the ACP role.

"There's no vision for it. People can't progress to more senior roles within advanced practice. It's basically an advanced practitioner. It's just it stops there." (FG3E)

"You know it, it always asks you at your appraisal what are your aspirations for the future and things, and I kind of felt like I was, I was a bit stuck in saying like what, what else would I do now?" (FG3B)

Without further investigation of the different factors that may have influenced where there has or has not been opportunities for career progression, it is difficult to say whether this was related to contextual differences in hierarchical structures in the participants organisations, or more broadly how closely they had been aligned to or been endorsed by the medical profession in their roles. However, it was clear that the opportunity for career progression was key to whether the participants had gone into or were planning to stay within an ACP role.

When discussing their experiences and the 'if only…', participants drew attention to potential financial implications. This included how the ACP role had impacted on

opportunities for additional or different types of paid work, which could boost their salary as well as broaden their scope of practice. It also included reference to how taking on an ACP role may have an impact on pension entitlements. This could be particularly significant for ACPs, as the recruitment questionnaire noted the majority are already a long way into their working lives and so plans for retirement may be a more pressing concern. Some participants also discussed the opportunity for flexible working and how taking on the ACP role may affect their costs for working, for example, commuting costs or opportunities for working from home for at least some of the time. Furthermore, financial implications were linked to how an ACP role can impact upon work-life balance and was a key factor in deciding whether to pursue or stay in the ACP role.

In Kalliath and Brough (2008, p. 326) review of 'work-life balance' they identified how achievement of this is determined by an individual perception that work and non-work activities are viewed as compatible and support growth or career progression in accordance with a person's priorities. Work-life balance has been associated with job satisfaction, reduced stress, and enhanced occupational performance (Sirgy and Lee, 2018). Because it is reliant on an individual perception of whether the balance is satisfactory and in line with individually set priorities, a 'one size fits all' approach is difficult to achieve and requires consideration of the individual's circumstances, needs, and priorities. Participants gave examples of where this has worked well, and not so well.

> *"So it could give you flexibility or half a morning or a day to work from home, and do your phone clinics from home….And that's something that's really appealing to me just for the life balance or doing four long days. I can still do*

my work because I'm not governed by the patients who are coming in every day, having the actual physical treatment, I have to be here. So that's something that appeals to me a lot, especially long term and in the long run when I'm more tired and got bad knees, I'm able to flex things a little bit." (FG3A)

"I was offered a post in another hospital. A job that I didn't apply for, the same job that was another 15 miles a day round trip to travel… without any, without being able to progress, up to the band 8a until I finish the course, but also without any financial support to recognise that I would lose money to take that post so essentially I was offered the same job, with a loss in salary." (FG1B)

Since salary banding was introduced by the NHS this has provided a benchmark for health providers (both within and outside of the NHS) to signal the level and scope of experience, training, and responsibilities that are expected within job roles by attributing a particular pay band. Where this may have previously been denoted by a job title (e.g., 'nurse' or 'sister') this has been replaced by reference to salary banding, (e.g., a band 7 is expected to… or the band 8 can do x,y,z). This is not common terminology that is used by the public where traditional job titles remain heavily laden with assumptions about the types of work that people working in the health service are expected to do and the seniority they hold. However, for those working within health services, NHS salary banding is a clear signal of seniority within a hierarchical structure and what their level of responsibility is. This provides a vehicle for comparison between staff of how they are perceived.

"Some of these places like I know in [place name] *they're paying FCPs as eights. So you're not going to get any additional pay for doing that other stuff. So then, why would you go down advanced practice?" (FG3E)*

"Currently, our ANP nurse role is a band seven which doesn't quite sit with where I look at, you know, colleagues that work in NHS settings where that would be a band, 8a." (FG3D)

Whilst participants were keen to note that financial and work-life balance implications were not the only reason that would determine their decision to go down the ACP route, these were aligned to how they perceived themselves, or the ACP role as being valued. There was a need for career progression opportunities to reflect their level of experience and responsibilities they are undertaking as an ACP for 'value' to be attributed to the ACP role.

"If I hadn't have done the ACP role I probably would have left. I think I was feeling very frustrated. Didn't have the kind of I don't know how to word it, but it's kind of…without sounding like, almost like the kudos, and respect to push things forward…and I recognise that would have been a huge waste of twenty-five years of haematology experience."(FG2D)

The ACP role is expected to provide a route for attaining value by recognition of experience and level or scope of responsibility. Participants wanted to be assured that taking on the role would not harm their opportunity for career progression. They highlighted how this was a significant factor in deciding whether to stay in an ACP role, the service, organisation, or even profession they had been qualified to work in.

"So, for example, I mainly get paid a band six whilst I'm doing my training, but I know that other people in the same trust are being paid a band seven. And it sort of puts me off thinking about the future of the ACP role." (FG1C)

“I cannot tell you how that made me feel. Undervalued, it's made me considering retiring…. I love my job. But for me it's had a profound effect of the value I feel.” (FG1B)

In addressing ‘being valued’ through the career progression opportunities that are, or could be, made available through the ACP role, participants discussed contribution to and feelings of job satisfaction. Where there was alignment or balance of career progression (including scope of practice, position in the hierarchy, financial implications, work-life balance) participants expressed that they had achieved job satisfaction in the ACP role. This was often compared to other possible jobs that are available denoting a positive choice had been made to pursue ACP.

“You know, I had ambition, and maybe I would have looked, maybe at non-clinical roles eventually, if that was the only option for me, I would have looked at maybe matron or director of nurse, that kind of thing… I don't think I would be as happy and contented in that role as I am now.” (FG2F)

“I completely agree with that. For me a big part of my job now is as, well as a trainee ACP still, is the job satisfaction…..I'm starting to think in the future, would I like to? You know once I get a bit tired of running around after patients, move into more of a research role. It's the broadening of opportunities and job satisfaction for me.” (FG3C)

“I think it's it just feels like the job that was made for what I want to do really.” (FG1E)

Policy, vision, structure

Through their experiences of the role and awareness of how ACP had been implemented elsewhere, participants understood that it worked well when there was a clear and coherent direction and support for the ACP role. This was shaped by the policies, vision, and organisational structures that are in place, which are translated into actions to implement and support the role. Policy, vision, and structure were viewed as integral to developing a good understanding of the ACP role and the ways in which it could be used effectively. These aspects were also primarily discussed as being beyond the control or remit of ACPs themselves, where they are relying on others at an organisational or national level to ensure these were in place.

> *"We don't have a lead, so no one else really knows what it is, what it's supposed to do. There's no vision for it…..I know if I just looked at my, so my trust um, you know very much it would be not started on pretty much any of it, you know, because there is no structure in place for it, which really hinders how it can progress, what new roles can be created, and how you are recognised for what you do in the first place." (FG3E)*

Participants discussed where policies, processes, or standards had been established for ACP and to what extent they were being recognised, embedded, or implemented within the organisation in which the participants were working as ACPs/ trainee ACPs. This included processes participants referred to as 'quality assurance' where mapping of an ACP, their role, or the work they do against policies or standards had (or should) take place.

“I think it's very important quality assurance, because I think that's where a lot of the historic barriers to implementations of ACP roles and challenges that ACP trainees and ACPs looking to go into ACP find. That you got these barriers because it's not quality assured. Anybody that's done one module can call themselves ACPs. I know that NHS England and the centre of advancing practice are looking to standardise the role so that its quality assured, recognised, and regulated, separately. I think that's very important; the quality assurance, so that then it can be recognised. Once it's recognised and there is a minimum standard, then you know what you're getting with an ACP…..So quality assurance is very important, because it reassures the commissioners, it reassures, you know, stakeholders. It reassures the public, and I think that's quite an important aspect” (FG2B)

It was recognised for the role to be effective there had to be ‘buy in’ and support from influential figures that impacted on ACPs work. Key stakeholders that appeared to wield significant influence in this arena were identified as line managers, more senior staff in the hierarchy (particularly doctors), and people at an executive level. This included the presence of role models and people that were seen as championing and supporting the role from the outset, including, but also beyond the personal relationships an individual ACP may have with colleagues within their own team.

“They hadn't consulted the medical leads at all, and then they were expected to supervise. So there was a lot of pushback from the medics in the first instance and frustrations, that impacted on us as trainees, so I think that that buying in, needs to be from all levels within the organisation to support you to

develop and once you get that in place, and you know I think the vision can then be achieved." (FG1E)

As noted in Chapter 2, since the Centre for Advancing Practice (CfAP) has been established this has provided a vehicle to begin to implement policies and structures for ACP. The introduction of ACP standards and policy could be said to have started with the Multi-Professional Framework (HEE, 2017). This document sets out the definition of ACP and has influenced standard setting and the accreditation process for ACP education programmes. The work of the CfAP has also galvanised organisations and regions to identify ACP leadership roles and to form networks and committees to influence localised policy based upon national initiatives from 'the centre'. These include guidance documents on ACP supervision standards, as well as 'readiness checklists' and the 'governance matrix' to allow for self-assessment of preparedness for ACP.

"If you can have a good AP lead, you know, with a vision to try and establish how people can work, how they can progress, and kind of what new roles can be created. I think that's crucial." (FG3E)

Whilst support and buy in was noted as requiring active engagement with planning and structuring the implementation of ACP roles, perhaps aided by tools such as the governance matrix, it was also recognised that there needed to be scope for the ACP role to evolve. This maybe a reflection of the ad hoc, unstructured way in which ACPs have traditionally developed, but also recognises that one of its strengths comes from the ability to 'flex' the role to meet with population or service needs. The need to have a workforce that could be flexibly applied was key to ACPs being included in the 'growing for the future' section of the NHS People Plan (NHS Improvement, 2020).

The more recently published NHS Long Term Workforce Plan (NHS England, 2023b) goes further still and includes an ambitious aspiration to expand the number of Advanced Practitioners to ‘optimise multi-disciplinary teams’. The intention here is to use expansion of new and extended roles (including ACPs) to broaden the skills within teams to “better meet the needs of patients” and “spread and embed future models of care that meet the needs of our population”.

> *“I guess that the advanced practice role for me just evolved over time really. We kind of went from very much being sort of plain injuries to, you can see illnesses to, oh do you want to cover for the junior doctors to come and do the injuries, do you want to come around and do the majors? And then I guess we realised we were doing the role.” (FG3B)*

> *“Because it's an evolving like profession, I can see there's so many avenues that ACP could go down.” (FG1F)*

> *“That was really important for me, and …. that was the drive, because it's part of the wider picture of what the NHS needs in terms of for sustainability, I think. For sustainability, you have to be quite aware of how your skills are going to complement and support a system that is struggling.” (FG2B)*

The extent to which ACP roles could be implemented, adapted, and permitted to evolve was noted as being significantly impacted by whether strategic oversight or policy and governance for ACP was innovative or supporting, or conversely missing, not consistent, directive or informative enough, or too far removed from the ‘coal face’ of working as an ACP. This has then allowed for localised variation in how effectively ACP is implemented within a particular team, service, or for an individual.

"We're a very top top-down organisation at the moment. So if you've got people at the top that don't necessarily have any grassroots knowledge of how the business functions they're not always, you know their finger's not on that pulse in terms of how we get the best out of what we've got. (FG3D)

"But the trust that I was at, at that time had gone with more of a physician's associate type model, so weren't really interested in training as ACP, so I moved." (FG1D)

"Then a hospital five miles down the road decides they don't want to do that, and then actually the staff go there for a higher pay band, but then, not having to put in the same level of work that you have, we have to put in, and I think this standardisation is important for that side of things as well." (FG3B)

Comparisons were made between participants' experiences where it was noted that ACP roles and teams which had been established for a significant period of time were more successful. These well-established teams were able to rely upon long-term investment in these roles having been secured, which then facilitated development to shape the service and individuals in the team to meet the needs of patients.

"I think it's because our team has been going for a while. The medics have seen the advantage of it, sort of seeing things like the introduction of a lumbar puncture service, so we can quickly turn around headache patients that need lumbar punctures. We can train doctors on lumbar puncture procedure. So something like that shows that if you allow us time to develop services and develop skills, it will develop into a service that will develop into benefits for the patients and the hospital overall. And so they've seen those longer term, you

know the investment, giving sort of longer-term sort of benefits. And so, it means that we've, we've been able to argue for why we should have non-clinical time, so there's non-clinical time for our team in in the rota. So we can do peer teaching, we can do, you know conference presentations and things that, or all work on some new services. But it's based, this is all because our team has been going for quite some time and they've had a chance, I think, to kind of show the benefits of it." (FG1A)

Participants therefore emphasised the powerful influence that policy, vision, and organisational structures can have on the experience of working as an ACP. This included to what extent their experience 'fitted' with the now commonly expounded expectations of Advanced Practice such as 'the four pillars'.

In reflecting on this theme, it underlines the importance of this research to strive to achieve the intended impact and outputs (appendix 13) by utilising its findings to influence policies, initiatives, and support structures, and strengthen awareness of the ACP role where gaps between expectation and reality are found. This helpfully leads to the next stage of the study: the follow-up questionnaire.

FROM FOCUS GROUP THEMES TO FOLLOW UP QUESTIONNAIRE

The themes discussed above were identified using rTA to allow for a follow up questionnaire to be developed. Because of its dominance over other aspects of the role 'clinical' has been placed as the first theme and the first set of questions in the follow up questionnaire. This will be a topic that ACPs will be comfortable with as from all previous research, as well as the perspectives given from participants in this study, 'clinical' activity will form the majority of their work. By placing 'clinical' questions first

in the follow-up questionnaire, it will ease participants in, starting with a topic they should feel confident to comment on from their own experience.

A common feature in the focus group discussions was also the development, sharing, full recognition, and autonomous utilisation of a diverse range of knowledge, skills and experience. This has been identified as the second theme to be included in the follow-up questionnaire. In understanding whether expectations regarding the ACP role are being met, an evaluation of what extent full KSE is a feature of participants' experience of the role will be included in the analysis from this research. This will include questions that address the child code themes based on the KSE tapestry, generalist versus specialist, professional development, and autonomy.

Focus group participants noted how their KSE can and should be linked to opportunities to be involved in leadership in quality improvement. Several examples were given of where ACPs had been frustrated in their attempts to be autonomous in decision making and to be involved in leading on quality improvement initiatives. This indicates there may be significant gaps between expectation and the realities of the ACP role in this regard. Questions pertaining to opportunities for leadership in quality improvement were therefore included in the follow-up questionnaire.

Similarly, there appeared to be a range of experience and discussions regarding career progression. Often these responses fell into the 'if only…' context code, and their influence on whether ACP was seen as an attractive career option to take. Follow up questions addressed this by asking about ACPs experience of moving up the hierarchy, changing their scope of practice, salary and financial status, work-life balance, feeling valued, job satisfaction, and whether this has influenced their decision to stay working in health care. An additional question was added in the 'background'

questions of the follow-up questionnaire to capture ACPs with portfolio careers as this was an emerging feature highlighted by some participants.

In referring back to the context codes, I also noted that the 'policy, vision, structure' theme was emphasised as being highly influential in terms of recruitment to and retention in the ACP role. This formed the final set of items in the follow-up questionnaire. When summing up the focus groups all participants were asked if there was anything else they wanted to highlight about their expectations versus the reality of working as an ACP. This helped to confirm that I had captured the key points that participants wanted to make in answering this question and was also used as the 'summing up' final question in the follow up questionnaire.

CHAPTER SUMMARY

In this chapter the results from the recruitment questionnaire have been reported alongside how these were used to create a diverse group of participants to take part in the focus groups for this study. The findings from rTA of the focus groups have then been presented under the 5 themes identified. Direct quotations from respondents have been utilised alongside reference to relevant contextual information and literature to create a 'story' of each of the themes. How these have then been drawn upon to create the items in the subsequent design of the follow up questionnaire has then been discussed.

CHAPTER 6- FOLLOW-UP

QUESTIONNAIRE RESULTS

INTRODUCTION

In this chapter the results from the follow up questionnaire will be presented. This will begin with an overview of the main features of the data collected, including where responses were filtered to ensure they met the inclusion criteria. Results will then be presented for questions which asked respondents about their background and the context in which they work as ACPs. This will be followed by discussion of the results under the 5 themes around which the remainder of the questions had been organised. It will conclude by examining the results from the 'deep dive' where selected questions within the main body of the questionnaire were analysed alongside the responses to demographic and background questions.

The follow up questionnaire (Appendix 15) was open from 7th June to 7th July. 253 people opened the follow up questionnaire. Response quality was rated as 96% by Qualtrics with 2 areas noted as minor risk; potential duplicates and 1 computer bot response; these responses were eliminated before analysis. On reviewing the results, some did not answer the 'I consent to participation in this research' questionnaire, and 1 responded 'no' to this question; these respondents were not permitted to proceed to complete the questionnaire. The 4 people who responded 'yes' to the question about being currently suspended or excluded from practising as a health care professional or currently under investigation for Fitness to Practise by your employer or regulatory body were automatically taken to the end of the questionnaire without opportunity to answer any further questions. Once filters were applied to remove data from the above, 230 responses were utilised for analysis. Not all respondents answered every question; the total number of responses for each question or data set is therefore provided alongside percentages (e.g. 50%/200 or n= x).

DEMOGRAPHIC BACKGROUND/ CONTEXT

The follow up questionnaire begun with asking respondents to provide some demographic details and information about their professional background and the context in which they work as an ACP. These questions were replicated from the recruitment questionnaire and have provided the opportunity for comparison between those that first responded to participate in the research and those that completed the follow up questionnaire. This provides a picture of the group of ACPs that responded to this part of the research, noting that the follow up questionnaire was aimed at capturing the current reality of people working or training as ACPs in the UK. The results and comparison for these questions can be found overleaf in Table 6.1

Table 6.1 Responses to background questions

FQ no.	Question topic	n=	Follow up Questionnaire Results	Comparison to recruitment questionnaire results
Q1B	Geographic location	210	All regions represented	Similar profile to geographical representation in the recruitment questionnaire.
Q2B	Profession	208	74% (n=154) were nurses, 25% (n= 52) AHPs, and 1% (n=2) were pharmacists	78% (n=160) were nurses, 21% (n= 42) AHPs, and 1% (n=3) 'other'
Q4B	Time since registration	191	The mode (36%, n= 69) had been working in their registered profession for greater than 20 years.	Similar to recruitment questionnaire results and the number (n=40) was the same that had been registered for 10 years or less.
Q5B	Area of speciality/ field of practice they are working in.	198	A range of specialities represented. Primary care was the largest group (38%, n=70) followed by 'Other' (25%, n=49). Acute Medicine and Emergency Department roles made up 7% (n=15) each, and all other specialties accounted for less than 5% each.	Similar profile (37 %, n= 74 Primary Care and 20% n= 40 'other') with frailty and oncology specialties mentioned more frequently than in the recruitment questionnaire.
Q6B	Portfolio career	195	23% (n= 45) said they had a contract with more than one employer.	Unable to compare as this question was not asked in recruitment questionnaire
Q7B	Job title	196	Generic 'ACP' or 'trainee ACP' titles were most common, and some also included reference to their profession (e.g. Advanced Nurse Practitioner) and/ or their field of practice (e.g. Emergency Nurse Practitioner).	Similar range and proportions of titles used in the recruitment questionnaire.
Q8B	Pay	193	Bands 7 (35%, n=68) & 8 (56%, n= 108) were most common	Same result as in recruitment questionnaire
Q9B & Q10B	? currently a trainee/ on a development programme to become an ACP	197	46% (n= 91) respondents noted that they were currently on a training or development programme to become an ACP, with the largest proportion of these (46%, n= 41) being in their final year of study.	This was a very similar profile to the recruitment questionnaire.
Q11B	? Fits the description of ACP & mapping to ACP framework	191	100% of respondents said that their job role fitted, or partially fitted with the description of ACP as defined by the MPF. 74% (n= 141) believed their role mapped fully to the MPF, although 33% (n= 64) of these had not undergone formal mapping. 26% (n= 50) thought their role only partially fitted the ACP description (including work across the 4 pillars).	In the recruitment questionnaire this compares to 97% (n=192) fit/ partial fit with ACP description. Proportionally more (38%, n= 75) had not been formally mapped. Fewer (23%, n= 46) thought there was a 'partial fit' with the ACP description given.
Q12B	Types of training (NB more than 1 choice available)	320	MSc 30% (n= 96), 4% (n= 13) completed a credentialling programme 21% (n=67) said they had received 'on-the-job' training	MSc and credentialling same results, on-the job training was cited by 23% (n= 79)
Q13B	Time spent in ACP role	182	53% (n =97) of respondents had been in their ACP role for 1-3 years. 13% (n= 23) had been in their role for 10 years or more.	Very similar profile: 53% (n= 102) 1-3 years and 11% (n= 21) 10 years or more.

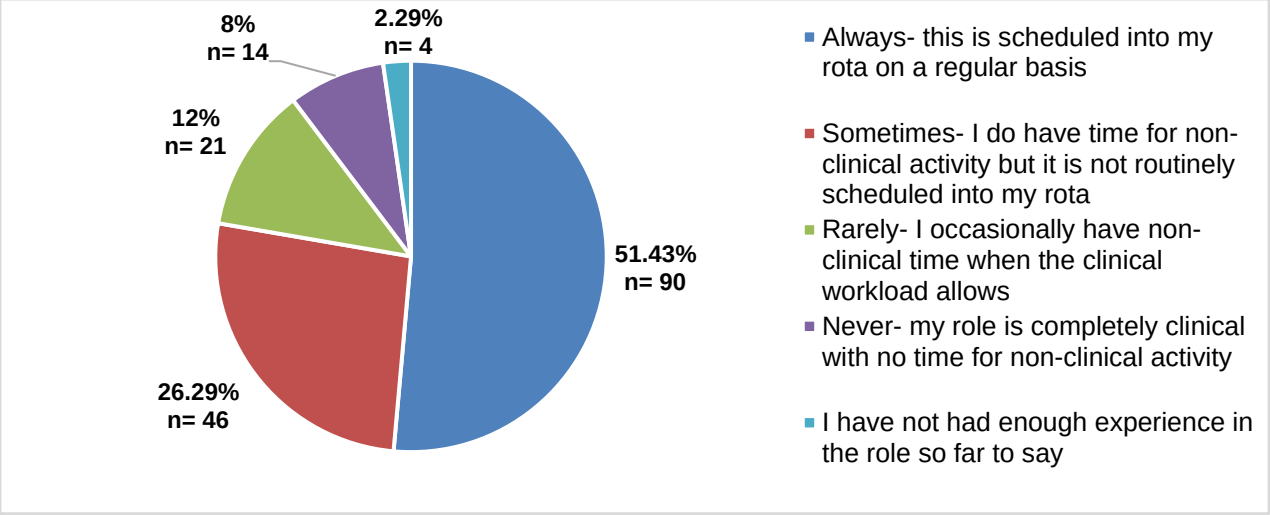
The remaining questions were organised around the 5 themes identified from the focus groups. Each set of themed questions included an opportunity for respondents to provide free text commentary on their experience in relation to that theme. The results for the theme questions will now be presented.

CLINICAL

Unsurprisingly, nearly all participants (99%/ 175) noted that their role involves clinical work on a regular basis (e.g., normally every week). The remaining 2 respondents said their role sometimes involves clinical work but on an infrequent basis (e.g. not every week). The expectation that ACPs have direct clinical contact with patients is therefore being met. In comparison, only 51%/ 175 noted they have non-clinical activity as part of their regular rota and 8% (n= 14) said they never had time for non-clinical activity, so would not be fulfilling the '4 pillars' brief as defined within the MPF.

Figure 6.1 Time allocation for non-clinical activity

FQ2 "In your role as an ACP/ trainee ACP, do you regularly have time for non-clinical activity (i.e. activity that does not involve direct physical interaction with patients, either face-to-face or through telephone/ video communication)?" [n= 175]



When asked about clinical and non-clinical activity, respondents were asked to use a sliding scale to denote if they thought the balance between the two was about right. The mean for clinical/ patient facing activity was heading toward ‘too much’, and non-clinical was more towards ‘not enough’. When taking account of standard deviation for both clinical and non-clinical, this shows that the majority of respondents are around the 5 or ‘about right’ rating.

Table 6.2- Balance of clinical/ non-clinical activity

FQ3 - Would you say that the balance between clinical and non-clinical activity in your current ACP/ trainee ACP role is about right for you? Use the sliders to denote where on the scale you think you have 'not enough' (0) or 'too much' (10) or 'about right' (5) amounts of time for each activity.

Question	Instruction	Scale	Mean	Standard Deviation
Clinical/ patient facing activity. [n= 174]	Use the sliders to denote where on the scale you think you have 'not enough' (0) or 'too much' (10) or 'about right' (5) amounts of time for each activity.	0-10 where… 0=not enough 5= about right 10= too much	6.34	1.95
Non-clinical (time away from direct contact with patients) [n= 163]			3.96	2.11

Having time set aside for clinical and for non-clinical activity was seen by the focus group participants as a way to attract in and retain people into the ACP role, as well as a necessity to work effectively across all 4 pillars. This was also reflected in the responses to the open text question about clinical/non-clinical activity in the follow up questionnaire, including one respondent who had set up a portfolio career.

> *“I have developed my portfolio career to access the other 3 non clinical pillars. They are not provided for or understood in my current clinical role.”*

A range of activities were cited by respondents as ‘non-clinical’ time in the open text question, including audit, training and development, managerial and leadership responsibilities, involvement in quality improvement, and research. Time allocated or taken up with ‘admin’ was often named in the free text comments as either non-clinical activity, or activity that eroded the time available for other non-clinical activity. This included time for writing up patient notes, making referrals, filing, or reviewing test results and were focussed on tasks that are required for management of patient care, although may not involve direct contact with the patient themselves.

> *“My admin slots are booked into my ledger, meaning they are frequently used as catch-up slots, resulting in not enough time to catch up with tasks, blood results, referrals and emails.”*

It could be argued therefore that ‘admin’ is being seen as non-clinical activity whilst the link between this kind of activity and fulfilment of the research, education, and leadership and management pillars is not clear.

Whilst in general the respondents were not too far off from believing that the balance between clinical and non-clinical was about right, nearly half of ACPs in this research are not getting regular, scheduled time for non-clinical activity. Some ACPs are getting no time away from clinical or patient facing activity, and there is a greater tendency to believe the time they do get for non-clinical activity is not enough or is often eroded by clinical workload.

> *“I’ve been told that I need to take my non-clinical time but with days just getting busier, where am I supposed to take it?”*

In the free text comments, several noted that they undertook non-clinical activity outside of their contracted hours.

> *"I am really passionate about the other three pillars and that is what makes our biggest impact however I end up doing a lot in my own time. It disheartens me that the value of giving us the time is not recognised."*

Lack of understanding or awareness of the value and significance of allocating time for non-clinical activity was a re-occurring theme in response to the 'clinical' question, where it appears there is variation in how this is seen and supported by others.

> *"I think colleagues struggle to appreciate the concept of indirect clinical activity."*

> *"Non-clinical activity is not given the same recognition as clinical activity".*

> *"I am very lucky in my department that colleagues have recognised and respected the value of non-clinical activity in my role. Others in other departments have not."*

Where there was a defined, planned split between clinical and non-clinical activity being scheduled there was considerable variation, although an approximate 80:20 (clinical: non-clinical) split was cited most often (Table 6.3). However, as noted above, 'non-clinical' was viewed differently by respondents where some referred to this only including activity that covered the leadership and management, education and research pillars and some included patient management administration tasks within this definition.

Table 6.3- Clinical/ Non-clinical time splits

Cited from "FQ4 - Please use the text box below to provide any comments (should you wish to do so) about clinical/ non-clinical activity from your experience of the ACP/ trainee ACP role so far." Words in italic font are direct quotations from respondents and are listed from the most to the least non-clinical time allocated.

• 50:50 split (*50% clinical, 50% research/education/leadership)* • *I currently work about 50/50*
• *On a good week there may be 2 admin days* (working in a clinical trials unit)
• 75% clinical and 25% *for the other 3 pillars*
• *80% clinical, 20% non-clinical* • *80:20 split* • *Currently do 25 hours clinical 15 hours non-clinical as a trainee when qualified will do 32 hours clinical 7.5 hours non-clinical.* • *One management day per week* • *Allocated day for off the job learning*
• *3 x30 min slots for f2f consultation and 1x 30min admin* (approx. 2 hours per day, 10 per week)
• *I get 6 hours per week admin time working full time 37.5 hours the rest is clinical*
• 20 min appointments, catch up of 20 mins three times daily *which allows some time for non-clinical* (1 hour per day, approx. 5 hours per week)
• *12 hours of CPD time in a month* • *12 non-clinical in 150hr. month…. so 138hrs clinical, 4 hrs. per other pillar per month*
• *I work part time…and only get 2 hours per week which is reduced if I have a day off* • *30 minutes allocated for admin at the start of my 9.5 hour day* (approx. 2 hours per week) • 2 hours per week on *'checking patient notes against a weekly audit to ensure that patients are receiving appropriate follow up and monitoring'*
• *6 study days allocated per year*

The time allocated for different types of activity may be influenced by the extent to which respondents had control over their work. There is some evidence that working as an ACP offers opportunities to personally manage this, either by opting for a portfolio career or by being given, as one respondent put it;

> *"the flexibility and autonomy to manage my own diary".*

Respondents noted the importance of allocating time for non-clinical activity.

> *"I view time given to & money spent on CPD/professional training as an investment which ensures I remain up-to-date (as much as is possible), safe, competent & confident in my decision making."*

However, primarily the comments, (34 separate comments made) noted how they did not have enough time for non-clinical activity as their clinical workload took precedence.

FULL KNOWLEDGE, SKILLS, EXPERIENCE (KSE)

In this section of the questionnaire respondents were asked 6 different questions on the theme of knowledge, skills, and experience. The responses across the different questions were generally positive and in the free text comments to the open question in this section a range of significant KSE was referenced. This included drawing upon a breadth and depth of experience to support their role and personal attributes needed within the role for their full KSE to be utilised.

> *"I am proactive in seeking out opportunity to do this. Only by being proactive are others aware of what ACPs have to offer, especially in areas where ACPs are relatively new to the team/department."*

Some noted how they worked across a number of different areas which allowed them to *"gain valuable insights"* and recognised the *"transferable skills"* they were utilising from their base profession (e.g. nursing) and other roles they had previously held (e.g. *"previous career in critical care outreach").* This enhanced their own KSE development as well as facilitating effective use of this in their ACP role.

Table 6.4 Summary of results from KSE questions

Full KSE? n=164		Generalist v Specialist KSE n=122			Used as advice/ support? n=162		Autonomy n=163		Opportunity for CPD n=163		Opportunity to support the development of others n=163	
Yes, regularly	71%	Generalist	1st	41%	Frequently	74%	Mean	7.67	Yes, regularly	58%	Yes, regularly	61%
Sometimes	23%		2nd	24%	Sometimes	17%	StD	2.33	Sometimes, but not enough	36%	Sometimes, but not enough	33%
			3rd	35%								
Rarely	2%	Mixture of Generalist/ Specialist	1st	32%	Occasionally	7%	>5	81%	No	3%	No	6%
			2nd	63%								
			3rd	5%								
No	1%	Specialist	1st	27%	Rarely	2%	5	8%	No, but don't feel it is necessary	1%	Not had enough experience to say	1%
Not had enough experience to say	4%		2nd	13%	Never	0%	<5	11%	Not had enough experience to say	2%		
			3rd	60%								

KEY

Positive	Neutral	Negative

The first question asked in this section was "FQ5 - Thinking about a typical week in your ACP role, do you feel able to utilise a range of knowledge, skills, and experience? This could include knowledge, skills, or experience from previous roles you have held, (either within or outside of healthcare), from your professional background or training, (e.g. paramedicine, physiotherapy, nursing) or from when you have worked in particular specialities or fields of practice before coming into your current role, (for example in emergency medicine, primary care, or oncology)." The majority believed they mostly or sometimes were able to utilise a range of knowledge, skills and experience within a typical week working as an ACP. This view was emphasised within the free text comments to FQ11 for this theme– "Please use the text box below to provide any comments (should you wish to do so) about effective utilisation of your knowledge, skills and experience in your ACP/ tACP role."

> *"My knowledge, skills and experience are drawn on frequently across multiple teams as well as through networks across organisations."*

> *"It's allowed me to use decades of accumulated skill and experience to help patients."*

To understand better the types of KSE they used with their ACP role, participants were asked FQ6 – "Would you describe your role as primarily in a 'generalist' or 'specialist' field of practice? (Generalist being where you primarily use a core set of generic skills such as clinical assessment in a range of patients or health care settings, and specialist where you provide patients with access to a specialist service drawing upon advanced knowledge, skills, and experience built up over time in a particular field.) Please rank in order which you think is most prominent in your role."

Generalist was most often listed first, followed by ‘a mixture’, and ‘specialist’ was placed last. One respondent noted in the free text comments

> *“I certainly feel very valued for my ACP generalist skills- rather than for my professional background.”*

However, this is not universal as others emphasised their specialist focus;

> *“In depth expertise within a specialist field of practice”*

> *“My 19 years’ experience in oncology is called upon daily.”*

Participants were asked in FQ7 – “In your ACP role do people refer to you for advice, to answer queries, or seek support from you in delivering effective patient care?”. The majority (74%/ 162) believed this was a frequent occurrence in their role. This endorses the expectation that ACPs are being seen as a ‘go to’ person for expertise in their teams and services in which they work. In the free text comments examples were given by respondents of how they are consulted for advice and support, including for policy development and training.

> *“My role in moving policies in the Trust forward is expanding getting implementation and de-implementation of policy and guidelines to happen. I find I am used by the MDT* [Multi-Disciplinary Team] *in advising in difficult situations particularly where students are involved around tools to support education and development.”*

Where such examples were given, links were also made to the seniority of their position within the teams in which they worked, both in relation to their extensive experience and the position given in the organisational hierarchy.

"I am often viewed as the most senior clinician apart from consultant on shift….. I am the most senior on the unit for 13 intensive care patients. This gives me a lot of accountability and autonomy."

The respondents in this survey mostly endorsed the expectation that they have autonomy over clinical decision making in their ACP role. As you might expect with Likert scales, (Kulas, Stachowski and Haynes, 2008), there is a peak of respondents that opted for the median value in the question asked about autonomy. However, you can see from visualisation of the data overleaf (Figure 6.2) that overall there is a leaning toward ACPs having some degree of heightened autonomy over decision making in their role, where 81%/ 163 gave a score of 6 or higher. 23%/ 163 gave a response of 10 denoting they have complete autonomy with no requirement to seek approval from others. Only 19%/ 163 put 5 or lower which suggests a relatively small proportion of ACPs more often than not need to gain approval from others. However, from the responses to the free text question the proportion that feel they have limited autonomy may be concentrated in particular areas or groups operating as ACPs.

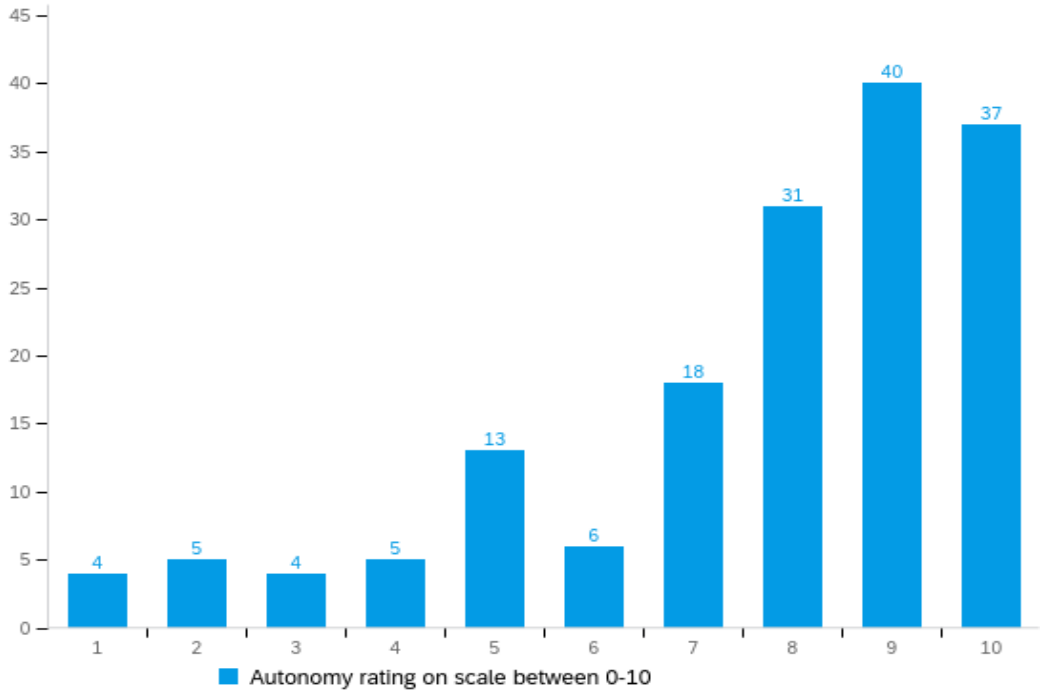
"My autonomy is hampered by our local trusts' policies on not allowing ANP's to request USS [ultrasound scans]- *we can request x-rays, but have to ask a GP to request USS, which simply does not make sense, but the radiology department will not accept that we are autonomous practitioners."*

"My employer gives me full autonomy to make decisions. However, the wider health community and government do not."

"As a paramedic, I am prevented from being fully autonomous by legal issues such as controlled drug prescribing, sick notes, and death certificates."

Figure 6.2 – ACPs perceptions of autonomy in the role.

FQ8 - Thinking about a typical day at work, to what extent do you feel you have autonomy over clinical decision making in your role as an ACP? For example, do you need to get approval from others for parts of assessment (such as ordering investigations) or treatment (such as prescribing medicines) or onward referral or discharge? If yes, you always need to get approval you would move the slider to 0 and if you never need to get approval for decisions like this, move the slider to 10. [n= 163]



It should be noted that some respondents (46%/ 197) said they were in training or development ACP roles and so may not yet have been given the full extent of autonomy over clinical decision making that they will ultimately receive once their training is successfully completed. Nearly half said they were in a training or development ACP role, yet only a small percentage more, 58%/ 163, said they regularly get an opportunity to develop their own knowledge, skills, and experience to enhance their practice and 61%/ 163 said they regularly support others in their development.

Figure 6.3- ACPs access to CPD

FQ9 – In your current ACP role have you had opportunity to develop your knowledge, skills, and experience to enhance your practice? You might find it helpful to think back to your previous appraisal, personal development review or revalidation and what development you have undertaken since then to help answer this question. [n=163]

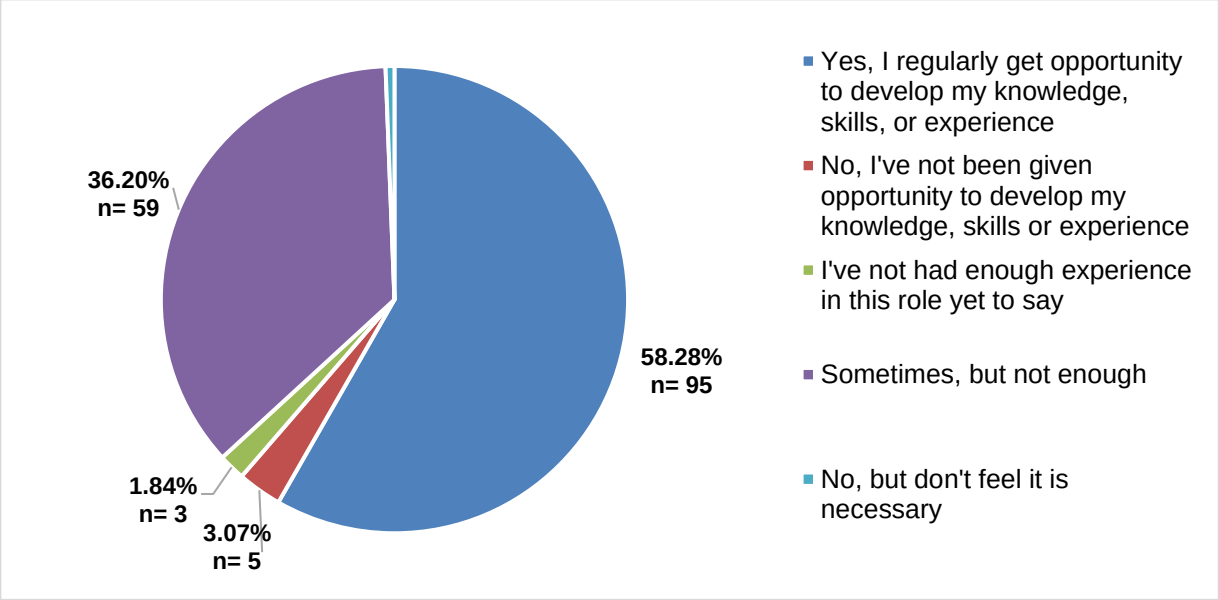
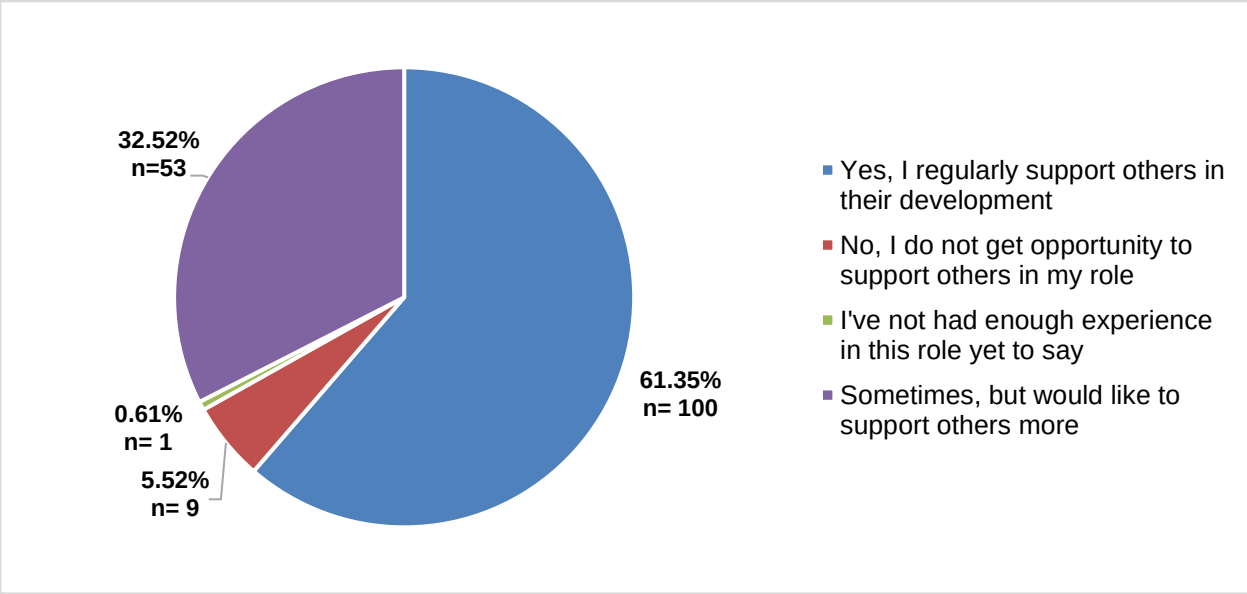


Figure 6.4 – ACPs opportunity to contribute to development of others.

FQ10 - As an ACP (or trainee ACP) have you had opportunity to use your knowledge, skills, and experience to support others in their professional development? [n=163]



Several examples were given in the free text comments of ACPs involvement in providing supervision, training, and development of other colleagues.

> *"I am fortunate that my role enables me to support students from multiple professions, pre-reg students to NMP trainees. I have always been passionate about learning and supporting development in others."*

However, around one third of respondents said they would like to have more opportunity to engage in professional development both for themselves and others. 33%/ 163 wanted to support others in their development more than they do currently. 36%/ 163 felt the opportunities they received for development were not enough.

> *"Was involved in paediatric upskilling in dept but told my teaching time was being tsling* [? taken] *away. No direct teaching with seniors, can't access trust specific training as need to cover department, can't access junior teaching as need to cover department."*

> *"As an ANNP I work fully on the medical rota. Whilst this has its benefits, it means that I move around a lot and do no get to support/share knowledge/teach the nursing team which I feel is a real shame."*

> *"I find it hard for an tACP to fit into the role within primary care - there has not been enough support for me within my area - they are happy for more to complete course and work full time once qualified but do not want to spend the time training."*

The desire for more opportunities to develop was also reflected in other free text comments where specific areas were identified that respondents felt they needed to gain further knowledge and skills in (e.g. leadership). Whilst for some they noted this was because they were new into the role, or that the role had been newly created in their organisation, for others they felt their formal training had not fully prepared them, that *"supervision is patchy"*, or that they needed support to gain confidence.

> *"Need more supervised practice not just observation to make up the numbers."*
>
> *"I do not think that our university component has provided adequate knowledge through lectures and assessments to be confident in our tACP role."*
>
> *"Imposter syndrome isn't something I knew of before embarking down this route. It is real and sometimes painful and lonely."*

LEADERSHIP IN QUALITY IMPROVEMENT

> Reported involvement in leading on aspects of quality improvement was relatively modest with a wide variety in the responses given. *"In my place of work it is very mixed, QI is definitely valued and supported but don't always allow leadership to flourish."*

Where opportunities had been available or sought out by respondents there were several powerful examples given in the free text comments where respondents had been involved in leading on change activity.

> *"I have been integral in changing Trust policy around delirium screening using the 4AT. This has required resilience and courage to engage senior people that have a lot of influence. Skills that I have further developed in my ACP Masters*

education built on following extensive previous leadership roles in a nursing capacity."

"On the back of the Masters courses, I had a couple of posters accepted at the Society for Acute Medicine, a poster at a HEE conference, and shortlisted for an award within the trust for the QI initiative. This was an enormous boost to confidence that I can lead and deliver on change, and that I have the credibility to do so, even among experienced senior medical colleagues. Since finishing the course, I've already targeted a couple of areas for QI initiatives and using my non-clinical time to take these forward."

Respondents were asked a series of questions about different aspects that the focus group had identified as contribution to their opportunity to be involved in leadership and more specifically activity related to quality improvement. In the first question for this theme participants were asked; FQ12 – "Thinking about the service/ team you work in and your ACP role in that team or service... To what extent do you get the opportunity to lead on quality improvement? (For example, leading on change which might include audit, or designing projects to enhance the services you provide or promote effective team working). Move the slider along to where fits best with your experience with 0 being not at all and 10 all the time." 35%/ 145 of respondents put less than the mid-point for this question, suggesting there is a large proportion who have limited, if any, involvement in leading on quality improvement.

Table 6.5 Summary of results from Leadership in Quality Improvement questions

QI leadership n=145		Consistent, coherent presence n=152		Continuity of care n=153		Reshaping services n=152		Patient safety and patient experience n=151	
Mean	5.54	Strongly agree	54%	Yes, significantly	37%	Yes, significant improvement	40%	Mean	7.76
StD	3.12	Agree but also provided by others	34%	Sometimes, but could be enhanced further	44%	Agree, some experience, more impact could be made through better use of ACPs	47%	StD	1.96
>5	52%	Disagree, not had enough experience to say	8%	Not really due to the set up	15%	Not had enough experience to say	7%	>5	88%
5	12%	Strongly disagree	4%	Not had enough experience to say	3%	Disagree ACPs not made a difference, others have been more significant	5%	5	5%
<5	35%			No	2%	Strongly disagree, services are less effective by inclusion of ACPs	1%	>5	7%

KEY

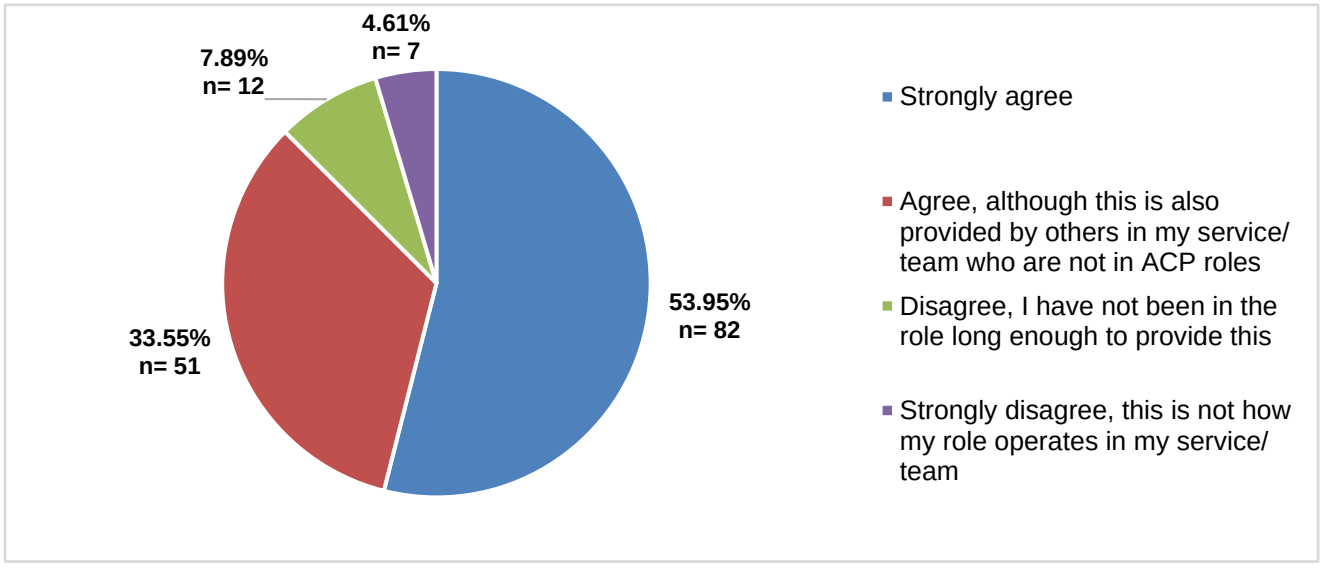
Positive	Neutral	Negative

The suggestion put forward by the focus group participants that ACPs provide a consistent and coherence presence within the services they work in was though endorsed by 88%/ 152 of respondents. The frame of reference given was where they are a constant member of a team as opposed to other staff who may rotate in or out, and examples of this were given in the free text comments.

> *"Within the unit where I work, the case for ACPs and their benefits has just about been won. It feels like the Trust is getting to this point too. Recent doctor strike action increased the exposure of ACPs within the Trust - and I think people are seeing that they do more than clerk, follow pathways, etc. and can really add value whether they work. It's their enduring, consistent presence and eagerness to do the best by their patients and improve patient experience and outcomes that is slowly being realised."*

Figure 6.5 – ACPs as a consistent presence.

FQ14 - In your current ACP role do you provide a consistent and coherent presence within the service in which you work, (e.g. more of a constant member of the team where others may rotate in/ out)? [n= 152]



Many of the respondents acknowledged that they were not the only people to act as a 'constant' in their service and a small number also said this is not how their role operates. Respondents also noted how the position they hold as an ACP within a team may act as a help or hindrance to involvement in quality improvement and leadership.

> *"As I work across multiple services across several trust sites I have found it very challenging to develop a consistent presence within teams. I see this as a major difference between my role and colleague ACPs who are embedded within a single service. It impacts on my capacity and in terms of leadership I have to be selective about the projects and tasks I take on."*

> *"Very difficult to make an impact or improve services as rotational post. There is no acknowledgement or support of the enhanced skills we have as ANNPs, rather we are just treated like SHO's and fill the medical rota slots."*

Whilst they are not the only staff to provide a consistent and coherent presence in multi-disciplinary teams, respondents believed they can contribute to effective utilisation and retention of knowledge, skills, and experience within a team.

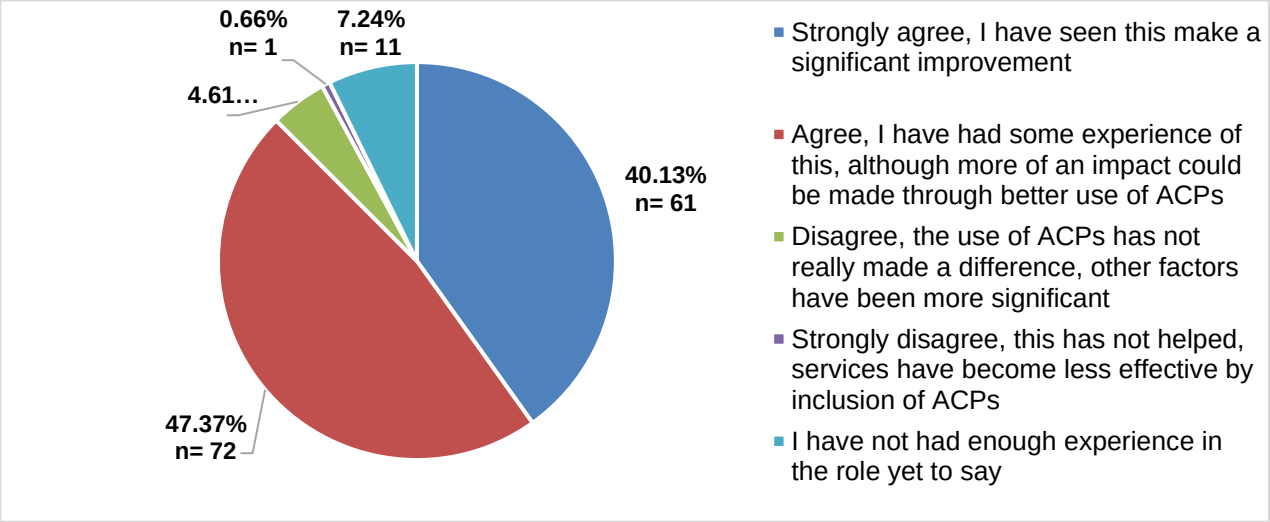
> *"I feel I am respected for my knowledge and leadership qualities and respected for the experiences I bring."*

> *"I think one of the exciting benefits is seeing how these roles are able to mobilise teams and individuals by being a credible and supportive member of the team. I am very aware of how challenging it can be provide measurable evidence of impact of the role outside of a specific QI project and there is so much nurturing and supportive work going on that is probably most impactful but hard to show."*

In the NHS Long Term Workforce Plan, it notes the intention to “spread and embed future models of care that meet the needs of our population” (NHS England, 2023b, p. 91). 88%/ 152 respondents believed that by including ACPs in the service in which they work this has helped to reshape a service to make it more effective. However, nearly half of the respondents believed this could go further with more impact able to be achieved through better use of ACPs.

Figure 6.6 – ACPs involvement in reshaping services.

FQ15 - In your experience, by including ACPs in the service in which you work, or by shifting activity to ACPs in your team/ organisation that was previously done by others (e.g. moving tasks from medical colleagues to ACPs) has this helped to reshape a service to make it more effective? [n= 152]



“Development of the ACP role is a golden opportunity to re-design NHS services with novel services providing joined up care closer to home. Unfortunately, the Trusts seem to prefer to keep throwing more people at the same problems hoping that the outcome will be different. I've proposed 2 or 3 new services which would make a huge difference but the inertia is palpable from middle management.”

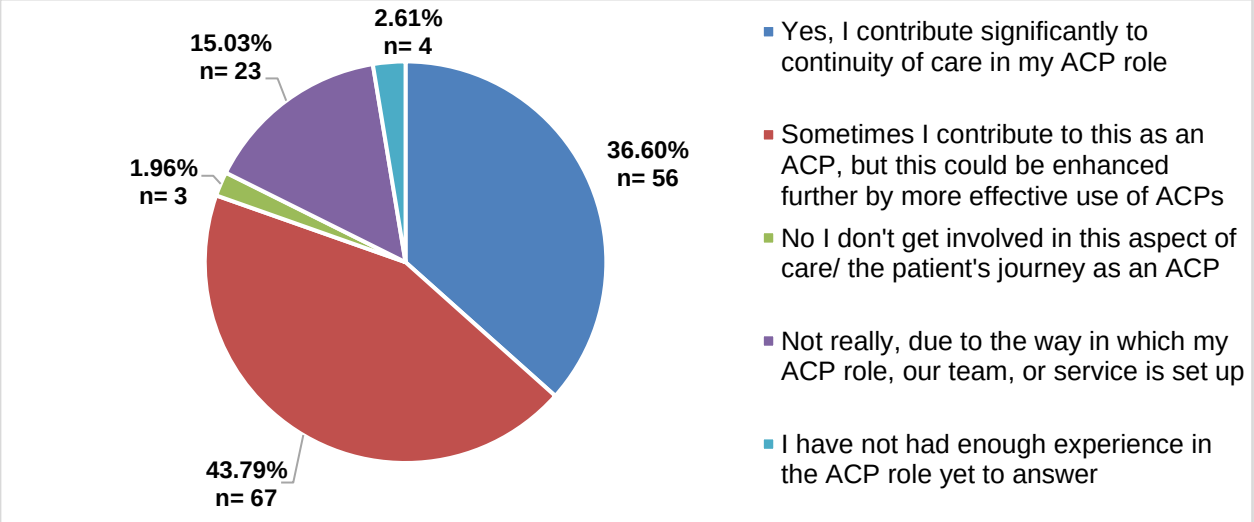
Expansion of ACP roles within multi-disciplinary teams has been identified as a key area of intended growth to “better meet the needs of patients, their families and carers” (NHS England, 2023b, pp. 90-95) (page 90). This approach was endorsed by the respondents to this questionnaire:

> *“I feel that the presence and the role of the ACP has huge benefits for patients and services. I believe that the role provides continuity and a much more holistic approach to the patients journey and experience.”*

In consideration of their role in providing continuity of care for patients and joining up or bridging services to make the patient journey more seamless, 80%/ 153 respondents said they contributed to this. The modal category was though ‘sometimes I contribute to this as an ACP, but this could be enhanced further by more effective use of ACPs’.

Figure 6.7 – ACPs contribution to continuity of care.

FQ13 - In your experience as an ACP, have you been able to enhance the continuity of care for patients; joining up, or bridging services and making their journey more seamless? [n= 153]



It should also be noted that 15%/153 said providing continuity of care was not part of their role due to the way in which the service or their team had been set up. Some potential reasons for this were given in the free text comments:

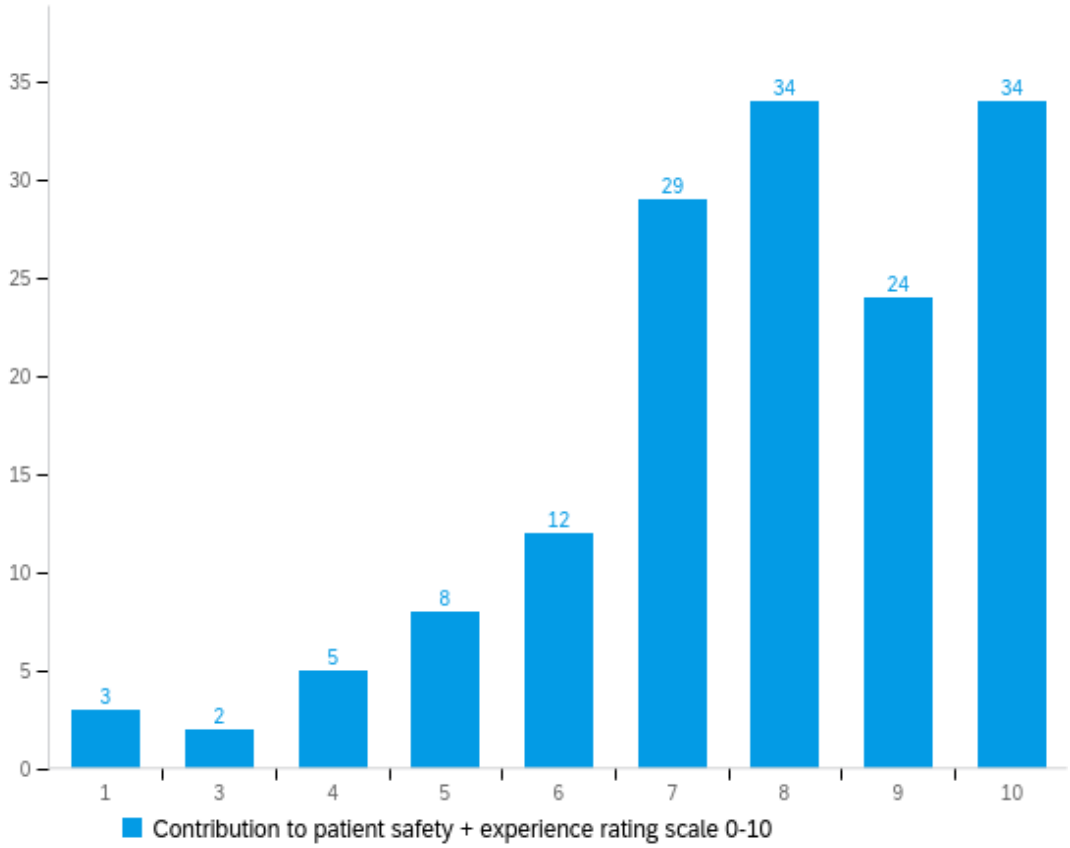
> *"No firm plans around job role makes it difficult to realise the full potential of the role. reluctance to develop new services or new models of healthcare is a real challenge."*

> *"Internal change is fully supported. External change e.g. pathways with other organisations is a block to supporting outcomes."*

The large proportion of respondents that did feel they contribute to continuity of care bodes well in terms of "better meeting the needs of patients" and is further endorsed by the response to the question about ACPs contribution to patient safety and patient experience.

Figure 6.8 – ACPs contribution to patient safety and experience

FQ16 - To what extent do you believe you have you been able to make a difference to patient safety and the patient experience in your role as an ACP? [n= 151]
Where…0 = not at all/ this is not part of my role and I don't feel like I make a difference and 10 = always/ this is the main focus of my role and I regularly feel like I make a difference



As noted in the focus group, and supported by Gulliford, Naithani and Morgan (2006), promotion of continuity of care is perceived to enhance patient experience and assist in maintaining patient safety, at the very least by not asking patients to repeatedly provide the same information. The majority of respondents gave a positive response regarding contributing to patient safety and experience; the mean was above the median point of the scale in the results for this question. As illustration of this, two respondents commented:

> *"I feel that the presence and the role of the ACP has huge benefits for patients and services. I believe that the role provides continuity and a much more holistic approach to the patients journey and experience."*

"The development of accps [Advanced Critical Care Practitioners] *in our service has made a significant impact to improve pt* [patient] *safety through the development of a senior rota."*

Whilst a high percentage (88%/ 151) scored 6 or more to this question, nearly 12%/ 151 did not see enhancing patient safety or patient experience as part of their role or felt they did not make a significant difference. As with other areas in the 'leading on quality improvement' theme, this provides a surprisingly mixed picture where it might be expected that localisation would not have such a significant impact on the ways in which ACPs are utilised to benefit patients, enhance services, and achieve positive outcomes.

CAREER PROGRESSION

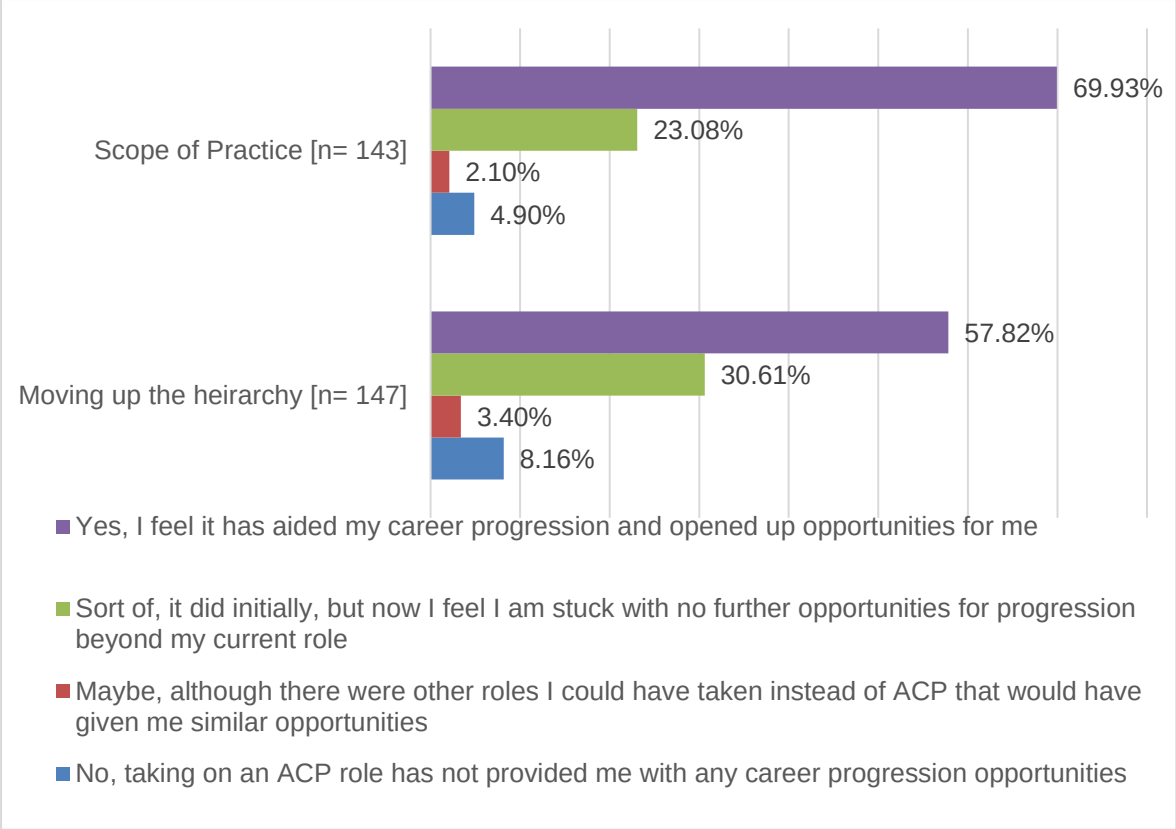
Both in terms of 'moving up the hierarchy' and broadening 'scope of practice', more respondents than not believed that taking on an ACP role had aided their career progression and created opportunities for them.

"ACP opens up so many opportunities. Best thing I ever did."

"Allowed me to progress as had previously hit a wall in development."

Figure 6.9 – ACPs view on opportunities for career progression.

FQ18 - For you, has taking on an ACP role provided you with career progression opportunities? This includes giving you opportunities to move up the hierarchy by getting a more senior role in your employing organisation, or to change the scope of practice you work in. (For example, changing the range of activities or services, or roles within your job that you are involved in that you would not otherwise have had if you had stayed in your previous role).



The majority affirmed that the ACP role had made a difference to their career progression. 70%/ 143 said that taking on an ACP role had opened opportunities to change their scope of practice. The majority (58%/ 147) also said the ACP role had helped them to move up the hierarchy. However, this still leaves the remaining 42%/ 147 either thinking it did initially make a difference but they now feel stuck, that it had not provided them with career progression opportunities, or, more rarely, that there were other roles they could have taken which would have given them similar opportunities.

> *"Feeling of glass ceiling to ACP role with only small hints of career progression opportunities, ACP achievement in first instance but depends then very much on employer whether further opportunity created."*

In the free text comments several barriers to career progression were highlighted including ambiguity or discrepancies in the route to follow, variable employer support for the role, profession or speciality specific barriers, and the limited range of job options available.

> *"Progression to 8b very unclear and different across specialties in the trust, no support to do further study/research/development post qualifying."*

> *"This is hard, not enough clear planning, strategy or joined up thinking organisationally and more widely, i.e. no clinical fellow or ACP leadership roles."*

> *"It is not widely understood in management and currently they are not really sure where my role fits within the wider structure."*

A set of questions then asked respondents to consider the impact of the ACP role on their finances.

Table 6.6- Financial impact of ACP role

Increase in salary? n=151		Positive impact on financial status? n=151		Is your salary reflective of your experience, responsibility, scope of practice? n=150	
Yes	72%	Yes	56%	Yes	45%
Not yet	12%	It has made no difference	36%	I do not have others to compare to	9%
No	16%	No, it has made it worse	85	No	46%

The majority 84%/ 151 had seen an increase in their pay or were expecting to see a rise once they had finished their training and 56%/ 151 said that taking on the ACP role had a positive impact on their financial status (e.g. pension benefits, opportunities for other paid work such as bank shifts, or reduced costs of working such as commuting to work costs). A small proportion said taking on an ACP role had made their financial situation worse. The examples given in the free text comments suggest this includes people that had not seen a pay rise (e.g., had been in an equivalent banded role such as a service manager before moving across into ACP), or had taken a pay cut to move into an ACP role. Examples were also given where they had taken on an ACP role but this had a negative impact on other aspects of their financial situation (e.g. increased commuting costs or limited opportunities for additional paid work). Examples were also given of disparity of pay bands given to ACPs within and across different organisations and statements often highlighted a difference between working in primary and secondary care. Comments were made that pay depended primarily on the organisation the respondent was working in, whether NHS pay banding was being used, how well established the ACP roles were, (including for all professions, not just for nurses), whether they aligned to the MPF, or whether their pay reflected any additional training or credentialling undertaken. Reference was also made to the limited opportunity to increase pay as people become more experienced in this role (e.g. after 5 years an upper limit on pay progression is reached). It should also be noted that only 45%/ 150 believed their salary or pay band reflected appropriately their level of experience, responsibility, and scope of practice in comparison to others working in their service. As noted in previous results, 86%/ 193 respondents reported they were being paid on band 7 or 8 which is the current recommended pay scale for tACP/ ACP (Centre for Advancing Practice, 2023).

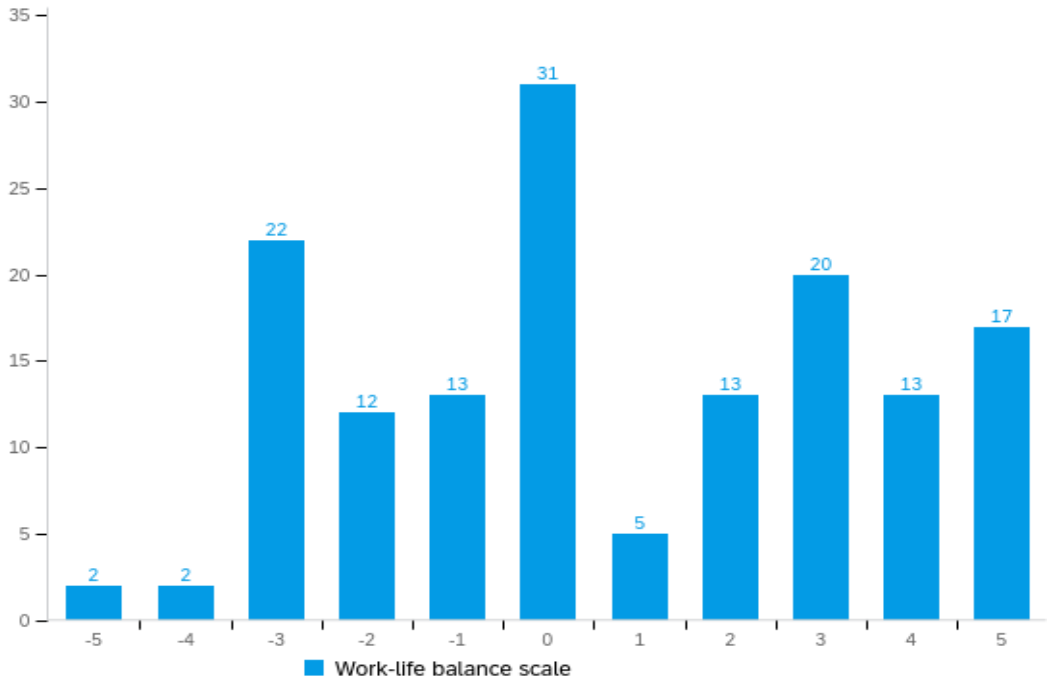
However, the focus group participants were also keen to note that pay or financial implications was not the only or primary factor in deciding whether to pursue ACP. When asked about work-life balance the results were broadly distributed but moderately positive.

Table 6.7- Work-life balance

FQ21 - To what extent does being in an ACP role enhance your work-life balance (For example, opportunities for flexible working, better shift patterns, or being able to better manage your 'outside work' commitments or hobbies)? [n= 150]

Instruction	Scale (min-max)	Mean	Standard Deviation
Move the slider along to what's fit best with your experience as an ACP	Where… -5 = it has made it much worse 0 = it has made no difference +5 = it has made a significant positive difference	0.71	2.75

Figure 6.10- Work-life balance scale responses



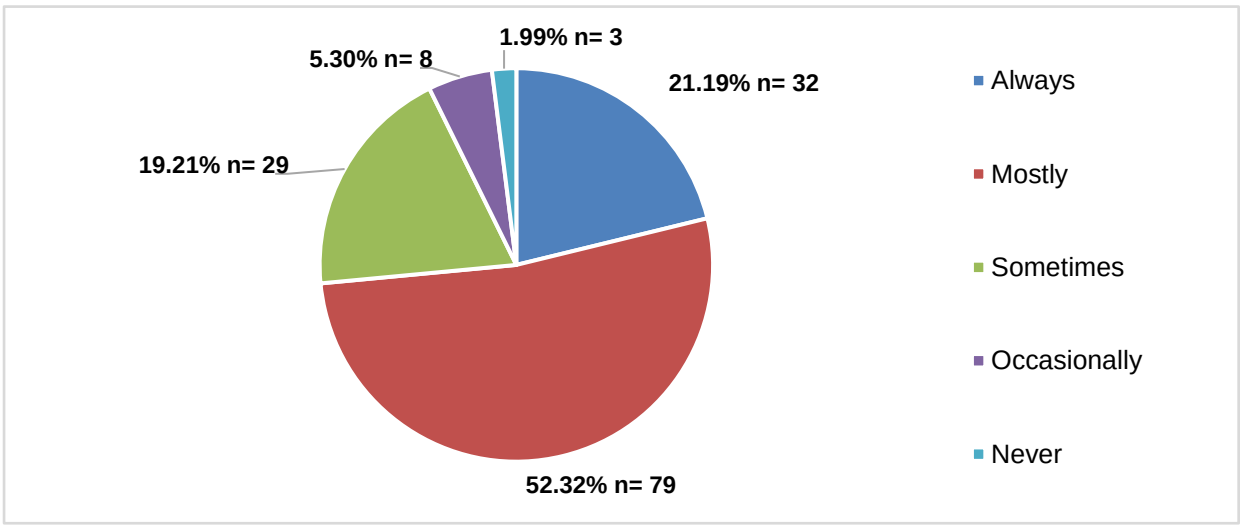
The results provide a limited indication that the ACP role is perceived to contribute to positive work-life balance, although for some this clearly had a significant impact.

> *"Whilst career progression is important, the role and move to primary care has helped keep me working. I have MS and was struggling with the physical aspect of hospital based care. This current role has meant I can still work, with less hours without taking a significant drop in pay."*

The aggregated results from the above questions regarding pay and work-life balance highlights a diversity of experience where assessment of whether taking on an ACP role will have a positive impact needs to be carefully considered at an individual level. As with pay, positive benefit for the individual cannot be guaranteed. This may to some extent also be influenced by the extent that ACPs 'feel valued'. The majority always or mostly felt valued in their role. This is despite 46%/150 believing their pay did not appropriately reflect their level of experience, responsibility, and scope of practice.

Figure 6.11 – ACPs perceptions of feeling valued.

FQ22 - Do you feel valued in your role as an ACP? [n= 151 responses]



In the open question about what or who contributes to the perception of feeling valued as an ACP, a range of responses were given which were clustered around particular individuals or groups as seen in the word cloud below.

Figure 6.12 –What or who contributes to your perception of feeling valued as an ACP?

[n= 117]

Also included in the responses were particular activities and actions taken by others that had made them feel valued.

> *"Feedback and inclusion in projects/ audits and also being valued by consultant supervisor who invests time and confidence in me."*

> *"Being listened to, being involved in decisions which affect my job role, being allowed time to complete admin tasks and study leave."*

> *"A effective PDR would be a great place to start. Valuing staff looks like knowing staff as individuals, truly understanding their role and appreciating the stresses*

of maintaining high quality services in ever stretched NHS, investing in developing them, speaking with kindness."

As exemplified by these quotes, good awareness of the role, feedback, understanding what ACPs can do and recognition of the training and experience that individuals have undertaken to get to this point were frequently cited as feeding into a *"sense of belonging"* and feeling valued. Alongside feeling valued, the responses regarding job satisfaction were largely positive.

Table 6.8- ACPs perception of job satisfaction

FQ26 Thinking about your experience so far, has being in an ACP role changed your level of job satisfaction? [n= 150]

Instruction	Scale (min-max)	Mean	Standard Deviation
Move the slider along to where fits best with your experience	-5 = it has made you far less satisfied in your job 0 = about the same as in previous roles you have held +5 = it has made a large positive change to satisfaction with your job	2.86	2.11

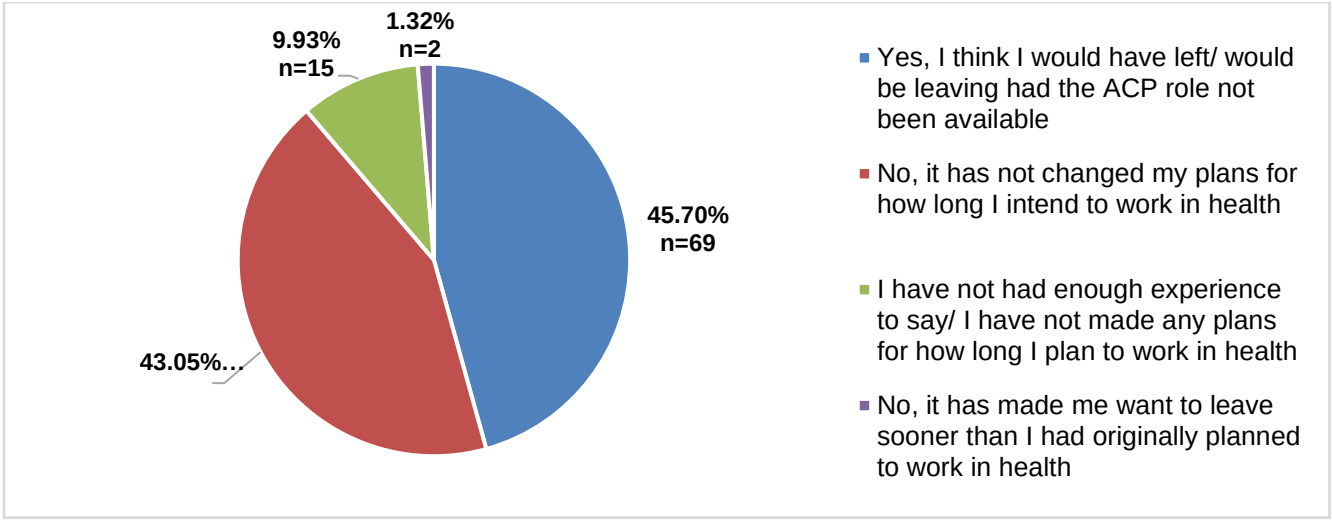
85%/150 of respondents placed the slider at 1 or more and 24%/150 placed it at the maximum of +5. In comparison, only 8%/150 of respondents placed it at zero (about the same as previous roles) and 7%/150 at minus one or below (worse job satisfaction). Individual experiences were cited by respondents as influencing their levels of job satisfaction. These included examples of personal financial impact, the ability to balance clinical and non-clinical activity, being given opportunities for training or involvement in service improvement, broadening their scope of practice and gaining greater autonomy, as well as organisational support for the role.

"I had a mid-life career change to nursing. I've progressed since I've made the change to ACP level. This is where I want to be until I retire - I get spend most of my days with patients, making a difference, and I get to influence positive change within our organisation. NEVER been as satisfied with my job as I am now. Acute Medicine provides ample interest and opportunities for me to develop within my role to keep me interested and engaged until I retire."

Perception of value and feelings of job satisfaction in the ACP role may be why 46%/ 151 (the mode) said that taking on an ACP role meant they had stayed working in health services longer than they would have done if this role had not been available. This is perhaps a powerful endorsement of advanced practice roles contributing to the 'retention' strategy as set out in the NHS Long term workforce plan (NHS England, 2023b, pp. 58-69). However, nearly as many also said that taking on an ACP role had not made a difference to their plans to stay working in health care (43%/ 151) or, more worryingly, a small number who said it had made them want to leave sooner (1%/151).

Figure 6.13 – Retention through the ACP role.

FQ25 - Has taking on an ACP role meant you have stayed working in health services longer than you would have done if this role had not been available? [n= 151]



This may be influenced by many of the themes and factors already discussed, as well as how the role is operationalised through policy and organisational structures.

> *"I feel my role is very unique and it has been a saving grace, being able to fully meet the 4 pillars has been a dream and I am much more motivated to continue working in healthcare as a result (previous ACP role was solely clinical practice based)."*

Overall, the 'career progression' data presents a mixed picture with a diversity of experience and perceptions about the role. This suggests that ACP is having a positive impact for many who take on this role, and this may be contributing to job satisfaction, 'feeling valued', and staff retention. However, due to significant variance in the responses given, multiple factors need to be weighed up at an individual level to take account of specific circumstances to decide whether becoming an ACP would be a good career choice for a person to make.

POLICY, VISION, STRUCTURE

The extent to which respondents viewed the organisational level support, structures, and investment in the ACP was addressed across several questions, where a mixed picture was evident from the results.

Table 6.9 Experience of ACP at an Organisational level

Organisational support (e.g. through team, mentors, role models or leaders) [n=148]		Organisational policy, processes, structure to support effective implementation of ACP? [n=146]		Organisational buy in [n= 142]		Long-term investment [n= 150]	
				Mean	5.94		
				StD	2.65		
Yes, I get good support	42.57%	Strongly agree	15.07%	>5	57.05%	Strongly agree	29.33%
Sometimes, although further development needed	41.22%	Agree	41.78%			Agree	46.67%
I have not had enough experience to say	1.35%	I have not had enough experience to say	3.42%	5	14.79%	I have not had enough experience to say	1.33%
No, I don't feel well supported	14.86%	Disagree	28.08%	<5	28.17%	Disagree	20%
		Strongly disagree	11.64%			Strongly disagree	2.67%

KEY

Positive	Neutral	Negative

The point of reference given for rating the level of 'buy-in' was whether their organisation gave opportunities to work across all four pillars, including involvement in clinical practice, leadership & management, education, research activity, and with an appropriate scope of practice and autonomy. One respondent summed up their experience by saying:

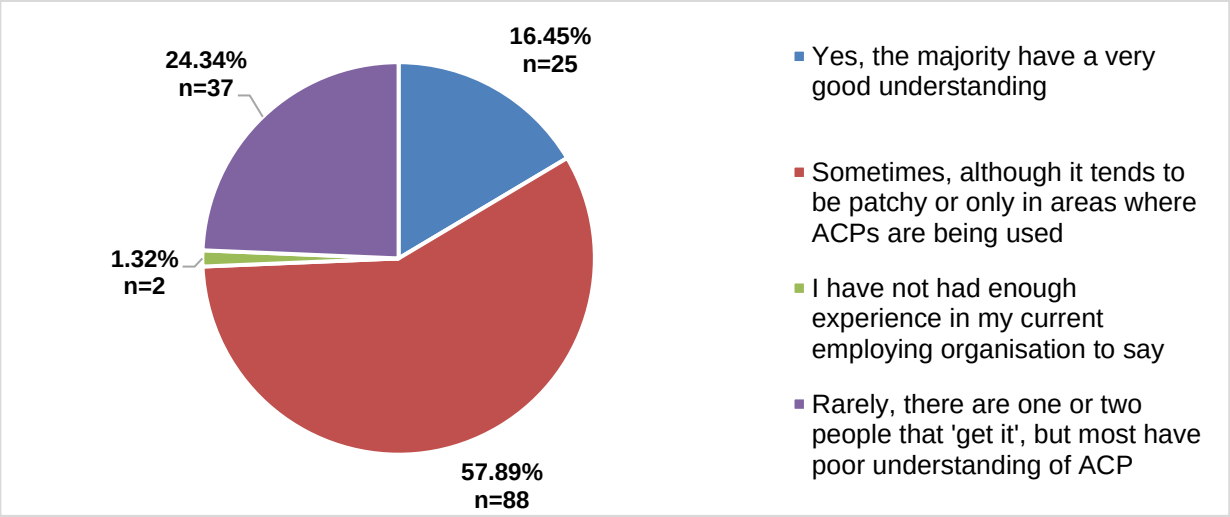
> *"I feel that ACP roles are very much an important part of the landscape of healthcare where I work. But feel that there is still a long way to go in my organisation, I think the ask/ need is there and recognised but not the vision/energy to achieve it."*

The responses provided regarding organisational policies, structures, processes, and buy in could be associated with the generally poor level of awareness of the ACP role in organisations. Only 16%/ 152 from the follow up questionnaire believed there was

good understanding of the ACP role, with the majority saying it was ‘patchy’ and nearly a quarter saying it was poor. These results reinforce conclusions drawn from other research and review of the current context in which this role operates (Palmer, Julian and Vaughan, 2023).

Figure 6.14 - Understanding of ACP

FQ28 - From your experience (e.g. from talking to colleagues or listening to managers) do you think there is a good understanding of the ACP role amongst staff and what they can do in your employing organisation/s? [n= 152]



This is exemplified by the following comment provided by one of the respondents:

> *“ACPs provide a wealth of experience, knowledge and skills which, from my experience, are not always recognised and appreciated by senior management. However, patients appreciate our input and ward staff benefit from the teaching and leadership we can provide. There needs to be wider recognition of the role, with a protected title, so patients, families, management, government etc are aware of the role and acknowledge the advantages of having ACP's.”*

In the free text comments, lack of awareness by particular groups of individuals were mentioned and came from the same groups identified in the question about who made the respondents feel valued; namely patients, medical colleagues, and management.

> *"Huge potential for benefit to patients and staff, but needs cultural change with medical teams and clarity to employers about what an ACP is, does and where we are going."*

They also noted the detrimental effect that lack of awareness of the role can bring, which often comes with active resistance to ACPs being able to operate their role effectively. The experience encountered by one respondent gives an illustration of this.

> *"There is still some lack of understanding and resistance to our role. Only yesterday I had a referral rejected because I am not a doctor and was told (in writing) to discuss it with a GP. This didn't take into account the reason for the referral and only affects the patient. Anecdotally, I know of several clinicians who have experienced similar issues just for the referral to be accepted when their doctor colleague submitted the same referral. Last month I was in a meeting in the PCN where a senior GP (not from my surgery (and they don't have any ACPs) started testing my clinical knowledge out of the blue, in a rude fashion asking how many nephrons are in the kidney and what are the names of the coronary arteries. They were also under the impression that we are not given enough A&P* [anatomy and physiology] *knowledge to prescribe. This I feel highlights some of the resistance the ACP role faces."*

The appointment of Advanced Practice leads has been used to promote awareness of and support for ACP roles. They are expected to act as "*a representative at board level who can advocate for effective advanced practice implementation and can help ensure it stays as a priority on the workforce agenda*" (NHS Employers, 2023b). Respondents endorsed the key role that ACP leads can play.

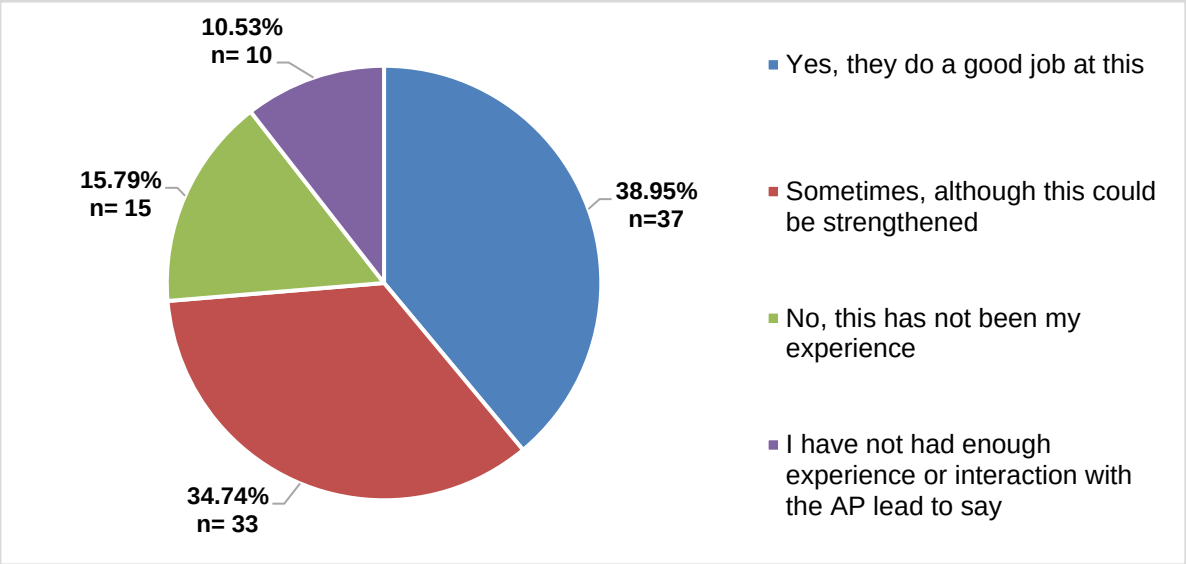
> *"New Trust ACP lead has opened the doors to developing ACPs in my trust - key for support and ACP development."*

In this questionnaire, 64%/152 were aware of there being an ACP lead in their organisation, with 7%/ 152 (n=10) identifying themselves as the ACP lead. However, only 39%/ 95 felt that their Advanced Practice lead did a good job of acting as a role model or championing the ACP role in their organisation.

> *"Unfortunately it appears senior management in my organisation are not fully aware of what the ACP role involved. For example, during a recent conversation with the Clinical Director it was clear she had no idea ACPs were able to prescribe! The ACP lead also lacks insight in the role and is therefore not able to advocate for us at a senior level."*

Figure 6.15 – ACP lead roles' performance

FQ30 - From your experience do you feel your Advanced Practice lead acts as a role model or champions the ACP role within your main employing organisation? [n=95]



At a broader, organisational level, 43%/ 148 said they felt well supported in their employing organisation in their ACP role (e.g. within their team or through other mentors, role models, or leaders).

> *"My organisation has implemented some innovative workforce plans to secure agreement to implement 8 AHP and 7 nursing ACP roles within the division I work in. There are challenges to providing supervision to such a large group of new ACP roles but systems are in place to support…..I feel supported through the vision and policy."*

Whilst some examples like the one above were given, the results to these last two questions highlight a significant population of ACPs who do not feel well supported, and who may not have good role models and advocates they can refer to locally. This could be because implementation of ACP is in the early stages.

"The ACP role is quite new to the trust they have started writing policies, but they are not in place yet."

"The Advanced Clinical Practice strategy has only just been finalised and is awaiting a formal launch. However, there are signs that there is buy-in and interest from senior levels in the organisation around this. I'm confident that things will accelerate from now onwards, but still early days."

Whilst potentially in the early stages of development, respondents noted how quality assurance of the role can and should come through development of governance processes using standardised definitions of ACP and policy documents to reduce inequity in how ACP roles are utilised, recognised, and rewarded.

"There is a large discrepancy in the way ACPs are used and supported by different organisations."

"My organisation had nothing in place to guide the educational development/supervision to develop the role. It had no policy, no standardised competencies to support the development of the role."

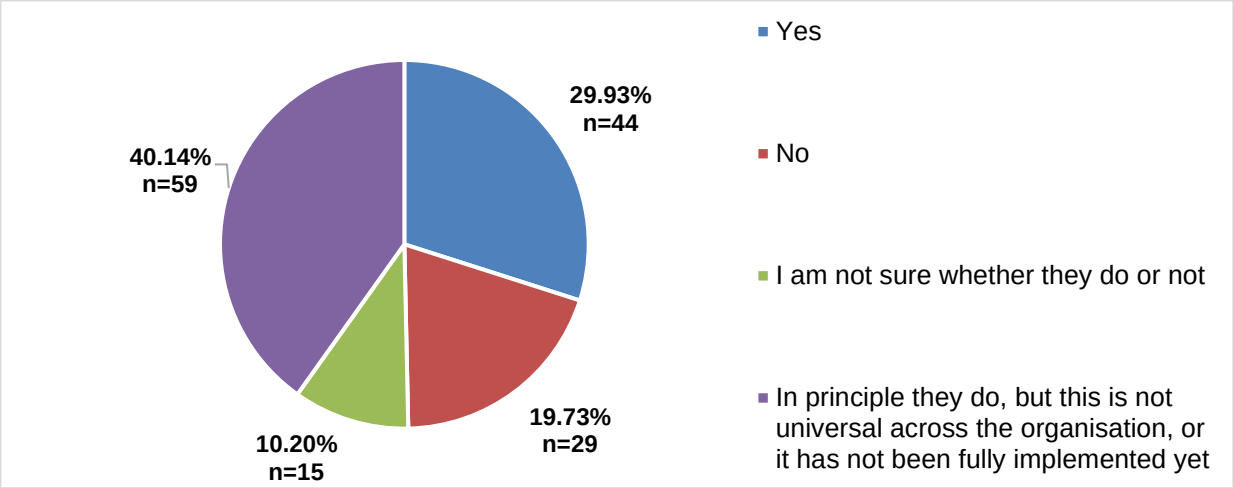
In terms of 'quality assurance' the MPF was used as a reference point in the next question. 70%/ 147 of respondents were in organisations where they believe quality assurance to some degree was being applied or implemented. This reinforces earlier responses where 74%/ 191 of respondents believed their role mapped fully to the MPF, although it should again be noted that 34%/ 191 said they had not undergone formal mapping.

Figure 6.16 – Quality Assurance of the ACP role.

FQ34 “Health Education England, along with other professional organisations, provide a definition for Advanced Practice roles in the ‘Multi-Professional Framework for Advanced Practice in England’. This sets down expectations about the training/ education qualification requirements and capabilities you are required to demonstrate to work at this level.

Are you aware of your employing organisation **quality assuring** the ACP role by mapping or reference to particular policies or standards?

(For example, they restrict the use of the ‘Advanced Practice’ job title to only those that meet a set of externally agreed criteria like the Multi-professional framework for Advanced Clinical Practice in England.)” [n= 147]

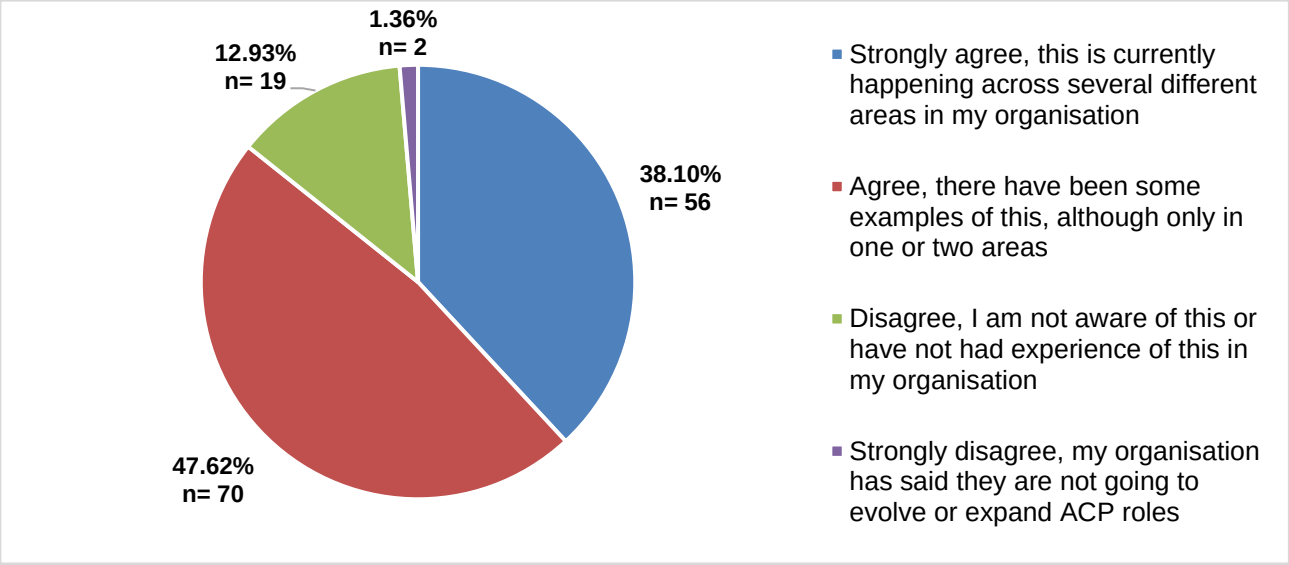


This result also endorses responses to other questions (e.g., pay banding, access to non-clinical activity to address all 4 pillars, making a contribution to continuity of care). It appears the experience of most ACPs does meet to some extent the expectations of the MPF, but there is a cohort that is not ‘quality assured’ and not yet experiencing the ACP role as it would expect to be according to national policies and guidance.

When relaying their experiences and expectations regarding ACP, flexibility to evolve the role over time was a common theme from the focus groups. This experience was also endorsed by the respondents to the follow-up questionnaire where 86%/ 147 said they had examples of this happening in their organisation. Only 2 respondents noted their organisation was not going to evolve or expand ACP roles.

Figure 6.17 – ACP as an evolving role.

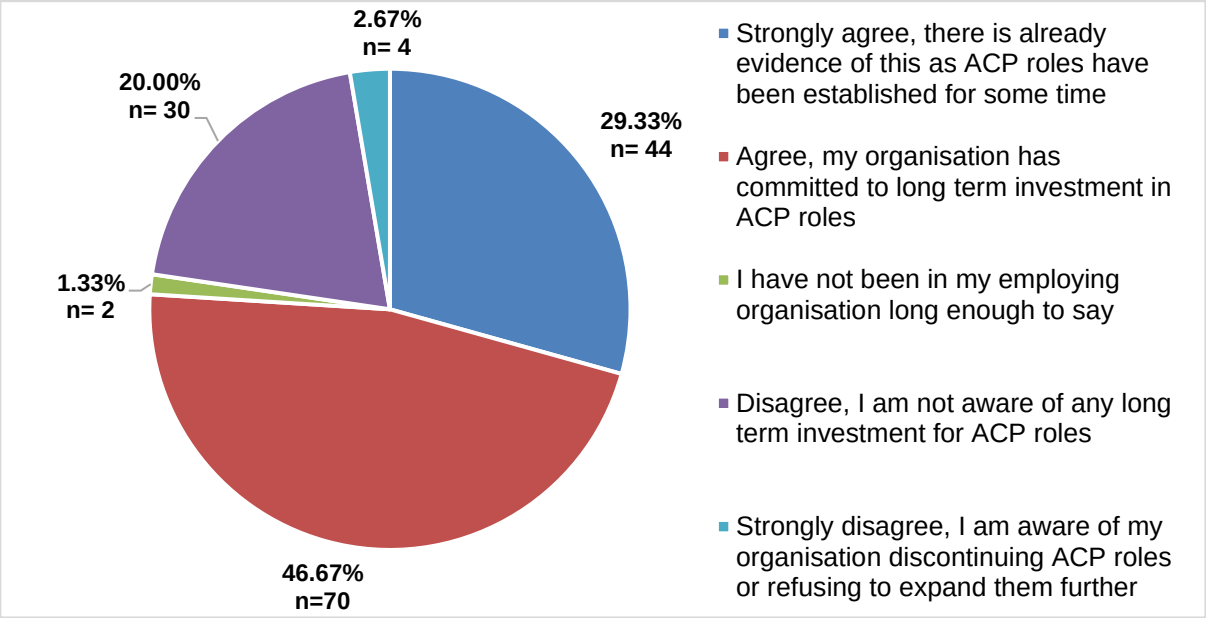
FQ35 - From your experience, has your employing organisation/s been supportive of the ACP role evolving or being adopted more broadly to adapt to new service or patient population needs? [n= 147]



Further positive news came from the question regarding long term investment in ACP roles where 76%/150 of respondents strongly agreed or agreed that their organisation had committed to this.

Figure 6.18 – Long-term investment in ACP.

FQ36 - Thinking about what you have seen, heard, or experienced, would you say there is long term investment in supporting the development of ACP role in your employing organisation/s? (You can select more than one answer). [n= 150]



As a key growth target specifically set within the NHS Long Term Workforce Plan (NHS England, 2023b) this is an encouraging result for the expansion of ACP roles, although there may be other factors which may curtail achievement of the intended growth.

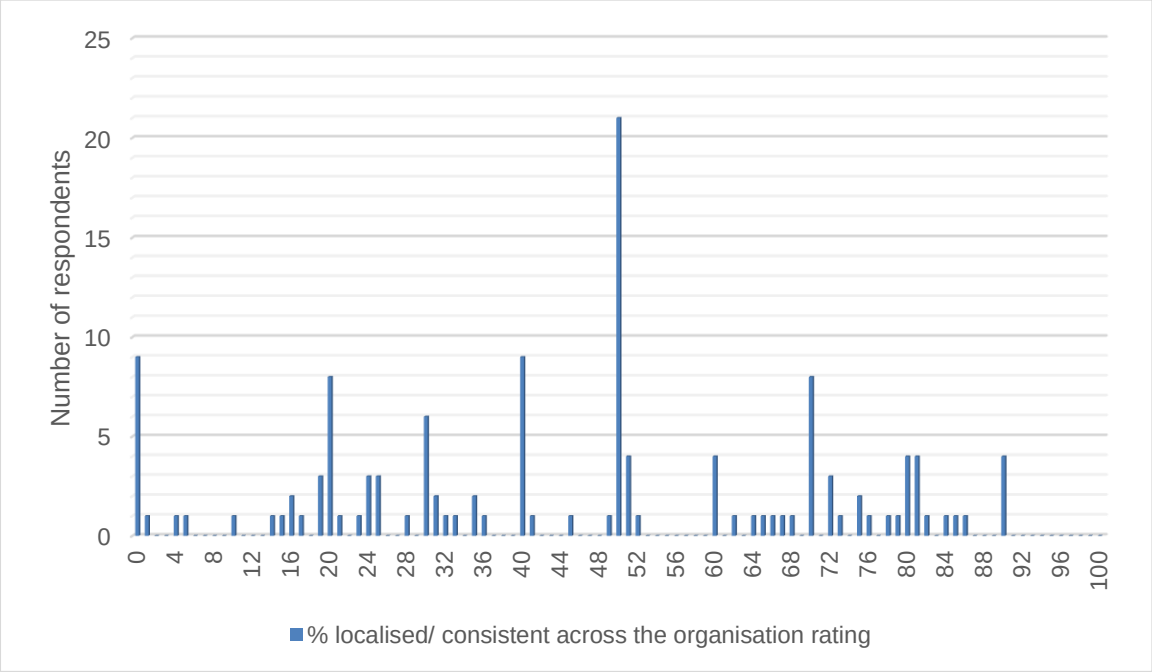
> *"There has been a lot of support to develop the ACPs within the organisation, however there remains a strong barrier with medics supporting ACP's to develop in some areas, and as this is new to the organisation, there is a lack of appropriately qualified ACP's to support all the trainee's. This needs to be strengthened."*

These potentially more localised factors were identified as potentially influential to the successful implementation of ACP roles in previous research (for example (De Bont *et al.*, 2016). Respondents were therefore asked about the extent to which there was a consistent approach to the operation of ACP roles in their employing organisation.

Figure 6.19 – Localisation of the ACP role.

FQ37 - To what extent is your ACP role being operated differently at a local level as compared to other teams/ services in your employing organisation?

Move the slider along to the best fit for the percentage that ACP roles are operated at a local rather than a consistent way across your organisation, (as far as you are aware). For example; 100% -all ACP roles operate in the same way across your employing organisation. 50% - there is an even balance of some aspects being specific for your team and some that are the same across the organisation. 0% -it is entirely local and bespoke for your team/ service. [n= 137]

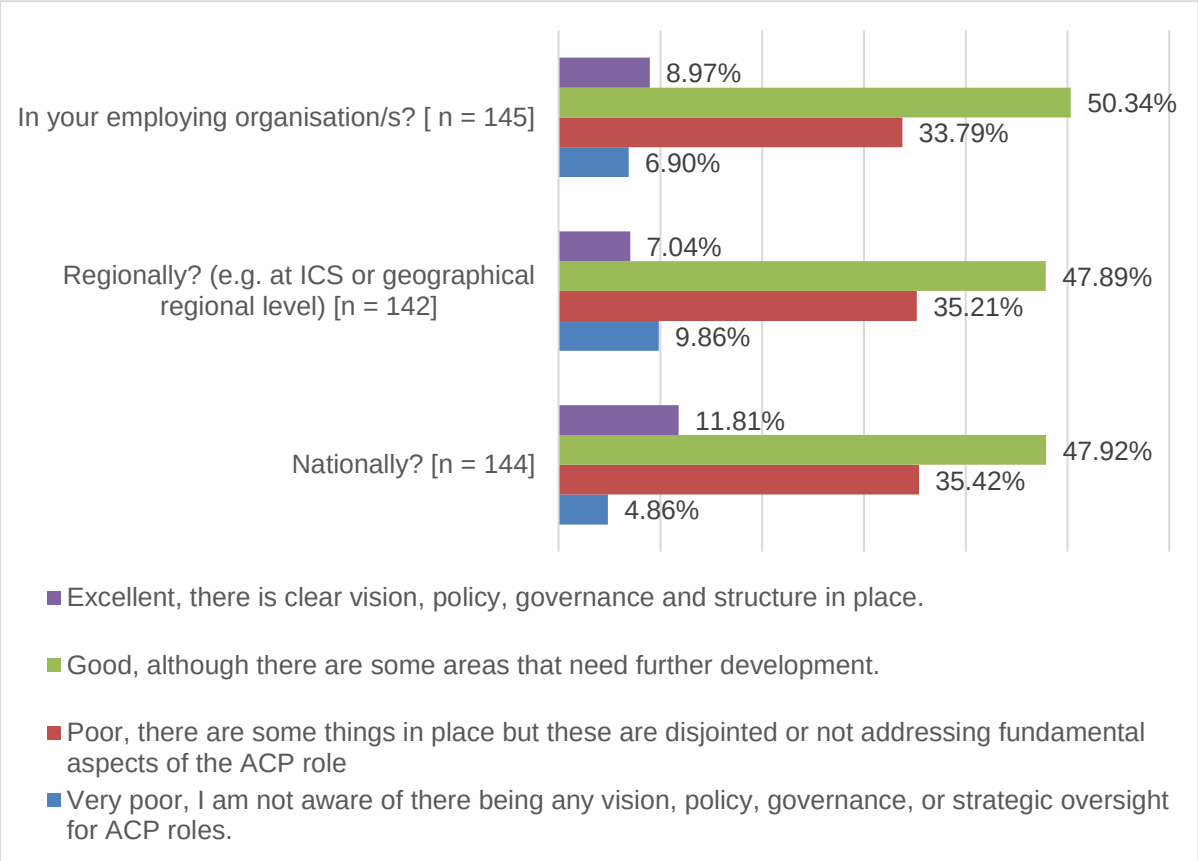


50%/ 137 was picked by the largest group (mode n= 21) but as can be seen from the bar graph above there was also a wide spread of responses given; the mean was 47.10 and standard deviation 26.81. Relatively little can therefore be concluded from this data, except that there is a mixture of localisation and standardisation in the way in which ACP is being implemented in organisations.

As a broader judgement regarding the policies, governance, and strategic oversight of ACP roles, respondents were asked to rate this at a local, regional, and national level.

Figure 6.20 – Policy, governance, and strategic oversight of ACP.

FQ38 - From what you have experienced in an ACP/ trainee ACP role, how would you rate the current policy, governance, strategic oversight for ACP roles?



With the majority of responses being in the 'need further development' or 'not addressing fundamental aspects' at all levels, there is a gap here between what is expected and the reality of practise as an ACP. This is exemplified by the free text comment given by one of the respondents:

> *"As an organisation we are utilising ACPs well. We have a fully qualified ACP paediatric nurse and myself (ACP paramedic) we have a trainee ACP (pharmacist) and a specialist mental health nurse who will be undertaking the ACP MSc in September this year. At local level the PCN* [Primary Care Network] *don't seem to want to invest in PCN staff to do the ACP route. Nationally, as I've described in a previous question, there is not equality across practice e.g. an ACP nurse can prescribe CDs and complete meds* [medication reviews]*, an ACP paramedic cannot."*

SUMMARY QUESTION

Finally, respondents were asked based on their experience of the ACP role so far

Table 6.10 – Realisation of ACP expectations

FQ40 "overall, would you say your expectations of the benefits of the ACP role have been realised from your current experience of the role so far". [n= 145]

Instruction	Scale (min-max)	Mean	Standard Deviation
Move the slider to what fits best with your experience so far	0-10 Where… 0 = my expectations have not been met at all 5 = the role is delivering as I had expected it would 10 = my expectations of the benefits of the role have been exceeded	6.6	2.23

Only 18%/ 145 scored 4 or less, suggesting that for the majority their expectations had been met, or to some extent had been exceeded. The respondent below provides a summary of their experience that reflects many of the themes and responses given;

> *"Currently on the MSc pathway, currently year 1 and it's a lot of work - would be lovely for the title to be more protected and valued for the work that we have to do and level of learning that is required. Security and better pay banding more recognised ACP are to support the work force, recognition is needed locally and nationally. If I was not on this course, I would probably have left my practice nurse role, I am really enjoying the step up in advanced training and very grateful for HEE providing funding as I would not* [be] *able to do it otherwise. It's an exciting time I am lucky to have the support of my colleagues in my surgery where I know not everyone does on my course."*

DEEP DIVE

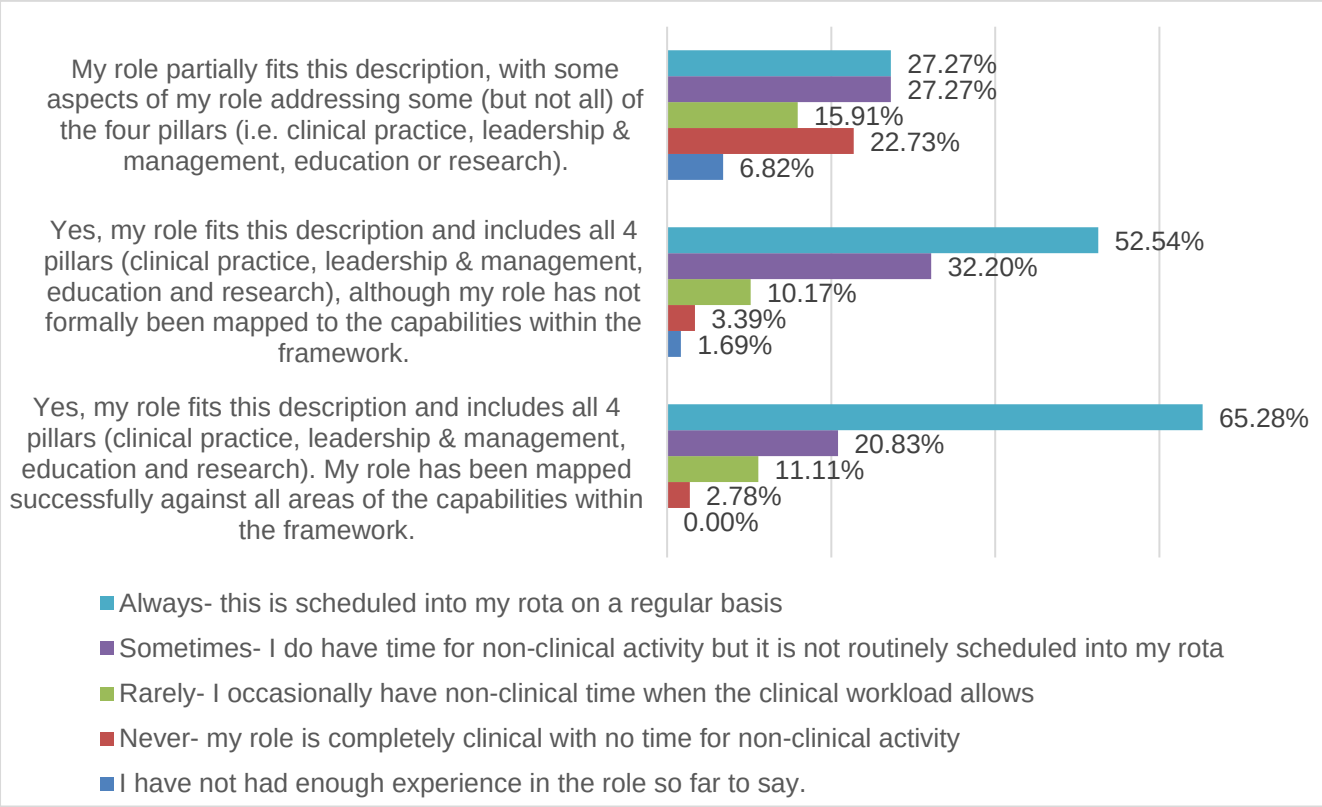
Within Exploratory Data Analysis the aim is not to identify data to test hypothesis (taking a confirmatory model to analysis) but to explore relationships between variables and identify unusual patterns. In terms of 'unusual patterns' Hartwig and Dearling (1979) described this as separating out the rough from the smooth. The smooth is the "underlying, simplified structure of a set of observations" that have been taken from exploring the data. The 'smooth' for this study has been provided above under the 5 themes from the focus group and follow up questionnaire. The 'rough' is recognition that data almost never conforms exactly to the smooth. We can learn more by bringing into the light those areas that don't quite fit with generalised characteristics of the data.

As discussed in chapter 4 the ‘deep dive’ questions have been chosen as they use a factor that could be changed in the organisational structure of an ACP role as opposed to responses that can be more influenced by perception of the individual ACP. I identify below characteristics of the data that did not quite fit with the patterns of results presented under the themes above. I did this by exploring the data from the demographic questions (QB) in the follow up questionnaire with data from a question under each theme (FQ) using the data analysis schema set out in appendix 14.

When exploring the ‘clinical’ theme, the data were examined to see if any appeared to deviate from the finding that the majority of ACPs do get time for non-clinical activity, although it is often not scheduled into their rota. The group who said their role partially fits with the MPF and addresses some but not all of the 4 pillars, were more likely to say their role was entirely clinical. 23%/175 in this group said they had no time allocated for non-clinical activity as opposed to 3%/175 of those who said they had been fully mapped and fitted the MPF description.

Figure 6.21 – MPF mapping and non-clinical activity.

FQ2 - In your role as an ACP/ trainee ACP, do you regularly have time for non-clinical activity, (i.e. activity that does not involve direct physical interaction with patients, either face-to-face or through telephone/ video communication)? [n= 175]



Respondents who declared they are paid at band 6, although a small proportion of the total number of respondents to this questionnaire (5%/ 193, n= 9), answered in equal amounts that they do get scheduled non-clinical activity time and that they rarely got non-clinical activity time (and only when clinical workload allowed). Those paid at band 6 were also more likely to be;

- in a tACP role,
- have had fewer years in their profession and role as an ACP/ tACP,
- to select that their training has thus far been through ‘on the job’ activities rather than a formalised programme of study (e.g. MSc in Advanced Practice).

In relation knowledge, skills, and experience (KSE), patterns were explored for the question regarding whether they had a generalist/ specialist role, noting that this question asks about the types of KSE they primarily draw upon in their role.

> *FQ6 - Would you describe your role as primarily in a 'generalist' or 'specialist' field of practice? Generalist being where you primarily use a core set of generic skills such as clinical assessment in a range of patients or health care settings, and specialist where you provide patients with access to a specialist service drawing upon advanced knowledge, skills, and experience built up over time in a particular field.*

There were some regional differences where in some areas they had placed specialist first and generalist last. Those working in community and primary care settings fitted closest to the overall trend of putting generalist 1st, a mixture of generalist/ specialist 2nd, and specialist last. As primary care constituted the largest group of respondents this may have influenced the overall data. However, the next largest group of respondents were in ‘other’ specialities and here they ranked ‘specialist’ KSE first. There were no other unusual patterns of note from running data and visualisations for KSE combined with the background (QB) questions.

Under the ‘Leadership in quality improvement’ theme Band 6, those in trainee roles, and ACPs with shorter periods of time in this role were more likely to say they had not been in role long enough to say whether they provide a consistent and coherent presence in their service. AHPs & pharmacists were also less likely to respond ‘strongly agree’ to this question and more often selected ‘agree, although this is also provided by others in my service/team who are not ACPs’.

Table 6.11 – Profession and consistent and coherent presence

FQ14 - In your current ACP role do you provide a consistent and coherent presence within the service in which you work, (e.g. more of a constant member of the team where others may rotate in/ out)? [n= 150]

	Allied Health Professional/ HCPC n=35	Pharmacist/ GPhC n=1	Nurse or Midwife/ NMC n=114
Strongly agree	34.29%	0%	60.53%
Agree, although this is also provided by others in my service/ team who are not in ACP roles	51.43%	100%	28.07%
Disagree, I have not been in the role long enough to provide this	11.43%	0%	6.14%
Strongly disagree, this is not how my role operates in my service/ team	2.86%	0%	5.26%

KEY

Positive	Neutral	Negative

In the ‘career progression’ theme, I explored whether any groups were more or less likely to have seen an increase in their salary. Overall there was 84%/151 of respondents who said they had seen an increase or were guaranteed one when they complete their training as an ACP). In the ‘deep dive’ for this question there were a large number of unusual patterns discovered here:

- In some regions 100% had received or were expecting an increase in salary or banding on the pay scale (South Central n=8, North East n= 6 & other areas not specified n= 3). However, in London (n= 13) only 54% had received an increase; the remaining 46% answered no to this question.
- 100% of those not on NHS pay banding (n= 5) said they had received a salary increase.

- 97%/ 32 of those with a portfolio career (i.e., holding more than one job role or with more than one employing organisation) had received or were expecting an increase in pay following completion of their training.
- Nurses were more likely (88%/ 114) than AHPs (76%/ 34) to have received/ were expecting a pay rise, although we do not know whether the AHP respondents' previous salary was typically higher than Nurses.
- Some ACPs working in particular specialties had not seen pay increases (Learning Disability n= 9, Community Pediatric n= 1), and of those working in Radiotherapy only 33%/ 4 had seen an increase.
- ACPs that said they only partially fitted with the MPF description of ACP and do not address all 4 pillars in their job roles were less likely to have received or expect to receive a pay rise; 26%/ 34 said they had not seen an increase in their salary or pay banding.
- ACPs that had been 10+ years in their role (n=10) were also less likely to have seen a pay rise; 60%/ 10 (as opposed to the general pattern of 84%/ 151) said they had received an increased salary or pay grade since becoming an ACP.
- ACPs that had received their training through an MSc (n=76) and/ or a credentialling programme (n= 10) were more likely (90%/ 151) to have received an increase in salary. In comparison only 50% of respondents who had no formal ACP training (n = 37) said their pay had increased.

In relation to the 'policy, vision, structure' theme whether or not an organisation was 'quality assuring' ACP roles (e.g. by mapping to the MPF) was further explored. The general pattern for this was that 70%/ 147 of respondents are in organisations where they believe quality assurance to some degree was being applied or implemented. Again, there were several atypical patterns noted in the data.

- Quality assurance/ mapping was more apparent in some regions than others For example, South Central 50%/ 8 answered no to quality assurance being in place, whereas in the West Midlands 100%/ 11 said they were fully mapped or that in principle the organisation was undertaking a quality assurance process but that it had not been fully implemented yet.
- Those in band 6 posts (n= 8) were less likely (38%) to be in an organisation that was providing quality assurance for ACP roles through mapping to policies or standards such as the MPF.
- No Pharmacists (n= 2) and 64% of AHPs (n= 33) said their roles had undergone mapping or were in organisations where this had at least been partially implemented; for nursing it was 72%/ 111.
- There was also a large amount of variation when this is broken down by specialty. In the biggest group for specialty, primary care (n= 52) had only 56% who said they were in organisations where they believe quality assurance to some degree was being applied or implemented.
- Respondents who said their role partially fitted with the MPF description (n= 33) were more likely to say either they did not know about their organisation's approach to quality assurance (18%) or there was no quality assurance/ mapping in their organisation (33%).

SUMMARY

This concludes the results analysis for the follow up questionnaire. These results will now be synthesised to form a narrative discussion (chapter 7), which will be followed by exploration of potential inferences and recommendations that can made from this study (chapter 8).

CHAPTER 7- DISCUSSION

INTRODUCTION

In drawing together the results from this research I have revisited the findings from the systematic literature review, focus group reflexive thematic analysis, and both the recruitment and follow-up questionnaires. I have drawn upon my reflective diary to develop the notes and insights I gained along the way to cultivate the discussion points contained within this chapter. I have also kept abreast on more recent publications in the field of Advanced Practice and have integrated these where relevant in the discussion below. This approach is in keeping with Braun & Clarke's suggested approach for the 'writing up' stage of rTA where it is expected that; "*This final phase involves weaving together the analytic narrative and data extracts, and contextualising the analysis in relation to existing literature."* (Braun and Clarke, 2022) Although more commonly used within systematic literature reviews, Lisy and Porritt (2016) refers to this as 'narrative synthesis' where different sources of evidence are integrated to form and present a view and the research questions are returned to for exploration as to whether they have been answered. There were many other avenues for exploration that arose during the period of this study, but in keeping with the underpinning philosophy of this research, I have chosen in this discussion chapter to explore the 5 main themes taken from the focus groups. This continues to 'give voice' to the areas identified by ACPs that they saw as significant to their experience to answer the research question posed regarding what were the expectations they had regarding the personal benefits of their role and from analysis of the data provided whether their expectations are being realised? Before launching into discussion of the 5 themes, it is though worth noting some key features drawn from the demographic and contextual data collected.

A PICTURE OF THE ACP COMMUNITY

From the recruitment questionnaire to the follow up questionnaire there was consistency in the demographic data. This has shown there is a diverse population of ACPs currently working in the UK, but there are also some trends that indicate aspects of the ACP experience which are common. For example, although collected almost one year apart, there were similar proportions in both the recruitment and follow up questionnaires of ACPs who had worked 1-3 years or 10+ years in this role. This consistent data provides insight that could be used to identify where further attention is needed to achieve the desired development of ACP in the UK. The ACP population is expected to grow (NHS England, 2023b). Whilst there was a large proportion of participants in my research who said they were 'in training', and so are creating a pipeline for new ACPs, there was also a significant group who are already at a late stage in their career. It is therefore unclear if the ambitious net growth targets set in the Long-Term Workforce Plan can be achieved based on the current picture of people working or training in ACP and those that may be looking to retire from the role in the next few years. This is particularly concerning when there has been a dramatic increase in the number of staff retiring from the NHS (Torjesen, 2022).

My research has also identified that there is a potential tension between the 'generalist' and 'specialist' nature of ACP. Mann *et al.* (2023) endorsed the view that ACP is seen as a combination of generalist and specialist skills. However, the data from the follow up questionnaire suggests that clinical settings which draw upon primarily 'generalist' knowledge, skills and experience currently dominate with primary care being the largest of these. This potentially highlights either:

- that generalist settings fit best with the range of knowledge, skills, and experience ACPs typically possess, or
- that the demand for ‘generalist’ ACP roles is higher and more job roles have been created in these settings (such as primary care), or
- the use of ACPs in specialist services is less valued or is at an earlier stage of development.

These theories certainly echo with the ambitions of the NHS Long Term Workforce plan (NHS England, 2023b, p. 91) where ‘generalist and core skills’ are prioritised. The dominance of Nursing professions in taking up ACP roles may lend itself particularly well to the generalist ACP. In the recruitment questionnaire 78%/ 205 were Nurses, and 74%/ 208 were Nurses in the follow up questionnaire. This compares to the NHS workforce which is approximately 68% Nurses, 32% AHPs. This could be explained by the fact that ACP roles developed first in the UK for Nurses and there are some ACP posts that remain only open to Nursing staff to apply (Rolewicz, Palmer and Lobont, 2022; Snaith *et al.*, 2023). The lack of ACP roles in some professions and specialties perhaps highlights the lack of development, opportunity, or need for ACPs within some settings. This may be because there are alternate preferential career options available for ‘ACP’ roles or because Advanced Practice activity has not been labelled as such in these specialities, thus meaning people in these settings do not identify themselves as ACP.

The largest participant group in this study said they were working in Primary Care, followed by ‘other’. The dominance of these very broadly defined ‘specialities’ perhaps highlights that the teams that people now commonly work in do not fit within traditional specialty boundaries. The dominance of ‘other’ and ‘primary care’ specialities reflects

a changing orientation and focus which may have arisen due to population need. As an example, there was a large group that said they were working in frailty services and Walsh *et al.* (2023) noted there has been a large increase in the prevalence of frailty in an ageing population. Walsh *et al.* analysed data from 2006-2017 which does not take account of any additional demand post-pandemic for supporting people with frailty resulting from NHS backlogs or due to long-covid. This suggests that newer or expanded services, such as in frailty or primary care, will require more bespoke, potentially reactive, innovative, specialist and multi-professional ACPs, or a wider mix of staff working at different levels and scopes of practice to address population needs.

From the data collected, there appears to be some standardisation being experienced in ACP, particularly around pay. Conversely, there continues to be proliferation of different job titles being used (Leary *et al.*, 2017) and most people working in ACP roles have not completed a defined training programme (MSc) and have not been through a formal process to assess their ACP capabilities. In both the recruitment and follow up questionnaires this disparity was highlighted where 45-46% said they were currently in a training or development programme but only 16-19% said they were in a trainee ACP role, and overall, only 30% had achieved a Masters qualification. This indicates there is a large proportion of people who are working in ACP roles without the underpinning expected academic qualifications.

A nationally agreed process for verification of people who meet the ACP definition has been implemented through the CfAP. This is intended to provide assurance that people working in ACP job roles in England meet set criteria. In the follow up questionnaire 100% believed they fitted or partially fitted with the definition of ACP as set out in the MPF. However, only 40% had gone through a mapping process and had

been found to fully meet the criteria. Despite this, there was a continued belief that they met the definition of working at Advanced Practice level. Increased awareness of the MPF and employers now only endorsing staff that have been verified as meeting the MPF requirements, may mean that participants are getting a clearer understanding of whether they have been mapped or not. However, participants self-selecting to respond to the questionnaire only if they already believed they were an ACP highlights the risk that all believed they were bona fide ACPs, but this had only been externally verified in the minority. For people who are not working as expected across all 4 pillars of the MPF. this also potentially threatens their satisfaction and retention in the role.

> *"being able to fully meet the 4 pillars has been a dream and I am much more motivated to continue working in healthcare as a result (previous ACP role was solely clinical practice based)."*

The CfAP verification process may help to achieve a better understanding of the ACP community in England. However, data on the numbers of verified ACPs is only just starting to be collated at a national level. A study by Fothergill *et al.* (2022) collected data from 4013 ACP staff in 2019 which was after the introduction of the MPF but before CfAP programme accreditation had fully begun. One of their main conclusions was that there is an inconsistent governance framework for ACP. In the absence of verification of ACP there will continue to be a population of people that believe themselves to be ACPs without having gone through a verification process due to:

- incomplete accreditation of all ACP programmes,
- limited numbers that have completed accreditation through the e-portfolio route,
- proliferation of unregulated job descriptions, and
- no protected title for Advanced Practice.

The picture of who makes up the Advanced Practitioner workforce, whilst contributed to by recent surveys and the results of my research, therefore remains unclear. We do not know how many people in England have been verified through the CfAP accreditation processes, how many others may be operating outside of this definition, and what the demographics of these populations are. As the NMC now begins its work to introduce regulation of Advanced Practice in the UK, (Nursing and Midwifery Council, 2024) from the CfAP experience having a definition will not in itself resolve this uncertainty. Whilst the NMC have said in recent webinars they intend to survey their members against this definition, again it is clear from the experience of the CfAP so far, there will be a significant number that believe they fit a definition of ACP but may not have had external verification to support this belief. If a survey by the NMC is conducted, this will of course not include AHPs who from my survey may make up to ¼ of the ACP population. Without this information it is difficult to measure the progress made against the targets set for expansion of ACPs or even whether these are realistic targets to strive for. Analysis of the demographic and context related data therefore presents a complex, diverse, and evolving picture of the ACP community and types of settings in which ACPs work.

CLINICAL

The key findings from the first theme in this research are that:

- Both clinical and non-clinical activity are valued and significant in influencing people to take on an ACP role and stay working in the health service.
- Non-clinical activity is poorly defined and is commonly not pre-planned, scheduled into work time, or ring-fenced from clinical workload.

These findings align with previous evidence. In the report conducted by Hardy (2021, p. 9) for the HCPC they noted that reaching a consensus on expectations regarding 'clinical' aspects of the role is *"more problematic as it is variable, dynamic, evolving, responsive to local clinical needs and often considered through a profession specific lens*". In my literature review the 'dominance of clinical practice' theme was highlighted in several papers published between 1998 and 2018. Despite the growing focus on the 'four pillars' of ACP since these papers were published, it is clear from my study and other more recent reviews that this is an aspect that still deserves attention (Evans *et al.*, 2021; Fothergill *et al.*, 2022). The dominance of clinical practice may have been exacerbated by increased burden on clinical health services following the Covid-19 pandemic. This has been further compounded by staff shortages and, more recently, industrial action.

It may also be the case that the increased awareness of the four pillars is drawing even more attention to a gap between expectation and reality regarding clinical and non-clinical activity for many ACPs. This will be intensified by the persistent poor understanding of the role by medical colleagues, management, and the general public that it should not be wholly clinical (Mackavey *et al.*, 2024). In my study only 16% of respondents believed there to be a good understanding of the role, which creates significant potential for conflict when trying to secure an ACP role that is not entirely taken up with clinical, patient-facing activity.

FULL KNOWLEDGE, SKILLS AND EXPERIENCE

ACPs in general feel that they can use their 'full knowledge, skills and experience' in their role and this has led (for most) to autonomous practice. In this study I have developed the concept of the tapestry of KSE that can be expected for people working at an Advanced Practice level. The tapestry metaphor recognises the strong foundation of profession specific practice that ACPs build upon by weaving in different knowledge and skills they have experienced over an often extensive health career.

> *"It's allowed me to use decades of accumulated skill and experience to help patients."*

There were examples cited by participants where they were frustrated that their full knowledge, skills, and experience were not always being acknowledged or utilised as effectively as it could be. As noted by Mackavey *et al.* (2024) and participants in my study, this lack of awareness leads to daily challenges and restrictions to advanced practitioners scope of practice. Mackavey *et al.* (2024) note how the lack of clarity regarding the ACP role in the UK further weakens the identity of ACPs and thereby service managers motivation to integrate them into the workforce. My research provides direct example from ACPs of their potential to use knowledge and skills commonly developed over many years of experience within healthcare being stifled. This further echoes the large number of papers from my literature review that identified barriers to the effective implementation of ACP roles (Table 3.4). Considering the emphasis that has been placed on development of these roles in the NHS Long term workforce plan, the costs of employing an ACP, and the universal conclusion that they have proven to be clinically effective when compared to others, this presents a worrying picture of underutilisation of a highly valuable resource.

> *"ACPs provide a wealth of experience, knowledge and skills which, from my experience, are not always recognised and appreciated by senior management. However, patients appreciate our input and ward staff benefit from the teaching and leadership we can provide. There needs to be wider recognition of the role, with a protected title, so patients, families, management, government etc are aware of the role and acknowledge the advantages of having ACP's."*

Participants also acknowledged the challenge that comes with developing as an ACP. They have highlighted that to maximise the effectivity of the role in generating positive outcomes there needs to be greater opportunity for ACPs to engage in professional development. In two textbook chapters I have written since commencing my PhD I discuss aspects of professional development and transition (Scott, 2023; Scott and Clift, 2023). Whilst this has always been an area of particular interest and expertise of mine, a focus on CPD was specifically requested by the editors as essential to be included in these core texts for Advanced Practitioners. From the data provided by participants in my research, the deficit of CPD opportunities was clearly an important feature of the ACP experience and worthy of further guidance and attention. Henderson (2021) further endorses the view of the textbook editors and the participants in my research by noting the importance of opportunities for continuing professional development (CPD) for ACPs. In their potted history of key actions, policies and research surrounding ACP in the UK, Henderson surmises this is necessary to facilitate ongoing monitoring and achievement against the ACP capabilities under the 4 pillars.

Under the education pillar of the MPF ACPs are expected to be *"Supporting the wider team to build capacity and capability through work-based and inter- professional learning, and the application of learning to practice"* (Health Education England, 2017b). In tune with this expectation, the participants in my research were keen to see themselves as a person who could be utilised to support the development of others, but again they did not always feel they were given the time or opportunities to do so. The experience of participants in my research is echoed in the work conducted by Stewart-Lord *et al.* (2020) and Evans *et al.* (2020) who highlight from their research that funding and workloads were often barriers to ACPs receiving and providing training and education. Their research looked at the experience of AHPs (Stewart-Lord *et al.*, 2020) and Nurses working in Primary care settings (Evans *et al.*, 2020) and they provide observations of the diverse and often localised way in which training and development of, and delivered by ACPs is supported. Beyond the opportunities for non-clinical time, (as cited by Stewart-Lord *et al*, Evans *et al* and Henderson and articles contained within my literature review in relation to the burden of 'workloads'), adequate and effective ACP champions, work-based support and supervision were also seen as influential contributors to whether or not participants could develop themselves or others. They also noted key personal attributes needed to actively 'push' forward effective utilisation of KSE in the ACP role in the current health care context.

> *"The individual and their drive is a very strong factor. Those who want to push the boundaries and challenge the status quo are able to make huge progress. Likewise, those who go into ACP and don't want to progress/ develop any further are often not pushed to do so."*

The view that ACPs commonly are highly self-driven and rely on intrinsic motivational factors has been endorsed by the work of Taylor *et al.* (2022) which reflects this as a 'masterly-related behaviour'. The need to learn independently and be self-driven to thrive in the environments in which ACPs work is viewed as a necessary characteristic. As noted in my literature review some alternative, more detailed definitions of ACP have been proposed that go beyond describing 4 pillars of expected ACP activity and focus on the characteristics or personal attributes needed to work effectively as an ACP (Dowling *et al.*, 2013; Hutchinson, 2014). Certainly, autonomy was viewed as an important part of the reality of working as an ACP and a sphere in which most participants believed they were operating. In the Lockwood *et al.,* (2022) narrative literature review they found that 'autonomy' of advanced nurse practitioners includes a sense of self-determination. This can be heavily influenced by organisational structures and support, but there is also a need for ACPs to be able to bounce back from challenges that threaten their ability to practice. Lockwood ***et al's*** view supports a major theory in psychology regarding self-determination, (Deci and Ryan, 2000) and its application within the 'NHS Change Model' (NHS England, 2018). For people to be motivated it is argued there needs to be an environment in which the psychological needs of autonomy, competence, and relatedness are facilitated (including through feedback). Extrinsic factors such as rewards and opinions of others, alongside intrinsic motivators like satisfying personal interests, beliefs and values can play heavily into sustained effort towards desired goals. Where these are absent it can have a major detrimental impact on 'wellness'. As noted in my literature review the potential for burnout and impact upon the wellbeing of ACPs has been previously highlighted by Read *et al.* (2001) and McConnell (2013).

The desire and determination to more effectively utilise, develop, and share the knowledge, skills, and expertise of ACPs is a key finding in my research. Potential facilitators or obstacles to harnessing and nurturing this talent and desired characteristics of ACPs have been illuminated by the experiences of participants. In particular there needs to be an enhanced awareness of what ACPs are and what they can do if the most is to be made of these highly skilled, knowledgeable, and experienced health care professionals.

LEADING ON QUALITY IMPROVEMENT

When it comes to leading on quality improvement, there appears to be considerable variation in whether ACPs are given the opportunity for or are being used effectively in team working, reshaping of services, and enhancing patient safety and experiences. This is despite there being a proven track record and several examples given of ACPs making a positive impact. The literature review by Read, Nindrajog and Mortimore (2024) gives good example of this where they found instances from across 4 countries of advanced nurse practitioners enhancing healthcare outcomes in frail older patients living in care homes. Impacts ranged from reduced hospitalisations, falls, depression, and incidences of aggressive behaviour from patients, to enhanced chronic disease review and management and improvement in care staff knowledge, confidence, and communication skills. Respondents to both the focus groups and follow up questionnaire in my study similarly referred to quality improvement projects they had been involved with in a variety of settings to enhance health care outcomes. There are of course clear limitations to accepting at face value self-report and the findings of Read, Nindrajog and Mortimore's literature review where there may be potential publication bias to only put in print research which supports a positive view of ACPs.

However, respondents to my research firmly believed that if they were given time, opportunity, structure, and support to enact their leadership skills (as defined and demonstrated through the leadership pillar), the role they are expected to play in transforming health services to address population needs would be expediated. This view is endorsed by the work of Gibson and Duffy (2024) who suggest that using a 'whole-system approach' could facilitate ACPs to maximise the impact and spread of service improvements.

In Mellors' (2023) article she highlighted some examples of, and practical ways in which ACPs can put the 'leadership pillar into action'. Whilst Mellors gave a nod in her article to the confounding factors that may prevent the realisation of this ambition, she did not highlight these barriers as strongly as the participants in my study have indicated. From analysis of the data, it is clear that ACPs believe they have the skills, attributes, and willingness to lead on quality improvement but the opportunity and support to do so is not always facilitated in the current context. The Nuffield Trust review of regulation of Advanced Practice for the Nursing and Midwifery council noted that *"The merits of advanced practice are not in doubt. Indeed, there is a substantial literature that demonstrates that it can support better delivery of services and improve a range of outcomes for people who use services*" (Palmer, Julian and Vaughan, 2023, p. 5). Yet typical of other comments, one of the respondents noted:

> *"I feel I have lots to offer but my current place of work doesn't seem to want to utilise me."*

Whilst in the minority, there was also a proportion of respondents in my research who felt they did not make a significant difference to patient safety and patient experience or did not see it as part of their role. This is a helpful reminder of where the focus should be in deploying people into health care roles, noting that the NHS Constitution has a key principle that *"the patient will be at the heart of everything the NHS does"* (Department of Health and Social Care, 2012). It should therefore be the case that if an ACP does not see this as part of their role or believe they are not making a difference to patient safety, experience, or clinical outcomes then something has gone wrong and needs urgent attention! A keener focus on engaging and facilitating ACPs to lead on quality improvement and measuring outcomes from these activities is therefore needed.

CAREER PROGRESSION

In general, taking the ACP path appears to provide increased job satisfaction and other benefits and opportunities for career progression that otherwise may not have been available. However, this is not universal and several, often localised, factors would need to be weighed up at an individual level to understand if this would be the right career move to make. This research has recognised the importance that has been attributed by ACPs to have opportunities to diversify their scope of practice, move up the hierarchy, achieve job satisfaction, maintain work-life balance, access CPD, feel valued, and to not be negatively financially impacted by taking on the role. Whilst my research has identified there are positive trends to indicate ACP roles can offer these benefits (e.g. 85% gave a positive response to feelings of job satisfaction), it also identified a significant proportion of the ACP population where this was not the case (e.g. 23% now felt stuck with limited opportunities to broaden their scope of practice).

Even where there appeared to be some consensus, the ‘deep dive’ data revealed that the speciality, geographical location, and the ACP’s profession introduces variation and uncertainty to the pay an ACP can expect to receive. The lack of standardisation therefore gives rise to inequity which has been long standing noting that ‘localisation’ and diversity of ACP was a key finding of my literature review with papers ranging from 1997-2020. People considering taking on an ACP role may therefore seek out posts where the pay is better or they could reject the ACP career as a financially unviable option to take. Recommendations from the Centre for Advancing Practice (2023) include expecting trainee ACPs are paid at Band 7, rising to a Band 8a Advanced Practitioner job once they have been able to verify that they meet the expectations of Advanced Practice. This has been facilitated by the increasingly utilised funding rules and the apprenticeship route for training ACPs where employers must guarantee an appropriate ACP role for those that enter and successfully complete this training. It is not surprising therefore that most participants in my research were paid on bands 7 or 8. However, the largest ‘specialty’ that ACPs are working in was Primary Care. This is also where the highest proportion of Private, Voluntary, or Independent (PVI) sector health care providers and non-NHS jobs are held. The use of standard NHS pay banding is not required in primary care and the PVI sector. The pay in this group of ACPs is therefore harder to discern and there is greater potential for variation in pay being offered for the same types of work. This matches with the data from a previous larger study of ACPs (Lawler, Maclaine and Leary, 2020). This was an aspect that respondents highlighted and where ACPs may therefore choose to relocate to seek out better pay.

“Currently, our ANP nurse role is a band seven which doesn't quite sit with where I look at. You know, colleagues, that work in NHS settings where that would be a band, 8a.” (FG3D).

“I am leaving simply because I can get a top band 8A in a GP practice.”

In the calls for standardisation regarding ACPs pay, this creates an issue. It is not within the remit of the PSRBs to control pay. The CfAP as the major body currently setting standards for ACP in England can only provide recommendations and guidance or create barriers to funding for ACP training; they do not have direct control over what pay is offered to ACPs. This may create a perverse affect where access to training is being blocked because workforce planning has not evolved or been resourced sufficiently to create the band 8a ACP roles needed. In my experience, as an admissions tutor for ACP programmes, increasingly otherwise eligible health care staff have been turned away from applying to train as an ACP as their service has not secured a job for them to move into at the end of their Masters programme.

Whilst the majority of respondents were on the CfAP recommended pay scales there were a significant proportion that felt that the pay did not adequately reflect their experience, level of responsibility, and scope of practice when compared to others. Respondents were not asked who they were comparing themselves to, but as a significant number work within teams alongside medical colleagues or in replacement of junior doctors (as was noted in the free text comments), the table overleaf may be a worthwhile illustration.

Table 7.1 -ACP/ Doctor Pay Scales

Advanced Clinical Practitioners		**Doctors in training**	
Band 7 (tACP)	£43,742-50,056	Foundation Training	£32,398-£37,303
Band 8a (ACP)	£50,952-57,349	Speciality Training (ST/StR)	£43,923- 63,152 (rising to £52,530-£82,400 as speciality Dr)
Source (cited 14th August 2023) https://www.nhsemployers.org/articles/pay-scales-202324		Source (cited 14th August 2023) https://www.healthcareers.nhs.uk/explore-roles/doctors/pay-doctors	
Prior to training as an ACP they will undertake healthcare pre-registration professional training of normally 3-4 years; undergraduate/ apprenticeship/ part-time or 2 years MSc. Entry onto ACP programmes are often restricted to a minimum of 3 years post registration as a health professional. Time in profession/ ACP role from data in this questionnaire suggests more often there is a much longer post registration experience before training/ working as an ACP. ACP Masters training is minimum 12 months but normally 3 years. **i.e., between 5-7 years minimum before entering training/ work as a tACP** and **6-10 years** (although commonly more) **before working as an ACP.**		Prior to this they will have done a minimum of medical degree 4-7 years, (normally 5 years minimum). This is followed by Foundation Training of 2 years. **i.e., between 6-9 years minimum** (normally 7 years) **to enter training/ work as a 'junior doctor' (FY 1 and FY2)** This must be undertaken before they can enter speciality training/ work as a (ST or StR) doctor. Speciality Training takes between 3 years (GP) or 5-10+ years (for other specialities).	

The basic salary scales above do not take into account extra pay that is given for working additional hours, nights, weekends, on-call and other allowances, or the outcome from recent industrial disputes regarding pay. It should also be noted, as per the results of this questionnaire, some ACPs are paid below Band 7 and others may be paid above Band 8a.

The comparison between junior doctors and ACPs could therefore be made that the time in training before working as an ACP or junior doctor is broadly the same. ACPs can achieve a higher salary at potentially an earlier stage in their health care training and career. However, unlike doctors who move into a significantly higher pay scale once they complete their speciality training, there are no defined career progression routes or pay scales for more experienced ACP trained staff.

> *"8a since 2015 initially in Crit Care then community, feeling of glass ceiling to ACP role with only small hints of career progression opportunities, ACP achievement in first instance but depends then very much on employer whether further opportunity created."*

One potential comparative career route would be where ACPs move into consultant level posts; however, these are also expected to be paid at Band 8a (NHS England, 2023a) and are commonly based only in secondary care settings (when the majority of respondents in this research were working in primary care). It should be recognised that there may be limited opportunities to access or progress beyond the role ACP. Just by looking at the large range of job titles used and relatively few that included reference to different levels of seniority in the role, it suggests that the ACP career pathway is unclear and there are limited examples where a development route for ACPs is offered. The research undertaken by Snaith *et al.* (2023) which utilised content analysis to review and compare job descriptions and adverts for ACP posts across the UK endorses this finding; there is significant inconsistency in the way that ACP jobs are being framed, recruited to, and structured to provide career development routes. This reinforces the view found in my literature review where Smith and Hall (2003) referred to ACP being a potential 'career cul-de-sac'.

The different potential job options available for progression in ACP roles provided by respondents in the free text comments included moving to a consultant level of practice, taking on an ACP lead role, developing a portfolio career, or moving into academia. Predominately the comments noted how these potential future job options were few and far between, so whilst they could potentially offer an opportunity for further career progression, they may not be realistic or open to the majority of ACPs. Some also noted the opportunity to move to equivalent levels in medical teams (e.g., *"have developed to registrar level*"). However, this raises the question as to whether these ACPs were being used as 'substitution' for others in a medical team and whether they would be able to evidence that they work across all 4 pillars.

> *"I thought that ACPs would be used in novel ways. This is not proving to be the case, it seems that we are to be used to plug gaps in the medical rota which raises all manner of concerns around governance, working hours, responsibility etc. "*

Ongoing career progression opportunities may not of course be important to the individual; this may depend upon the point at which an ACP role is taken up in a health career. From my data most ACPs enter into this role after many years of experience working in other positions. Without further understanding of the demographic constitution of the ACP community, it will be unclear as to how many may view the ACP role as the last in their long career or as a steppingstone to something else. It will be interesting to see if implementation of the NHS Long Term Workforce Plan (NHS England, 2023b) changes career progression opportunities for ACPs. This could include creating new consultant level posts or increasing opportunities for clinical academic roles to deliver the extra ACP training places that are hoped for.

Participants in my research were keen to highlight pay was not the only or dominant factor to take on or stay in an ACP role where broader opportunities for career progression played a significant part. From the data in my research, seeking out a portfolio career, ensuring the role is fully mapped to the 4 pillars, and undertaking a MSc or credentialling route for training/ verification of ACP appears more likely to result in an increase in pay for an ACP role and broaden their scope of practice. Knowing these factors could act as a career accelerator and may therefore be an influential consideration for the training and career choices healthcare staff make. The questionnaire results appear to indicate that most people working in ACP have not had a formal verification process to demonstrate they meet the ACP criteria as set down in the MPF. This may therefore limit their opportunity to access more preferential pay and career progression opportunities.

Only a small number of ACP programmes (24) had achieved CfAP accreditation by the time of collecting the recruitment questionnaire data and the first cohort of e-portfolio applicants (beyond the feasibility study) had not yet completed. The 4% of respondents in the follow up questionnaire who have undertaken ‘credentialing’ indicates a much lower uptake than might be expected considering these pre-date CfAP accreditation and were the first routes to be labelled as a way to be recognised as an ACP in some specialities. Some participants may have switched fields of practice or specialties and may therefore be undertaking a trainee role for their new specialty and so have not yet achieved recognition or verification of their ACP status in their current specialty. The lack of ‘on the job training’ reported is also surprising considering the high level of clinical skill that is required for this role, and the relatively short period since accredited academic ACP programmes have been in existence.

In the ‘Feeling valued at work’ research conducted by White and Mackenzie-Davey (2003) they stated that the work environment plays a key and consistent part. They noted that ‘environment’ is an area that is less influenced by personal beliefs (as opposed to inclusion and fairness) and can be used to drive the actions taken by organisations to provide affirmation of shared values. For example, White and Mackenzie-Davey (2003) highlighted that personal recognition was believed by their participants to be at least as important as pay in generating a sense of feeling valued, and that opportunities for personal development were seen as a significant contributor to feeling valued. They proposed that *“feedback and recognition are often received together, as two sides of the same coin, and are equally important in generating a sense of feeling valued. Feedback itself serves both as a form of recognition and an opportunity for personal development”* (page 230).

This work echoes what participants in my study had noted with regard to career progression. Their reported experience suggests that there may be an initial advantage to taking on an ACP role, but this may vary, and may be in a context where there are very few other job options available that could give similar opportunities. Financial impacts, work-life balance, and whether there is a mechanism to be formally recognised alongside being in an environment which encourages ACPs to feel valued all need to be weighed-up in deciding whether pursuing ACP would provide benefit to the individual. Pay is important to ACPs, but so are opportunities for CPD, feedback, being recognised for the work that they do, broadening their scope of practice and having effective organisational support and leadership.

POLICY, VISION, AND ORGANISATIONAL STRUCTURES

The previous theme feeds on well to the final area for discussion. Significant areas of policy, vision, and organisational structures have been identified from my research to have gaps between expectations and the reality of working in an ACP role. Nearly 40% of respondents were dissatisfied with the policies, structures, and processes currently in place in their organisation to support the effective implementation of ACP roles. There was a strong belief that there is more work to do regarding polices, vision and structure at all levels of implementation (local organisation, regional and national). The quote below from a respondent in the follow up questionnaire sums this up well.

> *"There seems to be so much potential for the role both professionally and for patient care. However it doesn't feel like we have created that potential just yet."*

Fundamental to this is the large-scale lack of understanding that exists around Advanced Practice, and what ACPs can do. Whilst support and understanding within teams that already have ACPs is perceived positively, the implementation of these roles remains 'patchy' and often operated differently in local organisations, services, or teams.

> *"I feel I am underused in the role, that employer doesn't really know where/ how I fit in and does not seem to have any foresight to how I can be of benefit post qualification."*

The lack of awareness of ACP may be compounded by the under-developed effective implementation of leads and champions for Advanced Practice that was reported by participants. This is in contrast to the recent work reported by Jenkinson and Fisher (2024) where ACP leads were introduced within a Mental Health and Primary care setting and 90% of respondents in this research had found the ACP lead they met with had been very helpful. Such projects, alongside the data from my research provides signs of progress, with organisational 'buy in', opportunity to evolve the ACP role, and long-term investment moving toward the more positive end of the scale.

Most participants believed that implementation of ACP utilising existing policy or standards, and particularly the MPF, was underway. However, there was also evidence of a mixture of both standardisation in the way that ACP roles are being operated as well as localisation, where within the same organisation different teams and services are using ACP roles differently. This may cause concern for those that are calling for increased standardisation of ACP roles (Fothergill *et al.*, 2022). Focus group participants highlighted lack of standardisation as a risk to ensuring a good understanding of what ACPs can do, quality assurance and public trust, and not losing staff to teams or organisations with more preferential conditions. This perception is supported by The Nuffield Trust independent review which stated that whilst there is no evidence of ACPs creating harm, there is latent risk to the public in the context of limited or early stages of standardisation (Palmer, Julian and Vaughan, 2023). My research identifies that there is still some considerable way to go before standardisation of ACP is fully implemented and there may be particular groups where greater focus on this is needed, for example mapping to the MPF in primary care or for allied health professions.

SUMMARY

From the discussion above a number of key features, particularly regarding the gaps between ACPs expectations of the benefits of the role and their reality of working in this role have been identified. It should though also be highlighted that when analysing the summary question and comments from the follow up questionnaire, as well as some areas that focus group participants identified as influential to them moving into or staying within the ACP for the majority their expectations of the ACP role had been met, or to some extent had been exceeded. As example, the majority found they were directly involved in delivering clinical practice, were able to use their knowledge, skills and experience in their work and had seen an increase in pay and job satisfaction since taking on the ACP role. This positive view of ACP should not be under-estimated and could be used as evidence to promote health professions moving into ACP roles. Increased promotion of the ACP role as a positive career choice may help to achieve the ambitions of the NHS Long Term Workforce Plan to significantly grow the number of ACPs and retain highly experienced skilled staff (NHS England, 2023b). The gaps as presented in the results and discussed in this chapter do however provide an impetus to determine inferences and recommendations that can be taken forward from this research. These are reported in the next chapter.

.

CHAPTER 8 – NARRATIVE INFERENCE

INTRODUCTION

In this chapter I provide a narrative inference from the results of this research. This sets out the key findings from my research and the contribution that can made from this study. These have been translated into specific recommendations to take forward with reference to the limitations of the research undertaken as well as the potential for generalisation of the findings of this research and intended impact activities.

KEY FINDINGS

The aim of this research was to provide an opportunity for the experiences of people working in ACP roles to be captured. The research question set was:

What are Advanced Clinical Practitioners expectations of the benefits in pursuing this role, and are they being realised?

This has been addressed by using a sequential, exploratory mixed method research design to ascertain:

1. What are the expectations ACPs have regarding the personal benefits of their role?
2. Do ACPs believe these are currently being achieved?
3. What factors appear associated with whether or not expectations are achieved?

Through having greater understanding of the ACP/tACP perspective on the expected benefits and the reality of working in this role, any gaps between expectations and reality can now be highlighted as key findings of this study. Gaps have been found between their expectation and reality of working as an ACP over five core themes;

- Opportunity for non-clinical activity
- Effective recognition and use of ACPs full knowledge, skills, and experience as well as opportunity for ACPs to access development of themselves and others.
- Consistent involvement of ACPs leading on quality improvement
- Opportunities for career progression within and beyond the ACP role
- The effectiveness of current policy, vision, and organisational structures to support the development and implementation of ACPs.

In addition to the findings above contextual and demographic data collected in this research has identified trends, characteristics, and factors that may have an influence over whether the expectations of the benefits of ACP are being realised. The diversity and localisation of the current reality of working as an ACP has been emphasised as a key feature of ACP. This new knowledge is intended to be used to better inform ACPs, potential ACPs, and those that provide advice, support, training, and education to these health professionals about the reality of working in this role. As set out in the logic flow diagram (appendix 13) this enhanced understanding is expected to be used to shape policy, guidance, information and support to

- reduce gaps between expectation and reality,
- improve the experience of ACPs,
- promote the recruitment to ACP roles and retention in the health care workforce.

However, before being able to state the contribution these findings can make and set out the recommendations that need to be taken forward from this research, consideration has been given to the limitations and generalisability of this study.

LIMITATIONS

When synthesising the discussion points in chapter 7 and identifying the key findings listed above, I have reflected upon and been aware of potential limitations of the research conducted. I have kept a reflective diary throughout my PhD journey and have been prompted by discussions within supervision, network meetings, and discussion with peers and leads within the field of Advanced Practice to note the limitations of the work I have created. I have used the Mixed Methods Appraisal Tool (Hong *et al.*, 2018) to further evaluate the methodological quality of the research undertaken (Appendix 18). Using the questions asked in MMAT alongside reflection on my research I highlight below those areas that I believe necessitate consideration when reviewing the work presented in this thesis.

To begin with, it is worth noting the current context of ACP, some of which is unknown or unpublished (Drennan *et al.*, 2021). This has made it difficult to identify who constitutes the ACP community and thereby whether the participants in my research can be said to be representative. The sample size calculation was revisited to reflect the degree of uncertainty, and whilst a sizeable number of participants were able to be accessed, other studies achieved higher numbers, albeit it with larger research teams, resources, and established networks. For example the study by Fothergill *et al.* (2022) which was conducted by IPSOS Mori, commissioned by HEE and distributed through regional survey and organisational leads also noted that it was not possible *"to define the target population for the study from the outset"* (page 3). As my research has highlighted, the CfAP and employers are at a relatively early stage in establishing whether people claiming to be ACPs have been mapped against agreed criteria to ensure they meet the standards expected for 'legitimate' ACPs.

The process for ‘legitimising’ a group of people can be fraught with difficulty, reveal inequality, and create controversy. It is the case that some will be left out (e.g. working in roles without ACP titles so they go undetected) or get caught up in a burdensome process to verify their worth. People may be working effectively within an advanced level of practice but without the ‘paperwork’ to prove it and have no access to resources or opportunities to enable them to gain the verification required. As example of this, alongside my nationally focussed study reported in this thesis, I have been working on repeating the research process within a local NHS organisation. From my initial discussion to the point at which we started to recruit to the study, we have had to significantly revise down the expected ACP population in this organisation, from around 150 to 82). Employing organisations, including the one I have been using for my local NHS organisation study, have begun to ‘sift’ through their staff to identify those that:

1. can be mapped and verified as working to the MPF definition of ACP.
2. have an ACP job title but cannot be verified as currently working to the MPF definition of ACP.
3. do not have an ACP role in the organisation but have met the expected standards as set out in the MPF (e.g., have obtained an MSc and are undertaking ACP work but are not recognised as such).

Whilst we cannot presume that this is replicated everywhere as there are local differences in how ACP roles have been managed and implemented, my research has confirmed that ‘unverified ACPs’ are very likely. The implication of this is that I can only state that the findings of this research came from a group of people who believed themselves to be working, or training, as ACPs.

It was clear very early on in my research that the ACP community is diverse, and there may be a significant level of 'localisation' in the way ACP roles are being utilised. Efforts have been made to capture the diversity of this population in my research and take account of this in the way in which the research has been conducted and reported. By collecting and reporting data on the demography, backgrounds, and context in which participants were working it has allowed me to highlight the diversity that exists. The recruitment data collected has been used to employ maximum variation sampling for the focus groups. The maximum variation approach ensured that, whilst not perfectly representative, views on the expectations of the ACP role have been collected and analysed from a diverse group. It is though acknowledged that resources, time, consent, and participant availability have constrained maximum variation and may have led to voluntary response bias where those that chose to participate are different in some ways to the general population of ACPs (Boughner, 2010). In reflecting on the diversity and representation of the ACP community, I acknowledge that the recruitment and data collection methods used may have attracted or excluded certain groups.

The research has relied upon on-line methods which for some may be convenient, time saving, and preferable, but for others may be daunting or off-putting. It has also relied upon use of social media platforms and established ACP networks which will never fully capture the whole ACP community as they may not be linked into these communication sources. The recruitment and data collection occurred at a time when health care staff were under immense pressure and scrutiny due to the Covid-19 pandemic. For some they have utilised social media more extensively in this time as a source of information, networking, and support (Glasdam *et al.*, 2022). Whilst specific UK data is scarce, it is estimated there was a worldwide increase in social

media use during the pandemic, including to reduce feelings of isolation and to gain and share information quickly and safely (without face-to-face contact which was prohibited at this time) (Dixon S., 2022; Cho *et al.*, 2023; Wong *et al.*, 2021). Conversely, for other health care staff they may have moved away from using these platforms to protect themselves from reading traumatising messages which may trigger symptoms of Post-Traumatic Stress Disorder or moral injury due to the devastating experiences of working clinically in the pandemic. As someone that went back to work in critical care during this time, I have certainly had to consider carefully when and how often I view social media. I have been cautiously aware of how I engage with posts that I find re-traumatising, distressing, challenging, or uncomfortable. Some ACPs may therefore have decided to withdraw from social media in this time to take a break away from 'work' to protect their mental health.

It can be assumed that the higher the response rate to surveys, the more likely it is you will get a diversity of views and avoid non-response bias. For those that have had a negative experience, the questionnaire could have been a channel to 'vent' about their views of ACP and so they are more likely to respond, especially if no other means for addressing their experience has been given. However, Wu, Zhao and Fils-Aime (2022) noted that "*it is possible that having a reasonable number of representative respondents is more important than having a high response rate."* As noted in my sampling strategy, I attempted to get an adequate response rate of a diverse group of ACPs based on the incomplete picture of how many potential respondents there may be and I was able to achieve the number of responses that had been planned for.

By clearly setting out the purpose and remit of this research in the participant information this may have created a demand response bias for participants to answer the questions in a way that was perceived as socially desirable. Potential participants were told that “In this study we want to explore people’s experiences of working or training as an Advanced Clinical Practitioner (ACP) in England, what their expectations of this role are, and whether they are being realised.” This may have indicated that I was looking for gaps between expectation and reality and therefore participants may have particularly focussed on relaying negative experiences that highlight a gap. That is not to say that the negative experiences were not genuine, but when reporting their prevalence may have been overstated. I have therefore been conscious of wording the questions and giving a sufficient range of options for respondents to choose from to avoid suggesting something may be inherently negative or positive. By using open questions and anchoring the question to the participants own experience. I have encouraged them to relay whatever their experience has been. The risk that participants have emphasised potential gaps or negative experiences has been accepted as it helps to achieve the objectives of the research; namely to identify any potential gaps between expectation and reality so that interventions can be tailored to address them. It will always be the case that further investigation may be needed at a local or individual level to see if each potential gap applies within a particular group or context, which is why I have continued to emphasise the diversity and localisation of ACP.

Returning to the principles of strong satisficing, I set up the questionnaires so that there were very few forced responses to avoid a large drop off rate in those that complete the later questions. There were two questions where respondents were automatically taken to the end of the survey (Q3B and Q12B). Whilst this was

purposeful to ensure only the data from those that met the inclusion and exclusion criteria was analysed, this may have excluded some people who believe themselves to be an ACP/ tACP from fully participating. Avoidance of forced responses in the questionnaires has also meant that not all respondents answered all the questions. additionally, it may be that when starting to respond to questions if there were topics or terminology used which were unfamiliar to the respondent this may have put them off from completing the questionnaire. Whilst directions and reference material were given in the participant information, eligible respondents may have been dissuaded from responding to the rest of the questionnaire if it used unfamiliar wording or covered topics they did not feel confident in. It could be considered therefore that people who are already well informed about ACP may have been more likely to fully complete the questionnaires.

My research identified that there is a minority of people (40%) that responded to this research who had been mapped against the MPF. When asking people about the MPF, those that had not been mapped or had not come across this definition before may have dropped out from responding to some or all of the subsequent questions. To verify if this was the case, I have checked to see if it was more likely for those that have been mapped and are aware of the current nationally agreed definition of ACP to fully complete the other questions. When running ‘break out’ data analysis using Qualtrics the response rates for the last few questions, these were broadly in line (+/- up to 3%) with the proportions that had said they were fully mapped or had not been mapped to the MPF. The diversity and proportion of people from different groups of respondents appears therefore to have been reflected throughout the response rates to the individual questions.

The continuing evolution of ACP and how these roles are verified, managed, and implemented has also had a potential impact on this research. Since starting on the literature review and throughout the different phases of this research significant changes have occurred. This includes increasing governance and standardisation of ACP, as well as increasing awareness of the diversity in which these roles currently operate. I therefore recognise the speed at which the findings and potential impact for this research may become outdated. Participants noted how it was important that ACP should continue to evolve, and this will necessarily mean the picture should expect to change. Participants also noted how governance structures, ACP leadership, and long-term investment in the role had begun to be embedded locally as well as regionally and nationally. My research therefore captures a point in the trajectory of ACP in the UK which will need to be contextualised and compared to the current picture when making any conclusions or acting upon the findings in the future.

Recognising the contextual nature of this research, it is noted that the speciality categories used within the background questions were taken from previous research (Lawler, Maclaine and Leary, 2020; Health Education England, 2021b). Whilst this should have resulted in the categories being easily recognisable to participants, it was clear from the results that many ACPs do not now fit within these more traditional service or speciality boundaries. In future research an open question that asks “what is the speciality, field of practice, or service you work in?” is recommended to reflect the evolving nature of the contexts in which ACPs work.

When choosing the methods employed in this research a number of considerations were taken into account. All methods have their benefits as well as their potential flaws. For example, it was noted in chapter 3 how using a validated questionnaire may

have created opportunities for comparative data analysis. However, this was set against the risk that by combining or reformatting a validated questionnaire to ensure content validity, may have negated the benefits by making the questionnaire too long or confusing due to change in styles or formats. As with this choice to design a new questionnaire, I believe I have provided adequate justification for the decisions made and can provide a sound rationale for the approach I have taken in this research. At times this will have been due to my pragmatism and consideration of the practicalities of the research (e.g. my level of expertise and time and resources available), or because of the desire to remain true to the philosophical underpinning of my research (e.g. to ensure the constructivist perspective facilitated capturing the truth as ACPs perceived their experience of the role to be). For example, when determining which data to analyse for 'deep dive' exploration I was well aware of the practical and philosophical factors in determining the choices made. I could have gone further in running analysis for every different combination of data sets. However:

1. In keeping with EDA principles, I chose to examine only those areas where unusual patterns were evident when running 'break out' visualisations of demographic data for selected questions. Where the results for particular groups (e.g. geographic location or those with a portfolio career) was different to the summarised data for all respondents, these have been reported.
2. I have taken a critical realist approach and therefore recognise potential 'fallibility'. To reduce this where possible I chose those items for deep dive exploration where perception may have taken a lesser role in the answer given (e.g., respondents should objectively know whether their pay has increased, if they have been mapped to the MPF, or whether they have time allocated for non-clinical activity etc.).

3. Running analysis for every different combination of data sets would have significantly extended the time taken to resolve my narrative synthesis and inference; the fast pace of change in ACP could diminish the impact of this research, whilst also recognising it creates opportunity for further research.

Finally, in discussing limitations of my research I acknowledge my own positionality. I have clearly stated that this is coming from an 'insider' emic perspective. Whilst some may emphasise the impact of bias, Braun and Clarke noted that we should see *"researcher subjectivity as a resource for research, rather than a threat to be contained"* (Braun and Clarke, 2023). By exposing my positionality, I have strived to be a 'knowing researcher' in which I am deliberate in my decision making and open in reporting the choices I have made. This has been aided by my reflexive approach which has not been passively employed but actively scheduled into my time to ensure I continue to take stock and think deeply about the choices made, particularly in how they relate to achieving the aims of my research and answering the questions that were determined at the start of this study. For example, I did not determine the themes in advance of data collection, and have endeavoured to write them as meaningful, interpretive stories rather than just topic summaries. Whilst participants were given the opportunity within the focus groups to check my summary of the discussion and this has formed the underlying structure of themes, I alone have created the final narrative for each of the chosen themes. For example, in discussing 'full knowledge, skills and experience' I highlighted both negative and positive experiences relayed by participants and the diversity of their recounted 'driving forces' to become an ACP. To embellish this, I have drawn attention to the context in which these experiences were encountered and utilise relevant previous research and my own 'tapestry' theory based upon my reflections to construct the 'full KSE' theme.

I have also been reminded of how salient it is to embrace *"meaning and knowledge as contextually situated, partial and provisional"* (Braun and Clarke, 2023). My role as an educator in the field of ACP has meant that I am directly involved in career coaching for ACPs, tACPs, and people considering this as a career path. As a programme lead, writer, and programme reviewer, I have provided consultancy and advice to ACP leads, employers, commissioners, and PSRBs. The diversity of the ACP population, the extent to which it is experienced differently in sub sections of the ACP community, and the continuing evolution of the role and the governance that surrounds it, have regularly arisen in my work. My lived experience of working within the field of ACP education has undoubtably influenced my research.

I therefore acknowledge and have exposed the context bound, incomplete, and evolutionary nature of ACP and my research within this field. As a pragmatist, I have kept the purpose of my research central to the choices I have made and the recommendations, generalisability, and impact that I believe this research can and is making.

GENERALISABILITY

The concept of 'generalisability' has been seen as a cornerstone to assessing the quality of research. However, this has traditionally been focused on statistical probability, which does not fit easily alongside qualitative research and its underpinning philosophy where multiple realities are accepted. That is not to say that all qualitative research lacks generalisability. There are different types of generalisation that may be relevant and applicable within qualitative research. I have used Smith's (2018) overview of the different types of generalisability to evaluate whether or how effectively these could apply to my research.

When considering ‘conceptual’ or ‘theoretical’ generalisability I have been clear in my methodological choices that the aim was not to test against a hypothesis, existing concept, or theory of ACP. Through using a sequential design, I have been able to draw upon focus groups to construct themes of ACPs experience of the role. However, this has stopped short of developing a generalised concept of the ACP experience, primarily due to recognition of diversity and lack of definition in the current ACP population. My research has though added ACPs’ perspective and endorsement to the desire for the ‘4 pillars’ of the MPF to underpin their work. For example:

- **Clinical** practice is a core part and a major driving force for working as an ACP. They expect to develop and utilise their full range of knowledge, skills, and experience to guide clinical practice to work autonomously in this role.
- ACPs see this role as a route for career progression and are keen to engage in the **educational** development of themselves and others.
- Respondents want to be involved in **leadership,** particularly in relation to quality improvement and reshaping services to meet population needs.
- This study has identified there is a need to enhance the support, investment, policy, and structures to effectively implement ACP. Respondents can see the great potential that could be gained if evidence-based practice (including **research**) is generated, captured, and shared to provide quality assurance of the role and to inform further development in this field.

These findings could be seen as adding weight to a core established concept of ACP. The MPF was first produced in 2017. Considering the consistent commentary that ACP is evolving, my research has highlighted that the ‘4 pillars’ remains pertinent to the lived experience and expectations of ACPs. This may suggest that rather than

discard this concept or rewrite the MPF it should continue to be embedded. It appears the 4 pillars is a sufficiently broad framework to capture the diversity and evolving characteristics of the ACP community. The majority who responded to this research have not though fully mapped to the MPF and so this may need to be revisited once there is a better handle on who the 'legitimised' ACP community includes. The validation of ACPs will of course be a self-fulling prophecy as only those that can evidence they are working across the 4 pillars will be verified as ACPs. Further research on health care professionals that have been left behind by this sifting and verification process may be needed to re-examine the 4 pillars and how it might apply to them or whether a new concept or theory is needed. This might include alignment of the 4 pillars to 'enhanced practice' which like the evolution of 'advanced practice' is beginning to be defined, structured, and embedded, (Leary, 2022).

In intersectional generalisation it is expected that research digs deeply and respectfully into a community to record its particular characteristics. Research seeking provocative generalisation tracks the patterns of the community under study and uses the findings to provoke people to put in place what is not yet is in practice. This can also be akin to 'generativity' where research invites people into an experience and moves them to act upon what they have read or seen (Smith, 2018). Revealing and raising awareness of the current experience of ACPs, as reported by them, is a fundamental part of this research. A core rationale for undertaking this research was that key stakeholders, including the participants and other ACPs, would use the information generated to enhance their understanding to inform decisions they undertake. This could therefore be said to be seeking generativity or provocative generalisation. However, there are two areas which limits any claims that can be made regarding generalisation in this respect.

The first is the actions taken by those that participated or read the findings from this research. I am at an early stage of disseminating the findings from this study. I cannot therefore claim that provocative generalisation has yet been achieved. In my discussion of dissemination and impact later in this chapter, this has been planned for and some work has begun. Time and ongoing tracking and revisiting this research will be needed to evaluate the extent of provocative generalisation that has been accomplished.

The second area which may limit a claim for 'intersectional' generalisation is the extent to which I can say I have dug deeply into a community. Normally this includes tracking patterns of a particular community over time. I cannot say that my research has achieved or set out to do this as it is a cross-sectional study, taken at a moment in the history of ACPs. In intersectional generalisation the aim is often to identify the particular features and history of an under-privileged or oppressed community. Although the literature review highlighted evidence of barriers to the effective implementation of ACP, I have not set out with the belief that the ACP community is oppressed. I have also been clear to note that the respondents in my research may not fully represent the diverse and as yet uncontained or legitimised features of the ACP community (oppressed or not).

Acknowledging the above also has implications for the transferability or 'inferential' generalisation of this research. Smith (2018) suggested there are different definitions of what is meant by 'transferability'. He noted that this does not just relate to following rigorous research procedures and methods to establish the quality of research, or how easily a research method can be repeated in a different setting and produce the same results. I have been clear in my research that whilst the process I have employed in

my research has been carefully considered and reported and therefore the method could be replicated, the results would very unlikely be able to be reproduced due to the diverse, context-bound, and evolving nature of ACP.

With regard to ‘naturalistic or ‘representational’ generalisability, I have found that my research has resonated with people from the ACP community. From the feedback received from conference presentations, publications, and contacts made from the executive summary being sent out to participants, it appears that the themes have reverberated with their experience. For example, when talking about ‘feeling valued’ the finding that feedback and effective supervision are key to this has consistently been endorsed and is an area where it is widely acknowledged further work is needed (Reynolds and Mortimore, 2021). In one of the conferences where I first presented some of my findings this became a key topic of discussion. The audience at this conference and trainee ACPs I work with have said they now recognise how powerful feedback (whether it is good or bad) and effective supervision as a vehicle to gain feedback can be to support their development. It is now something that I continue to emphasise to my students, and I have built it into a core assignment they need to produce for their MSc in Advanced Clinical Practice.

Ultimately, it will be the reader of my work that will decide whether or not my findings ring true with their own experience. I am conscious of the fast-moving pace of evolution in ACP, so the naturalistic generalisability of my work may not pass the test of time where the experience of working as an ACP will change and hopefully be enhanced by gaps between expectations and reality being closed. Smith referred to Tracy’s work (2010, pp. 844-845) to note that transferability can also relate to *‘evocative storytelling’* where research resonates with the reader. I have used the storytelling approach in

setting out the findings and narrative synthesis from this research. I have also noted my intention is that people that read or have participated in constructing this story may be moved to take action as a result. In further discussing impact, recommendations, my dissemination plan, and potential future research I therefore note the intended limits to, as well as possibilities for, generalisation of this research.

CONTRIBUTION OF THIS RESEARCH

At this point, it is worth re-stating what I believe this research can contribute to existing knowledge and the evidence base in the field of ACP. Firstly, this research provides an emic perspective of the current experience of ACP; their experiences have been captured to highlight what they expect as a benefit for undertaking this role. This is important to understand if we are to attract people into ACP and retain those who are working in this field. Emphasis is placed on creating roles and services to achieve organisational goals, particularly to address gaps in staffing. The needs of the population we serve should always remain central to how health services are run and this has been given prominence in the current definitions and policy of ACP. People who take on ACP roles are though also part of that population. Without understanding what their needs are and seeking to address them, the organisational objectives are likely to be missed. As an example, participants consistently said they took on the ACP role because they wanted to remain clinical and patient facing. This clearly aligns with organisational objectives where there is intense pressure to address waiting lists, shift the focus to preventative health, and adapt the health service to be able to cope with a growing population with co-morbidities. There is no disagreement that clinical practice is an important part of the role from both the ACPs and the organisational perspective and this should therefore be used to promote the role.

However, ACPs very clearly said that to attract them and retain them in ACP work it needs to not be 100% clinical. They need time and opportunity for ‘4 pillars’ working; to engage with the development of themselves and others (including through supervision) and to be involved in leadership of quality improvement. On the face it, this also aligns with organisational objectives as this will facilitate a safe, evolving, and innovative workforce who feel valued and supported to work autonomously. And yet…this is most often where there appeared to be divergence between expectation and reality with well-established barriers preventing the effective implementation of the role. I am reminded of the ‘too posh to wash’ accusations that were made when degree level education was introduced for Nursing and the backlash encountered by this profession wanting to move away from being used as doctor’s handmaidens. It is not that ACPs do not want to get their hands dirty and be involved in clinical work; they have clearly said this is central to being attracted into the role. However, to be effective in this role and meet the expectations of modern evolving health services they cannot be tied to the bedside. They need to be given opportunities to undertake activity that focuses on development (their own and the service they work in) and need to be empowered to be at the table for high impact decision making. My research has firmly endorsed this view.

By understanding from their perspective, the expectations that ACPs have for their role and whether these are currently being realised, a co-ordinated workforce plan can be designed and implemented to better achieve organisational objectives. This will allow the widely acknowledged positive impact ACPs have on clinical outcomes to be more effectively implemented, making the best use of ACPs to enhance patient care.

As noted above, the research has been designed as a way to ‘give voice’ to the participants as ACPs themselves, where previous research in this field relies heavily on the voices and opinions of others (e.g., employers, educators, or academic and lead ‘experts’). This provides an opportunity for a more realistic understanding of what the ACP role entails in practice by understanding the experience of those currently working or training in the role. For people considering the ACP career trajectory this can enable them to make an informed choice about undertaking the role. For people that advise, train, or employ ACPs, the findings of my research can facilitate enhanced understanding of the role to inform the support they give to ACPs and tACPs.

As a programme leader, writer, teacher, and reviewer for ACP, this was of course key to deciding on the focus for my research. I wanted to select a topic for my research that would enhance my understanding and to use this to underpin the information and support I give to others, particularly my students. I can therefore say this research has already had a direct impact on the work that I do on a daily basis. I have been able to advise those enquiring about the MSc how ACP is broadly viewed and experienced to be. I have encouraged them to weigh up local and personal factors that should be considered when deciding if this is the right route for them (e.g. pay, flexible working, access to supervision, work-life balance etc). An approach I have used throughout my career in working in CPD is to always ask why do you want or feel you need to do this? By probing people to get honest answers to this question, alongside a good understanding of the reality of expected outcomes I can confidently advise whether what they are expecting is likely to be achieved. These discussions promote health care professionals to take an active, informed approach to their development. I often find I need to remind them that the person most interested in their development is themselves, and they are best positioned to know what is most important to them. By

encouraging people to put at the heart of their decisions the things that are most significant to them (e.g. family, a sense of making a difference) it provides a clear anchor point to decide whether opportunities that arise are the right ones for them to take, whilst also acknowledging the alternative choices that are potentially available.

A key lesson that I have learnt through the process of this research is the need for support within the organisation in which people are wanting to work as an ACP. In the past I have encouraged people to pursue CPD that works best to achieve their objectives. This has at times meant they have commenced on their CPD courses as a way to build a case for renegotiation of their role or to enable them to move job roles to accommodate their new knowledge, skills, and experience. Whilst this remains true, my attitude has now shifted to ensure people do whatever they can to be in a position where good employer support and understanding is in place before embarking on their ACP training. I believe this provides a 'reality check' to potential students as to what is involved and how they can best ensure their success, even if that means delaying the start of their programme to negotiate with employers or seek employment elsewhere. Underlying this is encouragement for health care professionals to consider themselves as a valuable resource and to seek out or push for this to be recognised. Meanwhile, I aim to use this research to influence those with the power to create the environment in which ACPs expectations can be realised. Whilst informing people working in or considering becoming an ACP may be used to adjust expectations, changes to the infrastructure to support ACPs could adjust the reality of being an ACP. Both are intended to identify and narrow the gaps between expectation and reality. Further research identified as needed, the recommendations set, and plans made for dissemination of this research have therefore been aimed at both health care professionals and stakeholders with the influence to shape ACP.

FURTHER RESEARCH

In answering one question most research often raises further questions and other avenues to explore. This has certainly been the case in my research where I have had to consciously remain focussed on a particular objective despite many other interesting observations and topics being exposed within the process. Whilst I have made clear plans to ensure the objectives of my study are met, I have also identified where there are opportunities to take this work and research further.

One of the fundamental areas identified for further research is to establish who exactly falls within the ACP community. This currently creates significant limitations to research undertaken in this field and how applicable and useful the findings may be. Work is underway to verify the legitimacy of ACPs through the CfAP accreditation routes. Once a community of verified ACPs can be identified it would allow researchers to better understand the common characteristics of the ACP community. This would then allow for further exploration of why ACPs answered in the way they did, and why they may perceive there to be a gap between expectations of the role and the reality. By understanding, testing, and applying theory regarding ACP, researchers would then be in a better position to say what interventions may have greater chance of success in closing the gaps.

In the absence of a national, confirmed and reported picture of ACPs this could be done at a smaller, more localised level. My research and others have highlighted the diversity and localisation of ACP. It would therefore be beneficial to undertake a repeat of this study in specific organisations. A more direct link from the findings to influencing the policies, infrastructure, and support provided to ACPs in that organisation that addresses their particular needs would be achievable by more localised study.

When I first set out on designing and choosing the focus for my research, this had been my intention. However, due to the timing (during the impact of the pandemic), my limited availability (this being a part-time PhD) resources, and the time it takes to gain ethical approval and set up a project in the NHS it was clear that this need to be set as a longer-term goal. I have though now gained ethical approval for a localised repeat of the methods employed in this research and identified an organisation to implement this with. (*R&D Ref: 22/039. IRAS Ref: 314623. Short Title: Expectations of pursuing an Advanced Clinical Practitioner role. Amendment No: 1. HRA Approval: 3 Nov 2023*).

The approved study is to take place within a local NHS organisation which includes two hospitals and delivers community services in the East of England. They are at a more advanced stage of implementing the expected governance for advanced practice than other organisations in the region with the longest established ACP lead being in post. They have approximately 80 ACP/tACPs working in the NHS Trust which they have identified through mapping their posts to the MPF (whilst acknowledging there may be others in the organisation that may yet be undiscovered). I look forward to making progress with this research and then being able to compare the results between a national and localised study.

I have set out in this research with the intention to facilitate changes to enhance the experience of ACPs, particularly where they perceive there to be a gap in addressing their expectations of the role. Future research on any interventions that are made following my research should be used to establish whether the gaps between expectation and reality have become narrower as a result. For example, there is a

clear ambition to grow the number of ACPs, future research could identify what helps or hinders recruitment and retention.

The current context, where there is significant and continuing evolution of the policy, governance and organisational structures for ACP, will provide fertile ground for research opportunities to assess their effectiveness. It is noted that my research is cross sectional and future repeated research could allow us to view whether anything is shifting over time in response to changes made in this field.

My research has produced a rich well of data to explore and there were many areas (or rabbit holes) that I could have been tempted to analyse further. I have been clear about taking a pragmatic and rationalised approach to ensure the aims of my research have been met. I have been guided in this respect by my original theoretical stance taken where the voice of ACPs has taken primacy in deciding where to focus further exploration, (e.g. in deciding the themes to take forward into the follow-up questionnaire). However, there were other themes and combinations I would like to explore further. As an example, ‘feeling valued’ was highlighted by participants as important. Particular groups of people and activities were more frequently cited as helping them to feel valued. Further exploration of this as a theme in its own right would be worthy of further research to understand the factors that contribute to perceptions of value. Findings from research on this topic could then be used to aid the design of interventions to ensure ACPs feel valued.

There were some key features from the papers included in my literature review where the quality of evidence in the field of ACP could be enhanced. This included the need for more longitudinal studies. I could use the methods employed in this study to repeat the research to track any changes that occur over time. The papers I reviewed also

relied heavily on self-report, mostly from people other than ACPs themselves. Whilst I have tried to address this in my research by focussing on the voices of ACPs, other types of research methods (e.g. observational studies) would provide a broader evidence base. This provides an opportunity to build upon the research I have undertaken in this study.

Also within the findings of my literature review, and echoed by Palmer, Julian and Vaughan (2023) there is a lack of research that examines measurable outcomes of the risks of ACP. An assumption could be made that because negative incidents or risks of ACP roles have not been reported, they do not exist. Whilst it seems a negative approach to take and potentially wasteful when it appears it is not a common occurrence, data collection in this area may help to identify areas that need further attention (especially as options for regulation are being explored). As governance structures continue to evolve this provides an opportunity to gather such data. In the regional networks that I contribute to (e.g. at ICS level) risk registers and the governance matrix are being utilised; these provide an opportunity to identify areas that require further research to understand the risk and interventions needed to address (or hopefully avert) the negative consequences.

Finally, the literature review revealed a dearth of evidence relating to ACPs not coming from a Nursing background (AHPs). Since undertaking my literature review a new, multi-professional and international Journal for Advanced Practice has been published, (https://www.magonlinelibrary.com/journal/ijap). Alongside this, other outlets for ACP research are developing (e.g. through student dissertations, national conferences, ACP networks). Whilst at early stages these provide an opportunity to

capture better the diversity of ACP and the particular experience of ACPs who do not have a Nursing background.

The raised profile of ACP through these publication outlets and key policy documents such as the NHS Long-term workforce plan, provide a plethora of opportunities to undertake and disseminate research in this field, including systematic literature review to encompass the latest published research. I am excited to be entering this field as a researcher where there are so many future research opportunities to explore.

RECOMMENDATIONS FOR POLICY, PRACTICE AND EDUCATION

The key findings from this research and the contribution it makes to understanding ACP in the current context from the ACPs own perspective has clear implications for recruitment and retention of ACP roles. The ACP supply pipeline needs to grow if the aspirations of the NHS Long Term Workforce Plan (NHS England, 2023b) is to be realised. As a first step, this requires a targeted campaign with use of Advanced Practice champions and more effective use of Advanced Practice leads to increase the awareness and understanding of what Advanced Practitioners are and what they can and should be doing. This needs to be aimed both at the general public and people working in health care. It will be particularly important to include other health care workers who hold the power to influence policy on how ACP roles are implemented and supported. As noted in the study by Drennan *et al.* (2021), lack of funding combined with poor understanding or confusion regarding ACP along with resistance to ACPs are key inhibiting factors to their development, maintenance, and growth.

To enable workforce planning that supports the expansion of ACP roles, the current silos of funding will need to be reconfigured to create new posts that address

population needs rather than money continuing to flow through traditional professional or specialty boundaries. This might include, for example, reviewing the ‘medical’ or ‘nursing’ budgets and shifting funding instead to the Integrated Care Systems to address the population health priorities that have been set. One can see how this will require good understanding of what an ACP role can deliver, acceptance that the change is of benefit, and funding to support the changes needed. There will need to be *“supportive individuals in positions of decision-making power”* to enable this change to happen, which Drennan cites Abbot as commonly being the medical profession. Assuming that no new money is set aside to support the expansion of ACP roles, one could argue this can be likened to asking turkeys to vote for Christmas when it is medical budgets that may be reduced to enable the growth of ACP. Decision makers that are higher up in the funding supply chain, or new funding streams and powerful influencers will therefore be needed if the step change in ACP growth that is expected can be realised. A sufficient supply of ACP posts with the right level of pay need to be secured, (generally agreed to be at Band 7 for a trainee post and band 8a for a qualified and verified ACP). These posts need to have job descriptions that reflect the MPF, including opportunities to be involved in education, research, leadership and management, as well as clinical practice activity. This will require a concerted effort at national, regional, and organisational level to reform workforce planning to achieve the ambitious growth targets that have been set.

In addition to recruitment, retention initiatives are needed to ensure there is not a ‘leaky bucket’ where as many, if not more, ACPs leave as start in this role. The data from my study has revealed that many ACPs take on this role at an advanced stage in their career, and therefore may be looking at different options for career progression, career change, or retirement. From the experiences relayed in my research this needs to

include attention to pay, flexible career plans, and support for portfolio careers where part-time or job share opportunities are supported.

Further investigation of the demographics of the ACP community may also allow retention initiatives to be more effectively targeted. For example, there may be a significant group of ACPs who have other caring responsibilities where targeted support including opportunities for part-time or flexible working may be a high priority in deciding whether to stay in this role.

My research has also identified areas where there are gaps between the expectations ACPs hold about the role and the reality they have experienced in working in ACP. To support retention alongside increased recruitment, these gaps need to be addressed. The following 5 recommendations are made in relation to the gaps identified:

A. Ring-fence non-clinical activity.
B. Increase opportunities for CPD & Supervision.
C. Enhance opportunities for leadership.
D. Provide clear and individualised career plans.
E. Continue to embed and evaluate initiatives for standardisation of ACP.

Ring-fence non-clinical activity.

If the 4 pillars of ACP are to be fully realised, a specified percentage of time for non-clinical activity needs to be protected. Clear direction on which activities are expected to be included in this time is required. For example, rostered non-clinical time should not include ‘admin’ duties where these relate to clinical patient management. ‘Clinical’ time should make accommodation for the time needed to update patient records, follow up or report on physiological investigations etc. It may also be the case that

some of these duties could be more effectively managed through enhancement of administration or technological support, freeing up time for advanced clinical work.

This recommendation particularly focuses on the interpretation of what ACPs roles are for and the types of work activities they are involved with. From the literature review it was clear that ACP roles have often developed out of a need to fill gaps and substitute for other staff (particularly doctors) where there are deficits in provision.

Where substitution is evident this commonly leads to task allocation rather than full replication of the scope of practice. Within ACP it is clear this has often led to a dominance of clinical practice tasks. The people ACPs are replacing (e.g. junior doctors) would not normally spend 100% of their time on clinical activity; they also have expectations and time allocated for education, training, and research. Even if it is the case that ACPs are being used as ‘substitution’ we should therefore not expect them to only cover some aspects of the role; to do so will limit their potential. If we take the example of Physician Assistants, these were specifically introduced to allow for clinical tasks that were normally undertaken by doctors to be delivered by this new group of staff. As noted by Oliver (2023), even in this group which have a more closely defined scope of practice there is acknowledgement that they cannot just undertake clinical activity without the professional background, training, and supervision opportunities to be able to practice effectively. The concept of substitution is fundamentally flawed as it supposes you can directly replace one profession for another. Firstly, this makes an incorrect assumption that the skills, knowledge, experience, competence, and confidence are the same. Participants in this study were clear in stating their professional background and training was a key foundation to the KSE they now use in their advanced practice role. This creates the tapestry of ACP

where their professional background is the structure upon which different coloured threads of knowledge, skills and experience are built up over time. Use of ACP roles as substitution that wholly focus on clinical activity are therefore risky territory.

Creating new roles, teams, or services to provide ‘added value’ or supplementation to existing provision may be more successful. Enabling ACPs to operate a full scope of practice that encompasses time allocation to undertake activity that covers all 4 pillars is therefore a primary recommendation from this research.

Continuing Professional Development (CPD) & Supervision

Opportunities for ACPs to engage with CPD activity and to contribute to the CPD of others need to be improved. This needs to include mechanisms to receive feedback which could be enhanced by access to supervision.

In the Trainee Supervision Review final report undertaken in by Health Education England Faculty for Advancing Practice (2022) it noted how around 27% of trainee ACPs said they had no access to a supervisor. This review, alongside many other guidance documents and research, highlights the positive impact that effective supervision can make to the safety, confidence, and development of ACPs (Lee *et al.*, 2023; Reynolds and Mortimore, 2021; Health Education England, 2021a; Health Education England, 2020a; Health Education England, 2020b; Harding and Barratt, 2023; The Centre for Advancing Practice, 2022). 41% of respondents to the survey (Health Education England Faculty for Advancing Practice, 2022) also said they had no ‘supernumerary’ time to support their learning, including accessing supervision. This was echoed by the study undertaken by Lee *et al.* (2023) in which only 57% tACPs stated they had protected time for their studies.

Having time set aside for non-clinical activity could provide the space for ACPs to pursue CPD, and having effective ACP leads and champions in place could provide the support needed to implement effective supervision. All ACPs are regulated and require CPD to remain registered and practice in their profession. Tailoring re-validation, re-accreditation, and appraisal/ performance review processes to include attention to CPD, of the ACP themselves and how they support this with others, would further emphasise and facilitate enhanced opportunities for Advanced Practice.

Opportunity for leadership.

By placing particular attention on ACPs within the ‘reform’ section of the NHS Long Term Workforce Plan (2023b) ACPs ability to make positive changes has been recognised. Enhanced opportunities for leadership are though needed. This may though challenge traditional power dynamics and hierarchies which will need to be carefully managed. In the Kings Fund explainer by Holden (2023) they highlighted how much of the Long-term workforce plan is being left at the local Integrated Care Systems level to implement. Holden also commented that the necessary clarity, capacity, and investment to realise productivity gains that could be achieved by reform initiatives (including expansion of the numbers of trained ACPs) is currently lacking. Alongside government policy development and support, more direct action may therefore be needed at a local level to change organisational culture. Advanced Practice leads could be used to role model and create opportunities for leadership, ring-fence time for non-clinical activity, and raise awareness of the Advanced Practice role. This will be needed to allow ACPs to engage in the design and leadership, rather than just delivery, of quality improvement projects. ACPs need a place at the table when policies and new initiatives or projects are being planned. They should be seen

as a key stakeholder that holds both high power to influence and will have high impact on the success of projects to reshape services using multi-disciplinary teams, and to enhance continuity of care, patient safety and experience.

Career Plans

As noted above, to achieve the growth objectives for ACP, focus will need to be on ramping up recruitment whilst also providing conditions in which ACP can be used as a retention strategy. To facilitate this, clear and realistic career pathways for movement into and onward from ACP roles need to be provided. As noted in the commentary by Holden (2023)*"It will be important to develop the vision for what the workforce of the future should look like, e.g., how roles will develop and fit together".* Honest advice needs to be given at an individual level to weigh up potential benefits to help people decide if pursuing or staying in an ACP role will be the right choice for them and for the organisation or service in which they intend to work.

Career plans for ACP will also need to be clear and truthful about the extent to which the roles are expected to be generalist or specialist and substitution or supplementation. This may require further clarification and direction about what is acceptable or desired in the growth and implementation of ACP roles. Whilst this may to some extent be achieved by standardised documents to set out expected career paths, this will need to be supplemented with opportunities for people to access individual career coaching to be able to weigh up the different factors that influence the reality of working as an ACP in a particular context and to help people to choose the best path for them to follow. Locally I have seen career planning work effectively where the ICS Training Hubs have been providing 'career conversations' to people interested in pursuing ACP. Providing this advice away from the potential bias of

employers or education providers may better support an opportunity for objective appraisal of whether ACP is the right route to take for them at this time.

Standardisation

Efforts to standardise ACP (e.g., mapping against MPF, accreditation and verification of ACP capabilities) need to continue to be embedded and the effects of this measured for success before introducing any other initiatives. Whilst this has been echoed by the NMC and HCPC reports (Nursing and Midwifery Council, 2023; Hardy, 2021; Palmer, Julian and Vaughan, 2023), in recent months we have seen a proliferation of documents, standards, and guidance for ACP, and movement toward regulation. There is a risk that this becomes a confused context with individuals and organisations not knowing which documents to refer to, what is expected, what is guidance, and what is required. There is also a risk that initiatives to standardise continue to proliferate without evaluation of their success. As noted in my systematic literature review and echoed by Palmer, Julian and Vaughan (2023) we do not have robust evidence of what form of standardisation or regulation works effectively. From this research we have some evidence that initiatives such as the MPF are having a positive impact (e.g. on pay and 'quality assurance'). It also shows that there are still significant areas of the ACP population where this has not been fully implemented yet.

As an example one respondent noted that:

> *"I think that these aspects are still under development. In my organisation, a lead for ACPs has only been appointed in the last few months."*

This research, combined with local review of governance structures or 'organisational maturity' (Health Education England, 2022) should be used to identify priority areas to

roll out standardisation. For example, only 16% of AHPs said their job role fitted with the 4 pillars definition of ACP and they had been fully mapped to the MPF. This compares to 40% overall, or 84% of Nurses who said their role fitted and had been mapped. Of those working in Primary Care, (the largest 'specialty' group of respondents), only 27% said their role covered all 4 pillars and that it had been mapped. Implementing mapping and verification against the MPF for AHPs and people working in Primary Care would therefore be 'low hanging fruit'. This could lead to greater standardisation of pay and job titles across different professions and fields of practice, where only those that have been mapped and verified use an 'Advanced Practice' title. A more standardised and verified ACP workforce would then support the efforts needed to raise awareness of the ACP role and what they can do.

Recommendations from this research have therefore been made regarding recruitment and retention of ACPs including by addressing the gaps between expectations and the reality of working as an ACP through:

A. Ring-fencing non-clinical activity
B. Increasing opportunities for CPD & Supervision
C. Enhancing opportunities for leadership
D. Providing clear and individualised career plans
E. Continuing to embed and evaluate initiatives for standardisation of ACP.

DISSEMINATION

To ensure work is begun on achieving the recommendations of my research the first action I have taken is to compile a report of the findings which has been circulated to participants that shared their contact details with me and consented to receive further information about the research. This was sent on the 14th of September 2023 with an executive summary of the key headlines from the research. It was made clear this was a summary of the findings and did not at this stage provide narrative discussion or recommendations. Recipients were told that the next step following circulation of this report would be to disseminate this further through publications, conferences, and relevant networks. They were also asked to get in touch if they had any questions, and to let me know if they use these results to influence their work or in the development of Advanced practice policy, guidance, education, support etc. I also provided a way in which to cite my research, by creating a published version of the report:

http://researchdata.essex.ac.uk/190/

Vikki-Jo Scott, 2023. "What are Advanced Clinical Practitioners expectations of the benefits in pursuing this role, and are they being realised." University of Essex

DOI 10.5526/ERDR-00000190

Following this I got several emails thanking me for the report. Where participants said in these emails they were planning to utilise the findings to feed into other work or to share with others, I have asked if I could follow up with them for a witness statement of any impact that has been made as a result. One participant for example has noted they were using this in developing a new 3–5-year ACP strategy within a particular specialist team and also a regional ACP framework.

At a local and regional level, I have used the findings of my research to feed into discussions around ACP governance, support, and infrastructure. As an example, I am a member of the East of England Primary Care Advanced Practice forum. At one of their meetings, a question arose regarding the proportion of ACP staff with an AHP background and what their particular needs or experiences are. I was able to supply the figures from my research, noting that this is an under-researched group. I was able to endorse the particular tensions that AHPs face where opportunities to work as an ACP may be blocked by profession specific job adverts and that 'generalist' rather 'specialist' ACP roles may be more highly valued. I have also been able to emphasise in this forum that primary care represented the largest group in my research, and this was closely followed by 'other' specialities. I highlighted this means that ACPs are working in non-traditional services which often do not fit with the commonly used specialities within secondary care. Furthermore, I was able to note (from the results of my research) the significant work that needs to take place within primary care and AHPs to undertake mapping to the MPF and verification that they are working to the expected definition of ACP. This may be more of a challenge where AHPs are working in isolation and where specialist MSc pathways for ACP are less available.

I also actively participate in a group for HEIs which is chaired by the East of England Faculty for Advancing Practice (NHS England) lead. The terms of reference include:

The network will consider the national context of developments in advanced practice and how these shape and inform the education of the future advanced practice workforce…The East of England Faculty for Advancing Practice will utilise the experience and knowledge from the network to advise and inform on all aspects of advanced practice education, training, commissioning, recruitment, and retention.

In a recent meeting I was able to highlight how my research, alongside my day-to-day experience as a programme lead had identified poor workforce planning to be a major barrier to the effective implementation of ACP and a risk to education provision. The most recent funding rules for access to ACP training state that a Band 8a role that fits with the MPF definition of ACP needs to be secured before a person can be approved to enrol on a programme. Participants in my research, along with employers I liaise with through other networks as well as my own students, have highlighted the lack of appropriate ACP jobs being put in place. They have noted this may be due to a lack of awareness of what ACPs are and what they can do to benefit the service, or because of lack of funding for posts. This issue seriously threatens the ambitions of the NHS Long-term workforce plan. Following discussion at this meeting the regional lead noted how this has been relayed back to national level. She stated they are now making concerted efforts to influence workforce planning as a result, including being co-opted into groups where this is discussed and funding budgets are agreed. The regional lead's response highlights a finding in my research; that you need to be at the table where high impact decisions are being made to facilitate effective implementation of ACP. The above input I have given to local and regional networks at employing organisation, ICS, and regional level has been welcomed. I have received positive feedback from external partners regarding the information, guidance, and support I have given them and how this has been useful in their strategic planning.

At a national level, I have been successful in publishing and presenting my work through various outlets. I plan to continue to engage in these activities and have further drafts of publications and presentations in place to submit, (once the focus on completing my PhD has abated). In deciding upon my plans for publication I also want to build on the relationships I have made through publishing in the British Journal of

Nursing, the Internal Journal of Advancing Practice, and Wiley textbooks for ACP. As I have shown myself to be a pragmatist, where I can, I will utilise my established contacts to disseminate my research in as expedient way as possible, (again noting the speed at which ACP is developing and findings may become outdated). This has proved successful and an article detailing my research has now been accepted for publication in the International Journal for Advancing Practice.

I am also aware of the opportunistic nature of dissemination. For example, in the last few years a week in November has been used as the 'Advanced Practice week' and notable conferences and social media posts occur at this time. I have therefore prepared conference submissions and text for promotion of my work to coincide with these events. Within these planned events there are ad hoc opportunities to raise the profile of my research. For example, the 2023 conference run by the Centre for Advancing Practice focussed on equality, diversity, and inclusion issues. I was able to use the Q&A to highlight how my research has shown that there continues to be barriers in the way of effective implementation of ACP. We know that where barriers exist these will not apply equally; it is most often minority groups that will be most affected. This can be expected to follow through to who is supported to pursue ACP. I was able to note the significance participants in my research placed upon having a supportive lead to champion the role. This will be particularly important if we are to ensure the ACP community is inclusive.

Opportunities for dissemination often involves being 'in the loop' with key stakeholders so that opportunities can be capitalised upon. As an example, I have contributed to parliamentary enquiry. This includes being involved with policy development work wherever possible and I have actively sought this out. I maintain my involvement with

the Council of Deans of Health Advance Practice forum, and as a result of my contribution to these meetings have been invited to chair a UK wide meeting on latest developments in advanced practice. I have also engaged with the consultations for regulating advanced practice in Nursing and have signed up for future engagement and news briefings from a variety of ACP networks. I will continue my engagement with the networks I have built and will horizon scan for other such opportunities to make sure I am alert to them as they arise. Key actions for further dissemination of my work are therefore:

1. **Using my report of findings and executive summary to build an impact case**. I will follow up with participants and existing networks for witness statements in January 2024.
2. **To prepare for publication in relevant journals.** I will follow up with existing contacts and drawing upon university guidance and support in 2024. I will re-draft my template article in accordance with feedback received and submission requirements throughout 2024 with the aim to be published within 18 months.
3. **To submit abstracts for conference presentations**. I plan to present for at least one University, regional, and national or international conference in 2024. Based upon experience from previous years the majority will require submission between January-July 2024. (For example, in January I submitted an abstract for oral presentation at the International Council of Nurses Nurse Practitioner/ Advanced Nursing Conference to be held in September 2024).
4. **To continue to network on an ongoing basis**, setting aside time to respond to opportunities to promote my research as they arise. This will include attending relevant forum meetings, reviewing news briefings, responding where relevant on at least a monthly basis throughout 2024. (For example, I have

signed up to the ‘community of interest’ for the Nursing and Midwifery Council to be notified of future events connected to their ‘Advanced practice review.’)

CONCLUSION

The aim of the research presented in this thesis was to understand better the expectations Advanced Clinical Practitioners and trainee Advanced Clinical Practitioners have regarding the role and to evaluate whether those expectations are currently being realised. ACPs have been identified as a potential source to achieve innovation and reformation of health services to address population needs, particularly in addressing the expansion in workforce that is needed. Previous research has shown however there are barriers which are preventing the effective implementation of ACPs. A cross-sectional, mixed method, sequential exploratory design has been employed in this research. Focus groups were used to construct themes and a follow up questionnaire captured data from ACPs/tACPs of their experience to date based around those themes. The themes from this research are:

- Clinical- There needs to be a balance of clinical and non-clinical activity to attract and retain ACPs in the role. This would be aided by ring-fencing time for non-clinical activity.
- Full KSE– ACPs draw upon a tapestry of knowledge, skills, and experience but do not always feel like this is understood, recognised, or utilised as effectively as they could be. They are not getting enough opportunity to engage with professional development for themselves or others.
- Leadership in Quality Improvement- ACPs are keen to engage with and can provide examples of making a positive difference to patient safety and experience, reshaping services, aiding continuity of care and providing a

consistent and coherent presence in a team. Opportunities to lead on quality improvement are patchy.

- Career Progression- For the majority of ACPs moving into this role has provided personal benefits in terms of pay, diversifying their scope of practice and moving up the hierarchy. However, the localisation of how ACP has been implemented means that clear and honest information and careful consideration is needed of different factors (e.g. flexible working, opportunities for portfolio careers, costs of working) for an individual to decide whether this is the right move for them to make. Acknowledgement, being appreciated, and having a positive interaction with colleagues or patients are common experiences that made ACPs feel valued in their role. More effective access to supervision is recommended.
- Policy, vision, organisational structure – Whilst there is evidence of progress being made, there is a significant amount of work needed to ensure the right environment for effective ACP roles to thrive. Efforts to standardise ACP have begun but need to be further embedded and evaluated for their impact.

To achieve the objectives of reform, a better understanding of where there are disparities between expectation and reality is needed so that focused initiatives can be implemented. My research addresses this gap by drawing upon ACPs own perspective of the role to identify recommendations for future practice, governance, and research. It has placed emphasis on their voice of 'lived experience' to inform initiatives that will enhance the implementation and support of Advanced Clinical Practice. One respondent neatly summarised the outcome of my research:

"I think there is a journey still to realise the full benefits of the ACP role."

APPENDICES

APPENDIX 1- STARLITE- Literature Review Search Strategy

QUESTION:

What research has been conducted in UK settings with regard to the benefits of 'Advanced Clinical Practice' (ACP) Post-Graduate training and education for key stakeholders?

The key stakeholders are:

1. Health Care Professionals
2. Employers of ACPs (that include clinical practice in their role)
3. Post-Graduate training and education providers (as defined by FHEQ)
4. Post-Graduate training and education commissioners (including self-funded students)
5. Health Care Professional and Regulatory bodies (including organisations that provide credentialing of ACP)

NB excludes Patients/ Service Users and benefits such as clinical effectiveness or patient satisfaction.

Sampling Strategy	Mixed Method Systematic Literature Review.
Type of studies	Primary research & Literature review (not practice, policy or theoretical literature), to include: 1. Literature reviews (including systematic and others which may or may not be specified e.g. narrative) 2. Qualitative (all approaches included i.e. Phenomenology, Grounded Theory, Action research, Discourse Analysis, Ethnography and including e.g. surveys, interview, focus groups) 3. Mixed method 4. Quantitative (e.g. observational including cross sectional, data on cost, number of courses, number of ACPs). Experimental design is unlikely to be present but will not be excluded from search. Case control and cohort studies excluded as ACP as defined by framework (2017) has not been in existence long enough for these types of study to have been conducted effectively.
Approaches to searching	Electronic database search (list databases you choose to search) 1. EBSCO Host Research databases CINAHL complete MEDLINE APA PsycArticles APA PsycINFO 2. Cochrane Library 3. NICE evidence search 4. TRIP 5. Science Direct (Elsevier Science) 6. SAGE journals 7. Snowballing (from papers identified in the above searches, reference lists were then checked for additional relevant research to include) Where full text was not immediately available, an inter-library loan was requested and authors were contacted through ‘Research Gate’ or their name was searched on google for contact details and approached directly to request a full text copy.

	The databases chosen were those that I had available to me (i.e. convenience sampling) (but it is acknowledged that other appropriate sources may be available (e.g. those available to NHS staff).
Range of years	No limit placed. This search took place between 26th February 2020 and 18th May 2020. Alerts were placed on databases so that any new papers identified up until the 9th of June 2020 could be included in the study (when the PRISMA flow diagram was finalised). Dates search conducted: 1. EBSCO Host Research databases 26.2.2020 2. Cochrane Library 21.4.2020 3. NICE evidence search 9.3.2020 4. TRIP 9.3.2020 5. Science Direct (Elsevier Science) 3.4.2020 6. SAGE journals 3.4.2020 7. Snowballing 11-18.5.2020
Limits	UK- health care systems, structure, training and regulation vary considerably between different countries.
Inclusion and exclusion criteria	Words in bold are the headings used in PRISMA to identify where exclusion criteria have been applied. Exclusion criteria are: **Duplicates** (likely that duplicates will be returned as multiple databases/ sources used) Not **Primary research/ Literature review** **Clinical effectiveness**, practice patterns. Not **ACP** (i.e. not pre-registration or other types of training, education, clinical specialities/ specialist practice, professional development or stages of career, such as student nurses or student AHPs, nurse consultants, clinical educators, practice nurses or non-medical prescribers). ACP as defined by the framework is expected to be at Masters level. Some post registration/ qualification CPD is provided as non-accredited or not at post-

	graduate level so it is necessary to exclude these from the review to ensure it does fit with the definition of ACP. There are also some doctoral level training which is beyond the scope of ACP. Not **UK.** It is anticipated that by applying this criterion only papers written in the English language will be returned. If a paper written in another language but that pertains to the UK is returned, a translation will be obtained. <u>Inclusion criteria are:</u> UK (as described in 'Limits' section above). Primary research (not practice, policy or theoretical literature), or literature review (including systematic, and other types of review) as described in 'Type of studies' above. ACP to include the variety of nomenclature used to describe ACP, noting the exceptions as described above. Boolean operators, truncation and phrase searching as described below in 'Terms used' has been set to capture, wherever possible all types of ACP. This includes where this refers to formal training and education programmes from organisations that provide post-graduate education and training products as defined by the Framework for Higher Education Qualifications and regulated by the Office for Students in the UK. (Quality Assurance Agency, 2014). Where the type of training or education has not been specified in the research or where it includes reference to Masters (as defined above) as well as other types, this has been included.
Terms used	The concepts used in the search were 1. ACP 2. Benefits (including advantages pros, good, success, positive, impact, effect, influence or outcome). These concepts were used to determine the terms used and where necessary the use of Boolean operators, truncation and phrase searching: • advanc* was used to capture 'advance', advanced', 'advancing' • clinical and nurs* was used to capture all professions and alternative terms where a specific professional group is referred to within the broader concept of ACP • Practi* was used to capture different spellings (noun and verb) 'practice', 'practise', and practitioner' to include the person undertaking the practice/ practise.

	• Phrase searching was used in the above to ensure articles where singles words such as advanced, clinical, or practice are used (e.g. advanced directives or clinical effectiveness would then commonly be captured where these do not relate to the topic of this review). • OR was used to broaden the search to as far as possible capture all relevant research • AND used to narrow search to the 3 main concepts: ACP, education, benefits Specific parameters were used for each search (noting different databases use different approaches to truncation, phrase searching etc.): EBSCO Host: 1. "advanc* clinical practi*" OR "advanc* nurs* practi*" 2. education OR training OR masters 3. "advanc* clinical practi*" OR "advance* nurs* practi*" AND education OR training OR masters (1 & 2 combined) 4. advantages or benefits or pros or good or success or positive or impact or effect or influence or outcome 5. "advance* clinical practi*" OR "advance* nurs* practi*" AND education OR training OR masters AND advantages or benefits or pros or good or success or positive or impact or effect or influence or outcome (1, 2 & 4 combined) 6. Geographical limiter of 'UK/ Ireland' added. In Cochrane Library: a. "advanced clinical practice" OR "advanced nursing practice" was used which yielded a low number of results. (NB the advanced search function on Cochrane Library does allow phrase searching and automatically searches for word variants). MeSH descriptors were searched for but none that were appropriate came up (e.g. advanced only was linked with advanced clinical techniques or products and Nursing was linked with assessments, audits, assistants or auxiliaries). b. education OR training OR masters was searched and MeSH descriptors were used to search for terms 'Education, Professional', 'Education, Curriculum' and Education Continuing'. These yielded a high number of results. (NB other MeSH operators were not appropriate such as Education, Schools c. advantages or benefits or pros or good or success or positive or impact or effect or influence or outcome were searched with a high number of results

	When ‘a’ was combined with either ‘b’ or ‘c’ no results were yielded. The results from ‘a’ were therefore used in the identification phase of PRISMA. TRIP: A. “advanced clinical practice” OR “advanced nursing practice” was used which yielded a low number of results. (As with Cochrane phrase searching was allowed and automatically word variants were searched) B. when combined with ‘education OR training OR masters’ a large number of results were returned (>300,000). Just those that were returned under “advanced clinical practice” OR “advanced nursing practice” were therefore used in the identification phase of PRISMA C. A filter for ‘primary research’ and ‘systematic reviews’ is available on TRIP, which was used and thereby excluded all secondary evidence, evidence based synopses, guidelines, regulatory guidance, clinical Q&A, blogs, eTextbooks, (all other types of resources such as patient information leaflets, yielded 0 results in any case) Science Direct: I. “advanced clinical practice” OR “advanced nursing practice” was used which yielded a low number of results. (As with Cochrane phrase searching was allowed and automatically word variants were searched). II. A filter for ‘research articles’ is available on Science Direct, which was used and thereby excluded all secondary evidence, review articles, encyclopedia, book chapters, conference abstracts, book reviews, case reports, correspondence, discussion, editorials, and short communications. NICE Evidence: i. “advanced clinical practice” OR “advanced nursing practice” was used which yielded a low number of results. (As with Cochrane phrase searching was allowed and automatically word variants were searched) ii. When combined with ‘education OR training OR masters’ only 65 results were yielded and when this was further combined with ‘advantages or benefits or pros or good or success or positive or impact or effect or influence or outcome’ no results were returned. iii. The 65 results that combined “advanced clinical practice” OR “advanced nursing practice” AND education OR training OR masters were then reviewed.

	iv. Because of the type of database that NICE evidence is the exclusion criteria of empirical evidence was applied at the beginning before searching through all 65 records. The NICE evidence database allows you to filter only systematic reviews and primary research and exclude 'guidance and policy', Practice based Information', 'Implementation Support' and 'Information for the Public'. This yielded only 13 results which were then screened using the remaining exclusion criteria. v. When exclusion criteria were applied no results were yielded. The search was therefore re-run just using the "advanced clinical practice" OR "advanced nursing practice and then reviewed using the standard exclusion criteria (including the systematic reviews and primary research filters). This yielded 103 results of which, only 1 paper was retained after exclusion criteria were applied. SAGE journals: 1. "advanc* clinical practi*"~3 OR "advanc* nurs* practi*" ~3 2. education OR training OR masters 3. "advanc* clinical practi*" OR "advance* nurs* practi*" AND education OR training OR masters (1 & 2 combined) 4. advantages or benefits or pros or good or success or positive or impact or effect or influence or outcome 5. "advance* clinical practi*" OR "advance* nurs* practi*" AND education OR training OR masters AND advantages or benefits or pros or good or success or positive or impact or effect or influence or outcome 6. (1, 2 & 4 combined). This only identified articles that were not related to ACP so the search was repeated using just "advanced clinical practice" OR "advanced nursing practice" 7. this was then combined with 'education OR training OR masters' 8. when 'advantages or benefits or pros or good or success or positive or impact or effect or influence or outcome' this yielded no results so the search combining "advanced clinical practice" OR "advanced nursing practice" AND 'education OR training OR masters' was used 9. the filter for 'research article' was added, which excluded review articles, editorials, article commentary, letters, brief reports, calendar, and 'in brief' texts.
Electronic Sources	This review took place in the early part of 2020 when Covid-19 hit its peak in the UK and national lockdown occurred. Only electronic sources of information were therefore available for this search.

Inclusion criteria	Exclusion Criteria	Explanation
	Duplicates	Duplicate records that arose from searching different databases were noted and removed from the final number for review.
UK	Not UK	The multi-professional framework for Advanced Clinical Practice introduced, (HEE, 2017) applies to England only, but has taken feed in from the other 3 nations work in this area, which have similar structures and principles in the model and theories as well as implementation of ACPs in the UK. Where studies were 'international' in nature and included data from the UK or provided comparisons between the UK and other countries, these have been included.
Primary research & literature reviews	Not primary research or literature review	Not practice, policy or theoretical literature, but to include: Literature reviews Qualitative Mixed method Quantitative
	Clinical effectiveness	Practice patterns and outcome measures (e.g. patient waiting times, hospital re-admission rates, or patient satisfaction.)
ACP	Not ACP	As defined by the multi-professional framework for Advanced Clinical Practice introduced, (HEE, 2017), i.e. NOT pre-registration, clinical specialties/ specialist practice, professional development or stages of career, e.g. student nurses/AHPs, nurse consultants, clinical educators, practice nurses or NMPs. Where the type of training or education has not been specified, or where it includes reference to ACP in addition to others, these papers have been included.

APPENDIX 2- DATA EXTRACTION – (2nd Stage)

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
1	Bagley (2018)	Exploring emergency nurse practitioners' perceptions of their role.	4 key headings: Inadequate protected time for CPD, Importance of senior medical support in role expansion & CPD, inconsistent educational preparation for expanded roles, Perceived reasons for role expansion Education support and development opportunities are inconsistent. Scope of role is disparate and dependant on other factors such as availability of other staff, physicians' level of trust to delegate	6 ENPs from 3 hospitals in one geographical area. Gender was not 50/50 balance. Large range of number of years since qualification as a nurse and time working as an ENP. Previous education qualifications varied amongst participants. Questions assumed that role had changed. Responses and thematic analysis not externally validated (except by participants).	Yes, particularly around access to ACP education opportunities. Also ability to operate in a different scope of practice but not articulated directly what the perceived benefit of this is/ could be for key stakeholders	Yes, this could be broadened out to other ACPs, first identifying what their perceived benefit of ACP training and education would be, followed by a study of if these have been achieved (e.g. pay, job satisfaction, career development, retention in the profession.
2	Barea (2020)	What is a Primary Care Advanced Practice Role in Cornwall?	Wide variety in educational background, variety of professional groups and range of clinical skills/ tasks	ACPs in primary in Cornwall (61 GP practices) 60% response rate. Does not assess	No, it primarily confirms current definitions although does provide specific data on the	Yes, could be replicated in other case studies and as a precursor to implementation of the

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			associated with their scope of practice as ACPs. Wide variety in renumeration and this was not correlated with length of experience or education background or scope of practice, with paramedics only being an outlier in terms of lowest paid (although not consistently). Highlights no national agreement on expected pay band for ACPs. Appears the role has developed opportunistically and suggests this is due to lack of regulation.	directly whether agreed definitions of competency are met (e.g. for those that do not hold MSc do they have other equivalent experience that could be APEL)	scope of practice and landscape of ACP (i.e. numbers, level of education, pay, range of professions) but does also highlight the extent to which people identified as ACP would not meet agreed definition (i.e. MSc) but may be met by 'other equivalent experience as all have worked for many years- so confirms need for APEL	Centre for Advancing practice; would establish to what extent current ACPs would not meet criteria or would need to go down APEL route to do so.
3	Barratt (2010)	A focus group study of the use of video-recorded simulated objective structured clinical examinations in nurse practitioner education.	Use of video recorded scenarios can help prepare ACPs for OSCEs which are typically used in their training/ education. May help with visual learning and may help recall of learning gained in an OSCE. Can re-enforce learning, particularly reassuring learners that their independent learning was	2 focus groups but one f2f and one on-line. The online one was meant to be synchronous but this failed so was asynchronous. The different groups were made up of different stages of learners (i.e. f2f 1st year students, on-line	No, it focuses on one type of education methodology focussed on assisting students in passing their assessment, it does not measure the beneficial impact itself of ACP	Not directly, its absence of a quality, evidence based, generalizable outcome, potentially identifies gap in knowing what types of education methodology longitudinally are effective in the preparation/ assessment of

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			on the right track and provide clarification. Added convenience to learning experience by being able to revisit at their own time/ pace. Technical difficulties can hamper the above and may present inequity in access to learning. Post video discussions not useful. Getting an accurate representation (no use of mannequins) and uncluttered environment in the video is important. Proficiency of acting skills to ignore the camera can affect how useful this is.	2nd year). This makes the groups not comparable. Limited to one university, one course, so not generalizable, particularly as don't know how this is situated in the rest of the training/ education and how comparable this is to ACP programmes of training elsewhere.		competence of ACPs.
4	Bird and Kirshbaum (2005)	Towards a framework of advanced nursing practice for the clinical research nurse in cancer care	Makes reference to existing frameworks (e.g. Benner) to define research nursing within ACP. Noted that context is significant (i.e. US models not easily translatable to UK. Accords to McGee & Castledine re 3 elements of ACP: professional maturity, challenging boundaries and pioneering	V time limited search 2000-2005. 8 articles only. Noted limited empirical evidence and variable quality and were mainly opinion pieces.	No, it adds confirmation to the definition of ACP	No, confirms knowledge and understanding of ACP.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			innovations. And Aitkens & Ersser 15 attributes of ACP that can be applied as an educational model. Concludes that a research nurse in cancer care can be an ACP and a framework for this is proposed.			
5	Carney (2016)	Regulation of advanced nurse practice: its existence and regulatory dimensions from an international perspective	Notes the variety of types and levels of regulation of ANPs globally. From this makes statements that the lack of regulation leads to inconsistency in role definition and notes potential 'competition' with other professions in this arena (i.e. substitution for doctors or ANPs substituted by physicians' assistants).	Literature review from limited number of databases and websites. Inclusion/ exclusion criteria, method and results not clearly presented.	No, it adds confirmation that regulation varies for ACP and this feeds into definitions and scope.	No, it notes the role and variety of regulation in ACP development and practice. this is a weak study which draws conclusions not evident from the research conducted.
6	Cooper, McDowell and Raeside (2019)	The similarities and differences between advanced nurse practitioners and clinical nurse specialists.	Both ANP & CNS seen to add value, favourably received and enhance quality of care at least equivalent to Drs. Both are seen as cost effective and attributed with positive clinical effectiveness outcomes (e.g. waiting times). ANP & CNS had	1st world countries- not sure what this means and who/ why others were excluded. Consultant nurses were excluded where in some articles they have	No, it adds confirmation to the definition and clinical effectiveness of ACP but does highlight how this is similar/ different to CNS	No, confirms knowledge and understanding of ACP.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			almost equal positive impact. Similarities between roles with significant autonomy, acting as a resource and facilitator in an MDT. ANPs tend to be more prevalent in generalist areas (e.g. GP practices, ED). Goals of ANP education curricula broader and more medical based. CNS outcomes focussed on QoL whilst ANP patient satisfaction. ANPs score higher than CNS re patients discussing anxieties and confidence with the clinician. ANPs more likely to be involved in education of MDT and developing Masters curricula. Leadership for ANP at strategic/ national/ international level whereas CNS more at localised level inc MDT. ANPs more involved in research, CNS more audit although for both output is low. Regulation and education	been included as types of ACPs. English language only. Focus on nurses only which limits potential other differences between the two roles of CNS & ACP.		

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			preparation is country specific. Also makes reference to variety of regulation, education, use of titles and pay and suggests managers need to be aware of the above to get the right people in the right roles for the types of activity and outcomes needed. Calls for greater clarity of the roles as currently there is significant overlap and that education preparation, pay etc should be tailored to this.			
7	Currie *et al.* (2012)	Participants' engagement with and reactions to the use of on-line action learning sets to support advanced nursing role development.	Engagement with ALS was poor and this was seen as emanating from poor group cohesion which then limited +ve outcomes from ALS. The opportunity to learn about others' experience was seen as valuable and the associated reading material received positively. The potential for flexible access for geographically distant	The conclusion does not really match with the findings, saying that ALS has some merit. The (well established) barriers to on-line learning which it appears had not been fully addressed in implementing this ALS limits a fair	No, it focuses on one type of education methodology focussed on supporting ACP students in their development, it does not measure the beneficial impact itself of ACP as a result of this education methodology.	Not directly but potentially…. does use of a TNA and/ or activities for networking with other ACPs aid their development and effectivity as ACPs?

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			participants was viewed positively. Pressure of time, learning style, preference for f2f, confidence in IT, previous experience of using ALS were seen as influencing is effectivity. The TNA (Development Needs Assessment Tool) used as part of the process was found to be particularly helpful. No participants reported that the on-line ALS was the most helpful and 4/15 noted it as the least helpful.	assessment of its helpfulness. Sample size was small;15 and a large proportion of the 15 did not engage throughout the entirety ALS. Sample was from Scotland in one pilot programme of study, (where developments of this programme, including learning from this research) may be made.		
8	De Bont *et al.* (2016)	Reconfiguring health workforce: a case-based comparative study explaining the increasingly diverse professional roles in Europe.	There is significant variation across Europe of the type, scope and number of ACP roles both within countries, within particular types of health systems (tax or insurance funded and stage of technological advancement), within professional groups and particular clinical fields (i.e. heart disease, diabetes, breast cancer).	Based on 16 case studies in 8 countries over 3 specialities (care pathways); may not be generalisable to other examples including to other countries, or specialities. These were presented by elected people at a workshop which	No, it adds confirmation to the definition of ACP and the barriers/ facilitators of successful ACP implementation. It potentially measures (through case example) of what extent these barriers/ facilitators have impacted whether the	Yes, does the large extent to which 'localisation' occurs in ACP roles (including physicians wishes to delegate roles) affect the career pathway, opportunities, satisfaction, retention and realisation of benefits of ACPs.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			There is a significant element of localisation which affects the 'professional jurisdiction' (or scope) that an ACP is allowed to practice and confirms the barriers/ facilitators of effective implementation of ACP. This is particularly affected by autonomy given by physicians. Roles can be split into specialised (expert within a clinical speciality with extended authority to perform technical tasks in these specialities) and generic roles (goes across care journey: prevention-cure-care-rehabilitation, and involved to a greater extent in organisation & management rather than specific clinical tasks.	may have introduced bias in results presented and also inconsistency in the way in which these representatives conducted the research, (although standard topic list for interviews, protocol for observations and shared discussion of results plus training and regular meetings were held to minimise this).	benefits of ACP can be realised.	
9	Delamaire and Lafortune (2010)	OECD Health Working Paper No. 54 Nurses In Advanced Roles: A Description and Evaluation of Experiences In 12 Developed Countries	Confirms range of titles, scope and ways in which ACPs have developed and commonly this is in a situation where there is a shortage of Drs. 4 main aims- access to care,	Focuses on Nurses only. Includes CNS as well as ANP roles. Countries chosen as they were willing volunteers	Yes, it collates the evidence of benefits ANPs have in terms of cost, patient outcomes, patient satisfaction, access to care and	Note that 'career progression' was a key factor for a lot of countries in developing APN and that it may help to recruit and retain

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			enhance quality of care and contain costs and enhancing career prospects. Education preparation and level of experience required varies. Evidence shows they do enhance access to care (e.g. reduction in waiting times) and perform to at least equivalent level of Drs and that patient satisfaction is improved. Less evidence available on impact on health outcomes but where it has been done, they are at least equivalent to outcomes without APNs. Cost evaluations have not been done often and commonly don't include all costs of an APN (e.g. including costs of education), or measurements of productivity or impact on costs over long periods. Main finding appears to be whether the role is substitution or supplementation.	(so may be biased in results). Uses questionnaire completed by people in government departments (do they reflect the reality) and literature review so not direct collection of data.	to some extent career prospects. It adds confirmation to the definition and scope of ACP and the barriers/ facilitators of successful ACP implementation.	nurses in the profession and reduce emigration to other countries- not been tested and evidence presented in this study is weak/ based upon perception rather than actual evidence. Comparative study of outcomes between ACPs and Physician Assistants and ACPs.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			Substitution the impact is equal or reduction in costs, whereas supplementation can be cost increasing but this has commonly not been measured over longer periods of time when factors such as avoiding complications of care or repeat hospitalisation. Some variance as to the impact on continuity of care. Barriers and facilitators are categorised as 1) the professional interests of doctors and nurses (and their influence on reform processes); 2) the organisation of care and funding mechanisms; 3) the impact of legislation and regulation of health professional activities on the development of new roles; and 4) the capacity of the education and training system to provide nurses with higher skills. Opposition of medical profession main barrier. CNS more common in			

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			acute and APN in primary care. Highlights intro of physician assistants may decrease use of APNs.			
10	Dowling *et al.* (2013)	Advanced practice nursing: A concept analysis	Consensus around definition of ACP with subtle differences in distinguishing this from other roles such as CNS. Broadly reflects 4 pillars of framework with education, research, leadership and clinical practice common features. This is also reflected in the attributes expected such as clinical experts and leadership skills. In addition, 'autonomy' is seen as central for effective performance. Makes distinction between role extension (taking on roles previously undertaken by others) or role expansion (taking on additional skills in line with own core skills of that profession. I.e. adding value). Notes role extension may lead to fragmentation of care.	Very little data given other than in discursive discussion so not clear of the evidence base and methodology used to form the conclusions. Literature review so not direct observation and only English language so not able to get truly global picture, in fact only included 7 geographical regions. Drawn from a range of literature not just empirical research.	No, it adds confirmation to the definition and scope of ACP	No, confirms knowledge and understanding of ACP.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			Notes differences in legislation affecting prescribing rights. Re-affirms range of titles used to mean same thing and how this is linked to regulation and scope of practice. Recognise roles developed for a multitude of reasons and says 'external' antecedent is changes in medical practice and internal is higher education and clinical expertise. Again confirmed variety of education preparation and proposes that Masters is generally agreed as what should be the minimum with 5 years clinical experience before becoming an ACP.			
11	Duffield *et al.* (2009)	Advanced nursing practice: A global perspective,	Notes large number of titles, overlap of roles and that ACP developed on an ad hoc basis. Discusses inconsistency across countries in education, scope of practice, regulation as a barrier. ACP have proven to be	Literature review with small time frame 1982-2005 findings which may not completely apply to modern context of ACP. Focuses on nurses only.	No, it adds confirmation to the definition of ACP	No, confirms knowledge and understanding of ACP.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			clinically effective with improved patient outcomes.			
12	Elliott *et al.* (2016)	Barriers and enablers to advanced practitioners' ability to enact their leadership role: A scoping review.	Patient level barriers or enablers were not identified. 13 barriers and 11 enablers were identified and organised under 4 structural dimensions identified: health care system level, organisational level, team level, advanced practitioner level. Organisational level was the dominant barriers found, with large clinical caseload being the most reported. High volume/ focus on clinical tasks limited availability to undertake other aspects such as research and networking which would have been helpful (especially for visibility as a leader). No admin support and access to IT was also a factor. Lack of clarity over role, lack of authority and position,	Literature review rather than direct observation so may have some bias on what has been reported thus far. Literature from a range of countries who will have significant differences in context for ACP. Patient level barriers or enablers were not identified but? Not significant or just not researched/ reported. Quality appraisal of the literature not undertaken.	No, it adds confirmation to the barriers/ facilitators of successful ACP implementation, with a focus on the leadership aspect, which in itself identifies potential benefits of ACP implementation, but does not measure this directly.	No, confirms knowledge and understanding of barriers/ facilitators of ACP.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			subservience to physicians and opportunity to work at strategic level was also cited. Lack of education, mentorship or skill development. Networking (internal and external to the organisation) and skills development days/ opportunities were identified as key enablers. Personal attributes, accreditation and links with universities also noted.			
13	Endacott and Chaboyer (2006)	The nursing role in ICU outreach: an international exploratory study.	Patient interventions take up the largest part of the role, with use of scoring systems to assist with this, but with a move toward less direct patient care (i.e. doing it for the ward nurses rather than advising them) as the role has matured (more so in UK than in Australia). Educating, developing, advising and supporting staff across the hospital was significant. Liaison between ITU and other	Use of a particular model to evaluate however author notes that participatory action research would have been optimal for development of ACP roles. 2 countries, different contexts and maturity of the role. Limited to the role of ICU outreach nurse.	Yes & no… it provides evidence of potential benefit of ACP at a 'hospital wide' level which would be significant for key stakeholders and the factors that may influence this. The actual impact of ACPs working at hospital wide level has not though been directly measured. It	Yes & no… No, confirms knowledge and understanding of definition of ACP. Yes- presents opportunity to measure directly the impact of ACPs who are working at hospital wide level. It gives a definition of what 'hospital wide level' means, so ACPs that fit this criteria could be identified and

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			areas was evident, this and other aspects of the role fed into impact at a hospital wide level e.g. both in changes to practice within the ICU but also speeding up discharge and filtering referral. Gave a continuation to episode of care outside of ICU where the ICU consultants do not/ do not want to get involved outside of the ICU doors. Service development took priority (and to a lesser extent research. However, variation is evident between 2 countries and role in Australia is more limited in scope and recognition.		perhaps mainly confirms the definition of ACP and potential scope of practice, barriers & facilitators of that, which has been documented elsewhere.	compared with those that aren't or are in services that are absent of ACPs and see what beneficial impact there may be. Outcome measures for this would need to be identified.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
14	Gerrish *et al.* (2011)	Factors influencing the contribution of advanced practice nurses to promoting evidence-based practice among front-line nurses: findings from a cross-sectional survey	Majority were mature women, with significant experience. Majority had a UG degree with 28.9% Masters and 0.7% Doctorate. Some held no academic qualification and consultants had the highest number with Masters or Doctorate. NPs and CNS least qualified. Able to articulate definitions of EBP and refer to hierarchies of evidence and variety of research methodology and the value of systematic reviews. Value also placed on knowledge gained from practice and the individual perspective of the patient. The most common source of evidence used frequently was national policy/ guidelines (i.e. not the empirical evidence itself), followed by education programmes and CPD. Interactions with other ACPs and the MDT ranked higher than	Assumes that it is accepted that ACPs are meant to be change agents and leaders of championing and facilitating use of research/ EBP. Takes the stance that front line nurses value highly the opinion of such people and would look to them rather than seek out/ apply the evidence base directly themselves. 7 out of 28 SHAs at the time was used as sample. The APNs were identified by the Directors of Nursing (but as noted elsewhere does this really capture them all) and encompassed a range of roles including CNS (50% of respondents),	Yes, it identifies the potential for ANPs to be effective facilitators and change agents, and supportive resource for clinical problem solving and policy development but that barriers including level of education and workload are limiting this potential.	Could repeat this from the perspective of key stakeholders/ front line nurses themselves to see if they agree with conclusions drawn. Identifies areas where increase in confidence / skill is required so could test this as part of an education programme of ~ACPs to see if over time they increase their ability, for example, to work at levels of developing national policy, or to use direct empirical evidence in advising/ supporting front line nurses.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			published knowledge. Information from patient, product literature, organisations intranet and intuition were lowest ranked. A range of ways of influencing front line nurses were identified and respondents agreed with these. Clinical problem solving and disseminating information to colleagues was most frequently cited. 21% engaged with developing national policy. APNs positive about their impact. Largest proportion saw themselves as complete beginners/ novice in undertaking research but highest was using the web (even though reported low levels of using this as a resource) and being a change agent. Largest barrier was seen as workload and that they had insufficient resources to promote EBP. Those with Masters or above were more confident in	matrons, nurse consultants. Focus is on Adult Nursing only. Questionnaire developed from literature- but does not say what/ how the literature was chosen. Poor completion rate and some completed the questionnaire but were not APN Don't know how many questionnaires were distributed so cannot determine response rate. This was data gathered through self-report rather than direct observation or corroboration of others including front line nurses.		

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			their skills of promoting and facilitating EBP. In contrast to other research others (inc physicians and managers) not seen as a barrier.			
15	Gloster, Neville and Windle (2015)	An international perspective of advanced practice nursing regulation	Where countries said they had ANPs there was commonly more than 1 role. 4 said there were no ANPs in that country. The majority were regulated in some way with some who identified as not regulated still have some credentialing in place- UK is an outlier in this respect. Minimum education requirements vary but MSc was the most common and there were some that had no minimum education requirements (including the UK). Barriers were identified as opposition	Survey sent to 135 National Nursing Associations known to ICN- others may have been missed. Only 36 responded 6 of these sent incomplete data so was not used, and only 24 completed the full survey (i.e. inc the open-ended questions). Sent on-line and only in English which as an international survey with a variety of IT access and language	No, it adds confirmation to understanding the global context of ACP including barriers to successful ACP implementation, but does not measure this directly.	No, confirms knowledge and understanding of the global context of ACP and how the UK fits within this and the potential barriers to ACP being successful.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			from physicians and medical organisations, pharmacists and some governments. Legislative limitations on scope were seen as a barrier (including prescribing rights), poor representation at policy making, leadership and government level, variance in pay between physicians and ANPs. Oversight by physicians and lack of political strength of nurses also identified. Lack of title protection and regulation was directly cited as a barrier. Poor strategic leadership and lack of recognition, plus lack of standardisation of competencies and education requirements. Use of medical model and lower socio-economic status of women also cited.	barriers is an issue). Notes that use of the title ANP/ CNS may have confused as this research also confirms inconsistency in use of nomenclature		
16	Heale and Rieck	Future enhanced clinical role of pharmacists in	ACP pharmacists could contribute to managing workload in ED. (up to 1	Focuses on pharmacists rather than more broadly	Yes, gives evidence of contribution that	Yes, could be repeated with other

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
	Buckley (2015)	Emergency Departments in England: multi-site observational evaluation	in 13 or 7.8% of cases). Significant variation regionally as to the extent to which it is believed a pharmacist could have manged the patient. With additional training (i.e. ACP) it could rise to 36% being able to be managed by pharmacist. Training for ACP pharmacists in this context would need to include clinical examination & assessment, diagnostic skills, medical management & treatment and specific conditions/ tests (e.g. radiology, dermatology). General medicine and orthopaedics shown to have highest no. of cases that could have been managed by pharmacist and training therefore should be prioritised on these areas.	ACPs. Specific types of ED which may not be comparable to all EDs. 63 pharmacists undertaking observations and categorisation- not clear what training/ information was given for this role however good attempt to have categorisation randomly checked by another and other professional groups. (10.6% of cases differed between 1st and 2nd categoriser)	could be made to managing workload in Emergency Department by ACP pharmacists. Gives evidence for the types of training that are needed/ need to be prioritised for ACP pharmacists working in an ED.	types of ACP in other specialities.
17	Hughes *et al.* (2017)	Deriving Consensus on the Characteristics of Advanced Practice Nursing	Descriptive framework of ACP and highlight ways in which practice domains	Focus on Nursing only. Compares practitioner, CNS	No, it adds confirmation to the definition of ACP which in itself	No, confirms knowledge and understanding of definition of ACP.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			and role activities differ across ACP roles. 7 distinct domains identified and within these 19 categories of practice activity, constituent subcategories and related tasks There is heterogeneity between APN roles. Some features of APN not currently articulated well in models / definitions. Improving systems of care and developing others tend to characterise CNS as opposed to consultant or practitioner. Autonomous practice and research particular to CNS and consultant rather than practitioner. Variations across countries re APN role in developing & delivering education. Call for consolidation of roles. Role of APNs mitigating risk and promoting quality care seen as important and under-utilised.	and Consultant, defining all as ACP. Education finding may be due to measurement & definition rather than a substantive difference- needs further research. APN nomenclature potentially affected search results	identifies potential benefits of ACP implementation but does not measure this directly.	

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
18	Hutchinson (2014)	Evidence characterising skills, competencies and policies in advanced practice critical care nursing in Europe: a scoping review protocol.	In intro refers to benefits of ACP as quoted from elsewhere (? Evidence based) Standardised advanced practice positively impacts patient safety, decreases adverse events, prevents severe burnout syndrome, reduces attrition rates and minimises deskilling of nurses that meet barriers to performing at their level of qualification. Presence of APNs in emergency and intensive care units has a positive impact on patient safety, patient experience and quality of care, length of stay, time to consultation/treatment, mortality, patient satisfaction and cost. APNs have been shown to promote staff knowledge, skills and competencies, quality of work life, distribution of workload and teamwork, while also contributing to the achievement of organisational priorities	Focuses on critical care nurses only. Sets out how scoping review will be done but does not provide the results from this review in this article.	No, it adds confirmation to the definition of ACP and does not provide results from the scoping review. Some benefits are listed but does not examine the evidence base these have originally been drawn from.	No, confirms knowledge and understanding of ACP.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			and targets and development of policy. Notes variation in titles, education preparation			
19	Kaldan (2019)	Role development and effective practice in specialist and advanced practice roles in acute hospital settings: systematic review and meta-synthesis.	Personal characteristics including confidence, stamina, assertiveness, motivation, flexibility and skills for negotiation and conflict resolution influence the effectiveness of ACP role implementation. Prior experience in the speciality, hospital and service facilitated transition and involvement in service improvement. Regulatory barriers (including NMP) were perceived as leading to lack of consistency on education programmes, professional development and career pathways. Pay and grading can act as a motivational barrier. Education can have a significant impact on the above and lack of access to this education can act as a barrier. Individual	Excluded Mental Health & Midwifery specialities. Only qualitative studies included. Paucity of studies with full range of key stakeholders Mixture of studies of CNS and APN Focus on Nursing ACP roles only. Primary sources in this study did not focus on barriers/ facilitators (e.gg absence of a barrier does not mean it was irrelevant it was just not included in the study). Many of the studies included used small sample and cross-sectional self-report or self-	No, it adds confirmation to the barriers/ facilitators of successful ACP implementation which in itself identifies potential benefits of ACP implementation but does not measure this directly.	No, confirms knowledge and understanding of barriers/ facilitators of ACP.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			courses as opposed to whole programmes of education combined with clinical experience and a period of induction and availability of role models were seen as preferential. CPD vital for credibility and to avoid deskilling in their origin profession/ speciality. Appraisal, supervision and feedback is needed. Organizational culture including role ambiguity, lack of valuing of clinical expertise, and conflicting expectations of the role (including excessive workload dominated by clinical) prevented successful implementation of the full scope of ACP. Professional autonomy, access to ACP support networks, and attitudes of or relationships with other professionals can facilitate or impeded role transition/ implementation. Proposes broader integration of APNs into	reflection methodology. Number of the studies seen as low quality with no established validity and reliability.		

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			teams is warranted and goes beyond doctor substitution. 4 pillars not nuanced enough to reflect contemporary APN			
20	Lloyd Jones (2005)	Innovative strategies: Increased engagement and synthesis in online advanced practice nursing education.	Introduction of case-based discussion and gamification strategies improved test results (the test assesses / helps prepare ACP students for their licensure exam). Students responded positively to this change, noting opportunity for interaction with academic staff to ask them questions/ seek clarification and that case-based format allowed them to think critically.	One programme of one type of ACP, and? in US (not directly stated). Makes assumptions that this increased engagement, but this was not directly assessed. Did not measure whether this positive effect continued over a longer period of time, e.g. was it just because it was new that people responded well to it? Connection with academics and opportunity to share experiences noted as most beneficial impact- but this is broader	No, it focuses on one type of education methodology focussed on supporting ACP students in their development, it does not measure the beneficial impact itself of ACP as a result of this education methodology.	Not directly but potentially…. does use of a cased based discussion/ gamification and/ or activities for networking with other academics and other student ACPs aid their development and effectivity as ACPs?

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
				than just gamification, other strategies could equally achieve this.		
21	Mackavey and Cron (2019)	A conceptual framework for advanced practice: an action research project operationalizing an advanced practitioner/consultant nurse role.	Provides a conceptual framework to describe ACP which broadly echoes the ACP framework and common definition. It also provides direction as to the key ingredients needed in the context of introducing and supporting an ACP if it is to be effective: shared values & beliefs, open non-hierarchical management, organisational authority attributed to the post. Noted how useful it was having a foot in HEI (1 day a week) to support the role and saw education in its broadest sense central to this role- facilitating learning, coaching, educating on research techniques, using learning to develop protocols, acting as a consultant,	The role holder studied was the researcher. Not clear how the diary entries of activity where objectively verified, by how many other people, what grade/ role/ level of experience they had. 1997 so context may have changed significantly since then (although conceptual model actually chimes very well with more contemporary sources). Notes that at that time nurses don't download research' unless they go onto PG study, which may be less true and so	No, it adds confirmation to the definition/ scope of ACP and thereby identifies potential benefits of ACP implementation, particularly around the 'education' pillar. It identifies facilitators of effective introduction/ support of ACP roles.	No, confirms knowledge and understanding of ACP (particularly the education aspects) and potential facilitators.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			developing practice and creating a culture/ environment where reflective practice occurs.	could now have some of the 'advanced' skills (e.g. protocol writing, EBP, reflective practice) at an earlier stage- the understanding of what is standard/ advanced has shifted.		
22	Manley (1997)	Review of advanced nursing practice: the international literature and developing the generic features	Identifies 7 themes of the generic features of ANP (skills and attributes): Use of knowledge in practice, critical thinking and analytical skills, clinical judgement and decision making, professional leadership and clinical inquiry, coaching and mentoring, research skills, changing practice. Suggestions are then made as to how these have been translated into tasks/ activities associated with ACPs in practice.	Limited to last 15 years i.e. 1992-2007 when ACP was in existence/ has developed outside of this time. Encompasses non-empirically derived evidence to reach conclusions. Excluded ACP if it was not the prima facie of the article but could have contained relevant material. Excluded personal opinion/ editorial but said that it included all	No, it adds confirmation to the definition of ACP, particularly the skills and attributes that typifies ACPs, which in itself identifies potential benefits of ACP implementation, but does not measure this directly.	No, confirms knowledge and understanding of ACP, particularly the skills and attributes needed, which could then form a structure for education of ACPs. Yes. This could be tested to see if current ACP education programmes contain reference to development of these skills/ attributes.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
				types of literature so not clear how relevancy was determined. Used data saturation and highlighted 'seminal' articles but not clear how this was determined.		
23	Mantzoukas (2007)	Nurse practitioner practice and deployment: electronic mail Delphi study	Effective deployment of ACPs requires autonomy, common understanding of the role, clear management support. Team working, freedom to refer, seek advice and authorise investigations and prescribing rights are needed. A national standard for education was identified as crucial combined with facilitation in practice. Hierarchical and decentralized structure can inhibit ACP role development. Discussion of regulation and funding, and attitudes of other members of the MDT (including strangle hold of Drs) as a potential	Use of email which is noted as being 'novel' at that time so may have restricted access to relevant participants. Key thinkers were identified and then they recommended others- danger that the 'old boys' network' or club of people that all think alike are the only ones selected. Only 50% responded to stage 2 and so 'top 5' statements could not be identified- all 7 identified were	No- it adds to the knowledge base around barriers/ facilitators for full implementation of ACP	No, confirms knowledge and understanding of barriers to the implementation of ACP.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			confounding factor to effective implementation (? Evidence base for this from the results of this research). Local arrangements rather than centralised structured approach are seen as a barrier.	included. Short time frame made approach they could take limited. It is not clear where some of the items in the discussion section have been drawn from -? In this research data or from elsewhere.		
24	Marsden (2003)	Advanced practice in ophthalmic nursing: A comparison of roles and the effects of policy on practice in the UK and New Zealand.	Variety of roles and role titles, variety of renumeration, variety of education (noting that in NZ nursing is graduate level at pre-reg where in UK this is recent)... Driver for the role varied and this sometimes then influenced the later extent to which it was MDT. Driver often was filling a Dr gap. Noted could be due to need to increase number of sessions (so notes a benefit to service reconfiguration/ increase in demand). Does note that once role established nurses were seen as	Based on 2 studies- UK & New Zealand only, and only in ophthalmology nursing. Does not give detail of analysis methodology or data generated.	No, it adds confirmation to the definition of ACP and provides current state in this sub-section of ACP, including reference to barriers/ facilitators which in itself identifies potential benefits of ACP implementation, but does not measure this directly.	No, confirms knowledge and understanding of ACP and potential drivers.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			drivers how the role emerged (this does not match up with other studies findings). Noted different context as to extent of private/ public practice. Education 'controlled' mainly by doctors when it is a nursing role. Lack of time critical factor in access to education. Varying perception of whether they felt competent for the role they were performing. Co9ncludes lack of policy has actually provided opportunity to develop these roles and respond to particular needs albeit they are now very diverse (inconsistent).			
25	Marsden (2013)	Emergency nurse practitioners' perceptions of their role and scope of practice: Is it advanced practice?	Variation in education preparation (including non-MSc) Variation in pay bands 5-7 Scope of practice perceived to be determined by their own competence and to a lesser extent external factors such as patient	Evidence of ensuring content validity of survey, including use of a pilot. Restricted to ENPs working in A&E and MIU in Northern Ireland only.	No, it adds to the definition/ current state of ACP in this sub section of practice and adds confirmation to the barriers/ facilitators of successful ACP implementation, the focus is more on	No, confirms knowledge and understanding of barriers/ facilitators of ACP.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			wishes, age, wishes of medical staff, nursing management, referral rights and NMP authority. Obstacles to autonomy = lack of role development, control of the role by others. Clinical practice dominated with limited involvement at organisational/ policy making level.	70% response rate. Only 26.2% respondents with a PG study background, remainder were UG (35.7%) or short courses/ in-house training only (31% + 7.1%)	potential limiters on ACP fulfilling their full benefit.	
26	McConnell (2013)	The perceived impact of advanced practice nurses (APNs) on promoting evidence-based practice amongst frontline nurses: findings from a collective case study	It is difficult to capture impact of ACPs re promoting EBP in frontline nurses. However, was categorised into direct/ indirect, immediate/ delayed and intentional/ unintentional. Impact was themed as: developing competence, empowerment and improving care. Developing competence e.g. role shadowing, secondment or role modelling, and through contribution to education inc bedside instruction, in-house training and contributing to university	Focus on nursing only. case studies from 23 nurses +up to 10 others for each nurse across 7 SHAs. APNs included CNS, matrons, clinical educators etc so may not meet with the framework's definition of an ACP now). Notes impact was often reported subjectively rather than something that could be measured (e.g.	Yes, specifically re use of EBP which is not covered elsewhere in evidence but is within the definition of ACP. (So? does not add anything new to the existing definition). Does highlight the benefits for health care staff rather than to patients/ clinical outcomes.	No, confirms knowledge and understanding of ACP, encompasses all 4 pillars more so than other evidence. Yes, Highlights benefit to one key stakeholder but not whether this also transfers to a benefit for other stakeholders which could be explored further. Yes, highlights potential negative of disempowering other

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			based education. Also, contribution to TNA and leading a response to that, such as producing clinical guidelines. Empowerment: to solve problems (i.e. not telling people what to do) and thereby equip them with clinical decision-making skills and confidence for the future. Acting as a resource for specialist knowledge, latest guidance etc and thereby gain confidence when interacting with others. Nurturing questioning and learning environment. Can also be disempowering when ACP takes over or does not do the above- doing for rather than enabling people to do for themselves. Improving care: trouble shooting, detecting and solving clinical problems. Intervention by ACP leading to a change in care provided, including when remedial action was	introducing a clinical guideline as a response to TNA, does it actually increase competence in front line nurses?). Where it was measured (e.g. through re-test of competence) this was not then also measured in terms of +ve outcomes for patient/ clinical effectiveness. APNs identified stakeholders themselves so may be biased in self-selecting. Purposive sample of ACPs who responded to survey so may be the ones already more readily engaged with promoting EBP.		people working in the team if ACPs take over or 'do for' rather than providing support and resource for them to better 'do for themselves'. Could explore the extent to which people think this is the case (e.g. does having a critical care outreach team deskill ward nurses in managing the deteriorating patient and does this matter?) Yes, highlights that a study on whether the presence of and ACP impact on job satisfaction not just for themselves but also for others in that team would be worth exploring.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			needed to maintain expected standards. Includes audit used as a tool to identify issues and mobilise change. Role modelling and promoting holistic care. Introduction of guideline, protocols, tools. (but again? Whether impact on patient care has been tested).			
27	McDonnell (2012)	An evaluation of the implementation of advanced nurse practitioner (ANP) roles in an acute hospital setting.	ANPs contributed positively to continuity of care, communication, and patient experience and did so in a holistic way. Safety enhanced by ANPs being able to skilfully pick up issues in complex context and respond to them promptly (e.g. recognition of deteriorating patients). Staff found them to be approachable and available for EBP advice. Exemplary record keeping. No evidence of deskilling others/ detracting from junior doctors training. Staff found them to be reassuring and improved	Stakeholders selected from contacts the ACPs provided-? Bias towards positive impact. Focuses on medicine, surgical, orthopaedics in 1 acute hospital in North England	Yes, evidence for positive impact on patient experience, patient outcomes, patient safety (i.e. clinical effectiveness) but also staff experience, quality of life and their own development, and positive impact on the organisation including achievement of organizational priorities, targets and development of policy, processes and service delivery. Also	Yes, could explore further the positive impact on staff and on organisation. Did not explore impact on the ANP themselves so leaves this as a gap in evidence.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			the quality of working life of others. Reduction in workload on others and improved team working including interprofessional communication. Cost saving by supplementation for Drs vacant posts/ decrease in locum costs. Policy development including redesigning care pathways and protocols.		provides current status of a subset of ACPs including features such as variety of education	
28	McDonnell (2015)	A Survey of Specialist and Advanced Nursing Practice in England.	ACP posts lower in volume than CNS with >50% of Trusts saying they did not have ANPs. Variety in grade and pay and suggests more often act as substitutes rather supplementary roles. Where they were employed, focus was predominately on physical aspects of care where demand on medical staff was expected to be high. Scope of practice was varied but broadly reflects 4 pillars. Perception that they enhanced patient care, had greater competence than junior	Survey was in 1995- regulation landscape and health care context has changed since then including drivers for ACP such as degree level entry for nursing. Respondents were senior managers who may not be fully aware of advanced practice occurring. Did not track which Trusts did/ did not respond so can't make assumptions	No, it adds confirmation to the definition of ACP which in itself identifies potential benefits of ACP implementation but does not measure this directly.	No, confirms knowledge and understanding of ACP.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			Drs and therefore decreased risk to patients, freeing up medical staff for other tasks. Reference made to a range of benefits related to clinical effectiveness (e.g. reduced waiting time). Expressed concern that it may lead to deskilling others. Notes numbers have increased but clear Trusts are at early stage of considering the use of ACPs.	of trends in particular geographical areas/ contexts where ACP may vary. Results are reported from survey respondents rather than measuring outcomes directly (e.g. actual numbers of reduction in waiting times).		
29	McGee (1996)	Evaluation of Advanced Practitioner Roles	Predominant reason for intro of ACP was to reduce junior Drs hours and so the majority it was role supplementation rather than expanding the scope. Next was to increase service capacity and lastly to increase MDT working. Attempted to highlight claimed improvements of service delivery (e.g. improved patient care, reduction in length of stay), but there was little data to back up these claims, although in	Did not examine qualitative factors including 'staff morale'- limited to cost-benefit analysis. Highlights difficulty in collecting data in new roles and where objectives differ from locality to locality (i.e. different outcome measures). No pre-post comparison and so possible that	Yes, summarises much of the proposed benefits for ACP and provides an evaluation particularly regarding the cost-benefit elements related primarily to clinical effectiveness and service delivery/ re-design. Evidences potential issues re sustainability of ACP posts when	Yes, could be repeated following major developments in ACP i.e. framework in 2017 and NHS Interim People Plan 2019 to see if it has changed at all. Highlights paucity of evidence re qualitative such as staff morale (job satisfaction, opportunities for career development, CPD).

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			literature review it was noted there was 'burgeoning' attempts to identify the potential benefits. Lack of presence of HR and finance in the process which may have contributed to the poor planning, patchy implementation, lack of outcome measures to assess success, and shaky sustainability of the posts where they were not embedded in workforce plans or initial implementation was learned from for subsequent implementation/ changes in workforce. Individual people can make or break the implementation (i.e. you appear to need a dedicated champion for this to work and where there is resistance at a medical/ senior level from an individual it is less successful). Majority of sites had not used existing	outcome measures such as reduction in junior Dr hours will have occurred anyway, through other initiatives. Had to rely on literature review and case studies (n=4) in the end rather than direct primary data collection as the information was not being collected/ available in the same way in all sites. 2008 following 'Changing Workforce Programme which ran 2001-2005'. New documents since then (i.e. NHS Interim People Plan).	structured and supported planning is absent and training is not using methodologies for economies of scale and convenience (e.g. on-line delivery). Although…"The research revealed that there is currently little in the way of hard evidence within the UK to support the claims for the cost-effectiveness of introduction of the roles."	Highlights need for research which defines what the proposed benefits (i.e. outcome measures) they are looking for and then tests this once they have been introduced (pre-post evaluation).

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			guidance to structure implementation (DoH Good Practice, New Ways of Working document). Education pathways were costly and had not capitalised on generic elements of training that would provide economies of scale and therefore sustainability. On-line delivery was successful for elements of the training but this was not utilised as fully as it could be. Most sites did not have plans for training of further ACPs. Recruitment to ACP posts varied. Majority remained in sites where they had trained but some moved to higher paid posts elsewhere or into other positions (NHS management or academia). Few opportunities identified for CPD for ACPs. Lack of clarity and communication plan re introduction of the role was a barrier. There was resistance from			

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			medical colleagues but most had been won round when they saw how they could support their work. Recommendations given on how to capture data in future to inform workforce planning and assess effectively the impact of such new roles as ACP.			
30	Miller, Cox and Williams (2009)	An International Survey on Advanced Practice Nursing Education, Practice, and Regulation	Collected information on description of the role, education preparation, regulation, scope of role, policy and support for the role in the country surveyed. Included asking respondents more detailed information of one education programme and links to websites for education programmes. Majority had a formalised education programme and this was regulated. 90% of countries had programmes were at Masters level but these were offered alongside other programmes at lower levels- only 50% said Masters was the most	In depth data on education programmes not presented in the paper. Respondents were those registered with ICN INP-APNN so are likely to be those well connected, informed and perhaps already influenced by knowledge gained through this network of experiences elsewhere. 55% nurse educators where more typically ACPs note	No, it adds confirmation to the definition/ scope of ACP including education preparation and regulation.	No, confirms knowledge and understanding of ACP.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			prevalent. Majority said there was formal recognition either through professional organisations, government, hospitals/ care agencies or other (including medical, nursing and dental councils). 92% said it was a requirement to undertake an education programme, 76% registration and to a lesser extent clinical agency sponsorship or accreditation. Less than 50% were required to revalidate/ renew their licence although there was a majority with requirements for practice, CPD or other assessments. There was a range of scope including variety of field speciality and levels of independent autonomy (e.g. to refer, carry own case load, prescribe). Facilitators and barriers were identified including strongest supporters for the role.	the time they spend on non-clinical is low and this is not their main job. Wide range of titles including CNS, so? ACP. Online survey (so reliant on those with a connection) and evident it was shared with and completed by others who may not have been in the intended sample. Only in English language which may have prevented responses from some countries/ individuals.		

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			Highlights issue re range of nomenclature, leading to variation in education, scope, and mix between CNS and ANP. Acute settings have most prevalent numbers even though the role originated in primary care.			
31	Pulcini *et al.* (2010)	Education. Realizing specialist and advanced nursing practice: a typology of innovative nursing roles.	Examined particularly whether Nurse Practitioner is closer to CNS/ ACP role. Looked at typology and issue that one person may be holding different roles across different domains with the same title or vice versa. The majority of respondents felt they were somewhere in between CNS and ACP and for a significant portion were unable to distinguish between the two. Also noted that specific skills/ tasks were disappearing from CNS/ ANP role as they were being taken on by others not in this role (e.g. general nurses) and this is likely to continue to	Focuses on nursing only and now quite dated in relation to Nursing regulation- changes were happening at the time that have now become embedded and roles have developed. Part of a larger study. The 49 informants were purposively sampled as 'key stakeholders' as believed to be able to give an informed opinion- not clear how this was decided. Could this have introduced bias?	No, it adds confirmation to the definition of ACP which in itself identifies potential benefits of ACP implementation, but does not measure this directly.	No, confirms knowledge and understanding of ACP.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			happen over time so you can't say that a particular skill/ task is the sole domain of a CNS/ ACP and that's what helps to define them. Makes reference to changes in nursing regulation re specialist and advanced practice and titles on the register.	(e.g. largest number were clinicians). Large number could not fit into the typology framework that had been decided upon- not clear how this typology came about. Does note issues of using definitions from countries other than UK where context, regulation etc is different.		
32	Read *et al.* (2001)	Exploring New Roles in Practice (ENRiP) Final Report	Myriad of reasons for developing new roles inc, recruitment difficulties, medical profession deciding role was needed, government initiatives (including reduction in junior Drs hours, and waiting list targets), commissioner demands, changes to regulation in the profession (i.e. in Nursing Scope of Practice by UKCC), targeted funding (e.g. funding for	Conducted in late 90s when things such as the 'scope' and its influence have been superseded by other regulatory body changes, new funding models and government directives. Did not cover all types of health care provision. Was evident that	No, it adds confirmation to the volume and multivariate nature of ACP and how they have been established. Some potential 'clinical effectiveness' benefits of ACP implementation, are measured by self-report but these are not set against	No, confirms knowledge and understanding of ACP and provides some evidence of the 'clinical effectiveness' aspects of beneficial impact of ACPs. Could be repeated to see if there are differences between those with different types of training/ education.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			Macmillan nurses) and individual postholders making the case for the post. There was lack of planned structure and consistency in developing the roles with senior management often not having any organisational control or awareness of the roles (so ? how this fitted in with strategic direction of the organisation and their workforce plans). Confusion over titles, disagreement about training, grades & pay and differences in approach to risk management. 72% Nursing and 28% AHP new roles with Physio and radiography making up the largest portion of AHP. CNS was 33% and Nurse Practitioner 16% but under current definition the remaining 77% (not CNS) could be defined as ACP. Identified range of profession/ group that lead the role development with	knowledge/ understanding of ACP roles in AHP less known about. Taken from 20% of the acute sector and suggested this is reflected as the whole. Relies on self-report so not independently verified. Mixes specialist with advanced practice roles.	whether PG training affects this.	

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			largest proportion in Nursing recorded as 'no information' (? Developed a while ago so this information lost, or senior leaders interviewed not in control of these developments so could not answer). High proportions were not receiving clinical supervision. Findings re some aspects of scope demonstrate enhanced clinical effectiveness (e.g. scope to assess, order investigations, manage complete episodes of care, clinical procedures, accept patients into the service or refer to others thereby impact on service capacity/ delivery.)). Longitudinal relationships of role holders enhanced continuity of care and may provide evidence not just of substitution but 'value-added' component that improved qualitative experience of care for patients and their families.			

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
33	Roberts-Davis (1998)	An evaluation of therapeutic optimism in advanced nurse practitioner students.	Therapeutic optimism can provide hope of recovery in mental health patients. A disposition for therapeutic optimism was tested in ANPs and was tested again following studying a mental health module as part of their ANP (primary care) training. Reinforces a belief that a relationship exists between level of education and therapeutic optimism. Also appears to be link made between competence and confidence and therapeutic optimism	Small study using one module in a subset of ANPs in one geographical area. Makes reference to NICE guidelines where therapeutic optimism linked to better patient outcomes (but I have not evaluated this directly and this is not critiqued in the article). Would it be easier/ more direct to measure competence and confidence than therapeutic optimism – does it have the same effect on improving patient outcomes? Notes it's a combination of education and experience- may be difficult to distinguish which had the most	Yes- may provide evidence that education can contribute to improving therapeutic optimism which may enhance patient outcomes (in MH primary care).	Yes- could this be applied in other ACP fields. To what extent does motivation, disposition for a positive outlook (therapeutic optimism), confidence, competence, education level, length/ variety of experience have on measurable outcomes in ACP practice (either clinical effectiveness, or job satisfaction, retention, ability to implement full range of ACP role, service reconfiguration etc).

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
				significant influence on therapeutic optimism levels. Also noted those undertaking the programme may be more motivated to improve practice- is motivation rather than therapeutic optimism the key?		
34	Rogers (2013)	Effects of advanced practitioners' learning in one hospital.	Significant variation in ACP roles although broadly use same job plan. 6 main themes emerged, programme content, effects of time allowed as trainee ACP, CPD/ non-clinical activity time, sharing expertise with others, shaping the role, capturing the effects of the role. Included from this were observations around appraisal, clinical supervision, autonomy (this varies, is more limited in non-clinical and is often determined by others), involvement in leading	Based on ACPs working in a particular hospital. 'first past the post'- first 15 that responded were included, so may be more biased. Not clear who picked the timing of observation- the ACPs may have biased which day/ set of patients/ clinical skills that were observed. Observations from staff about ACPS- only positive ones	Yes and no- mainly it adds to the knowledge base around definition, scope and barriers/ facilitators for full implementation of ACP. There is reference to statements of potential benefits such as 'teaching others good practice', 'take quality seriously', 'stable workforce providing consistency, continuity', 'fewer	Yes, noted that capturing effects of ACP not currently done sufficiently/ broadly enough. Could test the anecdotal statements made of positives of ACPs as reported by staff.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			service developments, horizon scanning and setting the scope of their role. Lack of capturing impact of their role (e.g. through audit) was noted. Some conclusions drawn from this (? Dubiously linked) re need for support from middle managers for autonomy and benefits to be realised, flexibility to adapt retained when breadth and depth of skills retained (i.e. not becoming too specialised), greater clarification and infrastructure needed for ACP career pathways, non-clinical time should be ring fenced, networking opportunities required, formal clinical supervision, management shared by medics and mangers, rewards, incentives should be considered, robust processes to capture impact of role needed, portfolios with annual review recommended.	reported- was this because there were no negative, or bias in reporting? Jump made between respondents in study and that this proves the Salford programme apply significant amount of learning from this programme into their practice- it's not clear that this correlation can be made as not stated that they all did the Salford programme and as they completed at different times the current programme may not be the same- comparison between years of study not given (e.g. portfolio introduced in 2011 but some participants qualified before	breaches of targets', 'provide support to others. However, this is anecdotal reports from non ACP staff who volunteered comments.	

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
				that). Could have been years of experience or other factors that had a larger influence. Findings seem over-stated at times.		
35	Shearer D and Adams (2012)	Evaluating an advanced nursing practice course: student perceptions.	5 themes of perceived benefits from the programme; improved clinical assessment skills, benefits of a structured educational framework for their development, increased confidence, importance of networking and increased autonomy resulting in +ve change in ACP role. Noted a barrier that ACPs often have to negotiate the scope of their role with others. In discussion claims that findings from this study chime with RCN survey that ACPs did not see themselves as mini doctors (more like maxi nurses) and not a cheap alternative and that they had high levels of job	Participants were students the researcher had taught. 14 students from one programme only. Were in last stages of training so already invested in positive outcomes? Only 10 interviewed.	Yes, perceived benefits from perspective of ACP students, although not evidence that this independently observed or sustained post completion of education programme.	Yes, are the perceived benefits from ACP Masters programme realised and sustained post qualification. Is there consensus from all stake holders of the perceived benefits, and have these been tested in reality as actual benefits?

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			satisfaction, increased ability to give holistic care, and that it offered career development and a +ve effect on patient care.			
36	Smith and Hall (2003)	Developing a neonatal workforce: role evolution and retention of advanced neonatal nurse practitioners.	High % continue to work as ACP (86%) and high % continue to work in the unit they qualified in (87%) but a large number (58% would consider moving away if opportunities were on offer. Range of reasons for not continuing as ACP with the highest being inflexibility around other responsibilities (e.g. childcare, which may be linked to high proportion of ACPs being female). Range of scope is varied but broadly meet with ACP definition (inc education, audit, clinical governance). Prescribing scope seen as a key limiter. Salaries broadly similar, but funding stream varies with the majority from a nursing rather than a medical or separate budget (although they are rostered on both	Restricted to neonatal ACP who qualified from one HEI (apparently representing 28% of DGHs and 45% of UK neonatal units.) 18 years old would findings be the same now we have a definition, more developed ACP community? In direct measures of job satisfaction rather than directly measured (e.g. retention as an ACP, if they felt they had career progression prospects, not 'how satisfied are you with your job', have achieved what you hoped to achieve	Yes, gives some information regarding factors important to key stakeholders e.g. retention, CPD and career progression opportunities in profession and in locality, albeit for this one speciality	Yes, could this be replicated across a wider range of ACPs to test if the findings are echoed and are still current. Has it/ will it change now that the framework and apprenticeship standards for ACP are in place?

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			medical and nursing shift rotas most commonly). 72& agreed/ were unsure if they felt like they were in a career cul-de-sac- poorly defined career progression structure available, and this is combined with feelings of poor recognition of their role. Paucity of CPD at right level/ specifity of content relevant to their role.	as an ACP'). Large proportion of findings in the discussion does not come directly from the data generated here (e.g. 'they have been able to provide a standard of care that is consistent, reliable, and safe' but can't see where/ how this was measured.		
37	Taylor (2012)	The Experience and Effectiveness of Nurse Practitioners in Orthopaedic Settings: A Comprehensive Systematic Review.	Confirms re beneficial impact ACPs have on clinical effectiveness, and measures such as patient satisfaction, decreased length of stay etc and that this can be affected by a number of factors. Confidence, knowledge and experience seen as essential for the complexity of ACP caseload. Notes ACP is moving along a continuum of development rather than a specific point to reach (you've got it or you	Focuses on orthopaedic nurse ACPs only. Literature review so not direct observation, and author notes lack of quality in good proportion of the papers. Used primarily Australian websites and databases to identify papers so ? bias toward Australian experience/	No, it adds confirmation to the definition of ACP which in itself identifies potential benefits of ACP implementation but does not measure this directly.	No, confirms knowledge and understanding of ACP.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			haven't). ACPs relate to duality of purpose and that is relational and collaborative at a personal, professional and organisational level.	context. Full text of findings (not just summary) not available.		
38	Tee, Jowett and Bechelet-Carter (2009)	Evaluation study to ascertain the impact of the clinical academic coaching role for enhancing student learning experience within a clinical masters education programme.	Coaching was found to have a positive impact on ACPs learning, and particularly in transitioning into an ACP role. Having a coach with a relevant clinical background was significant. Appreciative inquiry, active listening, open communications and Socratic questioning were noted as helpful. Greater clarity between coach and other academics roles is needed, particularly in moving the learner to be the instigator of action and take personal responsibility for their own learning & development.	Based on 35 people from one programme in one HEI, (interview was 5 students and 5 coaches only). Participants were dominated by those on a neonatal full-time pathway. Aspects that were found to be 'not useful' not discussed.	No, it focuses on one type of education methodology focussed on supporting ACP students in their development, it does not measure the beneficial impact itself of ACP as a result of this education methodology.	Not directly but potentially…. Can this be replicated with a broader ACP student population…does use of coaching aid their development and effectivity as ACPs? Does this have a positive impact longitudinally?
39	Thompson *et al.* (2019)	Whole Systems Approach: Advanced Clinical Practitioner Development and Identity in Primary Care	5 factors have significant influence on role identity and development as an ACP in primary care: 1. role definition (inc consistent use of job	Restricted to Northern England ACPs in Primary Care, noting difficulty in capturing all that	No- it adds to the knowledge base around definition, scope and barriers/ facilitators for full implementation of	Not directly, it clearly notes that expectations of ACP are not being met and this follows after intro of the

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			descriptions etc) whilst noting variety of contexts in which people work 2. Education, inc both CPD for ACPs and MSc having positive impact on developing critical thinking, decision making and professional identity, whilst noting they vary in quality and calls for standardised (regulated) curriculum that has specific content focussed on primary care (i.e. not generic), and funding for release/ backfill is problematic 3. Support/ supervision, inc use of mentors and support for role transition from people that know & understand ACP, 4. Organisation & culture, inc whether it is just medic supplementation to fill the gaps and does not allow ACPs to operate at a leadership level/ exercise their full scope or autonomy of practice and that current organisation	may fit definition of ACP (particularly AHPs). 22 self-selected from a larger survey.	ACP and some education methodologies to support ACP development	framework and apprenticeship, (but may not yet have had enough time to embed to have made changes apparent.) So, does this study need to repeated once ACP apprenticeship or framework mapped students qualify and have become embedded in practice? Does create the question what can shift practice to make expectations of ACPs realised.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			of small practices run by GPs allows ACPs to be effective (could a pool of ACPs be held regionally to support a range of GPs or creating a conglomeration of GP practices), 5. Career pathway inc lack of clear career pathway beyond ACP and fir many they 'fell into ACP' rather than seeing it as a progression of their career, that introduction of ACP roles were reactive to local need (gap filling).			
40	Tsiachristas *et al.* (2015)	Costs and effects of new professional roles: Evidence from a literature review	Consultation and care provision most frequently delegated to ACPs. Most studies found there was no effect on cost (equal amounts reported higher and lower costs with ANPs). Positive clinical outcomes including patient satisfaction, patient information, QoL most frequently reported. Health Care access and utilization mainly found no difference, one noted it increased. Positive	Not confined to UK (49% were UK based). Publication range 1994-2013 (80%>2000). Noted most papers scored weakly in selection bias and overall, only 37% scored as strong quality. Variation in population, outcome measures. context in papers was noted. Notes lack	Yes, provides evidence of ACPs contributing to service redesign as well as improving/ maintaining clinical effectiveness. Refutes claim that it can decrease costs- this is not the case in all scenarios and in most it balances out although cost-effectiveness may improve over time	Yes, paucity of good quality evidence, particularly in acute care settings. Cost reduction is not a reason to introduce ACPs but clinical effectiveness is- are there other claims that could be equally tested in this way to establish the evidence base?

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			outcomes were higher for ACPs than CNS. Cost effectiveness increases as they become familiar with delegated tasks. Fewer studies on acute care- majority of change in skill mix by adding ACPs was in chronic care. UK may be pioneering in skill mix change (85% studies conducted in UK) or that more rationing is in place in the UK.	of blinding of profession type in some studies.	as role holders become familiar with tasks.	
41	Williams (2017),	Advanced practitioners in emergency care: a literature review.	Reference to ENPs reduction of waiting times, improve quality of care (e.g. reducing door to needle time) and use of holistic and patient centred care. States ACPs are cost effective alternatives to medical staff (although not clear how this has been measured). Includes table that identifies barriers/ facilitators to successful implementation. E.g. did highlight as a barrier blurring of role boundaries exacerbated by lack of	Only 4 papers- ? search strategy. Not clear what was biggest factor when inc/ exc applied to go from 601 papers to 3 (in abstract it says 4 but in PRISMA it says 3 with no quant but in main text refers to 1 quant paper). Said 8 out of 11 only suitable for background reading- not sure what the criteria	No- it adds to the knowledge base around definition, scope and barriers/ facilitators for full implementation of ACP	No, confirms knowledge and understanding of barriers/ facilitators of ACP. Could explore further the claim that nurses perceive this offers a career structure and recognition as this is disputed elsewhere (but no paper so far it appears has addressed this directly).

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			understanding of ACP role due to variation in job titles and scope of practice. "Drs created the most barriers to the proposed implementation of advance practice roles". Drs concerned about litigation and ACPs straying out of scope. Consensus that standardisation of education, skills, competencies was needed. Conflict also between ACPs and emergency nurses. Nurses believed it offered them enhanced career structure and recognition.	here was that determined this.- doesn't state as inc/ exc only looking for empirical evidence. Conclusion states more research needed about ACPs effect on clinical outcomes, patient satisfaction but this is evident to have already been established in other papers. All papers in this lit review single centred with small sample sizes.		
42	Williamson *et al.* (2006)	Change on the horizon: issues and concerns of neophyte advanced health care practitioners.	ACP programme offers personal and professional development inc enhancement of clinical practice. Seen as needed with current changes/ future developments in workforce, inc possible regulation of ACP title. Belief that it would result in a better paid job and increased job satisfaction,	Small sample from one HEI MSc ACP programme. Now several years old so ? still reflective of today's ACP student experience/ perceptions. Biased sample as to whether the course was	Yes, from the perspective of ACP students early in their training- does not test whether benefits are realised at end of training.	Yes, could repeat study and then test if these are realised post completion of ACP training.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			particularly in relation to increased autonomy to contribute to service/ role development. Time pressures were a common feature as a stressor and equitable access to learning opportunities may not be present due to constraints on time from balancing existing work/ family commitments. Concerns about lack of understanding of role from colleagues which may create conflict. Bias toward nursing. Overall seen as positive (whilst noting they are a biased sample).	positive and the potential +ve impact it will bring (they will have put themselves forward and continue to engage in the course to be included in this study).		
43	Wilson-Barnett *et al.* (2000)	Recognising advancing nursing practice: evidence from two observational studies.	Clinical practice dominant element of work, from this said to reflect the motivation for clinicians to take on this work as they want to retain a clinical aspect to their work. Clinical work included assessment of need, diagnostic tests, care planning and prescription + negotiations with MDT.	Derived from 2 other studies rather than direct measurement. (1 of which was from one region only). From perspective of experienced clinicians (? Bias) and only ACP from perspective of Nursing. Use of	Yes & No- it adds to the knowledge base around definition, scope and barriers/ facilitators for full implementation of ACP. It provides direct observation and reflection from ACPs to evidence that some aspects	No, confirms knowledge and understanding of barriers/ facilitators of ACP. Emphasises gap in evidence for non-clinical practice elements of ANP.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			Other aspects (not clinical) were giving advice to colleagues, facilitating professional development of others, and developing protocols for clinical work (which they believe linked to use of EBP and delivery of standardised care). Examples given of service development that had come from AN role incl one stop clinics and outreach services, cross agency working. Particular personal qualities seen as prerequisites for successful ACP role development: confidence, commitment, problem solving, being able to network, negotiate with MDT and management, inspire respect, reflect on practice and trouble shoot. Also believe new ACPs would need to have substantial experience in a specialist area, extensive knowledge in nursing and appropriate professional	reflective observation whereby questioning of those being observed may have led to altered perception of the activity that was being observed. Observed 1-3 shifts so may not capture full range of work as was a snapshot at that time. Wide range of years since qualified (6-27).	of the role are taking place- but only clinical practice tasks were directly observed.	

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			qualifications. Had built upon specialist clinical experience. Barriers also discussed- support from colleagues and managers. Self-directed role development resisted particularly in larger organisations (e.g. review of job descriptions to reflect current need/ role / service development)			
44	Woods (1998)	Identifying the practice characteristics of advanced practitioners in acute and critical care settings.	Diary entries were pre-structured into; direct care, admin and management, education & counselling, other along with times and frequency. Asked to identify what they considered to be new or advanced, what had helped/ hindered and record details of critical incidents that typified their development. Noted developed influenced by a number of personal, interpersonal and organisational factors. Direct care took up the majority of time in high dependency but in acute it	Paper focussed only on the analysis of the diaries which was a subset of the data collected. 5 case studies. Focussed on Nurses in acute/ high dependency only. Captured 5 days each month (so the weeks chosen may not have typified whole experience). Some diary entries were missing/ incomplete and	No- it adds to the knowledge base around definition, scope and barriers/ facilitators for full implementation of ACP. It provides self-report from ACPs to evidence that some aspects of the role are taking place in first 6 months.	Yes- what techniques could be used to ensure focus is not just on the clinical aspects? Could repeat study at intervals post qualification to see if emphasis on clinical or differences between acuity of patients/ different contexts are maintained.

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			was administration and management. Level of dependency did not seem to make a difference to the time spent on 'other' or 'education & counselling' activities. High dependency focussed more on physical needs alone whereas in acute it was more physical and psychological. Priority appears to be given to developing assessment, diagnosis and patient management above other skills. Level of acuity of patients not associated with whether more/ less advanced skills were undertaken and actually these ANPs spent the majority of time on standard (not advanced) interventions. Significant variation in types of activity and some suggestion as to barriers/ facilitators for this (e.g. time availability). Difference in high/ acute reflected in time spent on	rely on memory recall.		

No.	Reference	Title	Key Findings	Limitations	Does it answer the Lit review research question?	Does it identify a gap in evidence as of a focus for PhD
			protocol writing (high) or practice development (acute). Teaching, advising and troubleshooting also noted. Advise to medical staff and troubleshooting more so in acute rather than high dependency settings. ANPs ranked most highly patient assessment & management and invasive procedures and technical skills' as things that were 'new' or 'advanced'. Conclusion- in the first 6 months focus is on technical and clinical skills development and more eclectic roles such as education, leadership not so apparent.			

APPENDIX 3- ADAPTED HAWKER CRITICAL APPRAISAL TOOL

Adapted Hawker et al model for critical appraisal of systematic literature review containing papers using a mix of research methods.

A. Abstract and title: Did they provide a clear description of the study?

1	Very poor	No abstract
2	Poor	Inadequate abstract
3	Fair	Abstract with most of the information
4	Good	Structured abstract with full information and clear title

B. Introduction and aims: Was there a good background and clear statement of the aims of the research?

1	Very poor	No mention of aims/objectives. No background or literature review.
2	Poor	Some background but no aim/objectives/questions, OR Aims/objectives but inadequate background
3	Fair	Some background and literature review. Research questions outlined
4	Good	Full but concise background to discussion/study containing up-to date literature review and highlighting gaps in knowledge. Clear statement of aim AND objectives including research questions

C. Reliability: Is the method (including measurements and interventions where applicable) appropriate and clearly explained?

1	Very poor	No mention of method or protocol, AND/OR Method/ intervention inappropriate, AND/OR No details of data
2	Poor	Questionable whether method/ protocol/ intervention is appropriate. Method/ protocol/ intervention described inadequately. Little description of data
3	Fair	Method/ Protocol/ Intervention appropriate, description could be better. Data described.
4	Good	Method/ Protocol/ Intervention is appropriate and described clearly (e.g., questionnaires included). Clear details of the data collection and recording that would allow this study to be repeated

D. Sampling: Was the sampling/ search strategy appropriate to address the aims?

1	Very poor	No details of sample/ search strategy
2	Poor	Sampling/ search strategy mentioned but few descriptive details
3	Fair	Sample size and selection justified (in literature review this includes selection of sources). Most information given, but some missing.

4	Good	Details (age/gender/race/context) of who/ what was studied and how they were recruited. Why this group was targeted. The sample size was justified for the study. Response rates (e.g. use of PRISMA for literature review) shown and explained.

E. Data analysis: Was the description of the data analysis sufficiently rigorous?

1	Very poor	No discussion of analysis
2	Poor	Minimal details about analysis
3	Fair	Qualitative: Descriptive discussion of analysis. Quantitative: Measurements described but without sound rationale for why these were chosen. Use of validated measurements.
4	Good	Clear description of how analysis was done. Qualitative studies: Description of how themes derived/ respondent validation or triangulation. Quantitative studies: Reasons for tests selected, hypothesis driven/ numbers add up/statistical significance discussed, fully and accurately reported, (e.g. exposure, risk reduction, confidence intervals, p-values etc.)

F. Ethics and bias: Have ethical issues been addressed, and what has necessary ethical approval gained? Has the relationship between researchers and participants been adequately considered?

1	Very poor	No mention of issues/ potential bias.
2	Poor	Brief mention of issues without noting how these were attempted to be addressed.
3	Fair	Lip service was paid to above (i.e., these issues were acknowledged but not fully addressed).
4	Good	Ethics: Where necessary issues of confidentiality, sensitivity, and consent were addressed. Bias: Researcher was reflexive and/or aware of own bias and provision had been made to attempt to address this. Blinding has been used where appropriate.

G. Results: Is there a clear statement of the findings?

1	Very poor	Findings not mentioned or do not relate to aims
2	Poor	Findings presented haphazardly, not explained, and do not progress logically from results
3	Fair	Findings mentioned but more explanation could be given. Data presented relate directly to results.
4	Good	Findings explicit, easy to understand, and in logical progression. Tables, if present, are explained in text. Results relate directly to aims. Sufficient data are presented to support findings

H. Validity: Are the findings representative of the context described and are they transferable (generalizable) to a wider population?

1	Very poor	No description of context/setting
2	Poor	Minimal description of context/setting
3	Fair	Some context and setting described, but more needed to identify the focus for this study, and how reflective of reality the context of the study is PLUS fair score or higher in Question D
4	Good	Context and setting of the study is described sufficiently to define and compare with other contexts and settings, plus 'good' score in Question D (sampling).

I. Impact How important are these findings to policy and practice?

1	Very poor	None of the above. No discussion of limitations or confounding factors, or impact for policy/ practice
2	Poor	Only one of the above. No discussion of limitations or confounding factors, or impact for policy/ practice
3	Fair	Two of the above. Reference made to potential limitations or confounding factors but not how these could be/ were attempted to be addressed or taken account of in drawing conclusions. Broad discussion of potential impact for policy/ practice/ future research.
4	Good	Contributes something new and/or different in terms of understanding/insight or perspective. Suggests ideas for further research. Suggests implications for policy and/or practice. Clear and comprehensive discussion of potential limitations and confounding factors with evidence of how these could be/ were attempted to be addressed or taken account of when drawing conclusions.

RAG rating explanation:

Score	Description
9-17	Weaknesses outweigh strengths. Poor quality with limited validity/ reliability or both. No clear protocol used.
18-27	Balance of weaknesses and strengths. Quality restricted in some areas in terms of validity/ reliability or both. Some aspects of a protocol used.
28-36	More strengths than weaknesses. Quality is good with use of a systematic approach and evidence of a protocol being in place and adhered to.

APPENDIX 4 –CRITICAL APPRAISAL OF PAPERS - TABLE A

Below are the scores from adapted Hawker et al model for critical appraisal from systematic literature review-'What research has been conducted in UK settings with regard to the benefits of 'Advanced Clinical Practice' (ACP) for key stakeholders?', containing papers using a mix of research methods (quantitative, qualitative, mixed and systematic literature review).

Paper	Abstract & Title	Intro & Aims	Reliability	Sampling	Data Analysis	Ethics & Bias	Results	Validity	Impact	Total
Bagley	3	3	3	2	3	3	3	2	4	26
Barratt	3	4	3	2	2	2	3	2	4	27
Bird & Krishbaum	3	3	2	2	2	1	2	2	1	18
Barea	3	2	2	3	2	1	2	2	2	19
Carney	3	3	3	3	3	1	3	4	3	26
Cooper et al	3	3	3	3	3	2	3	3	4	27
Currie et al	3	3	3	3	3	2	2	3	3	25
De Bont et al	4	4	4	3	4	4	4	4	4	35
Delamaire & Lafortune,	2	4	2	3	2	1	4	3	4	23
Dowling et al	3	2	2	2	2	1	1	2	1	16
Duffield et al	3	2	1	1	1	1	2	2	2	15
Elliot et al	4	4	4	4	4	4	4	4	4	36
Endacott & Chaboyer	4	4	3	3	4	2	3	3	3	29
Gerrish et al	4	4	2	3	3	3	4	3	4	30
Heale & Reicke Buckley	3	3	2	2	1	2	2	2	4	21
Hughes et al	4	4	3	2	3	1	4	3	4	28

Paper	Abstract & Title	Intro & Aims	Reliability	Sampling	Data Analysis	Ethics & Bias	Results	Validity	Impact	Total
Hutchinson et al	4	4	4	4	4	1	4	4	4	33
Kaldan et al	3	4	4	3	1	2	1	4	3	25
Lloyd Jones	4	3	3	4	3	1	4	4	4	30
Mackavey & Cron	4	2	3	2	2	1	3	2	2	21
Manley	2	3	3	3	3	1	3	3	4	25
Mantzoukas & Watkinson	4	3	2	3	2	1	2	3	2	22
Marsden et al	4	4	3	2	2	3	3	2	3	26
Marsden et al	3	3	2	2	1	1	3	2	3	20
McConnell et al	4	4	2	2	2	1	4	2	3	24
McDonnell et al	4	4	3	4	3	2	3	4	4	31
McDonnell et al	4	4	4	3	4	3	4	3	4	33
McGee et al	2	2	2	2	1	1	3	2	3	18
Miller et al	3	4	4	4	2	3	3	4	4	35
Pulcini et al	4	4	3	3	3	3	4	3	4	31
Read et al	2	3	3	4	2	4	4	4	4	30
Roberts-Davis et al	2	2	2	1	1	1	2	1	1	13
Rogers et al	4	4	4	4	3	4	3	3	3	32
Satu Gloster et al	2	3	2	3	2	3	4	3	2	24

Paper	Abstract & Title	Intro & Aims	Reliability	Sampling	Data Analysis	Ethics & Bias	Results	Validity	Impact	Total
Shearer & Adams	3	4	3	2	3	3	3	3	3	27
Smith & Hall	3	4	2	4	1	1	2	2	3	22
Taylor & Staruchowicz	4	3	4	3	4	3	1	1	1	24
Tee et al	3	4	4	4	4	4	4	4	4	35
Thompson et al	4	4	3	3	3	1	4	3	4	29
Tsiachristas et al	3	3	4	4	3	3	4	4	4	32
Williams	2	3	3	3	2	1	3	3	2	22
Williamson et al	4	3	3	2	2	3	3	2	3	25
Wilson-Barnett et al	3	3	3	3	3	1	4	3	4	27
Woods	4	4	4	2	4	2	4	2	4	30
Total	144	147	128	124	112	89	135	124	140	1149
Mean (average)	3.2	3.3	2.9	2.8	2.5	2	3	2.8	3.2	26.1
Mode (most common)	4	4	3	3	3	1	4	3	4	18-27

APPENDIX 5 - CRITICAL EVALUATION OF PAPERS - TABLE B

The papers retrieved to answer the question 'What research has been conducted in UK settings with regard to the benefits of 'Advanced Clinical Practice' (ACP) for key stakeholders?' have been appraised and separated into methodology type, including RAG rating using the adapted Hawker et al model for critical appraisal. (Undertaken July 2020).

Literature Review

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
1.	Bird and Kirshbaum (2005) Towards a framework of advanced nursing practice for the clinical research nurse in cancer care	Literature review	Chooses a focused topic and defines 3 questions for the review with a narrow search window based on recent policy change. Recognises that to answer questions set needed to take into account different sources of evidence.	No defined search protocol, no inclusion/ exclusion criteria, extraction, analysis, reporting system. Reliability therefore poor. No reference to use of search tools (e.g. snowballing) and search strategy unclear. Notes weakness of some of the studies included. Not easy to see how results are derived from the literature and due to small results (8 papers) how valid and transferable this is.	18
2.	Carney (2016) Regulation of advanced nurse practice: its existence and regulatory dimensions from an international perspective	Literature review	Accesses a range of literature and uses most elements of a protocol to underpin the review (i.e. clear aims, content analysis tool + expert review, inclusion/ exclusion criteria). Presents results for each country acknowledging similarities/ differences.	Conclusion appears biased based on the wider variety that is presented in the results. Specific data missing (e.g. PRISMA, summary table including stats from results. Narrow range of databases used and other methods such as snowballing do not appear to have been used. No critical evaluation of papers gleaned.	26

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
3.	Cooper, McDowell and Raeside (2019) The similarities and differences between advanced nurse practitioners and clinical nurse specialists.	Systematic literature review	Accesses a range of literature and uses a systematic approach, including independent and peer review to undertake the search and evaluation of the literature. Presents results clearly and synthesises this into themes for discussion. Clear about the limitations of this study. Excellent info graph of difference between CNS & ACP.	Conclusion appears biased based on the wider variety that is presented in the results. More detail could have been provided re data extraction tool and how themes and conclusions were drawn. Restricted to 10-year search with no explanation. Limited to written in English when this was not restricted to English speaking countries. Snowballing not used.	27
4.	Duffield *et al.* (2009) Advanced nursing practice: A global perspective.	Narrative literature review	Accesses a range of literature to give global picture of ACP context in a certain time period, and highlights similarities/ differences between different countries.	There is virtually no discussion of a method or protocol, (e.g. inc/exclusion criteria, final data, critical evaluation of literature, or method for data analysis) making it difficult to assess validity and reliability of this study. There is no discussion of rationale or justification for the approach taken or recognition of the limitations this may have in attempting to achieve the aims.	15
5.	Elliott *et al.* (2016) Barriers and enablers to advanced practitioners' ability to enact their leadership role: A scoping review.	Scoping review	Clear structure and rationale for protocol used, noting limitations of this and drawing upon background/ context to set the scene for the study. Provides clear justification for the approach taken (including	Occasionally further justification for the approach taken or acknowledgment of the limitations this would cause could have been discussed further (e.g. why were lit reviews excluded, why is use of literature as opposed to direct	36

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
			why critical evaluation has not been used to filter articles that were included).	observation the 'best' method they chose to achieve the aim of this study). Patient level barriers were not reported when this has been shown to be significant elsewhere.	
6.	Lloyd Jones (2005) Role development and effective practice in specialist and advanced practice roles in acute hospital settings: systematic review and meta-synthesis.	Systematic literature review and meta synthesis	The focus for this study is well defined, with clear reporting of most parts of the protocol used to conduct this study. Rationale for taking the approach chosen is given in most areas. Reporting of results is comprehensive and provides a narrative discussion under key themes. Limitations are discussed and future work needed is identified.	There is limited discussion of how the papers were evaluated and the report of findings do not appear to have been structured using the framework they identified had been used. Some of the rationale for the approach taken could be debated (e.g. why only qualitative papers, and exclusion of papers that considered CNS/ physicians perceptions of the role). And so could have been discussed in more detail. The PRISMA results does not add up 19-3 =16 not 17 as stated, and then reduced to 14, presumably due to duplicates but this is not stated). There is a large batch from Bamford & Gibson- could author bias have been noted here? Jones does note the limitations of these studies (e.g. lack of study of some factors as barriers) which reduces the potential impact of this study.	30

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
7.	Kaldan (2019) Evidence characterising skills, competencies and policies in advanced practice critical care nursing in Europe: a scoping review protocol.	Five-stage scoping review methodology with a comprehensive systematic literature review	There is a clear and well referenced background and context provided with reference made to the potential impact and limitations of this study. Clear reference is made to the different stages of the intended research and the methods/ protocol that will be used, which appear appropriate for the research and achievement of its aims. A definitive timeline is given which appears realistic (although the appearance of Covid-19 in 2020 may prevent some of the dissemination strategy at conferences).	Sets out how scoping review will be done but does not provide the results from this review in this article. So, no results available! Focuses on critical care nurses only. Identifies limitation that it will only draw from papers published in European languages. Detail of how results will be analysed and synthesised is not given including the approach that will be taken. (e.g. narrative synthesis, or translation of data?)	25
8.	Mantzoukas (2007) Review of advanced nursing practice: the international literature and developing the generic features	Systematic literature review	A clear title and abstract are given specifying the aim. Extensive background is discussed to provide a historical perspective and background to the review. Themes are utilised to draw literature together from a large number of sources	The methodology is lacking in detail in some areas, e.g. what sources, data extraction and thematic analysis tools were used (if any). Justification for approach taken is not given or is weak (e.g. only last 15 years when ACP has been in existence before that). Not always made clear how data saturation was reached or how relevancy of literature was determined. No reference is made to limitations, ethical considerations or	22

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
				whether systematic critical evaluation of the literature was undertaken to inform the results. The specific results are not provided (e.g. no PRISMA). Implications for policy/ practice are not discussed extensively or with a sound basis emanating from the review.	
9.	Taylor (2012) The Experience and Effectiveness of Nurse Practitioners in Orthopaedic Settings: A Comprehensive Systematic Review.	Systematic literature review. Use of JBI-MAStARI tool for quant analysis and JBI-QARI for qual and textual data extraction using JBI-NOTARI	Clear title, and structure to set out the methodology with rationale given behind the choices made. Discussion of context and acknowledges the bias towards Australia and own bias as an orthopaedic nurse.	Results of the study are not given other than in summary. PRISMA not used. Research questions could have been made clearer. Bias noted but strategies to overcome this have not really been addressed. Limited value in terms of impact as relates to one speciality and one profession, with a predominance drawing from Australian experience. Lack of good quality papers to use for this review noted (so ? can sound conclusions be drawn).	24
10.	Tsiachristas *et al.* (2015) Costs and effects of new professional roles: Evidence from a literature review	Systematic Literature review with use of EPHPP for quality assessment	Wide ranging study with good exploration of the background and clear conclusions drawn regarding significant impact this research could have for policy in this field. Robust presentation of results and acknowledgement throughout where there are limitations/	Detail and rationale for the approach taken in some of the methodology chosen, including thematic analysis is not given. Notes limitations of current evidence, (e.g. selection and rated poor in quality assessment, lack of blinding and variation in types of study) thus? how sound the conclusions drawn are.	32

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
			considerations that need to be taken into account.		
11.	Williams (2017) Advanced practitioners in emergency care: a literature review.	Literature review.	PRISMA is used and there is reporting of the methodology with a comprehensive discussion of the background/ context.	Rationale lacking e.g. says only from 2000 as these are new roles, but they were in existence since 1980s. Further explanation of why particular databases were chosen not given. Detail of how the 924 papers reduce to just 4 (i.e which exclusion criteria were applied here) not given. No discussion of data extraction or data analysis tools/ approach chosen and why. This makes drawing conclusions that are a sound basis for the proposed impact for practice difficult to swallow.	22

Quantitative

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
1.	Barea (2020) What is a Primary Care Advanced Practice Role in Cornwall?	Questionnaire	Provides a narrative discussion throughout of the results as articulated to current issues/ context. Is the latest paper to be gleaned from the literature search so provides most up to date picture with reference to current policy, guidance and practice. Focussed on the sample chosen given validity of results for that sector. Asks questions that are alluded to in other studies but have not before been directly tested.	There is limited information about the protocol used, particularly regarding sampling, data analysis methodology. Not clear what the questions asked were- e.g. were respondents able to record any types of clinical presentations (i.e. free text) or did they have to choose from a list? If the latter this may have missed some relevant information. Results could have been presented more clearly to allow for better appraisal of whether the conclusions fit with the results. Notes that there are a range of job titles but not made clear how they then ensured they had captured all relevant staff from the 61 GP practices as it seems this was gleaned from looking at job titles on websites. Focus of discussion and conclusion is that ACP needs regulating, but the direct correlation between this research and whether regulation has been proven to be a benefit is not made soundly.	19

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
2.	Heale and Rieck Buckley (2015) An international perspective of advanced practice nursing regulation	On-line questionnaire, frequency statistics, descriptive data for survey questions and content analysis for the 2 open-ended questions.	Provides a comprehensive background. Focuses on regulation which has not been researched elsewhere and attempts to capture a global picture. Notes limitations and potential implications for practice and future research.	There is limited information about the protocol used, and evidence of poor methodology (e.g. response rates, how inclusive the sample is when the survey was done on-line and only in English and only to Nursing associations within the ICN). There is no discussion of how data analysis was carried out or what specific questions were asked, making it difficult to assess how well the conclusions drawn fit with the results. Limitations are noted but it appears this occurs as an after-thought rather than building consideration of this into the design of the study.	21
3.	Mackavey and Cron (2019) Innovative strategies: Increased engagement and synthesis in online advanced practice nursing education.	One-way analysis of variance to compare Health Education Systems Incorporated examination scores between semester cohorts of students, followed by a post hoc pairwise comparison	Focussed topic that looks at a particular education method used in ACP training and makes a comparison pre and post intervention to identify that it has shown some benefit in this case.	Limited discussion of the context in terms of how it relates to ACP training. Because of this it makes it difficult to provide any sound argument of wider impact. Minimal information regarding the methodology and justification for choosing this approach. No or little discussion of potential ethical considerations, limitations or bias or future research, specifically for ACP education.	21

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
4.	Pulcini *et al.* (2010) An International Survey on Advanced Practice Nursing Education, Practice, and Regulation	Cross-sectional, descriptive Web-based survey preceded by pilot study. NB whilst questions were 'open-ended' only quantitative data analysis was used (SPSS) to determine results.	A detailed description of the global background/ context with reference to current policy, practice and issues is given. Attention is given to reporting the study in a clear and structured way. There is clear acknowledgement of the limitations and biases as well as how this study can be positioned in relation to future research.	Justification for some of the methodology/ approaches taken are not given/ explored, and this may have contributed to some of the weaknesses (identified by the authors) of the study. The sample focuses on nurses only accessed through one particular network and there were clearly issues in 'controlling' the sample making it difficult to draw conclusions about how representative this is. A global study but web based and only in English is a major limitation. Detail of the questionnaire and the results were not given in as clear a way as could have been possible (e.g. more extensive use of tables).	31
5.	Rogers (2013) An evaluation of therapeutic optimism in advanced nurse practitioner students	Quasi-experimental Pre and post-test evaluation	A broad ranging description of the background/ context with reference to current policy, practice and issues is given. Attention is given to reporting the study in a clear and structured way, covering relevant details to understand methodology (therefore more easily allowing it to be repeated). There is acknowledgement of the limitations and biases with a reflective approach clearly being	Further justification of some of the approaches taken would have been beneficial. Limited information is given as to how representative the sample is. Some of the conclusions appear to have come from combining previous research/ knowledge rather than directly focussing on what this study tells us- the conclusions drawn are a bit of a stretch! The results are not presented clearly in detail, making	32

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
			taken to enhance this and future studies.	it more difficult to directly assess them.	

Qualitative

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
1.	Bagley (2018) Exploring emergency nurse practitioners' perceptions of their role.	Phenomenological study using semi-structured interviews	Clear background and use of a literature review to identify gap in knowledge as justification for this research. Use of others' work to structure the approach to this research. Findings reported in an easy-to-follow format. Clear about the limitations of this small study with identification of future research needed/ now underway.	Justification for the sampling strategy could have been stronger, with reference to how this sample relates to the broader context. (validity). Detail of the data collection and analysis method (e.g. inclusion of the interview guide developed and data regarding to Kvale's quality criteria that was apparently used) would have made checking findings against the data/ results more transparent and would have added strength to the conclusions drawn. CASP apparently used in lit review but no reference than made to the quality of the papers found, or indeed use of PRISMA to report results.	26
2.	Barratt (2010) A focus group study of the use of video-recorded simulated objective structured clinical examinations in nurse practitioner education.	Focus group	A good case is made as to why this research is needed for an education methodology commonly used in ACP education, by extensively exploring the background including reference to personal experience and literature. Justification is given for many of the choices made (e.g.	Abstract could have been structured to more easily point to key headings. Whilst it is noted the limitations of the sample, it does not say how the group of students were chosen from the wider group of students. The approach taken to data analysis	27

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
			streaming platform used, why focus groups) and this is tested in the research and returned to in the discussion. Clear recognition of limitations/ bias.	is discussed but detail of how this was actually employed and the results that came from this (data) is not reported clearly making it difficult to know how well the findings/ conclusions drawn relate to the results. Two different pieces of research appear to have been rolled into one here, when clearer reporting and stronger justification and conclusions could have been achieved by addressing them separately. The limitations have been recognised (including technical failure of on-line focus groups) but appear not to have been thought about in the planning stage.	
3.	De Bont *et al.* (2016) Reconfiguring health workforce: a case-based comparative study explaining the increasingly diverse professional roles in Europe.	Case studies (x16) including interviews (x160) and observations (600+ hours)	Clear, abstract, aim with defined questions and scope with a contemporary exploration of the context in the introduction. Large study capturing global practice. Methodology has been thought through using protocol and bringing people together for training and workshops to attempt to enhance quality throughout. Sampling strategy was clearly reported, planned, verified throughout the	Acknowledge that as the research was conducted by a large group that inconsistencies may be present. The analysis was drawn from reports written by each country (16), but the analysis was done by only 2 of the authors. It says preliminary results were shared but not whether this was verified with the 16 researchers	35

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
			research with detail given (with more detail potentially in additional files not visible to me). Acknowledges limitations and sets out potential for future research alongside suggestion of how this research has implications for practice.		
4.	Dowling *et al.* (2013) Advanced practice nursing: A concept analysis	Rodgers's evolutionary method of concept analysis	Concisely sets the scene in terms of other research and policy currently in ACP. Identifies and chimes with a key issue identified in other research in terms the large variety of nomenclature and definitions of ACP. Uses this to propose a concept framework of ACP attributes. Offers commentary within a global perspective of ACP.	Throughout there is poor reporting of the protocol/ methodology chosen and no justification given for this. Ethics, bias, limitations are not acknowledged or discussed. Results in terms of data is not given- just that the initial search gave 184 papers, but not then how/ if this was further filtered and how the papers were then analysed/ summarised. The conclusion drawn is weak in terms of how this flows from the research conducted here. This is not new knowledge and there is no future research proposed. The conclusion is that continued debate (? Research) on the definition is hindering ACP development, but this is (yet another) paper that does exactly that.	16

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
5.	Endacott and Chaboyer (2006) The nursing role in ICU outreach: an international exploratory study.	Descriptive case study design using semi-structured interviews and job descriptions as sources of evidence	The abstract and background provide a robust picture of the context with reference to previous research, current policy and practice. Clear description of the methodology is given with justification for taking the approach chosen being provided. In particular this research has used a case study approach to capture a complex and multi-factorial context/ issue.	The methodology is described but lacks detail at times making it difficult to assess how robustly this was implemented or how well the findings and conclusions drawn fit with the results. Whilst some limitations and ethical issues are mentioned these are not explored and potential bias and other issues are not discussed.	29
6.	Manley (1997) A conceptual framework for advanced practice: an action research project operationalizing an advanced practitioner/consultant nurse role.	Action research	A background to this specific context and project is given. Methodology choice is underpinned by discussion of a rationale that relates to the aims of the project. A comprehensive discussion of results is given with clear application made to the impact it had on practice and the potential for future impact / implications being highlighted.	The abstract could have more clearly and succinctly noted the aims, method, results. Whilst a rationale is given for the 'sample' it is questionable that the sample turns out to be the researcher themselves. This and the author's own 'take' on topics such as what ACP is noted but not highlighted as a potential for bias that could weaken the study. Some data from the results are missing when provision of this would have provided a more solid basis for drawing the conclusions it has from the findings (e.g. more detail of how thematic analysis was undertaken and the specific	25

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
				frequency/ volume that the themes emerged from).	
7.	McDonnell (2012) The perceived impact of advanced practice nurses (APNs) on promoting evidence-based practice amongst frontline nurses: findings from a collective case study	Collective instrumental case study	A comprehensive background is given and there is clear acknowledgement of the context and limitations of this study, including selection of people already engaged in EBP who may therefore provide a biased view. Description of methodology is given along with justification for the choices made. Results are presented logically with use of data and qualitative material. The conclusion and discussion fits with the results presented and a case is made for the implications for policy/ practice/ future research needed.	At times more fulsome detail could have been given and presented in a clearer way (e.g. the research question, and how this and the methodology achieves the aim). More detail of the sample would have been helpful to understand how representative it was and to compare with any replication of this study, particularly if this was repeated on a potentially less biased sample who had not been identified as already actively engaged in EBP. Ethics and bias are very briefly noted rather than explored or discussed.	31
8.	McDonnell (2015) An evaluation of the implementation of advanced nurse practitioner (ANP) roles in an acute hospital setting.	Collective case study.	A comprehensive background is given with reference to relevant literature, policy and practice. Throughout the research is presented in a concise, logical and detailed manner. The results are fulsome, including both numerical data and individual quotes from participants. This allows for clear conclusions that are derived from the results and findings. The	Some aspects of the sample are self-selecting which may introduce bias, and this has not been fully acknowledged by the authors. Greater attention could have been drawn to justification for choosing the focus for this case study and how representative the subject of this case study is for a broader population.	33

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
			limitations and implications for practice are clearly highlighted.		
9.	Shearer D and Adams (2012) Evaluating an advanced nursing practice course: student perceptions	Descriptive qualitative study using a framework for thematic content analysis	A contemporary, concise and helpful background is given to provide context. Details and data related to methodology are reported well. Findings are organised under themes, with direct quotes included from the qualitative data collected. Acknowledgement of some limitations and bias.	The rationale for the choices made regarding methodology is not explored. Details of the sample are given but their rationale for the selection is not justified. Only 14 students (not sure how representative these are more generally) and 10 randomly selected- why random selection and how was this done? The reporting is a bit haphazard at times with things such as ethics placed under 'method' when this could have been separated out, explored in greater depth; it notes potential bias but does not really explain how this was built into the design to prevent it, or how this should be taken account of when drawing conclusions. More detail of the full list of categories before these were 'collapsed' would have better demonstrated findings fitting with the results/ data generated.	27
10.	Smith and Hall (2003) Developing a neonatal workforce:	Semi-structured open-ended questionnaire	A clear abstract and background is given with reference to relevant contemporary issues, practice and	The method is inadequately described, with no detail provided of the questions asked in the	22

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
	role evolution and retention of advanced neonatal nurse practitioners.		policy. Specific data and discussion of findings are presented which captures information not evidenced in other research. Clear in that this relates to this university and this speciality and so further research may be needed. Places findings in the context of a broad discussion of implications for policy/ practice.	survey or how the data was then extracted and analysed. This makes determining whether the findings relate to the results difficult to establish (as only findings and selected results are given). The size of sample is justified, but how representative this was and therefore how well it could be repeated/ generalised, particularly to other specialist fields of ACP is difficult to establish. Discussion of ethics/ bias is not included. Arguably asking a question about whether they thought they were in a career cul-de-sac could be a leading question!	
11.	Tee, Jowett and Bechelet-Carter (2009) Evaluation study to ascertain the impact of the clinical academic coaching role for enhancing student learning experience within a clinical masters education programme.	Case study research design with a two-stage evaluation with analysis of structured questionnaires and interviews (x10)	Methodology is clearly described with justification for choices made being discussed. Ethical issues were highlighted and clear attempt had been made to address these in the methodology of the study. The results are fulsome in their presentation. The context is clearly described with limitations being highlighted as well as clear conclusions being drawn for future practice/ research.	Researcher bias could have been discussed as it is not clear who undertook the interviews and what the relationship was between the interviewer and the respondents and if this could be construed as introducing bias. The questionnaire is not provided so it's difficult to know whether the questions asked were appropriate and if the findings fit with the results.	35

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
12.	Thompson *et al.* (2019) Whole Systems Approach: Advanced Clinical Practitioner Development and Identity in Primary Care	Qualitative using online survey followed by interview and Braun & Clarke's 6 phase method for data analysis	Clear abstract and background that draws on contemporary literature and policy to set the context for this research. The methodology is described clearly with rationale given for choices made. Description of sample is detailed. Fulsome presentation of results is given, including direct quotes from the interview transcripts. A framework is produced from the results and clear implications for future policy, practice and research are noted along with the fact that this is already forming part of a wider study and policy making. Limitations to the study are clearly highlighted.	Demographics of the sample and how well this relates to the broader context could have been explored further. Whilst themes for the interview questions are provided the more specific interview schedule is not provided. Ethics is covered in 1 sentence in relation to the approval process- engagement in discussion of potential issues, including bias, and how this were/ could be addressed or how this should be taken account of in drawing conclusions is not discussed.	29
13.	Williamson *et al.* (2006) Change on the horizon: issues and concerns of neophyte advanced health care practitioners.	Qualitative design: focus group interviews	A clear title, abstract and background is given with reference to relevant literature. Ethical issues relating to approval and using someone not connected to the programme to collect the data is noted, and there is recognition of some of the issues that using a focus group approach raises. Results are presented with direct quotes from respondents. Reference is made to how this may be able to feed into future areas of	Research questions could have been more clearly defined. How the approach/ structure of thematic analysis was decided upon and undertaken is not presented, making it difficult to be able to repeat this study, or confirm the 'fit' of results with the conclusions drawn. There are few details of the sample given, with little justification for their selection or how this may compare to the broader context.	25

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
			research and how it articulates to existing evidence.	Broader discussion of potential ethical issues, and particularly in preventing bias is absent. (author bias, and also that results are based upon self-selection and self-report from participants.)	
14.	Wilson-Barnett *et al.* (2000) Recognising advancing nursing practice: evidence from two observational studies.	Reflective observation	A comprehensive background including how this study articulates to other research/ existing evidence is provided. Methodology choice and justification for the choices made are described. Fulsome details of the results are given, including quantitative data and quotes directly from respondents alongside themes from observation/ analysis. Presents a direct observation of the role, scope, and key topics surrounding ACP is given and this is linked to how policy and practice can be impacted by this.	The specific aims and research questions for this project (which derives data from 2 other studies) is missing clear definition. Most information is provided in the abstract but could have been presented in a more structured way. The method is described but not in an easy-to-follow structured way. Demographic information of sample is not provided and it remains unclear (despite an attempt in the text to describe this) how/ why the individuals from the 'scope' side of the project were selected- it appears this is largely self-selection with some confirmation that they fit the criteria.	27
15.	Woods (1998) Identifying the practice characteristics of advanced practitioners in acute	Longitudinal, multiple case study. Interviews with ANPs and other colleagues, observation of	Clear and concise title, abstract and introduction with reference to literature to underpin this study, in particular highlighting current gaps in knowledge. The methodology appears to have been generated	Very limited detail of how the sample was selected and why, with no detail of demographic data, making it difficult to repeat this study or assess how this fits within the broader context of	30

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
	and critical care settings.	clinical practice and self-report role development diaries completed over their first 6 months as an ACP.	from this context. Full details and justification not published in this paper but are provided in another paper and the reference is given. Evidence gathered directly and provides new insight to the role of ACP, whilst noting where further research may be needed. Use of longitudinal data is novel in this context.	ACP. Discussion of ethical issues, approval or bias and how this was/ could have been addressed or may impact what can be concluded is rarely discussed, except to note the potential drawbacks of using diaries. This may be addressed more fully in the other paper but is not referenced here.	

Mixed Method

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
1.	Currie *et al.* (2012) Participants' engagement with and reactions to the use of on-line action learning sets to support advanced nursing role development.	On-line survey and in-depth interview	An introduction to the context of ACP, Action Learning Sets and how this research fits with a larger set of studies is given. Relevant details of the sample and their response rates were given to show the broad range of participants that had been recruited. Results are presented with direct quotes from participants. Size and location of study and how this may affect ability to generalise findings is acknowledged in the discussion. Suggestion is made for further research needed.	Abstract is not clearly structured and does not provide enough detail of the research. The aims research question could have been defined more clearly. Exactly how the participants were recruited is not discussed, nor was how representative this group was of the broader group undertaking this programme or more generally in the ACP context. Some demographic detail missing. Further detail of how data analysis was undertaken for the different methodologies used could have been provided, rather than just the under-pinning principles used. Ethics approval was noted but discussion of potential issues and bias, especially as it is noted this was a commissioned study where participants were required to respond is lacking. The results are not presented in full – it is described what types of data would be collected but that data is then not fully presented. Notes	25

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
				the key findings/ themes are not 'new' but are confirmed within this particular context	
2.	Delamaire and Lafortune (2010) OECD Health Working Paper No. 54 Nurses In Advanced Roles: A Description and Evaluation of Experiences In 12 Developed Countries	Policy and data questionnaire. Plus, review of the literature.	The introduction is comprehensive, with reference to literature, and relevant policy & practice and aims/ research questions have been clearly defined. Detail of each of the participating countries is given with detail on the particular context of ACP phenomenon (including development, progress to date etc) in these countries. Comprehensive detail is provided of the results for each country and these are used to coalesce around themes. Provides a global picture of ACP including the trajectory of progression that one can expect and summarises well the key themes highlighted in other research pertinent to ACP.	The abstract is more like a summary of the context than giving the clear, structured precis of the research conducted. At times the terms used are a bit vague, making unclear how systematic the research has been undertaken (e.g. 'they represent a good mix of countries', 'the information contained in this study comes largely from a policy and data questionnaire'. The actual method/ protocol (or the eluded to questionnaire) and how this was analysed and triangulated with the literature review and panel of experts contributions is not described and rationale for this choice of methodology is not explored. Ethics. Bias is not discussed.	23
3.	Gerrish *et al.* (2011) Factors influencing the contribution of advanced practice nurses to promoting evidence-based practice among front-	Cross-sectional survey using questionnaire with 5-point ordinal scale plus open questions	Clear title, abstract, aim and introduction which summarises key points of context with reference to existing literature, policy & practice. Ethics and potential bias are discussed with reference to some steps taken to address	There were clear issues with control of distribution and receiving completed responses, whilst this is acknowledged, this may have been better handled by building this into the design at the outset. Purposive sampling is	30

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
	line nurses: findings from a cross-sectional survey		potential issues. Results are presented in a logical sequence with sufficient detail and including both data and direct commentary to draw sound conclusions. These are articulated into the current context with clear implications for future practice/ development/ research.	used which appears appropriate but further detail of the criteria used would make interpreting results/ repeating the study/ drawing conclusions more transparent. Discussion of choices and process for developing the questionnaire, data analysis as well as ethical issues and potential bias could have been more detailed.	
4.	(Gloster, Neville and Windle, 2015) Effects of advanced practitioners' learning in one hospital.	Mixed methods evaluation using Kirkpatrick's model which includes questionnaire, measurement of outcome (increase in knowledge) from a portfolio of evidence (assignment outcomes, end of programme questionnaire), interviews and observation in practice and assessment against KPIs.	There is a useful introduction which provides a broad background to ACP and the specific context of this research, with a statement of the aims that informed this research. There is a good description of the (small) sample. There is clear description of ethical considerations that were taken account of and managed in the research. There is clear and comprehensive presentation of data, and the text explains these alongside establishing relevant findings and conclusions that can be drawn from the data. There are clear and appropriate implications made for policy and practice	The title and abstract are limited and does not provide the key points of the research. A more extensive literature review and clearly defined research questions is lacking in the introduction. The description of the methodology is limited and clear reporting of the data collection (i.e. questionnaires used) is not provided. Rationale for the approach in sampling is implicit rather than explicitly described (it is an evaluation of a particular programme, so it follows that students from only this programme should be the sample). However, it is debateable whether 'first past the post' is the most appropriate way to get an unbiased and	24

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
				representative sample. Minimal discussion of data analysis is provided, with no explanation of how or why this approach was taken. Potential Bias is not fully acknowledged or explored. Discussion of limitations of this research and potential future development/ research is not discussed.	
5.	(Hughes *et al.*, 2017) Future enhanced clinical role of pharmacists in Emergency Departments in England: multi-site observational evaluation	Non-interventional, multi-site, cross-sectional observational study. Quantitative primary categorization of data (whether case could be managed by a pharmacist) and qualitative analysis of secondary outcomes (TNA and evaluation of impact in clinical areas)	Clear title, abstract. Background succinct, reference to current policy, practice & literature and clearly defined aims. Methods clearly described, with use of pilot study. Comprehensive reporting of data and tables of results are explained. Highlights the limitations of this study, why this was the case, and how this could have been rectified, is noted along with identifying areas for future development/ research.	Detail is not given of how the sample hospitals were selected, or how the 'representative sample' of cases was established. Justification or discussion of rationale for the methodological choices is not discussed. Just what ethical approval was gained is discussed- no broader discussion of potential ethical issues, bias or how these could/ were addressed or may impact what conclusions can be drawn from findings.	28
6.	Hutchinson (2014) Deriving Consensus on the	A three-phase approach involved (a) systematic	The title, abstract, introduction and aims are clearly stated and relevant to the context. Detailed	Further discussion of the rationale for addressing the aims in this way could have been given to	33

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
	Characteristics of Advanced Practice Nursing	review of the literature, (b) qualitative meta-summary of practice characteristics extracted from manuscripts (c) statistical analysis of domains across advanced practice categories.	description of methodology used and some rationale for choice of methodology is given. Results are presented clearly and explained in the text with reference to the context, previous research and implications for future practice/ further research.	more solidly demonstrate how this research will comprehensively & accurately address the aims. In the limitations it is noted the poor quality and small sample size as well as variety of nomenclature used that limits the impact of this research- this is stated at the outset so it is questionable why use of literature review is therefore pursued. There is no discussion or description of consideration of ethical issues including any bias from the researchers.	
7.	Marsden (2003) Nurse practitioner practice and deployment: electronic mail Delphi study	Delphi study using e-mail	The title, abstract and introduction are clear with reference to relevant literature/ policy. Aims and research questions are defined and explained. Consideration has been given to some potential ethical issues. The results from the second round are clearly presented with rationale as to why 7 rather than just 5 are included. The small sample size is acknowledged including how use of email may have limited this (but in this case did not). In the discussion and conclusion clear links are made to current policy	They focussed the sample on experts or key thinkers with the rationale of preventing local issues dominating however there is a risk that this introduces bias and actually patterns in local issues are not highlighted. The sample size is small and details are not given to be able to identify how representative they are of the more general context or to provide specificity to the conclusions that can be drawn. Snowballing is used to identify the sample which may promote 'more of the same' rather than	26

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
			developments and practice which provides clear direction of how the narrative from this research could impact future practice.	broadening the range of expertise that is drawn upon for this research. Time pressures appear to have driven some of the methodology choice- rationale for choices made could have been more robust. More detail of the approach taken in data analysis is warranted. Some ethical considerations are noted but effective management of these could have been improved and reflection on potential bias is not addressed. Although email is described as 'novel' in this paper some of the (now well known) issues of using email are not explored). Detail of the statements generated from the larger sample in round 1 is not presented. Potential limitations of this study are not fully addressed (e.g. use of a self-selecting panel of experts). The claims made in the 'what this paper adds' section is somewhat spurious.	
8.	(Marsden, 2013) Advanced practice in ophthalmic nursing: A comparison of roles and the effects	Mixed method questionnaire	The introduction provides a helpful context to ACP development and current policy and practice in each of the countries studied. Some of the results are clearly presented	A more structured abstract with clear aims and research questions here or in the introduction would have been better. The rationale for choosing	20

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
	of policy on practice in the UK and New Zealand.		and explained in the main text. Articulation to policy and practice and future developments is clearly presented, with acknowledgement that this provides a 'snapshot' of a small sample. It provides a new insight/ perspective, particularly around regulation and development of ACP.	the methodology is not explored and the specific questions are not provided, nor are they the same between the 2 samples. The sample is self-selecting and convenience- only those attending a national conference were sampled which may not be reflective of the broader population actually practising in this field. The sample size is slightly different between each country studied, demographics are not provided. The approach taken for data analysis is not mentioned or described. Discussion of ethics is limited the approvals gained. Some results are presented as pure summary narrative so it's difficult to establish how accurate these findings match with the data collected.	
9.	(McConnell, 2013) Emergency nurse practitioners' perceptions of their role and scope of practice: Is it advanced practice?	Survey using mixed method questionnaire. SPSS used for statistical analysis of data and content analysis for thematic	The introduction is useful in providing a background with reference to current issues, policy and practice and previous research. Aims and objectives are clearly presented. The results are presented clearly and the findings and conclusions drawn logically	The rationale for choosing the methodology employed, including sample selection and the specific questionnaire used is not provided. The tools used for data analysis are briefly described but no rationale is given for their choice, or enough detail provided	24

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
		analysis of qualitative data	flow from the results as well as reference to previous literature and research undertaken in this area. Clear acknowledgement of most of the potential limitations of this research are provided.	to establish how robust this was or if it could be repeated (e.g. 'themes were identified from the open-ended questions'- how?) Ethical considerations are restricted to briefly noting that approval was given. There is limited discussion of how the sample selected fits within a broader context of ACP/ ENP, although reference is made at times to comparisons between countries. Development of the discussion re limitations and potential implications for practice, including further research needed would have been beneficial.	
10.	McGee (1996) A Survey of Specialist and Advanced Nursing Practice in England.	Survey using mixed method questionnaire	The research aims are clearly stated. The sample size is large and should have captured the majority of the sector at the time of the research and fits well with the aims of the research. In all but the 'considerable amount of data generated in relation to the advantages of SNs and ANPs' the results are presented clearly and logically and findings flow directly from the data presented. This research contributes new data in this field at that time and is clear	The title, abstract and introduction are inadequate in succinctly providing a clear description of the study, its key elements and a background to include reference to a literature review. There is limited discussion of the methodology (e.g. how was the questionnaire and pilot study developed/ implemented) or the rationale for choosing this approach. There were clearly issues with managing the response of the sample by not	18

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
			about potential implications for policy and practice and the further research that is needed.	including identifying information on the questionnaires before they were sent out meaning follow up was not undertaken. It is unclear, (knowing what we do about the lack of transparency of who can be identified as ACP) that asking the chairman and chief nurse is the best way to achieve the accurate data and responses needed to address the aims. There is no discussion of data analysis or ethical considerations including bias. There is no discussion of potential limitations of this research, or how this has/ could be managed or how these need to be considered when drawing conclusions or developing future research.	
11.	Miller, Cox and Williams (2009) Evaluation of Advanced Practitioner Roles	Comparison survey via questionnaire, plus case studies elicited from site visits	Clear and comprehensive aims and objectives for the research are presented. Although not concise there is a comprehensive background which includes a literature review. Clear explanation of the methodology and rationale for its use is given, including discussion of the process used to develop the questionnaire. Clear description of sample	This is presented in project report form rather than traditional publication structure. There is no 'abstract' as such, but the executive summary and introduction provides all the relevant information you would expect to see, except perhaps in a less concise manner. There is no direct reporting of the exact data analysis process undertaken,	35

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
			selection and recruitment process is provided. There is not a specific section in the report of 'ethical considerations' however throughout a reflexive approach is taken to highlight the potential limitations and (to a somewhat lesser extent) bias throughout. The findings are presented in a structured, logical and comprehensive manner. There are clear implications for policy, practice and future research that are appropriately identified.	although is broader discussion of the general approach and rationale given for taking that approach in this study. The raw data is not provided which makes it difficult to have confidence that the findings follow accurately the results and data generated.	
12.	Roberts-Davis (1998) Education. Realizing specialist and advanced nursing practice: a typology of innovative nursing roles.	Delphi technique, Literature review and Interview	There is a limited but useful introduction with reference made to relevant background, context, policy and practice and existing literature. There is reference made to potential impact for policy and practice and future research.	The abstract is not structured and does not clearly and succinctly provide all the key elements of the research (e.g. methodology). The aims and research question/s are not clearly defined. The methodology is poorly described and emerges rather than being clearly set out with little description of the data generated (including no description of data analysis, PRISMA or specifics research process/ strategy for the literature review). 'Key informants are identified as the sample, but it is not said how these were identified and the criteria by which	13

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
				it was decided they could give an 'informed opinion' on the matter. Limited details of the sample (only job role) are given. There is no discussion of ethical considerations including reference to any potential bias. Some data is provided in tables, but this is often not explained or referred to in the text and findings/ conclusions are presented disconnected from the data. Limitations of the study are not identified or addressed.	
13.	Read *et al.* (2001) Exploring New Roles in Practice (ENRiP) Final Report	stage one – a mapping exercise to identify the range and purpose of new roles) stage two – a set of case studies stage three – a survey	Background to some key areas of the policy and practice context is provided with reference made to relevant literature. The methodology is clearly described including the process through rationale was explored and choices were made. Discussion of the sample and the rationale for selection within the aims and remit of the study is provided with good use of piloting and snowballing. Detailed description is given of how data was collected and recorded. Robust exploration of ethics and potential bias, including reference to issues and lessons	This is presented as a report rather than a traditionally structured paper. There is consequently not a clear, succinct abstract with the key description of the project but an executive summary which provides some but not all of the key points, and the aims/ research questions are not clearly defined in the introduction but are provided in the sections related to methodology. Clear and concise description of the methodology and data is lacking. Limited discussion of the approach taken	30

No.	Author/s, (Year), Title	Methodology type	Strengths	Weaknesses	RAG
			learnt from other studies. Data and findings are clearly presented and links made between the two in the text, alongside narrative summary that supports the findings/ conclusions drawn. Clear recommendations based on the results of this research are provided, which include acknowledgement of limitations and where further development and investment is needed for future research.	to data analysis and the rationale for this is presented.	

APPENDIX 6- COREQ CHECKLIST

(COREQ = COnsolidated criteria for REporting Qualitative research)

Domain 1: Research team and reflexivity

Personal characteristics (Reported on Pages 11, 122-123)

1. Interviewer/facilitator: Vikki-Jo Scott (Chief Investigator)
2. Credentials: MaLT, PhD student, RGN
3. Occupation: Senior Lecturer/ Advanced Clinical Practice Programme Lead
4. Gender: Female
5. Experience and training: Currently undertaking PhD and have attending training/ read about best practice in conducting Focus Groups.

Relationship with participants

6. Relationship established: (Reported on Page 133 'Recruitment to the study')
   No, some may have been connected to the primary researcher through the social media platforms utilised to advertise the research, or come across her work at national ACP conferences, but none of the participants were personally known to the researcher.
7. Participant knowledge of the interviewer: (Reported on Page 455, Appendix 9 Participant Information & Consent)
   This was told to potential participants as part of the recruitment materials, noting this was part of her PhD studies, and the aim of the research was given. This was repeated when being invited to take part in focus groups and at the beginning of each focus group.
8. Interviewer characteristics: (Reported on Page 455, Appendix 9 Participant Information & Consent)
   It was noted that the researcher is a nurse, working in ACP education, and that the interest for this research was due to her PhD studies including what had been found in a systematic literature review.

Domain 2: Study design

Theoretical framework (Reported on Pages 123-126 'Theoretical and Philosophical Approach')

9. Methodological orientation and theory:

   Pragmatic, Mixed Method, Exploratory design with use of an instrumental developmental model, taking an emic perspective and using Reflexive Thematic Analysis in this (the Focus Group) stage of the research.

Participant selection

10. Sampling: (Reported on pages 132-138 'Focus Group Sampling Strategy' and pages 162-165 'Follow-up Questionnaire Sampling Strategy'

    Purposive sampling strategy using maximum variation sampling from the recruitment questionnaire (which used convenience sampling) for recruitment to the focus group.

11. Method of approach: (Reported on pages 132-138 'Focus Group Sampling Strategy' and pages 162-165 'Follow-up Questionnaire Sampling Strategy'

    On-line recruitment questionnaires via social media platforms, (twitter, Facebook) and distribution through membership list of a National organisation (AAPE-UK). Potential participants were contacted via email for those that consented to be approached for the Focus Group, (using the email address they had provided to be used for this purpose).

12. Sample size: (Reported on Page 179 for the 'Recruitment Questionnaire', page 182-183 for 'Maximum variation sampling', and page 221-223 for 'Follow-up Questionnaire results')

    17 in the Focus Groups (6, 6 & 5) from 217 that answered the recruitment questionnaire and gave consent to be contacted about invitation to the Focus Group. Qualtrics was used to select random batches of 30 from the 217 that had consented to be contacted about focus groups. Those selected were given a link

to doodle poll to declare their availability, reminding them they should only fill this out if they were willing to participate in the focus group. Due to a low response rate, all 217 were ultimately invited to a doodle poll. Only those that were available at the times set for the focus groups were reviewed for maximum variation sampling and then sent a meeting invite via zoom for participation in a focus group.

13. Non-participation: (Reported on Pages 182-183 'Maximum Variation Sampling')

No-one dropped out from the focus group once these were started and conducted.

- x1 dropped out prior to the Focus Group taking place having said they couldn't join due to their ill health.
- x1 dropped out prior to the Focus Group taking place having said they couldn't join due to staff sick leave in their team (limiting her availability to attend).
- x1 withdrew once contacted for invitation to the focus group due to her currently being on maternity leave and so was nervous about not reflecting current practice.
- x1 declined to take part in focus groups once sent the invite to take part as they felt they would not have the time needed for participation in the focus groups.

x1 withdrew from the whole study (not just the Focus Group) after completing the recruitment questionnaire and before they were invited to focus groups as they picked up in the study information and questions asked that it referred to the experience of ACPs working in England rather than the UK (they were based in one of the other nations).

Setting

14. Setting of data collection: (Reported on Page 139)

    Via zoom, so the setting for each participant varied. The researcher was in her home with a non-descript background. From the backgrounds on camera the majority joined the focus group from their place of work.

15. Presence of non- participants: (Reported on Page 184)

    All but one participant appeared to be in a room on their own, with the one that was using headphones to listen and speak through which will have protected participants from being overheard by the other person in the room.

16. Description of sample: (Reported on Pages 179-183, 221-223)

    Please see maximum variation sampling table and the recruitment questionnaire and follow-up questionnaire results where demographic details of participants have been reported from the responses they gave.

Data collection

17. Interview guide: (Reported on Pages 469-470, Appendix 11 'Focus Group Topic Guide')

    A topic guide was used. This had not been pilot tested.

18. Repeat interviews:

    N/A (Interviews not used, there were 3 focus groups in total).

19. Audio/visual recording: Reported on Page 143-144, Table 4.3

    Yes, this was recorded using Zoom software and then downloaded and stored on Box as video, audio, and transcript files for each focus group (FG).

20. Field notes: Reported on Page 144

    Notes were made during and after. The notes within the FG were primarily to assist the moderator in summarising and member checking at the end of the FG to ensure the key themes participants had highlighted in their discussion had been captured. The notes made during the focus groups did then feed into the researcher's notes made after (which were recorded in a reflective diary and have been drawn upon to write the narrative 'thick description' in the focus group analysis summary).

21. Duration: Reported on Page 184

    FG 1 & 2 lasted 60 mins, FG 3 lasted 90 mins

22. Data saturation: Reported on Page 184

    This was not used. Whilst this research is trying to get a broad range of views, it is made clear that if this study was repeated it is not presumed that the findings would be the same as they would always come from different people, different perspectives and experiences, at different times. However, the study could have just kept going with more focus groups to make sure a broader range of views were collected, (although there are practical reasons why this would have been unlikely to work noting non-participation above). As an observation, common themes were identified, and will be helpful when it comes to designing the follow up survey; i.e. the finding is there is lots of diversity in ACP but there are common experiences that a diverse group of ACPs have reported. The number of times a theme is mentioned has not influenced whether it is noted as a code but helps to highlight where there were common experiences encountered by a diverse range of ACPs.

23. Transcripts returned: Reported on Page 143-144

    Moderated, anonymised, and checked transcripts were returned to participants, but they were not asked to provide comment or correction (noting that this is not the approach being used for member checking in this research).

Domain 3: analysis and findings

Data Analysis

24. Number of data coders: (Reported on pages 143-144

    One

25. Description of the coding tree: (Reported on Page 156 'Context codes' and Page 187 Table 5.2 Focus group themes and codes)

    Initial coding looked at broader context-based themes to reflect the background or reason why participants gave a particular response, (e.g. due to their experience, their hopes or aspirations, driving forces, or what they perceived as a key theme of ACP). However, this did not capture the themes (top level and child codes) in relation to the question in sufficient detail. All the top-level and child codes fell into several of the context-based themes (i.e. the reason why they highlighted a theme that became a code was because of one or more of the context codes). The top-level codes provide an over-arching theme for each 'story' under which different aspects of the narrative (child codes) contribute to telling this story. This can also be likened to a recipe, where the top-level code is the meal, and the child codes are the ingredients that contribute to the making of the meal, with the context codes as being the method of preparing the recipe.

26. Derivation of themes: (Reported on Page 185-187

    Not defined in advance, although the 'context codes' were to some extent influenced by the trigger questions that were pre-determined in the topic guide.

27. Software: (Reported on Pages 123, 144, 165, 176)

    Qualtrics for on-line questionnaire, NVivo for thematic analysis, Box for storage

28. Participant checking:

    N/A (please refer to 'transcripts returned' section regarding member checking)

Reporting

29. Quotations presented: Yes

These have been integrated within the focus group and follow up questionnaire results chapters as well as CHAPTER 7- DISCUSSION and CHAPTER 8 – NARRATIVE INFERENCE.

30. Data and findings consistent Yes

A story telling approach has been used for the results chapters bringing together analysis of quantitative and qualitative data. These have been weaved into a CHAPTER 7- DISCUSSION.

31. Clarity of major themes: Yes

This is presented as a summary table as well as a record being kept of how the 6 phases approach of Braun and Clarke's reflexive thematic analysis was used to construct the major themes discussed on pages 185-187.

32. Clarity of minor themes: Yes

This is presented as a summary table as well as a record being kept of how the 6 phases approach of Braun and Clarke's reflexive thematic analysis was used to construct the major themes discussed on pages 185-187.

Developed from: Tong A, Sainsbury P,
for interviews and focus groups. International Journal for Quality in Health Care. 2007. Volume 19, Number 6: pp. 349 – 357

APPENDIX 7- PARADIGM CONTRAST

Research study mapped against Tashakkori et al 2021 (page 62) 'Expanded and Revised Paradigm Contrast Table Comparing Five Points of View'. KEY:

Best fit with the research aims, objective, question		
Least best fit with the research aims, objective, question		

Dimensions of Contrast	Constructivism	Transformativism	Pragmatism	Postpositivism	Positivism
Methods and methodologies	QUAL	Both QUAL and QUAN; community of participants involved in methods decisions	Both QUAL and QUAN; researchers answer questions using best methods	Primarily QUAN	QUAN
Logic or scientific method(s)	Inductive	Inductive, hypothetico-deductive, and any other logics that are helpful in transforming society	Recommends use of any logic that might help answer research questions (e.g., inductive, deductive, abductive, critical, dialectical)	Hypothetico-deductive	Hypothetico-deductive (originally inductive)
Epistemology (when can a knowledge claim be made?)	Relies on subjective and intersubjective/group viewpoints; reality and knowledge are literally co-constructed with participants	Relies on subjective, intersubjective, and "objective" sources of knowledge. Also relies on participatory approaches	Uses any source and method that can help produce knowledge claims that have "warranted assertability"	Recommends attempting to be as objective as possible; relies on empirical data for knowledge claims	Mostly relied on quantitative data about the world to make universal and certain knowledge claims
Axiology (role of values and value systems)	All inquiry is value bound	Research is guided by concerns about the lack of social justice	Values guide what we study and how we interpret and use research results. The goal is to fulfil the purpose of each research study and, ultimately, to make the world better (John Dewey)	Social and epistemological values influence the selection of questions and interpretation of results. The most important epistemological values are description, prediction, and explanation	Research was said to be value free
Ontology (the nature of reality)	Ontological relativism— reality is constructed and multiple (varying for each individual and group). There is no objective reality	Pluralistic (multiple kinds of reality exist). The reality of inequality is paramount (including its objective and factual aspects)	Multiple kinds of reality exist (e.g., subjective, intersubjective, objective/physical). Different disciplines also identify important parts of reality (economic, psychological, social)	Critical realism (external reality that is understood imperfectly and probabilistically)	Classical positivists thought that the only reality is that which we can perceive. Reality is primarily material and physical (with an emphasis on physics)
Possibility of causal linkages	It is impossible to distinguish causes from effects; credibility of descriptions is important	Causal relations exist and should be understood within the framework of social justice	Causal relations exist, but they are often particularistic and transitory. Both internal validity and credibility are important	Causation (between variables) is of primary importance and is identifiable in a probabilistic sense that can change over time; internal validity is very important	Positivism originally was interested in universal laws far more than the metaphysical idea of "causation"
Generalization	Only idiographic/particularistic statements are possible; transferability is for the reader or user of the research to decide	Both local and general statements can be important, and they are linked to issues of social inequality and justice	Some pragmatists emphasize local subjective generalizations (William James); others allow larger claims if they are warranted by the data (John Dewey)	Postpositivists are interested in making nomothetic/general data-based claims; external validity is very important	Positivists were interested in universal claims about the natural world.

APPENDIX 8- INVITATION TO PARTICIPATE

The following text was used when advertising for participants:

Title: Looking for Advanced Clinical Practitioners (ACPs) or trainee ACPs to take part in a study

Text:

"What are the realistic expectations of pursuing an Advanced Clinical Practitioners role?"
ARE YOU AN ACP OR CURRENTLY TRAINING TO BE?
WOULD YOU CONSIDER TAKING PART IN A STUDY ABOUT YOUR EXPEREINCES OF ADVANCED CLINICAL PRACTICE?

If so please click on the link below:

[Link used for Recruitment Questionnaire;]

https://essex.eu.qualtrics.com/jfe/form/SV_6KXLIDWRXxBslds

[Link used for Follow-Up Questionnaire;]

https://essex.eu.qualtrics.com/jfe/form/SV_exnGXyrK4GDxWho

Place in comments/ replies or in later text in email:

In this study we want to explore ACPs expectations of the role, whether they are being realised and what factors may influence this. We are interested in finding out about your experiences of working or currently training as an ACP.

Who is conducting the study? My name is Vikki-Jo Scott. I'm a doctoral student and Senior Lecturer in the School of Health and Social Care at the University of Essex.

[Include text relevant to stage of research from this paragraph] What will participating in this project involve? If you agree to participate in the project, you will be invited to complete 2 online questionnaires. You may also be invited to participate in a focus group. I will ask you questions about your experiences of working or training as an ACP.

There is no obligation to participate in this research. The data you provide will be protected and personal information will not be shared as part of this research. You can withdraw at any time, and you can decide to only participate in the online questionnaires if you do not wish to be part of the focus group.

[Include text relevant to stage of research from this paragraph] The first questionnaire is expected to take less than 10 minutes to complete, and the second is expected to take less than 30 minutes of your time. The focus group will be held on-line via zoom and will last no more than 90 minutes.

Further information can be found by clicking on the link below. By clicking on this link you are not consenting to participate in the research; this will be asked and confirmed within the questionnaire if you choose to complete this. If you are interested in hearing more about the study or want to take part please click on the link below.

APPENDIX 9- PARTICIPANT INFORMATION & CONSENT

Welcome to the research study:
What are the realistic expectations of pursuing an Advanced Clinical Practitioners role?
You are being given this information because you are invited to take part in a research study. This information sheet describes the study and explains what will be involved if you decide to take part.

What is the purpose of this study?
In this study we want to explore people's experiences of working or training as an Advanced Clinical Practitioner (ACP) in England, what their expectations of this role are, and whether they are being realised.

Who is conducting the study?
My name is Vikki-Jo Scott. I'm a PhD student and Senior Lecturer within the School of Health and Social Care at the University of Essex. I am a Critical Care Nurse by background. I lead the programmes at the University that have been mapped to the Multi-Professional Framework for Advanced Clinical Practice in England.
Centre for Advancing Practice

What will participating in this project involve?
If you agree to participate in the project, you will be asked to complete a recruitment questionnaire that asks for general information about your role and experience to date with regard to Advanced Clinical Practice. You will complete this on-line by clicking on the link given at the end of this consent form. The questionnaire is expected to take no more than 10 minutes to complete.

Once all the data for the recruitment questionnaire has been analysed, we may then ask you to take part in a focus group discussion with around seven other people. You do not need to decide on whether you want to take part in the focus group now; we will provide further information and we will ask for your consent to participate should you be selected to take part in the focus group.

Once the focus groups have been completed and the data has been analysed (in approximately 6 months' time) we will then ask you to complete a follow up questionnaire about your current experiences of working or training as an ACP. You will complete this on-line; we will provide a link for you to click on to complete this questionnaire. This will be sent to the email you provide in the recruitment questionnaire. The follow up questionnaire is expected to take no more than 30 minutes to complete.

Participating in this research will therefore mean you will undertake a recruitment and a follow up questionnaire. You may also be asked to participate in a focus group but are not obliged to do so.

Do I have to take part?
No, it's completely up to you whether or not you take part in the study. If you agree to take part, you are free to change your mind at any time without giving me a reason. If you have any questions or concerns about participating you can contact me at my email address Vikki-Jo Scott.

What will happen to any information I give?
Any information I have about you and everything you provide to me will be kept confidential. If a matter arises in your responses to this study that create a health, safety, or safeguarding

concern (for example regarding the care of a patient or fitness to practise) this information will be shared with relevant persons and authorities as required.
Your name and contact details will be kept separately from the data provided in the questionnaires and any details that could be used to identify you will be removed from the data prior to analysis and before results are reported or shared with anyone else. Any extracts from what you say in the questionnaires will be entirely anonymous.

All electronic data will be stored on a password protected computer. Any paper copies will be kept in a locked filing cabinet in my office. All data from the study will be retained, in a secure location, for 10 years.

What will happen to the results of the project?
The anonymised results of this study will be used in academic papers for publication and in presentations as well as my PhD Thesis. I would be happy to send you a summary of the results if you wish, (you will be asked about this as part of the consent survey).

What are the possible benefits of taking part?
There will be no immediate benefits for you, but by taking in part in this study you can help us better understand what the expectations are of Advanced Clinical Practitioner roles and whether these are being realised. As ACP has been identified within the NHS People Plan as key 'growing for the future' significant investment is anticipated in this area. By researching this topic and publishing it more widely it is hoped that this can inform the career development and continuing professional development that is offered to Advanced Clinical Practitioners. This includes understanding what is realistic to expect from holding such a role and how best to support staff in ACP roles or those that are intending to pursue a career in this field.

Are there any risks?
No. There is no known risk if you take part in this study. We recognise this will take time for you to complete, so please do be aware of any competing priorities you may have and prioritise these accordingly. We have designed the questionnaires to be undertaken on-line at a time that suits you.

The process of engaging in this research may prompt you to reflect on your role and raise questions about your own career, CPD, and the support offered to you. We recommend if you have any questions about this, please discuss this with your line manager or education/ Advanced Practice lead within your employing organisation. You may find that your local University and education providers can provide further support in exploring your career and professional development options. The resources available via Health Education England's Centre for Advancing Practice are also freely available to you to explore further the Advanced Practice role. The NHS also offers free advice and links to support services through their 'supporting our NHS people' website. You should also contact your local health and wellbeing to see what support offers are available within your own employing organisation.
Contact details
I am the main contact for the study. If you have any questions about the project, please don't hesitate to ask. My contact details are:
Vikki-Jo Scott

Email: v.j.scott@essex.ac.uk
Tel: 01206 874487
School of Health & Social Care, University of Essex, Wivenhoe Park, Colchester, Essex, CO4 3SQ

If you wish to contact a senior member of the University about the research or make a complaint please contact:
Sarah Manning-Press
Email: sarahm@essex.ac.uk
Tel: 01206 873561
Research & Enterprise Office, University of Essex, Wivenhoe Park, Colchester, Essex, CO4 3SQ

The study is being undertaken as part of my PhD studies. It has no external funding or other conflicts of interest to be declared.

Thank you for considering taking part in this study and taking the time to read this information.

If you are willing take part in the questionnaires for this research project, please click on the 'NEXT' arrow below.

This will take you to the consent survey where you can confirm whether you consent to participate in this research.

You can press the 'BACK' button if you want to revisit this information at any time during the questionnaire.

Page Break

Q1 I confirm that I have read and understand the information sheet provided for this study. I have had the opportunity to consider the information, ask questions, and have had these answered satisfactorily.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If I confirm that I have read and understand the information sheet provided for this study. I have h... = No

Q2 I understand that my participation in this study is voluntary and that I am free to withdraw at any time, without giving a reason.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If I understand that my participation in this study is voluntary and that I am free to withdraw at a... = No

Q3 I understand that the information provided by me will be digitally recorded.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If I understand that the information provided by me will be digitally recorded. = No

Q4 I understand that information given in the questionnaires may be used by the research team in future publications, reports, or presentations.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If I understand that information given in the questionnaires may be used by the research team in fut... = No

Q5 I understand that any personal data that could be used to identify me will be removed from the data to be analysed and that I will not be identified in any publications, reports, or presentations.

- Yes (1)
- No (2)

Skip To: End of Survey If I understand that any personal data that could be used to identify me will be removed from the da... = No

Q6 I understand that the anonymised data I provide will be deposited in a secure location.

- Yes (1)
- No (2)

Skip To: End of Survey If I understand that the anonymised data I provide will be deposited in a secure location. = No

Q7 I consent to participation in this research.

- Yes (1)
- No (2)

Skip To: End of Survey If I consent to participation in this research. = No

End of Block: Questionnaire Informed Consent

Start of Block: Contact details

Information
Thank you for agreeing to take part in this study

Your name and email address will be kept separately to the answers you give in any subsequent stages of this research (e.g. participant/ follow up questionnaire and focus groups) that follow.

We will only use your name and email address to contact you with the questionnaires for this research and to provide you with a summary of the results if you wish to see these.

Your contribution to this research is very much appreciated.

Q1 Please tell me your name

_____

Q2 Please tell me your preferred email address

_____

Q3 Do you want to be contacted with the results of this research once it has been completed (if yes we will use the email address you have provided above to send this to you)?

- ○ Yes (1)
- ○ No (2)

Instruction Thank you for providing the information above. On clicking the arrow button below you will be submitting the information you have provided to be used in this research. Your name and email will only be used to contact you with further information about this research and to provide an update of the findings of the research (if you have answered yes to receiving this).

For the remainder of this research we will not use your name or email address to identify any responses you give to ensure we protect your anonymity.

On clicking the 'NEXT' arrow button below you will be given the link to our first questionnaire in this research. This will ask you some background information about the ACP role you are currently undertaking.

APPENDIX 10- RECRUITMENT QUESTIONNAIRE

Start of Block: Information

Information
Thank you for agreeing to take part in this study

You should only complete this questionnaire if you have said 'Yes' to the questions in the consent form.

The questions used here replicate the information being gathered by Health Education England (2021) in their 'deep dive' which is being used to identify and scope out the ACP workforce in the East of England.
https://advanced-practice.hee.nhs.uk/deep-dive-into-the-east-of-england-eoe-faculty/
They also utilise the questions utilised within the Lawler J, Maclaine K, Leary A. 2020 Workforce experience of the implementation of an advanced clinical practice framework in England: a mixed methods evaluation. Published in Hum Resour Health. 2020 Dec 3;18(1):96. doi: 10.1186/s12960-020-00539-y. PMID: 33272304; PMCID: PMC7713001.
The questionnaire is expected to take no more than 10 minutes to complete.

When you are ready please click the 'NEXT' arrow to start the questionnaire.

You can click on the 'BACK' button if you want to return to a question and the questionnaire will remain open for 2 weeks if you need to leave and return to finish the questionnaire at a later time.

Your contribution to this research is very much appreciated.

End of Block: Information

Start of Block: ACP background data

Q1 Which region of England do you practise in?

- ○ West Midlands (1)
- ○ South West (2)
- ○ South East (4)
- ○ South Central (5)
- ○ Northern and Yorkshire (6)
- ○ North West (7)
- ○ North East (8)
- ○ London (9)
- ○ East Midlands (10)
- ○ East (11)
- ○ Other (12) _____

Q2 What is your professional group/ regulatory body?

- ○ Nurse/ NMC (1)
- ○ Allied Health Professional/ HCPC (2)
- ○ Other (3) _____

Q3 Are you currently suspended or excluded from practising as a health care professional or currently under investigation for Fitness to Practise by your employer or regulatory body, (e.g. NMC/ HCPC)?

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If Are you currently suspended or excluded from practising as a health care professional or currentl... = Yes

Q4 How long have you been registered as a health professional in your current professional group (i.e. registered nurse, physiotherapist, occupational therapist, paramedic etc).

	0 2 4 6 8 10 11 13 15 17 19 21
Slide the bar along to the number that most closely fits with how long you have been registered. If you have worked more than 20 years, please move the bar to 21. ()	

Q5 Which speciality or area of clinical practice do you work in?

- ○ Acute gerontology (7)
- ○ Acute medical (adult) (8)
- ○ Acute medical (paediatric) (9)
- ○ Acute mental health (10)
- ○ Acute paediatric (11)
- ○ Acute surgical/ theatres (12)
- ○ CAMHS (13)
- ○ Community care (14)
- ○ Community long term condition (e.g. respiratory) (15)
- ○ Community mental health (16)
- ○ Community paediatric (17)
- ○ Critical care (18)
- ○ Emergency department (adult) (19)
- ○ Emergency department (adult and paediatrics) (20)
- ○ Emergency department (paediatrics) (21)
- ○ Learning disability (22)
- ○ Long term condition (e.g. cancer) (23)
- ○ Midwifery (24)
- ○ Neonatal (25)

- ○ Pre-hospital care (27)
- ○ Primary care (28)
- ○ Radiology (29)
- ○ Radiotherapy (30)
- ○ Other (26) _____

Q6 What is your job title?
(e.g. Advanced Clinical Practitioner, Advanced Nurse Practitioner, Advanced Physiotherapist etc)

_____

Q7 What is your Pay Band?

	Pay band 0 1 2 3 5 6 7 8 9
Use the slider to select the pay band you sit most closely to. Select 0 if you are not on NHS pay banding ()	

Page Break

Q8 Are you currently a trainee ACP or on a development programme to become an ACP?

- ○ Yes (1)
- ○ No (2)

Skip To: Q9 If Are you currently a trainee ACP or on a development programme to become an ACP? = Yes

Skip To: Q10 If Are you currently a trainee ACP or on a development programme to become an ACP? = No

Q9 What stage of training are you at?

- ○ Just started/ in my first year (1)
- ○ Mid way through my programme/ have completed 60 credits (2)
- ○ In my final year/ at the dissertation or end point assessment stage (3)

Page Break

Q10 Would you say that your current role fits the description of Advanced Practice as set down in the Multi-Professional Framework for Advanced Clinical Practice in England?

"Advanced clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence.

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

This definition therefore requires that health and care professionals working at the level of advanced clinical practice will exercise autonomy and decision making in a context of complexity, uncertainty and varying levels of risk, holding accountability for decisions made."

Multi-Professional Framework for Advanced Clinical Practice in England

- ○ Yes, my role fits this description and includes all 4 pillars (clinical practice, leadership & management, education and research). My role has been mapped successfully against all areas of the capabilities within the framework. (1)
- ○ Yes, my role fits this description and includes all 4 pillars (clinical practice, leadership & management, education and research), although my role has not formally been mapped to the capabilities within the framework. (2)
- ○ My role partially fits this description, with some aspects of my role addressing some (but not all) of the four pillars (i.e. clinical practice, leadership & management, education or research). (3)
- ○ No, my role does not fit with this description. (4)

Page Break

Q11 What training/ formal education have you successfully completed to date to work in your current role?
Please select all that apply.

- ☐ Masters in Advanced Practitioner/ Advanced Clinical Practice programme to a full Masters level (3)
- ☐ Advanced Practitioner/ Advanced Clinical Practice programme to a Postgraduate Certificate or Postgraduate Diploma level (2)
- ☐ On the job training (e.g., non-accredited courses, mandatory training delivered by your employer, role shadowing, observed clinical supervision or assessment in your workplace). (1)
- ☐ Individual modules/ courses relevant to my role as an ACP but not built into an award (e.g. a standalone Prescribing or Clinical Assessment or Specialist Practice

module that has not formed part of a Postgraduate Certificate, Postgraduate Diploma or a Masters) (4)

☐ A specialist credentialing programme for your field of practice (e.g. Advanced Critical Care Practitioner delivered via the Faculty of Intensive Care Medicine or for Emergency Practitioners through the Royal College of Emergency Medicine). (5)

☐ I have not received any training or formal education for my Advanced Clinical Practice role (7)

☐ I am not currently working in an Advanced Clinical Practice role (6)

☐ I am currently in an Advanced Practice trainee role (8)

Skip To: End of Survey If What training/ formal education have you successfully completed to date to work in your current r... = I am not currently working in an Advanced Clinical Practice role

Q12 How long have you been working in an advanced clinical practice / trainee advanced clinical practitioner role?

	0 1 2 3 4 6 7 8 9 10 11
Slide the bar along to the number that most closely fits with how long you have been in your current role. If you have worked in this role for more than 10 years, please move the bar to 11. (1)	

End of Block: ACP background data

APPENDIX 11 – FOCUS GROUP TOPIC GUIDE

INTRODUCTION (recap participant information & consent).

- -my name, role
- -thank for the time they are giving
- -aim of research
- -intended purpose and dissemination
- -how the focus group will run including time, moderator, use of trigger questions, recording of zoom and checking of transcript, and member checking.
- "As this is a focus group discussion, we would like you all to talk to each other; would like to get your views on what's important not ours; not testing you – no right or wrong answers."
- "Participation is voluntary. You can say as much or as little as you want."
- Note how participants can withdraw at any time (NB noting that once the focus group has begun we cannot withdraw their data as this will impact on the data collection of others, but reminding participants of storage arrangements made to protect anonymity)
- -support systems available (communication with researcher, career development advice, wellbeing & psychological support available within the Trust)
- -check consent
- -is it ok to begin? (Y-continue to trigger questions, N- answer any queries/ deal with any issues where needed).

TRIGGER QUESTIONS:

Engagement: Can I first of all ask everyone to introduce themselves and say what made you choose to pursue your current role as an ACP?

Exploration: Other than enhanced patient care and good quality outcomes for your patients, when embarking on your current role/ training as an ACP, what did you hope or expect from the role?

Probing: For example (to be used if prompting or clarification is required and will note these have been taken from existing research)

Increased grade/ pay	Enhanced Job security
Opportunity to remain clinical	A new challenge
Increased job satisfaction	Career progression

To be able to take on new skills (not normally undertaken by someone in your previous role/ profession)

Increased autonomy to make decisions/ implement actions

Better working conditions (e.g. increased flexibility over working hours)

To be part of a team/ service you wanted to work in

Other

Has it encouraged/ allowed you to stay working longer in the NHS than you otherwise would have done? (Make reference to NHS People Plan if needed)

Exploration: What future aspirations do you have in your role as an Advanced Clinical Practitioner?

Probing: For example (prompt if needed) if someone was to ask you what you hope to achieve in 1 year or 5 years' time (or longer) what would this be?
How do you hope and expect your current role to change (if at all) in the future?

MEMBER CHECKING: From the discussion we have had so far the 3 main themes that are emerging are x,y,z, is that correct? Are there any others that you think have been missed?
(This will be repeated until saturation is reached and the group believe there are no further key themes from their discussion.)

END
Repeat what happens next with the data and communication with them about the progress/ results and outputs from the research, support systems that are available, as well as how they can contact the researcher. Thank again for their time.

APPENDIX 12- FOCUS GROUP PARTICIPANT INVITATION, CONSENT & INFORMATION

Using the contact list created in Qualtrics for all those that gave their contact details having consented to participate in the research, I instructed Qualtrics to create a random sample of up to 30 participants. This data was extracted into an excel file. Any that did not have a full email address were deleted. The remaining email addresses were then copied and pasted into the BCC on an email from my work address that said:

Thank you for recently completing the recruitment questionnaire for the first stage of my research on
"What are the realistic expectations of pursuing an Advanced Clinical Practitioners role?"

The next stage of this research is to conduct focus groups where we will explore what your expectations for the ACP role are. We will use the themes that participants in the focus groups identify to construct a follow up questionnaire which will evaluate whether these expectations are being realised.

Further information is provided below, which we recommend you read and consider before deciding whether to take part.

If you would be willing to be part of a focus group please click on the link below to complete the consent form.
https://essex.eu.qualtrics.com/jfe/form/SV_a5zXDBhPRWNFlmS

I will then send you further details to set up a date for your focus group.

ACP Focus Group Consent form- National
This survey is being used to confirm consent to participating in the focus groups being run by Vikki-Jo Scott for her research regarding the expectations of ACPs and whether these are being realised.
essex.eu.qualtrics.com

What will participating in this part of the project involve?

You are being invited to take part in a focus group discussion with around seven other people. During the discussion we would like to hear about your expectations of working or training as an Advanced Clinical Practitioner.

The group discussion will take place at a time and place that is convenient for you and the rest of the group. We will be using zoom to conduct this focus group. If you are unfamiliar with zoom please click on the link below to find out more, (and don't worry I will remind you of the 'top tips' of using zoom at the start of the focus group and answer any questions you may have): Zoom How-to tutorials

We will not be using the 'chat', 'share screen', or 'breakout rooms' facility. If you wish

to speak in the focus group please use the 'raise hand' button which can be found by clicking on the 'reactions' icon at the bottom of your screen; I will then direct the conversation toward you and will ensure that all have an opportunity to contribute.

The focus group will last up to 90 minutes and will be guided by me. The discussion will be recorded via zoom. The transcript of the focus group discussion (which is automatically generated by zoom) will be checked and amended for accuracy by me. This means I don't have to take detailed minutes during the discussion but can instead concentrate on facilitating the focus group and making notes about any key features that come out of your discussion.

You will be provided with a date, time, and web-link to join via your email address. You just need to click on the link provided at the time the focus group is scheduled to take place, making sure your camera and audio are turned on and that you are in a comfortable, quiet, secure and confidential place in order to participate in the focus group.

There will be time at the beginning of the zoom meeting to ask any questions about zoom and what will be happening in the focus group.

Do I have to take part?
No, it's completely up to you whether or not you take part in the focus group. If you agree to take part, you are free to change your mind at any time without giving me a reason. You can contact me at v.j.scott@essex.ac.uk if you have any questions or concerns about participating.

What will happen to any information I give?
Any information I have about you and everything you say during the discussion will be kept confidential. Your name and contact details will be kept separately from the transcript and any details that could be used to identify you will be removed from the transcript. Any extracts from what you say that are quoted in written work will be entirely anonymous.

We will ask you and others in the group not to talk to people outside the group about what was said during the discussion. However, we cannot stop or prevent participants who were in the group from sharing things that should be confidential.

All electronic data will be stored on a password protected computer. All digital recordings will be destroyed after completion of the project. Other data from the study will be retained, in a secure location, for 10 years. Once the study is completed, transcripts will be retained, in a secure location, for 10 years.

What will happen to the results of the project?
The results of this study will be used in academic papers for publication and in presentations as well as contributing to my thesis I am writing for my PhD. I would be happy to send you a summary of the results if you wish, (you will be asked about this as part of the questionnaire).

What are the possible benefits of taking part?
There will be no immediate benefits for you, but by taking in part in this study you

can help us better understand what the expectations are of Advanced Clinical Practitioner roles and whether these are being realised. As ACP has been identified within the NHS People Plan as key 'growing for the future' significant investment is anticipated in this area. By researching this topic and publishing it more widely it is hoped that this can inform the career development and continuing professional development that is offered to Advanced Clinical Practitioners. This includes understanding what is realistic to expect from holding such a role and how best to support staff in ACPs roles or those that are intending to pursue a career in this field.

Are there any risks?
No. There is no known risk if you take part in this study. We recognise this will take time out of your schedule to participate, so please do be aware of any competing priorities you may have and prioritise these accordingly.

The process of engaging in this research may prompt you to reflect on your role and raise questions about your own career, CPD, and the support offered to you. We recommend if you have any questions about this, please discuss this with your line manager or education/ Advanced Practice lead within your employing organisation. You may find that your local University and education providers can provide further support in exploring your career and professional development options. The resources available via Health education England's Centre for Advancing Practice are also freely available to you to explore further the Advanced Practice role. The NHS also offers free advice and links to support services through their 'supporting our NHS people' website. You should also contact your local health and wellbeing to see what support offers are available within your own employing organisation.

Contact details
I am the main contact for the study. If you have any questions about the project, please don't hesitate to ask. My contact details are:
Vikki-Jo Scott
Email: v.j.scott@essex.ac.uk
Tel: 01206 874487
School of Health & Social Care, University of Essex, Wivenhoe Park, Colchester, Essex, CO4 3SQ

If you wish to contact a senior member of the University about the research or make a complaint please contact:
Sarah Manning-Press
Email: sarahm@essex.ac.uk
Tel: 01026 873561
Research & Enterprise Office, University of Essex, Wivenhoe Park, Colchester, Essex, CO4 3SQ

The study is being undertaken as part of my PhD studies. It has no external funding or other conflicts of interest to be declared.

Thank you for considering taking part in this study and taking the time to read this information.

Vikki-Jo Scott

(she/her/hers)
Senior Lecturer, MA Learning & Teaching, SFHEA, RGN
School of Health & Social Care
University of Essex
Room No. 2S2.4.11

T +44 (0)1206 874487
M 07747232097
E v.j.scott@essex.ac.uk
► www.essex.ac.uk/departments/health-and-social-care
W www.vjscpd.com

By clicking on the consent form link participants were presented with a repeat of the participant information above and were then asked to complete the following:

This is your consent form to participate in the focus groups for this research.

Please click the 'NEXT' arrow to answer the questions below to confirm whether you consent to participate in this part of the research.

You can press the 'BACK' button if you wish to revisit this information whilst completing the consent form, or please contact Vikki-Jo if you need a copy of this information at any time during this study.

Page Break

Q1 I confirm that I have read and understand the information sheet provided for the focus group part of this study. I have had the opportunity to consider the information, ask questions, and have had these answered satisfactorily.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If I confirm that I have read and understand the information sheet provided for the focus group part... = No

Q2 I understand that my participation in this study is voluntary and that I am free to withdraw at any time, without giving a reason.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If I understand that my participation in this study is voluntary and that I am free to withdraw at a... = No

Q3 I understand that the focus group will be digitally recorded and transcribed.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If I understand that the focus group will be digitally recorded and transcribed. = No

Q4 I understand that information given in the focus group discussion may be used by the research team in future publications, reports, or presentations.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If I understand that information given in the focus group discussion may be used by the research tea... = No

Q5 I understand that any personal data that could be used to identify me will be removed from the transcript of the focus group and that I will not be identified in any publications, reports, or presentations.

- Yes (1)
- No (2)

Skip To: End of Survey If I understand that any personal data that could be used to identify me will be removed from the tr... = No

Q6 I understand that the anonymised data I provide will be deposited in a secure location.

- Yes (1)
- No (2)

Skip To: End of Survey If I understand that the anonymised data I provide will be deposited in a secure location. = No

Q7 I consent to participation in this research.

- Yes (1)
- No (2)

Skip To: End of Survey If I consent to participation in this research. = No

End of Block: Focus Group Informed Consent

On completing the focus group consent form their email contact would be added to the ‘focus group’ contacts list in Qualtrics. They would be sent the following message on completion of the consent form:

Thank you for completing the consent form regarding Vikki-Jo Scott's ACP research.

If you answered 'yes' to the consent questions then you have consented to participating in the focus group part of this research. Please can you now go to the doodle poll on the link below to give your preferred dates and times for a focus group. (The focus group will be conducted by zoom so you do not have to attend a particular place in person, you just need to have access to a suitable Wi-Fi connection and device on which you can use zoom).

https://doodle.com/meeting/participate/id/eVmqO7od

If you answered 'No' to any of the consent questions you will be removed from our contact list regarding the focus groups and you will not hear anything further from us about this part of the research.

If you have any questions about the project, please do not hesitate to ask. My contact details are:
Vikki-Jo Scott
Email: v.j.scott@essex.ac.uk
Tel: 01206 874487
School of Health & Social Care, University of Essex, Wivenhoe Park, Colchester, Essex. CO4 3SQ

If you wish to contact a senior member of the University about the research or make a complaint, please contact:
Sarah Manning-Press
Email: sarahm@essex.ac.uk
Tel: 01206 873561
Research & Enterprise Office, University of Essex, Wivenhoe Park, Colchester, Essex, CO4 3SQ.

When going to the doodle poll potential participants are asked to select from the dates and times provided, with the following message being presented:

Congratulations! You have been selected to be a part of the focus groups for Vikki-Jo's research on Advanced Clinical Practitioners expectations of the benefits in pursuing this role, and whether these are being realised. Please complete the poll to tell me what dates and times from those listed that you would be available for attending a focus group. Once I have got enough participants together from a diverse range of backgrounds in ACP, I will contact you with details of how and when to join the focus group. Please hold the date in your diary!

The dates/ times given were over 22-July- 28th September as one and a half hour time slots of 10 am and 8pm. In the doodle poll the moderator's name was displayed as available to attend but this was listed as a hidden invite, so that only I could see all the names and votes.

APPENDIX 13-LOGIC FLOW DIAGRAM

Project: ***Advanced Clinical Practitioners expectations of the benefits of pursuing this role and whether these are being realised***

Conditions *Local context / Policy context / What needs to be in place for change to occur?*
ACP is currently not regulated. It is multi-professional and therefore ACPs fall under several bodies who have the power to influence this role. Health Education England through their 'Centre for Advancing Practice' (CfAP) have been driving policy in this area and using the fact that they provide funding for ACP training to influence operation of the role. CQC [theoretically] can use the standards set by CfAP in their inspections that include evaluating the infrastructure for ACP. Employers are therefore currently the primary force behind how/ where/ when ACPs practice and the ways in which the role is operating. The NHS People plan has highlighted ACP as a way to retain experienced staff.

Programme objectives *High level summary of intended outcomes*
*Provide a platform to people in ACP/ trainee ACP roles to voice their experience of the role.
*To increase understanding of the reality of practice of the ACP role in the current context.
*To establish to what extent expectations of the role are being met in practice (ACPs perspective).

Rationale
Evidence & assumptions linking outputs to outcomes & impacts
Undertaking research that takes an emic approach will illuminate the ACP/tACPs experience of the role. (Noting the literature review found this was lacking).

ACPs/tACPs can help to identify key themes regarding what is expected of the role and they will provide honest answers about their experience.

Key stakeholders will use the information generated to enhance their understanding to inform interventions/ support/ advice/ training/ policy decisions they undertake.

Inputs
What resources do you have?

Time

Research expertise (developed and supported through supervision for experienced researchers)

Access to training

Access to IT (data collection, analysis, reporting)

Contacts/ network of ACPs/tACPs including through social media and connection with AP groups and AP influencers/ policy holders/ makers.

Activities
What will the individuals working on this project do?

Participants:
Explore expectations of the role.

Provide a picture of their experience of the role.

Researcher:
Gain insight to the role from the ACPs perspective.

Disseminate findings to inform stakeholders who have an influence on the ACP/tACP role.

Outputs
What will the project provide?

A record of ACP/tACPs perspective on their experience of the role.

A set of themes regarding key aspects of the role.

Comparative data between expectations of the role and to what extent these are being realised.

Publications to include recommendations, information, guidance.

A PhD for the chief investigator.

Intended impacts
What is the change you want to see?
Where expectations are not meeting with the reality of current ACP practice, (as understood from the ACP perspective) interventions are put in place to address these gaps to enhance ACPs experience and recruitment/ retention to the role.

Intended outcomes
What are you trying to achieve?

A realistic understanding of what the ACP role entails in practice so that people considering this career trajectory can make an informed choice about undertaking the role.

For people that advise/ train/ employ ACPs to have enhanced understanding of the role to inform the support they give to ACP/ tACPs

The experience of practising as an ACP is improved by narrowing the gap between expectation and reality.

That ACP/ tACPs feel they have had an opportunity for their experience of the role to be heard.

APPENDIX 14- DATA ANALYSIS SCHEMA

Deep dive

Those questions coloured in orange in the table below were used to identify if there were any possible factors related with whether expectations are being realised by undertaking exploratory analysis using the 'breakout' visualisation function within Qualtrics. Data from the selected FQ question was broken down according to the each of the QB (background or demographic questions) to see if there is an unusual pattern which does not conform with the overall, summated results for the selected FQ question .

NB where 'frequency' was analysed this included both choice count in whole numbers and % to 2 decimal places. Mean, SD & variance was calculated to decimal spaces.

Question	Nature	Type	Response options	Forced response/ skip logic	Analysis	Presentation/ inclusion in thesis
CONSENT QUESTIONS						
Q1-7	Consent	Binary	Yes/ No	Q1-7 skip to end of survey if 'no' selected. Q7 forced response	Used to confirm consent, any that answer no or do not answer Q7 will be excluded from further data collection.	Noted in ethical considerations section
CONTACT QUESTIONS						
QA	Request to be contacted	Binary	Yes/ No	Skip to next block (Q1B) if 'no' selected	Not included in analysis of data.	Noted in description of data collection
QB + QC	Name E-mail text entry	Descriptive	Free text entry	If details are provided these will be logged as a contact in Qualtrics.		

Question	Nature	Type	Response options	? skip logic	Analysis
Q1B	Region	Nominal	Choice of 10 regions which reflect the regions in the Centre for Advancing Practice. 'Other' with text entry given as an option in case not sure or are outside of England	Nil	**Descriptive statistics** (frequency, mode) **Exploratory Data Analysis** (Bar chart and 'breakdown' visualisation) **Deep dive** (Bar chart visualisation with selected FQs to identify any unusual patterns when broken down by QB)
Q2B	Professional group/ regulatory body	Nominal	Nurse/ NMC Allied Health/ HCPC Pharmacist/ GPhC (this covers all registered health professionals that currently come under ACP framework) 'other' with text entry given in case they fall outside of these.	Nil	**Descriptive statistics** (frequency, distribution, mode) **Exploratory Data Analysis** (Pie chart visualisation) **Deep dive** (Pie chart visualisation with selected FQs to identify any unusual patterns when broken down by QB)
Q3B	? suspended/ FtP	Nominal	Yes/ No	Skip to end of survey if 'yes' selected.	Not included in analysis; used to confirm meets inclusion criteria only
Q4B	Time registered	Ratio	0-21 NB uneven integers displayed although all numbers can be selected (e.g. 5 not displayed but can be selected). Displayed primarily in 2 year intervals as this can denote stage of career (new, mid, or very experienced) and asked to put 21 if have any number of years beyond 20+ as will denote very experienced	Nil	**Descriptive statistics** (frequency, distribution, mean, mode, range, SD & variance) **Exploratory Data Analysis** (Bar chart visualisation) **Deep dive** (Bar chart visualisation with selected FQs to identify any unusual patterns when broken down by QB)
Q5B	Speciality	Nominal	23 options (taken from CfAP 'deep dive' data collection) plus 'other' with text entry. NB in recruitment survey found 'other' was used a lot.	Nil	**Descriptive statistics** (frequency, distribution, mode, range) **Exploratory Data Analysis** (Bar chart, 'breakdown' visualisation, and 'word cloud' visualisation for free text entered under 'other') **Deep dive** (Bar chart visualisation with selected FQs to identify any

					unusual patterns when broken down by QB)
Q6B	Portfolio career	Binary	Yes/ No	Nil, although told if answer 'yes' should refer to main/ 1ry ACP role to answer the remaining questions	**Descriptive statistics** (frequency) **Exploratory Data Analysis** (Bar chart visualisation) **Deep dive** (Bar chart visualisation with selected FQs to identify any unusual patterns when broken down by QB)
Q7B	Job title	Descriptive	Free text entry	Nil	**Descriptive statistics** (frequency, range) **Exploratory Data Analysis** ('word cloud' visualisation)
Q8B	Pay/ grade	Ratio	0-9 (reflects the NHS banding although exact pay between each band is not equal).	Nil	**Descriptive statistics** (frequency, distribution, mean, mode, range, SD & variance) **Exploratory Data Analysis** (Bar chart visualisation) **Deep dive** (Bar chart visualisation (FQ2 +FQ6), Pie Chart visualisation (FQ14, FQ19 + FQ34), frequency, range, mean, mode, SD & variance with selected FQs to identify any unusual patterns when broken down by QB)
Q9B	? trainee	Binary	Yes/ No	Skip to Q11B if 'no'	**Descriptive statistics** (frequency) **Exploratory Data Analysis** (Bar chart visualisation) **Deep dive** (Bar chart visualisation with selected FQs to identify any unusual patterns when broken down by QB)
Q10B	Stage of training	Ordinal	Just started/ in 1st year, Midway/ 60 credits, Final year/dissertation/EPA	Nil	**Descriptive statistics** (frequency) **Exploratory Data Analysis** (Bar chart visualisation)

					Deep dive (Bar chart visualisation with selected FQs to identify any unusual patterns when broken down by QB)
Q11B	MPF	Ordinal	Fit, 4 pillars + mapped Fit, 4 pillar, not mapped Partial fit, (not all 4 pillars) No fit	Nil	**Descriptive statistics** (frequency, distribution, mean, mode, SD & variance) **Exploratory Data Analysis** (Bar chart visualisation) **Deep dive** (Bar chart visualisation (FQ2 +FQ6), Pie Chart visualisation (FQ14, FQ19 + FQ34), frequency, mean, mode, SD & variance with selected FQs to identify any unusual patterns when broken down by QB)
Q12B	Training/ education	Nominal	Masters PG Dip/PG Cert On the job training Individual modules Specialist credential No training ACP trainee Not in ACP/trainee role	Skip to end if 'Not in ACP/tACP role' to ensure meets inclusion criteria	**Descriptive statistics** (frequency, distribution, mode) **Exploratory Data Analysis** (Bar chart visualisation,) **Deep dive** (Bar chart visualisation with selected FQs to identify any unusual patterns when broken down by QB)
Q13B	Time in ACP role	Ratio	0-11 NB asked to put 11 if have any number of years beyond 10+ as will denote v experienced	Nil	**Descriptive statistics** (frequency, distribution, range, mean, mode, SD & variance) **Exploratory Data Analysis** (Bar chart visualisation,) **Deep dive** (Bar chart visualisation with selected FQs to identify any unusual patterns when broken down by QB)

Question	Nature	Type	Response options	? skip logic	Analysis
FQ1	Clinical activity	Ordinal	Always Sometimes Rarely Never (with descriptors and an example for each) NB 'not enough experience' not included as an option as lit review noted it dominates in ACP roles, so they would know straight away if this was not going to part of the role	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation)
FQ2	Non-clinical activity	Ordinal	Always Sometimes Rarely Never Not enough experience to say (with descriptors and an example for each) NB from lit review, whilst this is meant to be included tends to get neglected, so may need to be in role for a while to know how much it features.	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation) **Deep dive** Visualisations conducted as described above for QB for comparison across different groups
FQ3	Clinical/ non-clinical balance	Interval	0-10 (with 5 = balanced/ about right, 0 not enough, 10 too much)	Nil	**Descriptive statistics** (frequency, range, mean, median, mode, SD & variance) **Exploratory Data Analysis** (Gauge Chart visualisation)
FQ4	Open question re clinical	Descriptive	Text box	Nil	**rTA**
FQ5	KSE utilisation	Ordinal	Yes Sometimes Rarely No Not enough experience to say (with descriptors/ example for each)	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation)
FQ6	Generalist/ Specialist	Rank	Generalist Mixture Specialist	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Bar Chart visualisation)

					Deep dive Visualisations conducted as described above for QB for comparison across different groups
FQ7	Advice/ queries/ seek support	Ordinal	Frequently Sometimes Occasionally Rarely Never	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation)
FQ8	Autonomy	Interval	Slider 0-10 with 1 point intervals	Nil	**Descriptive statistics** (frequency, range, mean, median, mode, SD & variance) **Exploratory Data Analysis** (Gauge Chart and Bar chart visualisations)
FQ9	Development of KSE	Nominal	Yes, I regularly get an opportunity to develop KSE Sometimes, but not enough No, but don't feel it is necessary No, I've not been given an opportunity to develop KSE Not enough experience to say	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation)
FQ10	KSE used to support others	Ordinal	Yes, I regularly support others Sometimes, but would like to support others more No, I don't get an opportunity Not enough experience to say	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation)
FQ11	Open question re KSE	Descriptive	Text box	Nil	**rTA**
FQ12	Lead on QI	Interval	Slider 0-10 with 1 point intervals	Nil	**Descriptive statistics** (frequency, range, mean, median, mode, SD & variance) **Exploratory Data Analysis** (Gauge Chart visualisation)
FQ13	Continuity of care	Ordinal	Yes Sometimes Not really No	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation)

			I have not had enough experience (with descriptors/ example for each)		
FQ14	Consistent & coherent presence	Ordinal	Strongly agree Agree Disagree Strongly Disagree (with descriptors/ example for each, 'disagree' gives option for not enough experience yet)	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation) **Deep dive** Visualisations conducted as described above for QB for comparison across different groups
FQ15	Reshape a service	Ordinal	Strongly agree Agree Disagree Strongly Disagree Not enough experience to say (with descriptors/ example for each)	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation)
FQ16	Patient safety/ experience	Interval	Slider 0-10 with 1 point intervals and example for each end & middle of the scale	Nil	**Descriptive statistics** (frequency, range, mean, median, mode, SD & variance) **Exploratory Data Analysis** (Gauge Chart visualisation)
FQ17	Open question re QI	Descriptive	Text box	Nil	**rTA**
FQ18	Career progression/ moving up hierarchy + scope of practice	Ordinal	Yes Sort of Maybe No (with descriptors/ example for each) NB they are asked to rank about hierarchy & scope separately	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Bar Chart visualisation)
FQ19	Salary increase	Ordinal	Yes No Not yet (tACP with expected salary rise)	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation) **Deep dive** Visualisations conducted as described above for QB for comparison across different groups

FQ20	Financial status	Ordinal	Yes No difference No, made worse	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation)
FQ21	Work-Life balance	Interval	Slider -5 to 5 with 1 point intervals and example for each end & middle of the scale	Nil	**Descriptive statistics** (frequency, range, mean, median, mode, SD & variance) **Exploratory Data Analysis** (Gauge Chart and Bar Chart visualisations)
FQ22	Value	Ordinal	Always Mostly Sometimes Occasionally Never	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation)
FQ23	Who/ what contributes to value	Descriptive	Text box	Nil	**Exploratory Data Analysis** (Word Cloud visualisation) **rTA**
FQ24	Appropriate salary	Ordinal	Yes No I don't have others to compare to	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation)
FQ25	Retention	Ordinal	Yes Not enough experience/ no plans No hasn't changed plans No made me want to leave sooner	Nil	
FQ26	Job satisfaction	Interval	Slider -5 to 5 with 1 point intervals and example for each end & middle of the scale	Nil	**Descriptive statistics** (frequency, range, mean, median, mode, SD & variance) **Exploratory Data Analysis** (Gauge Chart and Bar Chart visualisations)
FQ27	Open question re Career Progression	Descriptive	Text box	Nil	**rTA**
FQ28	ACP role understanding	Ordinal	Yes, the majority Sometimes, patchy Not enough experience to say Rarely, most have poor understanding	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation)

FQ29	Lead for AP	Binary	Yes No	Skip to FQ31 if 'no'	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation)
FQ30	Role model	Ordinal	Yes, good job Sometimes, could be strengthened No, not my experience Not had enough experience to say	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation)
FQ31	Well supported	Ordinal	Yes, good support Sometimes, needs further development No Not had enough experience to say	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation)
FQ32	Policy/ structure/ process	Ordinal	Strongly agree Agree Disagree Strongly disagree Not enough experience to say	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation)
FQ33	Buy in	Interval	Slider 0-10 with 1 point intervals and example for each end & middle of the scale	Nil	**Descriptive statistics** (frequency, range, mean, median, mode, SD & variance) **Exploratory Data Analysis** (Gauge Chart and Bar Chart visualisations)
FQ34	Quality assurance	Ordinal	Yes Yes, not universal/ fully implemented No Not sure	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart and Bar Chart visualisations) **Deep dive** Visualisations conducted as described above for QB for comparison across different groups
FQ35	Evolving role	Ordinal	Strongly agree Agree Disagree Strongly disagree (with descriptors/ example for each, disagree gives option for not enough experience)	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation)

FQ36	Long term investment	Ordinal	Strongly agree Agree Disagree Strongly disagree Not been employed in this organisation long enough to say (with descriptors/ example for each)	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Pie Chart visualisation)
FQ37	Local operation	Interval	Slider 0-100 with 10% point intervals from local to consistent across organisation	Nil	**Descriptive statistics** (frequency, range, mean, median, mode, SD & variance) **Exploratory Data Analysis** (Gauge Chart and Bar Chart visualisations)
FQ38	Policy, governance, oversight	Ordinal with separate scales for 'national', 'regional', 'in your organisation'	Excellent Good Poor Very poor (with descriptors/ example for each, very poor allows for 'not aware' (including if not had enough experience)	Nil	**Descriptive statistics** (frequency, mean, mode, SD & variance) **Exploratory Data Analysis** (Bar Chart visualisation)
FQ39	Open question re Policy, vision, structure	Descriptive	Text box	Nil	**rTA**
FQ40	Overall realisation of expectations	Interval	Slider 0-10 with 1 point intervals and example for each end & middle of the scale	Nil	**Descriptive statistics** (frequency, range, mean, median, mode, SD & variance) **Exploratory Data Analysis** (Gauge Chart and Bar Chart visualisations)
FQ41	Any other comments	Descriptive	Text box	Nil	**rTA**

APPENDIX 15- FOLLOW-UP QUESTIONNAIRE

Start of Block: Participant Information

Information
Welcome to the research study:

What are the realistic expectations of pursuing an Advanced Clinical Practitioners role?

You are being given this information because you are invited to take part in a research study. This information sheet describes the study and explains what will be involved if you decide to take part.

What is the purpose of this study?
In this study we want to explore people's experiences of working or training as an Advanced Clinical Practitioner (ACP) in England, what their expectations of this role are, and whether they are being realised.

Who is conducting the study?
My name is Vikki-Jo Scott. I'm a PhD student and Senior Lecturer within the School of Health and Social Care at the University of Essex. I am a Critical Care Nurse by background. I lead the programmes at the University that have been mapped to the Multi-Professional Framework for Advanced Clinical Practice in England.
Centre for Advancing Practice

What will participating in this project involve?
If you agree to participate in the project, you will be asked to complete a questionnaire about your current experiences of working or training as an ACP. You will complete this on-line; we will provide a link for you to click on to complete this questionnaire. The follow up questionnaire is expected to take no more than 30 minutes to complete.

Do I have to take part?
No, it's completely up to you whether or not you take part in the study. If you agree to take part, you are free to change your mind at any time without giving me a reason. If you have any questions or concerns about participating you can contact me at my email address Vikki-Jo Scott.

What will happen to any information I give?
Any information I have about you and everything you provide to me will be kept confidential. If a matter arises in your responses to this study that create a health, safety, or safeguarding concern (for example regarding the care of a patient or fitness to practise) this information will be shared with relevant persons and authorities as required.

Your name and contact details will be kept separately from the data provided in the questionnaires and any details that could be used to identify you will be removed from the data prior to analysis and before results are reported or shared with anyone

else. Any extracts from what you say in the questionnaires will be entirely anonymous.

All electronic data will be stored on a password protected computer. Any paper copies will be kept in a locked filing cabinet in my office. All data from the study will be retained, in a secure location, for 10 years.

What will happen to the results of the project?

The anonymised results of this study will be used in academic papers for publication and in presentations as well as my PhD Thesis. I would be happy to send you a summary of the results if you wish, (you will be asked about this as part of the consent survey).

What are the possible benefits of taking part?

There will be no immediate benefits for you, but by taking in part in this study you can help us better understand what the expectations are of Advanced Clinical Practitioner roles and whether these are being realised. As ACP has been identified within the NHS People Plan as key 'growing for the future' significant investment is anticipated in this area. By researching this topic and publishing it more widely it is hoped that this can inform the career development and continuing professional development that is offered to Advanced Clinical Practitioners. This includes understanding what is realistic to expect from holding such a role and how best to support staff in ACP roles or those that are intending to pursue a career in this field.

Are there any risks?

No. There is no known risk if you take part in this study. We recognise this will take time for you to complete, so please do be aware of any competing priorities you may have and prioritise these accordingly. We have designed the questionnaires to be undertaken on-line at a time that suits you.

The process of engaging in this research may prompt you to reflect on your role and raise questions about your own career, CPD, and the support offered to you. We recommend if you have any questions about this, please discuss this with your line manager or education/ Advanced Practice lead within your employing organisation. You may find that your local University and education providers can provide further support in exploring your career and professional development options. The resources available via Health Education England's Centre for Advancing Practice are also freely available to you to explore further the Advanced Practice role. The NHS also offers free advice and links to support services through their 'supporting our NHS people' website. You should also contact your local health and wellbeing to see what support offers are available within your own employing organisation.

Contact details

I am the main contact for the study. If you have any questions about the project, please don't hesitate to ask. My contact details are:

Vikki-Jo Scott
Email: v.j.scott@essex.ac.uk
Tel: 01206 874487
School of Health & Social Care, University of Essex, Wivenhoe Park, Colchester,

Essex, CO4 3SQ

If you wish to contact a senior member of the University about the research or make a complaint please contact:
Sarah Manning-Press
Email: sarahm@essex.ac.uk
Tel: 01206 873561
Research & Enterprise Office, University of Essex, Wivenhoe Park, Colchester, Essex, CO4 3SQ

The study is being undertaken as part of my PhD studies. It has no external funding or other conflicts of interest to be declared.

Thank you for considering taking part in this study and taking the time to read this information.

If you are willing take part in the questionnaire for this research project, please click on the 'NEXT' arrow below.

This will take you to the consent survey where you can confirm whether you consent to participate in this research.

You can press the 'BACK' button if you want to revisit this information at any time during the questionnaire.

Once started, you can also come back to complete the questionnaire within a 2 week period if you need to take a break from answering questions.

Page Break

Q1 I confirm that I have read and understand the information sheet provided for this study. I have had the opportunity to consider the information, ask questions, and have had these answered satisfactorily.

- ○ Yes (6)
- ○ No (7)

Skip To: End of Survey If I confirm that I have read and understand the information sheet provided for this study. I have h... = No

Q2 I understand that my participation in this study is voluntary and that I am free to withdraw at any time, without giving a reason.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If I understand that my participation in this study is voluntary and that I am free to withdraw at a... = No

Q3 I understand that the information provided by me will be digitally recorded.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If I understand that the information provided by me will be digitally recorded. = No

Q4 I understand that information given in the questionnaires may be used by the research team in future publications, reports, or presentations.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If I understand that information given in the questionnaires may be used by the research team in fut... = No

Q5 I understand that any personal data that could be used to identify me will be removed from the data to be analysed and that I will not be identified in any publications, reports, or presentations.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If I understand that any personal data that could be used to identify me will be removed from the da... = No

Q6 I understand that the anonymised data I provide will be deposited in a secure location.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If I understand that the anonymised data I provide will be deposited in a secure location. = No

Q7 I consent to participation in this research.

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If I consent to participation in this research. = No

End of Block: Participant Information

Start of Block: Contact details

Information
Thank you for agreeing to take part in this study

Your name and email address will be kept separately to the answers you give in any subsequent questions that follow.

We will only use your name and email address to provide you with a summary of the results if you wish to see these.

QA Do you want to be contacted with the results of this research once it has been completed (if yes we will use the email address you have provided above to send this to you)?

- ○ Yes (1)
- ○ No (2)

Skip To: Instruction If Do you want to be contacted with the results of this research once it has been completed (if yes... = No

QB Please tell me your name

_____

QC Please tell me your preferred email address

_____

Instruction Thank you for providing the information above. On clicking the arrow button below you will be submitting the information you have provided to be used in this research. Your name and email will only be used to contact you with further information about this research and to provide an update of the findings of the research (if you have answered yes to receiving this).

For the remainder of this research we will not use your name or email address to identify any responses you give to ensure we protect your anonymity.

On clicking the 'NEXT' arrow button below you will be taken to the follow-up questionnaire in this research. This will ask you some background information about the ACP role you are currently undertaking, followed by a series of questions about your experience of working or training as an ACP.

The questionnaire is expected to take no more than 30 minutes to complete. When you are ready please click the 'NEXT' arrow to start the questionnaire.

You can click on the 'BACK' button if you want to return to a question and the questionnaire will remain open for 2 weeks if you need to leave and return to finish the questionnaire at a later time.

End of Block: Contact details

Start of Block: Background questions

Q1B Which region of England do you practise in?

- West Midlands
- South West
- South East
- South Central
- Northern and Yorkshire
- North West
- North East
- London
- East Midlands
- East
- Other _____

Q2B What is your professional group/ regulatory body?

- Nurse/ NMC
- Allied Health Professional/ HCPC
- Pharmacist / GPhC
- Other _____

Q3B Are you currently suspended or excluded from practising as a health care professional or currently under investigation for Fitness to Practise by your employer or regulatory body, (e.g. NMC/ HCPC/ GPhC)?

- Yes (1)
- No (2)

Skip To: End of Survey If Are you currently suspended or excluded from practising as a health care professional or currentl... = Yes

Q4B How long have you been registered as a health professional in your current professional group (i.e. registered nurse, physiotherapist, occupational therapist, paramedic etc).

	0 2 4 6 8 10 11 13 15 17 19 21
Slide the bar along to the number that most closely fits with how long you have been registered. If you have worked more than 20 years, please move the bar to 21. ()	

Q5B Which speciality or area of clinical practice do you work in?

- ○ Acute gerontology
- ○ Acute medical (adult)
- ○ Acute medical (paediatric)
- ○ Acute mental health
- ○ Acute paediatric
- ○ Acute surgical/ theatres
- ○ CAMHS
- ○ Community care
- ○ Community long term condition (e.g. respiratory)
- ○ Community mental health
- ○ Community paediatric
- ○ Critical care
- ○ Emergency department (adult)
- ○ Emergency department (adult and paediatrics)
- ○ Emergency department (paediatrics)
- ○ Learning disability
- ○ Long term condition (e.g. cancer)
- ○ Midwifery
- ○ Neonatal
- ○ Pre-hospital care
- ○ Primary care
- ○ Radiology

- ○ Radiotherapy
- ○ Other _____

Q6B As an ACP do you hold more than one job role, or are you employed by more than one organisation (i.e. do you have a '**portfolio career**')?

NB if 'yes' please answer the remaining questions in relation to your main or primary ACP role.

- ○ Yes (1)
- ○ No (2)

Q7B What is your job title?
(e.g. Advanced Clinical Practitioner, Advanced Nurse Practitioner, Advanced Physiotherapist etc)

_____

Q8B What is your Pay Band?

	Pay band 0 1 2 3 5 6 7 8 9
Use the slider to select the pay band you sit most closely to. Select 0 if you are not on NHS pay banding ()	

Q9B Are you currently a trainee ACP or on a development programme to become an ACP?

- ○ Yes (1)
- ○ No (2)

Skip To: Q11B If Are you currently a trainee ACP or on a development programme to become an ACP? = No

Q10B What stage of training are you at?

- ○ Just started/ in my first year (1)
- ○ Mid way through my programme/ have completed 60 credits (2)
- ○ In my final year/ at the dissertation or end point assessment stage (3)

Q11B Would you say that your current role fits the description of Advanced Practice as set down in the Multi-Professional Framework for Advanced Clinical Practice in England?

"Advanced clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence.

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

This definition therefore requires that health and care professionals working at the level of advanced clinical practice will exercise autonomy and decision making in a context of complexity, uncertainty and varying levels of risk, holding accountability for decisions made."

Multi-Professional Framework for Advanced Clinical Practice in England

- ○ Yes, my role fits this description and includes all 4 pillars (clinical practice, leadership & management, education and research). My role has been mapped successfully against all areas of the capabilities within the framework. (1)
- ○ Yes, my role fits this description and includes all 4 pillars (clinical practice, leadership & management, education and research), although my role has not formally been mapped to the capabilities within the framework. (2)
- ○ My role partially fits this description, with some aspects of my role addressing some (but not all) of the four pillars (i.e. clinical practice, leadership & management, education or research). (3)
- ○ No, my role does not fit with this description. (4)

Q12B What training/ formal education have you successfully completed to date to work in your current role?
Please select all that apply

- ☐ Masters in Advanced Practitioner/ Advanced Clinical Practice programme to a full Masters level (3)
- ☐ Advanced Practitioner/ Advanced Clinical Practice programme to a Postgraduate Certificate or Postgraduate Diploma level (2)
- ☐ On the job training (e.g., non-accredited courses, mandatory training delivered by your employer, role shadowing, observed clinical supervision or assessment in your workplace). (1)
- ☐ Individual modules/ courses relevant to my role as an ACP but not built into an award (e.g. a standalone Prescribing or Clinical Assessment or Specialist Practice

module that has not formed part of a Postgraduate Certificate, Postgraduate Diploma or a Masters) (4)

☐ A specialist credentialing programme for your field of practice (e.g. Advanced Critical Care Practitioner delivered via the Faculty of Intensive Care Medicine or for Emergency Practitioners through the Royal College of Emergency Medicine). (5)

☐ I have not received any training or formal education for my Advanced Clinical Practice role (7)

☐ I am currently in an Advanced Practice trainee role (8)

☐ I am not currently working in an Advanced Clinical Practice or trainee role (6)

Skip To: End of Survey If What training/ formal education have you successfully completed to date to work in your current r... = I am not currently working in an Advanced Clinical Practice or trainee role

Q13B How long have you been working in an advanced clinical practice / trainee advanced clinical practitioner role?

	0 1 2 3 4 6 7 8 9 10 11
Slide the bar along to the number that most closely fits with how long you have been in your current role. If you have worked in this role for more than 10 years, please move the bar to 11. (1)	

End of Block: Background questions

Start of Block: Follow-up Questionnaire

Information The next set of questions will ask you about your personal experience of working as an ACP/ trainee ACP. You should answer these honestly and from your own perspective of what you personally have experienced whilst being in this role.

The questions have been constructed from themes that have been identified in a previous phase of this research where we asked a group of ACPs/ trainee ACPs what their expectations of the role are. These questions are aimed at finding out whether these expectations are being realised in the current experience of ACPs/ trainee ACPs.

The questions ask you to provide an answer using a rating scale (e.g. agree-disagree).
Try not to spend too long thinking about each answer!

Remember this is about your personal experience to date, not what you think or hope it should or will be, or what others have told you or that they have experienced.

You are also given an opportunity to provide any further comment for each question theme; this is entirely voluntary and you do not need to provide further comment if you do not wish to do so.

FQ1 Thinking about your current ACP/ trainee ACP role, would you agree that it includes a **clinical** aspect where you undertake direct, patient facing activity on a regular basis?

- ○ Always- my role involves clinical work on a regular basis (e.g. normally every week) (1)
- ○ Sometimes- my role sometimes involves clinical work but on an infrequent basis (e.g. not every week) (2)
- ○ Rarely- my role occasionally involves direct clinical work but it is not part of my routine work (e.g. ad hoc, or only in exceptional circumstances) (3)
- ○ Never- my role is not clinical and I normally do not have direct contact with patients (4)

FQ2 In your role as an ACP/ trainee ACP, do you regularly have time for **non-clinical** activity, (i.e. activity that does not involve direct physical interaction with patients, either face-to-face or through telephone/ video communication)?

- ○ Always- this is scheduled into my rota on a regular basis (1)
- ○ Sometimes- I do have time for non-clinical activity but it is not routinely scheduled into my rota (2)
- ○ Rarely- I occasionally have non-clinical time when the clinical workload allows (3)
- ○ Never- my role is completely clinical with no time for non-clinical activity (4)
- ○ I have not had enough experience in the role so far to say. (5)

FQ3 Would you say that the balance between **clinical and non-clinical activity** in your current ACP/ trainee ACP role is about right for you? Use the sliders to denote

where on the scale you think you have 'not enough' (0) or 'too much' (10) or 'about right' (5) amounts of time for each activity.

	0 1 2 3 4 5 6 7 8 9 10
Clinical/ patient facing activity ()	
Non-clinical (time away from direct contact with patients) ()	

FQ4 Please use the text box below to provide any comments (should you wish to do so) about **clinical/ non-clinical activity** from your experience of the ACP/ trainee ACP role so far.

You can use the 'back' button if you want to come back to this later in the questionnaire.

Page Break

FQ5 Thinking about a typical week in your ACP role, do you feel able to utilise a range of **knowledge, skills, and experience**?

This could include knowledge, skills, or experience from previous roles you have held, (either within or outside of health care), from your professional background or training, (e.g. paramedicine, physiotherapy, nursing) or from when you have worked

in particular specialities or fields of practice before coming into your current role, (for example in emergency medicine, primary care, or oncology).

- ○ Yes, mostly I do get to use a range knowledge, skills, and experience in my ACP role. (1)
- ○ Sometimes, but my range of knowledge, skills and experience could occasionally be used more often. (2)
- ○ Rarely do I feel my range of knowledge, skills, and experience are used in my ACP role. (3)
- ○ No, my ACP role mostly uses a very limited amount of my knowledge, skills, or experience. (4)
- ○ I have not really had enough experience in the ACP role so far to say. (5)

FQ6 Would you describe your role as primarily in a **'generalist' or 'specialist'** field of practice?

(Generalist being where you primarily use a core set of generic skills such as clinical assessment in a range of patients or health care settings, and specialist where you provide patients with access to a specialist service drawing upon advanced knowledge, skills, and experience built up over time in a particular field.)

Please rank in order which you think is most prominent in your role.

_____ Generalist (1)

_____ A mixture of generalist/ specialist (2)

_____ Specialist (3)

FQ7 In your ACP role do people refer to you for **advice, to answer queries, or seek support** from you in delivering effective patient care?

- ○ Frequently (1)
- ○ Sometimes (2)
- ○ Occasionally (3)
- ○ Rarely (4)
- ○ Never (6)

FQ8 Thinking about a typical day at work, to what extent do you feel you have **autonomy over clinical decision making** in your role as an ACP?

For example, do you need to get approval from others for parts of assessment (such as ordering investigations) or treatment (such as prescribing medicines) or onward referral or discharge? If yes, you always need to get approval you would move the slider to 0 and if you never need to get approval for decisions like this, move the slider to 10.

	0 1 2 3 4 5 6 7 8 9 10
Move the slider along to where fits best with your experience in an ACP/ tACP role with down to 0 being no autonomy, or up to 10 being complete autonomy. ()	

FQ9 In your current ACP role have you had opportunity to **develop your knowledge, skills, and experience** to enhance your practice?

You might find it helpful to think back to your previous appraisal, personal development review or revalidation and what development you have undertaken

since then to help answer this question.

- ○ Yes, I regularly get opportunity to develop my knowledge, skills, or experience (1)
- ○ Sometimes, but not enough (4)
- ○ No, but don't feel it is necessary (5)
- ○ No, I've not been given opportunity to develop my knowledge, skills or experience (2)
- ○ I've not had enough experience in this role yet to say. (3)

FQ10 As an ACP (or trainee ACP) have you had opportunity to **use your knowledge, skills, and experience to support others** in their professional development?

- ○ Yes, I regularly support others in their development (1)
- ○ Sometimes, but would like to support others more (4)
- ○ No, I do not get opportunity to support others in my role (2)
- ○ I've not had enough experience yet in this role to say. (3)

FQ11 Please use the text box below to provide any comments (should you wish to do so) about effective utilisation of your **knowledge, skills and experience** in your ACP/ tACP role.

You can use the 'back' button if you want to come back to this later in the questionnaire.

_____

Page Break

FQ12 Thinking about the service/ team you work in and your ACP role in that team or service...

To what extent do you get the opportunity to **lead on quality improvement**?

(For example leading on change which might include audit, or designing projects to enhance the services you provide or promote effective team working).

	0 1 2 3 4 5 6 7 8 9 10
Move the slider along to where fits best with your experience with 0 being not at all and 10 all the time. ()	

FQ13 In your experience as an ACP, have you been able to enhance the **continuity of care** for patients; joining up, or bridging services and making their journey more seamless?

- Yes, I contribute significantly to continuity of care in my ACP role (1)
- Sometimes I contribute to this as an ACP, but this could be enhanced further by more effective use of ACPs (2)
- Not really, due to the way in which my ACP role, our team, or service is set up (4)
- No, I don't get involved in this aspect of care/ the patient's journey as an ACP (3)
- I have not had enough experience in the ACP role yet to answer (5)

FQ14 In your current ACP role do you provide a **consistent and coherent presence** within the service in which you work, (e.g. more of a constant member of the team where others may rotate in/ out)?

- Strongly agree (1)
- Agree, although this is also provided by others in my service/ team who are not in ACP roles (2)
- Disagree, I have not been in the role long enough to provide this (4)
- Strongly disagree, this is not how my role operates in my service/ team (3)

FQ15 In your experience, by including ACPs in the service in which you work, or by shifting activity to ACPs in your team/ organisation that was previously done by others (e.g. moving tasks from medical colleagues to ACPs) has this helped to **reshape a service** to make it more effective?

- ○ Strongly agree, I have seen this make a significant improvement (1)
- ○ Agree, I have had some experience of this, although more of an impact could be made through better use of ACPs (2)
- ○ Disagree, the use of ACPs has not really made a difference, other factors have been more significant (3)
- ○ Strongly disagree, this has not helped, services have become less effective by inclusion of ACPs (4)
- ○ I have not had enough experience in the role yet to say (5)

FQ16 To what extent do you believe you have you been able to make a difference to **patient safety and the patient experience** in your role as an ACP?

	0 1 2 3 4 5 6 7 8 9 10
Move the slider along to what's fit best with your experience as an ACP with 0 being not at all/ this is not part of my role and I don't feel like I make a difference, to 10 being always/ this is the main focus of my role and I regularly feel like I make a difference ()	

FQ17 Please use the text box below to provide any comments (should you wish to do so) about **leadership and quality improvement** as it relates to your experience of the ACP/ tACP role.

You can use the 'back' button if you want to come back to this later in the questionnaire.

Page Break

FQ18 For you, has taking on an ACP role provided you with **career progression** opportunities?

This includes giving you opportunities to move up the hierarchy by getting a more senior role in your employing organisation, or to change the scope of practice you work in. (For example, changing the range of activities or services, or roles within your job that you are involved in that you would not otherwise have had if you had stayed in your previous role).

	Yes, I feel it has aided my career progression and opened up opportunities for me (1)	Sort of, it did initially, but now I feel I am stuck with no further opportunities for progression beyond my current role (2)	Maybe, although there were other roles I could have taken instead of ACP that would have given me similar opportunities (4)	No, taking on an ACP role has not provided me with any career progression opportunities (5)
Moving up the hierarchy (1)	○	○	○	○
Scope of Practice (5)	○	○	○	○

FQ19 Has taking on an ACP role **increased your salary**/ banding on the pay scale?

○ Yes (1)

○ No (2)

○ Not yet, I am currently a tACP where my salary is guaranteed to increase once I finish my training (3)

FQ20 Has taking on the ACP role had a positive impact on your **financial status** (e.g. pension benefits, opportunities for other paid work such as bank shifts, or reduced costs of working such as commuting to work costs)?

- ○ Yes, it has improved my finances (1)
- ○ It has made no difference to my finances (2)
- ○ No, it has made my financial situation worse than if I had stayed in my previous role (3)

FQ21 To what extent does being in an ACP role enhance your **work-life balance**

(For example, opportunities for flexible working, better shift patterns, or being able to better manage your 'outside work' commitments or hobbies)?

	-5 -4 -3 -2 -1 0 1 2 3 4 5
Move the slider along to what fits best with your experience, with -5 being it has made it much worse, 0 it has made no difference, or 5 it has made a significant positive difference. ()	

FQ22 Do you feel **valued** in your role as an ACP?

- ○ Always (1)
- ○ Mostly (2)
- ○ Sometimes (3)
- ○ Occasionally (4)
- ○ Never (5)

FQ23 What or who contributes to your perception of **feeling valued** as an ACP?

_____

FQ24 Do you believe your level of experience, responsibility, and scope of practice is reflected appropriately in the **salary/ pay band** you are on as an ACP currently in comparison to others working in your service?

- ○ Yes (1)
- ○ No (2)
- ○ I don't have any others to compare to (3)

FQ25 Has taking on an ACP role meant you have **stayed working** in health services longer than you would have done if this role had not been available?

- ○ Yes, I think I would have left/ would be leaving had the ACP role not been available (1)
- ○ I have not had enough experience to say/ I have not made any plans for how long I plan to work in health (3)
- ○ No, it has not changed my plans for how long I intend to work in health (2)
- ○ No, it has made me want to leave sooner than I had originally planned to work in health (4)

FQ26 Thinking about your experience so far, has being in an ACP role changed your level of job satisfaction?

	-5 -4 -3 -2 -1 0 1 2 3 4 5
Move the slider to where fits best with your experience. -5 means it has made you far less satisfied in your job, 0 about the same as in previous roles you have held, or 5 it has made a large positive change to satisfaction with your job. ()	

FQ27 Please use the text box below to provide any comments (should you wish to do so) about **career progression** as it relates to your experience of the ACP/ tACP role.

You can use the 'back' button if you want to come back to this later in the questionnaire.

Page Break

FQ28 From your experience (e.g. from talking to colleagues or listening to managers) do you think there is a good **understanding of the ACP role** amongst staff and what they can do in your employing organisation/s?

- ○ Yes, the majority have a very good understanding (1)
- ○ Sometimes, although it tends to be patchy or only in areas where ACPs are being used (2)
- ○ I have not had enough experience in my current employing organisation to say (3)
- ○ Rarely, there are one or two people that 'get it', but most have poor understanding of ACP (4)

FQ29 Are you aware of there being a **lead for Advanced Practice** within your employing organisation/s?

- ○ Yes (1)
- ○ No (2)
- ○ I am the Advanced Practice Lead for my organisation (4)

Skip To: FQ31 If Are you aware of there being a lead for Advanced Practice within your employing organisation/s? = No

Skip To: FQ31 If Are you aware of there being a lead for Advanced Practice within your employing organisation/s? = I am the Advanced Practice Lead for my organisation

FQ30 From your experience do you feel your Advanced Practice lead acts as a **role model or champions** the ACP role within your main employing organisation?

- ○ Yes, they do a good job at this (1)
- ○ Sometimes, although this could be strengthened (2)
- ○ No, this has not been my experience (3)
- ○ I have not had enough experience or interaction with the AP lead to say (4)

FQ31 More broadly, do you feel **well supported** in your employing organisation/s for your ACP role (e.g. within your team or through other mentors, role models, or leaders)?

- ○ Yes, I get good support for my role as an ACP (1)
- ○ Sometimes, although this is an area that needs further development (2)
- ○ No, I don't feel well supported in my ACP role by my employing organisation (3)
- ○ I have not had enough experience in my current employing organisation to say (4)

FQ32 From what you have experienced would you say that your employing organisation has **policies, structures, processes** in place to support the effective implementation of ACP roles?

- ○ Strongly agree (1)
- ○ Agree (2)
- ○ Disagree (4)
- ○ Strongly Disagree (5)
- ○ I have not had enough experience in my current employing organisation to say (3)

FQ33 From your experience of the role, to what extent do you feel your employer has '**bought in**' to effectively implementing the ACP role? (For example, across all four pillars, including involvement in clinical practice, leadership & management,

education, research activity, and with an appropriate scope of practice and autonomy).

	0 1 2 3 4 5 6 7 8 9 10
Move the slider to what's fits best with your experience, with 0 being not at all and 10 being comprehensively. ()	

FQ34 Health Education England, along with other professional organisations, provide a definition for Advanced Practice roles in the 'Multi-Professional Framework for Advanced Practice in England'. This sets down expectations about the training/ education qualification requirements and capabilities you are required to demonstrate to work at this level.

Are you aware of your employing organisation **quality assuring** the ACP role by mapping or reference to particular policies or standards?

(For example, they restrict the use of the 'Advanced Practice' job title to only those that meet a set of externally agreed criteria like the Multi-professional framework for Advanced Clinical Practice in England.)

- ○ Yes (1)
- ○ In principle they do, but this is not universal across the organisation, or it has not been fully implemented yet (4)
- ○ No (2)
- ○ I am not sure whether they do or not (3)

FQ35 From your experience, has your employing organisation/s been supportive of the **ACP role evolving** or being adopted more broadly to adapt to new service or patient population needs?

- ○ Strongly agree, this is currently happening across several different areas in my organisation (1)
- ○ Agree, there have been some examples of this, although only in one or two areas (2)
- ○ Disagree, I am not aware of this or have not had experience of this in my organisation (4)
- ○ Strongly disagree, my organisation has said they are not going to evolve or expand ACP roles (5)

FQ36 Thinking about what you have seen, heard, or experienced, would you say there is **long term investment** in supporting the development of ACP role in your employing organisation/s? (You can select more than one answer).

- ☐ Strongly agree, there is already evidence of this as ACP roles have been established for some time (1)
- ☐ Agree, my organisation has committed to long term investment in ACP roles (2)
- ☐ Disagree, I am not aware of any long-term investment for ACP roles (4)
- ☐ Strongly disagree, I am aware of my organisation discontinuing ACP roles or refusing to expand them further (5)
- ☐ I have not been in my employing organisation long enough to say (3)

FQ37 To what extent is your ACP role being **operated differently at a local level** as compared to other teams/ services in your employing organisation?

Move the slider along to the best fit for the percentage that ACP roles are operated at a local rather than a consistent way across your organisation, (as far as you are aware). For example,
100% -all ACP roles operate in the same way across your employing organisation.
50% - there is an even balance of some aspects being specific for your team and some that are the same across the organisation.

0% -it is entirely local and bespoke for your team/ service.

	0 10 20 30 40 50 60 70 80 90 100
Move the slider along to the best fit for the percentage that ACP roles are operated at a local rather than a consistent way across your organisation. ()	

FQ38 From what you have experienced in an ACP/ trainee ACP role, how would you rate the current **policy, governance, strategic oversight** for ACP roles?

	Excellent, there is clear vision, policy, governance and structure in place. (1)	Good, although there are some areas that need further development. (2)	Poor, there are some things in place but these are disjointed or not addressing fundamental aspects of the ACP role (3)	Very poor, I am not aware of there being any vision, policy, governance, or strategic oversight for ACP roles. (4)
In your employing organisation/s (1)	○	○	○	○
Regionally? (e.g. at ICS or geographical regional level) (2)	○	○	○	○
Nationally? (3)	○	○	○	○

FQ39 Please use the text box below to provide any comments (should you wish to do so) about **organisational policy, vision, structure** as it relates to your experience of the ACP/ tACP role.

Page Break

FQ40 Overall, would you say your **expectations of the benefits of the ACP role** been realised from your current experience of the role so far?

	0 1 2 3 4 5 6 7 8 9 10
Move the slider to what fits best with your experience so far, with 0 my expectations have not been met at all, to 10 being my expectations of the benefits of the role have been exceeded and 5 being the role is delivering as I had expected it would. ()	

FQ41 This is the final question in this survey.

Is there anything else you would like to say about the expected benefits of the ACP role and whether, from your experience so far, these have been realised?

_____

_____

_____

_____

_____

End of Block: Follow-up Questionnaire

APPENDIX 16- STUDY TIMELINE

KEY:
RQ= Recruitment Questionnaire (Green)
FG= Focus Groups (purple)
FQ=Follow-Up Questionnaire (Blue)

Timeline	Dec21-March 22	Apr 22	May 22	June 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	March 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23
Instrument Design & Pilot	RQ	FG Topic Guide										FQ Instrument Design			FQ Pilot				
Recruitment			RQ		FG											FQ			
Data collection			RQ ran from 30th May- 15th July			FG held 12.8.22 + 31.8.22	FG held 28.9.22									FQ ran from 2nd June to 7th July + 2 weeks given to complete responses			
Data Analysis	RQ Pilot (Dec 21)				RQ (used for) Maximum variation sampling		FG rTA								FQ Pilot			FQ	

APPENDIX 17- ETHICAL APPROVAL

From: ERAMS <erams@essex.ac.uk>
Date: 23 May 2022 at 05:51:34 BST
To: "Scott, Vikki-Jo" <v.j.scott@essex.ac.uk>
Subject: Decision - Ethics ETH2122-1092: Ms Vikki-Jo Scott

University of Essex ERAMS

23/05/2022

Ms Vikki-Jo Scott

Health and Social Care, Health and Social Care

University of Essex

Dear Vikki-Jo,

Ethics Committee Decision

Application: ETH2122-1092

I am pleased to inform you that the research proposal entitled "What are the realistic expectations of pursuing an Advanced Clinical Practitioners role? A mixed method study using a sequential, cross-sectional, exploratory design." has been reviewed on behalf of the Ethics Sub Committee 2, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Extensions and Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Please note that this approval does **not** include any activities requiring NHS approval and that this must be sought separately where required.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in

mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.

Yours sincerely,

Dr Aaron Wyllie (a.wyllie@essex.ac.uk)

Ethics ETH2122-1092: Ms Vikki-Jo Scott

This email was sent by the University of Essex Ethics Review Application and Management System (ERAMS).

APPENDIX 18- MIXED METHODS APPRAISAL TOOL (MMAT)

(Hong *et al.*, 2018)

Category of study designs	Methodological quality criteria	Responses Comments	Page reference
Screening questions	S1. Are there clear research questions?	Yes. A clear overarching question has been given with specific sub-questions that have been used for different phases of the research	126
	S2. Do the collected data allow to address the research questions	The topic guide for the focus group was utilised effectively to answer 'what are ACPs expectations of the role' and the themes from this phase of the research have been used effectively to design the follow up questionnaire to collect data on whether these expectations are being realised. The demographic questions in both the recruitment and follow up questionnaires have allowed for exploration of any factors that may be associated with the realisation of ACPs expectations.	129
Mixed Methods	5.1 Is there an adequate rationale for using a mixed methods design to address the research question?	Yes. Through exploration of different research paradigms it has been noted that MMR best allows for the research question noting that this addresses the nature of ACP expectations and the magnitude of whether they are being realised.	123-129
	5.2 Are the different components of the study effectively integrated to answer the research question?	Yes. Using a sequential exploratory design where the focus groups findings have fed into the design of the follow up questionnaire, this has allowed for effective integration to answer the question.	126-128
	5.3 Are the outputs of the integration of quantitative and qualitative components adequately interpreted?	Yes. Both quantitative descriptive statistics and qualitative thematic analysis for each theme and its associated sub-questions (designed on the basis of the qualitative focus group thematic analysis) have been integrated in the presentation of findings (chapter 6) and interpreted in chapter 7. Effort has been made to keep returning to each research question and theme to ensure these have been adequately addressed.	221-298

Category of study designs	Methodological quality criteria		Responses Comments	Page reference
Mixed Methods	5.4 Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?		Yes. Qualitative statements given in response to the open questions in the follow up questionnaire and in focus group discussion reflect the quantitative data, whilst noting that the intention of this research was to identify gaps between expectation (identified in the focus group) and reality (identified through the follow up questionnaire). Unusual patterns/ potential divergences are reported and explored in the 'deep dive'.	267-273
	5.5 Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?		Yes. In the methodology chapter each of the quality criteria that are relevant to the methods employed have been explored and reported, including use of CoREQ and consideration of reliability and validity. (These are further described below as 1. Qualitative and 4. Quantitative descriptive in MMAT)	446-452 148-153
	Qualitative Studies	1.1 Is the qualitative approach appropriate to answer the research question?	Yes, as noted in answer to the screening questions above. The qualitative elements of this study have been used to capture the respondents experience.	128
		1.2 Are the qualitative data collection methods adequate to address the research question?	Yes. Consideration of different approaches and the rationale for choosing to use focus groups and open questions has been discussed.	130-131
		1.3 Are the findings derived from the data?	Yes. All transcripts and text from responses to the open-ended questions were used within the rTA process.	141-144 185-219
		1.4 Is the interpretation of results sufficiently substantiated by data?	Yes. Selected quotes are used from the coding undertaken to illustrate specific points made within the findings.	185-219 + 225-270
		1.5 Is there coherence between qualitative data sources, collection, analysis and interpretation?	Yes. Clear links are made between data sources, collection, analysis and interpretation; the 5 themes derived from the data sources are carried through the analysis and interpretation processes.	217-219 Chapters 5- 7

Category of study designs	Methodological quality criteria		Responses Comments	Page reference
Mixed Method	Quantitative descriptive studies	4.1 Is the sampling strategy relevant to address the research question?	Yes, justification for purposive and maximum-variation sampling has been given noting previous research that identifies the diverse population of ACPs. The methods used were chosen to facilitate this in a timely and cost-effective way.	132-138 + 162-165
		4.2 Is the sample representative of the target population?	Can't tell. The ACP population has not been accurately defined and verified to measure this.	179-183, 221-223, 302-308
		4.3 Are the measures appropriate?	Yes. The Zhou (2019) process has been used to ensure the measures were appropriate for answering the research question in this phase of the research. A pilot test was undertaken and reliability and validity have been considered (noting that use of a previously validated tool was rejected).	145-162
		4.4 Is the risk of nonresponse bias low?	Can't tell. The ACP population has not been defined and continues to evolve, it is therefore difficult to know to what extent there has been non-response bias. Sampling strategies have been chosen to ensure as far as possible a diversity of ACP views have been captured. The 'generalisability' discussion in chapter 8 reflects upon the inferences can be made about whether the findings from this research represents the broader ACP population.	302-308 + 311-316
		4.5 Is the statistical analysis appropriate to answer the research question?	An iterative process was used to ensure the correct statistical (descriptive) analysis method has been used for each question whilst keeping aware of the intended audience for this research and the logic flow diagram produced. Limitations are discussed in chapter 8.	Appendix 14 479-488 302-311

REFERENCE LIST

Abu-Qamar, M. Z., Vafeas, C., Ewens, B., Ghosh, M. and Sundin, D. (2020) 'Postgraduate nurse education and the implications for nurse and patient outcomes: A systematic review', *Nurse Educ Today,* 92, pp. 104489.

Allen, M. (2017) 'Focus Groups', in *The SAGE Encyclopedia of Communication Research Methods* [Online]. Version. Available at: https://methods.sagepub.com/reference/the-sage-encyclopedia-of-communication-research-methods

Aromataris, E. and Munn, Z. (2020) *JBI Manual for Evidence Synthesis* https://synthesismanual.jbi.global.: Joanna Briggs Institute.

Arslanian-Engoren, C., Hicks, F. D., Whall, A. L. and Algase, D. L. (2005) 'An Ontological View of Advanced Practice Nursing', *Research & Theory for Nursing Practice,* 19(4), pp. 315-322.

Badampudi, D., Wohlin, C. and Petersen, K. 'Experiences from using snowballing and database searches in systematic literature studies', *Proceedings of the 19th International Conference on Evaluation and Assessment in Software Engineering*, 1-10.

Bagley, S. (2018) 'Exploring emergency nurse practitioners' perceptions of their role.', *Nursing Standard,* 32(26), pp. 41-50.

Barea, S. (2020) 'What is a Primary Care Advanced Practice Role in Cornwall?', *Practice Nursing,* 31(1), pp. 31-36.

Barratt, J. (2010) 'A focus group study of the use of video-recorded simulated objective structured clinical examinations in nurse practitioner education', *Nurse Education in Practice,* 10(3), pp. 170-175.

Beauchamp, T. L. and Childress, J. F. (2019) *Principles of biomedical ethics.* Eighth edition. edn. New York: Oxford University Press.

Begley, C., Elliott, N., Lalor, J., Coyne, I., Higgins, A. and Comiskey, C. M. (2013) 'Differences between clinical specialist and advanced practitioner clinical practice, leadership, and research roles, responsibilities, and perceived outcomes (the SCAPE study)', *J Adv Nurs,* 69(6), pp. 1323-37.

Benoot, C., Hannes, K. and Bilsen, J. (2016) 'The use of purposeful sampling in a qualitative evidence synthesis: A worked example on sexual adjustment to a cancer trajectory', *BMC Med Res Methodol,* 16, pp. 21.

Bevans, R. (2023) *Choosing the right statistical test; types & examples*. https://www.scribbr.com/statistics/statistical-tests/: Scribbr. Available at: https://www.scribbr.com/statistics/statistical-tests/ (Accessed: 29 February 2024).

Bhaskar, R. (2008) *A realist theory of science. A realist theory of science with a new introduction*: Routledge [PDF]. Available at: https://uberty.org/wp-content/uploads/2015/09/Roy_Bhaskar_A_Realist_Theory_of_Science.pdf (Accessed: 4.10.21).

Bird, J. and Kirshbaum, M. (2005) 'Towards a framework of advanced nursing practice for the clinical research nurse in cancer care. ', *Clinical Effectiveness in Nursing,* 9(3-4), pp. 161-171.

Birt, L., Scott, S., Cavers, D., Campbell, C. and Walter, F. (2016) 'Member Checking', *Qualitative Health Research,* 26(13), pp. 1802-1811.

Booth, A. (2006) 'Brimful of STARLITE: Toward standards for reporting literature searches', *Journal of the Medical Library Association* 94(4), pp. 421-9.

Boughner, R. L. (2010) 'Volunteer Bias', in *Encyclopedia of Survey Research Methods*. pp. 1609-1610 [Online]. Version. Available at: https://dx.doi.org/10.4135/9781412961288.

Braun, V. and Clarke, V. (2019) 'Reflecting on reflexive thematic analysis', *Qualitative Research in Sport, Exercise and Health,* 11(4), pp. 589-597.

Braun, V. and Clarke, V. (2020) 'Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches', *Counselling and Psychotherapy Research,* 21(1), pp. 37-47.

Braun, V. and Clarke, V. (2022) *Thematic Analysis. A Practical Guide* London: Sage Publications. Available at: https://uk.sagepub.com/en-gb/eur/thematic-analysis/book248481.

Braun, V. and Clarke, V. (2023) 'Toward good practice in thematic analysis: Avoiding common problems and be(com)ing a knowing researcher', *International Journal of Transgender Health,* 24(1), pp. 1-6.

Breen, R. L. (2006) 'A Practical Guide to Focus-Group Research', *Journal of Geography in Higher Education,* 30(3), pp. 463-475.

British Medical Association (2023) *NHS backlog data analysis* Analysis of monthly data releases by NHS England to highlight the growing backlogs across the NHS - including operations data, cancer waiting list GP referrals and A&E waiting times. Available at: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis (Accessed: 9.7.23.

Brown, K. M., Elliott, S. J., Leatherdale, S. T. and Robertson-Wilson, J. (2015) 'Searching for rigour in the reporting of mixed methods population health research: a methodological review', *Health Educ Res,* 30(6), pp. 811-39.

Cambridge University Press and Assessment (2023) *Cambridge Dictionary*. https://dictionary.cambridge.org/dictionary/english/tapestry: Cambridge University Press. Available at: https://dictionary.cambridge.org/dictionary/english/tapestry (Accessed: 27.11.23 2023).

Campbell Foundation (2020) *2020: What is a Systematic review*. Available at: https://campbellcollaboration.org/what-is-a-systematic-review.html.

Carney, M. (2016) 'Regulation of advanced nurse practice: Its existence and regulatory dimensions from an international perspective', *Journal of Nurse Management,* 24, pp. 105-114.

Centre for Advancing Practice (2023) *Advanced practice training funding models 2023/4*, https://advanced-practice.hee.nhs.uk/regional-faculties-for-advancing-practice/regional-faculty-for-advancing-practice-east-of-england-2/guidance-and-resources/. Available at: https://advanced-practice.hee.nhs.uk/regional-faculties-for-advancing-practice/regional-faculty-for-advancing-practice-east-of-england-2/guidance-and-resources/ (Accessed: 10th August 2023).

Chatfield, C. (1986) 'Exploratory data analysis', *European Journal of Operational Research,* 23(1), pp. 5-13.

Cho, H., Li, P., Ngien, A., Tan, M. G., Chen, A. and Nekmat, E. (2023) 'The bright and dark sides of social media use during COVID-19 lockdown: Contrasting social media effects through social liability vs. social support', *Computers in Human Behavior,* 146, pp. 107795.

Cochrane Library (2020) *About Cochrane Reviews*. Available at: https://www.cochranelibrary.com/about/about-cochrane-reviews (Accessed: 27th July 2020).

Cooper, M. A., McDowell, J. and Raeside, L. (2019) 'The similarities and differences between advanced nurse practitioners and clinical nurse specialists', *British Journal of Nursing,* 28(20), pp. 1308-1314.

Creswell, J. W., and, and Plano Clark, V. L. (2017) 'Complex Applications of Core Mixed Methods Designs', *Designing and Conducting Mixed Methods Research.* Third ed: Sage Publications Inc.

Critical Appraisal Skills Programme (2020) *CASP Checklists*. Available at: https://casp-uk.net/casp-tools-checklists/ (Accessed: 3rd August 2020).

Currie, K., Biggam, J., Palmer, J. and Corcoran, T. (2012) 'Participants' engagement with and reactions to the use of on-line action learning sets to support advanced nursing role development', *Nurse Education Today,* 32(3), pp. 267-272.

De Bont, A., Van Exel, J., Coretti, S., Ökem, Z. G., Janssen, M., Hope, K. L., Ludwicki, T., Zander, B., Zvonickova, M., Bond, C. and Wallenburg, I. (2016) 'Reconfiguring health workforce: a case-based comparative study explaining the increasingly diverse professional roles in Europe', *BMC Health Services Research* 16, pp. 1-14.

Deci, E. L. and Ryan, R. M. (2000) 'The "What" and "Why" of Goal Pursuits: Human Needs and the Self-Determination of Behavior', *Psychological Inquiry,* 11(4), pp. 227-268.

Delamaire, M.-L. and Lafortune, G. (2010) *Nurses in Advanced Roles: A Description and Evaluation of Experiences in 12 Developed Countries*: Organisation for Economic Co-operation and Development54). Available at: https://dx.doi.org/10.1787/5kmbrcfms5g7-en.

Department of Health and Social Care (2012) *NHS Constitution for England*, www.gov.uk/government/publications/the-nhs-constitution-for-england: UK government. Available at: https://www.gov.uk/government/publications/the-nhs-constitution-for-england (Accessed: 8th August 2023).

Dillman, D. A., Smyth, J. D. and Christian, L. M. (2014) *Internet, phone, mail and mixed-mode surveys: The tailored design method.* 4th edn.: John Wiley & sons.

Dixon S. (2022) *Social media use during COVID-19 worldwide- statistics and facts*. Available at: https://www.statista.com/topics/7863/social-media-use-during-coronavirus-covid-19-worldwide/#editorsPicks (Accessed: 13.12.23).

Dixon-Woods, M., Cavers, D., Agarwal, S., Annandale, E., Arthur, A., Harvey, J., Hsu, R., Katbamna, S., Olsen, R., Smith, L., Riley, R. and Sutton, A. J. (2006) 'Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups', *BMC Med Res Methodol,* 6, pp. 35.

Dodgson, J. E. (2019) 'Reflexivity in Qualitative Research', *Journal of Human Lactation,* 35(2), pp. 220-222.

Dowling, M., Beauchesne, M., Farrelly, F. and Murphy, K. (2013) 'Advanced practice nursing: A concept analysis', *International Journal of Nursing Practice* 19, pp. 131-140.

Drennan, V. M., Collins, L., Allan, H., Brimblecombe, N., Halter, M. and Taylor, F. (2021) 'Are advanced clinical practice roles in England's National Health Service a remedy for workforce problems? A qualitative study of senior staff perspectives', *Journal of health services research & policy*.

Duffield, C., Gardener, G., Chang, A. M. and Catling-Paull, C. (2009) 'Advanced nursing practice: A global perspective', *Collegian,* 16(2), pp. 55-62.

Dunn, L. (1997) 'A Literature Review of Advanced Clinical Nursing Practice in the United States of America', *Journal of Advanced Nursing,* 25, pp. 814-819.

Dyba, T., Dingsoyr, T. and Hanssen, G. K. (2007) *Applying Systematic Reviews to Diverse Study Types: An Experience Report*.

Elliott, N., Begley, C., Sheaf, G. and Higgins, A. (2016) 'Barriers and enablers to advanced practitioners' ability to enact their leadership role: A scoping review', *International Journal of Nursing Studies,* 60, pp. 24-45.

Endacott, R. and Chaboyer, W. (2006) 'The nursing role in ICU outreach: an international exploratory study', *Nursing in Critical Care,* 11(2), pp. 94-102.

England, N. (2018) *The Change Model Guide*. https://www.england.nhs.uk/sustainableimprovement/change-model/: NHS England. Available at: https://www.england.nhs.uk/sustainableimprovement/change-model/ (Accessed: 23.4.23 2023).

Evans, C., Pearce, R., Greaves, S. and Blake, H. (2020) 'Advanced Clinical Practitioners in Primary Care in the UK: A Qualitative Study of Workforce Transformation', *International Journal of Environmental Research and Public Health,* 17(12), pp. 4500.

Evans, C., Poku, B., Pearce, R., Eldridge, J., Hendrick, P., Knaggs, R., Blake, H., Yogeswaran, G., McLuskey, J., Tomczak, P., Thow, R., Harris, P., Conway, J. and Collier, R. (2021) 'Characterising the outcomes, impacts and implementation challenges of advanced clinical practice roles in the UK: a scoping review', *BMJ Open,* 11(8), pp. e048171.

Fern, E. F. (2001) 'Advanced Focus Group Research', [Online]. Version. Available at: https://methods.sagepub.com/book/advanced-focus-group-research.

Fielding, N. G., Lee, R. M. and Blank, G. (2017) *The SAGE Handbook of Online Research Methods.*

Fink, A. (1995) 'How to ask survey questions', *The Survey Kit*: SAGE Publications Ltd.

Fothergill, L. J., Al-Oraibi, A., Houdmont, J., Conway, J., Evans, C., Timmons, S., Pearce, R. and Blake, H. (2022) 'Nationwide evaluation of the advanced clinical practitioner role in England: a cross-sectional survey', *BMJ Open,* 12(1), pp. e055475.

Gerrish, K., Guillaume, L., Kirshbaum, M., McDonnell, A., Tod, A. and Nolan, M. (2011) 'Factors influencing the contribution of advanced practice nurses to promoting evidence-based practice among front-line nurses: findings from a cross-sectional survey', *Journal of Advanced Nursing,* 67(5), pp. 1079-1090.

Gibson, S. and Duffy, R. (2024) 'Enhancing quality in same-day emergency care: a service improvement perspective', *International Journal for Advancing Practice,* 2(1), pp. 8-13.

Glasdam, S., Sandberg, H., Stjernswärd, S., Jacobsen, F. F., Grønning, A. H. and Hybholt, L. (2022) 'Nurses' use of social media during the COVID-19 pandemic—A scoping review', *PLOS ONE,* 17(2), pp. e0263502.

Gloster, A. S., Neville, L. and Windle, J. (2015) 'Effects of advanced practitioner' learning in one hospital', *Nursing Management – UK,* 21(10), pp. 23-30.

Greenhalgh, T. and Peacock, R. (2005) 'Effectiveness and efficiency of search methods in systematic reviews of complex evidence: audit of primary sources', *BMJ,* 331(7524), pp. 1064-5.

Greenhalgh, T., Thorne, S. and Malterud, K. (2018) 'Time to challenge the spurious hierarchy of systematic over narrative reviews?', *Eur J Clin Invest,* 48(6), pp. e12931.

Gulliford, M., Naithani, S. and Morgan, M. (2006) 'What is 'continuity of care'?', *J Health Serv Res Policy,* 11(4), pp. 248-50.

Haigh, F., Kemp, L., Bazeley, P. and Haigh, N. (2019) 'Developing a critical realist informed framework to explain how the human rights and social determinants of health relationship works', *BMC Public Health,* 19(1).

Harding, D. and Barratt, J. (2023) 'Enabling effective and supportive supervision for the development of advanced practitioners', *International Journal for Advancing Practice,* 1(3), pp. 109-110.

Hardy, M. (2021) *Advanced Practice: Research Report*, https://www.hcpc-uk.org/resources/policy/advanced-practice-full-research-report/: Health and Care Professions Council. Available at: https://www.hcpc-uk.org/resources/policy/advanced-practice-full-research-report/.

Hartwig, F. and Dearling, B. E. (1979) 'The Exploratory Perspective', in *Exploratory Data Analysis*. *Quantitative Applications in the Social Sciences* [Online]. Version.

Hawker, S., Payne, S., Kerr, C., Hardey, M. and Powell, J. (2002) 'Appraising the evidence: reviewing disparate data systematically', *Qual Health Res,* 12(9), pp. 1284-99.

Heale, R. and Rieck Buckley, C. (2015) 'An international perspective of advanced practice nursing regulation Nursing Regulation', *International Nursing Review* 62, pp. 421-429.

Health and Care Professions Council (2024) *Updates on Advanced Practice*: HCPC. Available at: https://www.hcpc-uk.org/news-and-events/blog/2024/updates-on-advanced-practice/ (Accessed: 11.11.24 2024).

Health Education England (2017a) *Developing Advanced Practice in Clinical Care: Analysis of Physical and Online Workshops."* Available at: https://www.hee.nhs.uk/sites/default/files/documents/Report_Developing%20advanced%20practice%20in%20clinical%20care_CleverTogether.pdf.

Health Education England (2017b) *Multi-Professional Framework for Advanced Clinical Practice in England*.

Health Education England (2020a) *Analysis of the online workshop to consider the impact of Covid-19 and the implications for the future of advanced and consultant practice* Available at: https://www.hee.nhs.uk/our-work/advanced-practice/reports-publications/impact-covid-19-future-advanced-consultant-practice.

Health Education England (2020b)*: Workplace Supervision for Advanced Clinical Practice: An integrated multi-professional approach for practitioner development*. Available at: https://www.hee.nhs.uk/our-work/advanced-practice/reports-publications/workplace-supervision-advanced-clinical-practice.

Health Education England (2021a) *Advancing Practice: Signpost for Continuing Professional Development*.

Health Education England (2021b) *Deep dive into the East of England (EoE) faculty*: Health Education England. Available at: https://advanced-practice.hee.nhs.uk/deep-dive-into-the-east-of-england-eoe-faculty/ (Accessed: 15.9.21 2021).

Health Education England, Health Education England,, Faculty of Advancing Practice East of England (2021c) *Supporting Advanced Practitioner Training: A guide to funding and processes*: Health Education England,.

Health Education England (2022) *Governance Maturity Matrix- Governance of advanced pactice*. https://advanced-practice.hee.nhs.uk/news-and-events/governance-of-advanced-practice-in-health-and-care-provider-organisations/: NHS. Available at: https://advanced-practice.hee.nhs.uk/news-and-events/governance-of-advanced-practice-in-health-and-care-provider-organisations/ (Accessed: 15.12.23 2023).

Health Education England Faculty for Advancing Practice (2022) *Trainee Supervision Review: Final Report*, https://advanced-practice.hee.nhs.uk/regional-faculties-for-advancing-practice/regional-faculty-for-advancing-practice-east-of-england-2/advanced-practice-supervision/: Health Education England. Available at: https://advanced-practice.hee.nhs.uk/regional-faculties-for-advancing-practice/regional-faculty-for-advancing-practice-east-of-england-2/advanced-practice-supervision/ (Accessed: 15.12.23).

Health Research Authority (2023a) *Introducing the hallmarks of People-Centred Clinical Research*. https://www.hra.nhs.uk/about-us/news-updates/introducing-hallmarks-people-centred-clinical-research/: Health Research Authority. Available at: https://www.hra.nhs.uk/about-us/news-updates/introducing-hallmarks-people-centred-clinical-research/ (Accessed: 27.11.23 2023).

Health Research Authority, NHS (2023b) *UK Policy Framework for health and social care research*.

Health Research Authority (2023c) *What approval and decisions do I need?* https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/: Health Research Authority. Available at: https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/ (Accessed: 27.11.2020 2020).

Henderson, C. (2021) 'Advanced practice education and development', *Practice Nursing,* 32(11), pp. 443-448.

Heyvaert, M., Hannes, K., Maes, B. and Onghena, P. (2013) 'Critical Appraisal of Mixed Methods Studies', *Journal of Mixed Methods Research,* 7(4), pp. 302-327.

Holden, J. (2023) 'The NHS Long Term Workforce Plan explained', *Productivity: Workforce and Skills: The NHS Long Term Workforce Plan explained*, Available at: The Kings Fund. Available at: https://www.kingsfund.org.uk/publications/nhs-long-term-workforce-plan-explained (Accessed 15.12.23).

Hong, Q. N., Pluye, P., Fabregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., Gagnon, M. P., Griffiths, F., Nicolau, B., O'Cathain, A., Rousseau, M. C. and Vedel, I. (2018) 'MIXED METHODS APPRAISAL TOOL (MMAT) VERSION 2018 User guide', Available at: McGill. Available at: http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/fetch/127916259/MMAT_2018_criteria-manual_2018-08-01_ENG.pdf (Accessed 23rd September 2024).

Hughes, E., Terry, D., Huynh, C., Petridis, K., Aiello, M., Mazard, L., Ubhi, H., Terry, A., Wilson, K. and Sinclair, A. (2017) 'Future enhanced clinical role of pharmacists in Emergency Departments in England: multi-site observational evaluation', *Int J Clin Pharm,* 39(4), pp. 960-968.

Hutchinson, M., East, Leah, Stasa, Helen, Jackson, Debra (2014) 'Deriving consensus on the characteristics of advanced practice nursing: Meta-summary of more than 2 decades of research', *Nursing Research,* 63(2), pp. 116-128.

Jenkinson, C. and Fisher, S. (2024) 'Supporting advanced practice: feedback from a mental health, community and primary care advanced practice support project in South Yorkshire, UK', *International Journal for Advancing Practice,* 2(3), pp. 139-143.

Joanna Briggs Institute (2017) *Critical Appraisal Checklist for Systematic Reviews and Research Syntheses*: Joanna Briggs Institute. Available at: http://joannabriggs-webdev.org/research/critical-appraisal-tools.html.

Johnson, R. and Onwuegbuzie, A. (2004) 'Mixed Methods Research: A research paradigm whose time has come', *Educational Researcher,* 33(7), pp. 14-26.

Jupp, V. (2008) 'Summated rating scale', *Encyclopedia of Survey Research Methods*.

Kaldan, G., Nordentoft, Sara, Herling, Suzanne Forsyth, Larsen, Anders, Thomsen, Thordis, Egerod, Ingrid (2019) 'Evidence characterising skills, competencies and policies in advanced practice critical care nursing in Europe: A scoping review protocol', *British medical Journal,* 9(9).

Kalliath, T. and Brough, P. (2008) 'Work–life balance: A review of the meaning of the balance construct', *Journal of Management & Organization,* 14(3), pp. 323-327.

Kitzinger, J. (1995) 'Qualitative Research: Introducing focus groups', *BMJ,* 311(7000), pp. 299-302.

Kline, R. (2020) *Psychometrics* London. Available at: https://methods.sagepub.com/foundations/psychometrics (Accessed: 2023/03/24).

Kolb, D. (1984) *Experiential Learning: Experience As The Source Of Learning And Development.* Prentice-Hall, Inc.

Komorowski, M., Marshall, D. C., Salciccioli, J. D. and Crutain, Y. (2016) 'Exploratory Data Analysis', in Data, M.I.T.C. (ed.) *Secondary Analysis of Electronic Health Records*. Cham: Springer International Publishing, pp. 185-203.

Krosnick, J., A., Narayan, S., S. and Smith, W., R. (1996) 'Satisficing in surveys: Initial evidence', in *Advances in survey research*. pp. 29-44 [Online]. Version. Available at: https://pprg.stanford.edu/wp-content/uploads/1996-Satisficing-in-surveys-Initial-evidence.pdf (Accessed: 29th July 2021).

Kulas, J. T., Stachowski, A. A. and Haynes, B. A. (2008) 'Middle Response Functioning in Likert-responses to Personality Items', *Journal of Business and Psychology,* 22(3), pp. 251-259.

Lavrakas, P. J. (2008a) 'Forced choice', [Online]. Version. Available at: https://methods.sagepub.com/reference/encyclopedia-of-survey-research-methods.

Lavrakas, P. J. (2008b) 'Questionnaire', in *Encyclopedia of Survey Research Methods* [Online]. Version. Available at: https://methods.sagepub.com/reference/encyclopedia-of-survey-research-methods.

Lavrakas, P. J. (2008c) 'Satisficing', in *Encyclopedia of Survey Research Methods* [Online]. Version. Available at: https://methods.sagepub.com/reference/encyclopedia-of-survey-research-methods.

Lawler, J., Maclaine, K. and Leary, A. (2020) 'Workforce experience of the implementation of an advanced clinical practice framework in England: a mixed methods evaluation', *Hum Resour Health,* 18(1), pp. 96.

Leary, A. (2022) *The Principles of Enhanced Level Practice*. Available at: https://www.hee.nhs.uk/our-work/enhanced-practice-0 (Accessed: 13.12.23).

Leary, A., Maclaine, K., Trevatt, P., Radford, M. and Punshon, G. (2017) 'Variation in job titles within the nursing workforce', *J Clin Nurs,* 26(23-24), pp. 4945-4950.

Lee, G. A., Baker, E. E., Stewart, C. and Raleigh, M. (2023) 'Advanced practice and clinical supervision: An exploration of perceived facilitators and barriers in practice', *Journal of Clinical Nursing,* 32(5-6), pp. 780-788.

Lewis, R. (2022) 'The evolution of advanced nursing practice: Gender, identity, power and patriarchy', *Nursing Inquiry,* 29(4).

Li, T., Higgins, J. P. T. and Deeks, J. J. (2019) 'Chapter 5: Collecting data', in *Cochrane Handbook for Systematic Reviews of Interventions* [Online]. Version. Available at: https://training.cochrane.org/handbook/current/chapter-05#section-5-4 (Accessed: 27th July 2020).

Liamputtong, P. (2011) 'Focus Group Methodology: Principles and Practice', [Online]. Version. Available at: https://methods.sagepub.com/book/focus-group-methodology.

Lisy, K. and Porritt, K. (2016) 'Narrative Synthesis: Considerations and challenges', *JBI Evidence Implementation,* 14(4), pp. 201.

Lloyd Jones, M. (2005) 'Role development and effective practice in specialist and advanced practice roles in acute hospital settings: systematic review and meta-synthesis', *Journal of Advanced Nursing,* 49, pp. 191-209.

Lockwood, E. B., Lehwaldt, D., Sweeney, M. R. and Matthews, A. (2022) 'An exploration of the levels of clinical autonomy of advanced nurse practitioners: A narrative literature review', *International Journal of Nursing Practice,* 28(1), pp. 1-17.

MacInnes, J. (2022) 'Statistical Inference and Probability', [Online]. Version. Available at: https://methods.sagepub.com/book/statistical-inference-and-probability.

Mackavey, C. and Cron, S. (2019) 'Innovative strategies: Increased engagement and synthesis in online advanced practice nursing education', *Nurse Education Today,* 76, pp. 85-88.

Mackavey, C., Henderson, C., Leeuwen, E. d. Z. v., Maas, L. and Ladd, A. (2024) 'The advanced practice nurse role's development and identity: an international review', *International Journal for Advancing Practice,* 2(1), pp. 36-44.

Maier, C. B., Barnes, H., Aiken, L. H. and Busse, R. (2016) 'Descriptive, cross-country analysis of the nurse practitioner workforce in six countries: size, growth, physician substitution potential', *BMJ Open,* 6(9), pp. e011901.

Mangold, K., Kunze, K. L., Quinonez, M. M., Taylor, L. M. and Tenison, A. J. (2018) 'Learning Style Preferences of Practicing Nurses', *J Nurses Prof Dev,* 34(4), pp. 212-218.

Manley, K. (1997) 'Manley conceptual framework ACP action research', *Journal of Clinical Nursing* 6(3), pp. 179-190.

Mann, C., Timmons, S., Evans, C., Pearce, R., Overton, C., Hinsliff-Smith, K. and Conway, J. (2023) 'Exploring the role of advanced clinical practitioners (ACPs) and their contribution to health services in England: A qualitative exploratory study', *Nurse Educ Pract,* 67, pp. 103546.

Mantzoukas, S., Watkinson, Sue (2007) 'Review of advanced nursing practice: The international literature and developing the generic features', *Journal of Clinical Nursing* 16, pp. 28-37.

Marsden, J., Dolan, Brian, Holt, Lynda MA, Marsden, Janet (2003) 'Nurse practitioner practice and deployment: electronic mail Delphi study', *Journal of Advanced Nursing* 43(6), pp. 595-605.

Marsden, J., Shaw, Mary E., Raynel, Sue (2013) 'Advanced practice in ophthalmic nursing: A comparison of roles and the effects of policy on practice in the UK and New Zealand', *Journal of Research in Nursing,* 18(1), pp. 7-18.

Mathers, N., Fox, N. and Hunn, A. (2007) *Surveys and Questionnaires*.

McConnell, D., Slevin, Oliver D., McIlfatrick, Sonja J. (2013) 'Emergency nurse practitioners' perceptions of their role and scope of practice: Is it advanced practice?', *International Emergency Nursing,* 21(2), pp. 76-83.

McDonnell, A., Gerrish, Kate, Kirshbaum, Marilynne N., Nolan, Mike, Tod, Angela, Guillaume, Louise (2012) 'The perceived impact of advanced practice nurses (APNs) on promoting evidence-based practice amongst frontline nurses: Findings from a collective case study', *Journal of Research in Nursing,* 18(4), pp. 368-383.

McDonnell, A., Goodwin, Emma, Kennedy, Fiona, Hawley, Kay, Gerrish, Kate, Smith, Christine (2015) 'An evaluation of the implementation of Advanced Nurse Practitioner (ANP) roles in an acute hospital setting', *Journal of Advanced Nursing* 71, pp. 789-799.

McEvoy, P. and Richards, D. (2016) 'A critical realist rationale for using a combination of quantitative and qualitative methods', *Journal of Research in Nursing,* 11(1), pp. 66-78.

McGee, P., Castledine, George, Brown, Roswyn (1996) 'A survey of specialist and advanced nursing practice in England', *British Journal of Nursing,* 5(11), pp. 682-686.

McLeod, S. (2019) 'What's the difference between qualitative and quantitative research?', *Simply Psychology*. Available at: https://www.simplypsychology.org/qualitative-quantitative.html (Accessed 11.6.21).

Mellors, E. (2023) 'Taking the lead: the leadership pillar in action', *International Journal for Advancing Practice,* 1(3), pp. 129-133.

Michaelidou, N. and Dibb, S. (2006) 'Using email questionnaires for research: Good practice in tackling non-response', *Journal of Targeting, Measurement and Analysis for Marketing,* 14, pp. 289-296.

Miller, L., Cox, A. and Williams, J. (2009) *Evaluation of the advanced practitioner roles.*, www.employment-studies.co.uk: Institute for Employment Studies (9781851844203, 465). Available at: www.employment-studies.co.uk.

Nadaf, C. (2018) 'Perspectives: Reflections on a debate: When does Advanced Clinical Practice stop being nursing?', *Journal of Research in Nursing,* 23(1), pp. 91-97.

Nash, K., Trott, V. and Allen, W. (2022) 'The politics of data visualisation and policy making', *Convergence,* 28(1), pp. 3-12.

NHS Employers (2023a) *Confirmed industrial action strike days*. Available at: https://www.nhsemployers.org/articles/confirmed-industrial-action-strike-days (Accessed: 9.6.23 2023).

NHS Employers (2023b) *The role of governance in advanced practice*. https://www.nhsemployers.org/articles/role-governance-advanced-practice: NHS Employers. Available at: https://www.nhsemployers.org/articles/role-governance-advanced-practice (Accessed: 25th August 2023 2023).

NHS England (2018)*: The Change Model Guide*. https://www.england.nhs.uk/publication/the-change-model-guide/: NHS England [Guidance]. Available at: https://www.england.nhs.uk/publication/the-change-model-guide/ (Accessed: 6th February 2024).

NHS England (2021) *What are integrated care systems*. Available at: https://www.england.nhs.uk/integratedcare/what-is-integrated-care/ (Accessed: 18th Febraury 2020 2020).

NHS England (2023a) *Agenda for change-pay rates*. https://www.healthcareers.nhs.uk/working-health/working-nhs/nhs-pay-and-benefits/agenda-change-pay-rates. Available at:

https://www.healthcareers.nhs.uk/working-health/working-nhs/nhs-pay-and-benefits/agenda-change-pay-rates (Accessed: 14th August 2023 2023).

NHS England (2023b) *NHS Long Term Workforce Plan*, england.nhs.uk/publication/nhs-long-term-workforce-plan: NHS England. Available at: england.nhs.uk/publication/nhs-long-term-workforce-plan (Accessed: 8th August 2023).

NHS Improvement, DHSC, Care, H.S. (2020) *NHS People Plan.* https://www.england.nhs.uk/ournhspeople/online-version/: UK Government.

Noblit, G. W. and Hare, R. D. (1988) *Qualitative Research Methods: Meta-ethnography. .* Thousand Oaks, CA: SAGE Publications, Inc.

Nursing and Midwifery Council (2023) *Advanced Practice Review*. Available at: https://www.nmc.org.uk/about-us/our-role/advanced-practice-review/ (Accessed: 13.10.23 2023).

Nursing and Midwifery Council (2024) *Advanced Practice review- our proposals*. https://www.nmc.org.uk/about-us/our-role/advanced-practice-review/our-proposals/. Available at: https://www.nmc.org.uk/about-us/our-role/advanced-practice-review/our-proposals/ (Accessed: 20.10.24 2024).

O'Shea, A., Boaz, A. L. and Chambers, M. (2019) 'A Hierarchy of Power: The Place of Patient and Public Involvement in Healthcare Service Development', *Frontiers in Sociology,* 4.

Oliver, D. (2023) 'David Oliver: The fractious debate over physician associates in the NHS', *BMJ,* 383, pp. p2449.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffman, T. C., Mulrow, C. D. and al, e. (2021) 'The PRISMA 2020 statement: an updated guideline for reporting systematic reviews', *British Medical Journal,* 372.

Palmer, W., Julian, S. and Vaughan, L. (2023) *Independant report on the regulation of advanced practice in nursing and midwifery*, https://www.nmc.org.uk/about-us/our-role/advanced-practice-review/: The Nuffield Trust. Available at: https://www.nmc.org.uk/about-us/our-role/advanced-practice-review/ (Accessed: 11th August 2023).

Pett, M. A. (2016) 'Nonparametric Statistics for Health Care Research: Statistics for Small Samples and Unusual Distributions', [Online]. Version. Available at: https://methods.sagepub.com/book/nonparametric-statistics-for-health-care-research-2e.

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Britten, N., Roen, K. and Duffy, S. (2006) *Guidance on the Conduct of Narrative Synthesis in Systematic Reviews*: ESRC Methods Programme.

Pulcini, J., Jelic, M., Gul, R. and Loke, A. Y. (2010) 'An international survey on advanced practice nursing education, practice, and regulation', *Journal of Nursing Scholarship,* 42(1), pp. 31-39.

Quality Assurance Agency (2014) *The Frameworks for HE Qualifications of UK Degree-Awarding Bodies*, https://www.qaa.ac.uk/quality-code/qualifications-frameworks. Available at: https://www.qaa.ac.uk/quality-code/qualifications-frameworks.

Quality of Working Life (2019) *Quality of Working Life: research based organisational scales and surveys* https://www.qowl.co.uk/qowl_surveys_overview.html. Available at: https://www.qowl.co.uk/qowl_surveys_overview.html (Accessed: 26.11.23 2023).

Read, H., Nindrajog, B. and Mortimore, G. (2024) 'How do advanced nurse practitioners enhance healthcare outcomes in frail older patients living in care homes?', *International Journal for Advancing Practice,* 2(1), pp. 14-19.

Read, S., Jones, M. L., Collins, K., Mcdonnell, A., Jones, R., Doyal, L., Cameron, A., Masterson, A., Dowling, S., Vaughan, B., Furlong, S. and Scholes, J. (2001) *Exploring New Roles in Practice (ENRiP) Final Report King's Fund Nursing Developments Programme* King's Fund.

Reference, O. satisficing.

Reynolds, J. and Mortimore, G. (2021) 'Clinical supervision for advanced practitioners', *British Journal of Nursing,* 30(7), pp. 422-424.

Roberts-Davis, M., Nolan MR, Read S, Gilbert P (1998) 'Realizing specialist and advanced nursing practice: a typology of innovative nursing roles', *Accident & Emergency Nursing,* 6(1), pp. 36-40.

Rogers, M., Hemingway, Steve, Elsom, Steve (2013) 'An evaluation of therapeutic optimism in advanced nurse practitioner students', *The Nursing Standard,* 27(36), pp. 35-39.

Rolewicz, L., Palmer, B. and Lobont, C. (2022) *The NHS Workforce in Numbers*: Nuffield trust. Available at: https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers# (Accessed: 04.06.23).

Schoonenboom, J. and Johnson, R. B. (2017) 'How to Construct a Mixed Methods Research Design', *Kolner Z Soz Sozpsychol,* 69(Suppl 2), pp. 107-131.

Scott, V.-J. (2023) 'Continuing Professional Development, appraisal and revalidation', in Diamond-Fox, S., Hill, B., Stone, S., McCrea, C., Gardner, N. and Roberts, A. (eds.) *Acute, Emergency & Critical Care for the Advanced Practitioner* 1st ed: Wiley-Blackwell, pp. 19-35.

Scott, V.-J. and Clift, E. (2023) 'Professional Development and Transition ', in Peate, I., Diamond-Fox, S. and Hill, B. (eds.) *The Advanced Clinical Practitioner : A Framework for Clinical Practice*: Wiley Publishing, pp. 404-418.

Shannon-Baker, P. (2016) 'Making Paradigms Meaningful in Mixed Methods Research', *Journal of Mixed Methods Research,* 10(4), pp. 319-334.

Shea, B., Reeves, B., Wells, G., Thuku, M., Hamel, C., Moran, J., Moher, D., Tugwell, P., Welch, V., Kristjansson, E. and Henry, D. (2017) 'AMSTAR 2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both', *British Medical Journal,* 21.

Shearer D and Adams, J. (2012) 'Evaluating an advanced nursing practice course: student perceptions', *The Nursing Standard,* 26(21), pp. 35-41.

Sim, J. and Waterfield, J. (2019) 'Focus group methodology: some ethical challenges ', *Quality & Quantity,* 53, pp. 3003-3022.

Sirgy, M. J. and Lee, D.-J. (2018) 'Work-Life Balance: an Integrative Review', *Applied Research in Quality of Life,* 13(1), pp. 229-254.

Smith, B. (2018) 'Generalizability in qualitative research: misunderstandings, opportunities and recommendations for the sport and exercise sciences', *Qualitative Research in Sport, Exercise and Health,* 10(1), pp. 137-149.

Smith, J., A,, Flowers, P. and Larkin, M. (2009) *Interpretative Phenomenological Analysis: Theory, Method and Research.* London: Sage Publications Limited, p. 232.

Smith, S. L. and Hall, M. A. (2003) 'Developing a neonatal workforce: Role evolution and retention of advanced neonatal nurse practitioners', *Archives of Disease in Childhood,* 88(5), pp. 426-429.

Snaith, B., Sutton, C., Partington, S. and Mosley, E. (2023) 'Scoping of advanced clinical practitioner role implementation using national job advertisements: Document analysis', *Journal of Advanced Nursing,* 79(7), pp. 2675-2683.

Spector, P., E. (1992) 'Summated Rating Scale Construction', [Online]. Version. Available at: https://methods.sagepub.com/book/summated-rating-scale-construction.

Stern, C., Lizarondo, L., Carrier, J., Godfrey, C., Rieger, K., Salmond, S., Apostolo, J., Kirpatrick, P. and Loveday, L. (2020) 'Methodological guidance for the conduct of mixed methods systematic reviews', *JBI Database of Systematic Reviews and Implementation Reports*.

Stewart-Lord, A., Beanlands, C., Khine, R., Shamah, S., Sinclair, N., Woods, S., Woznitza, N., Baillie, L. and (2020) 'The Role and Development of Advanced Clinical Practice Within Allied Health Professions: A Mixed Method Study', *J Multidiscip Healthc,* 13, pp. 1705-1715.

Tashakkori, A., ; , Burke Johnson, R., ; and Teddlie, C. (2021) *Foundations of Mixed Methods Research*: Sage

Taylor, A., Staruchowicz, L., (2012) 'The Experience and Effectiveness of Nurse Practitioners in Orthopaedic Settings: A Comprehensive Systematic Review', *Joanna Briggs Institute Library of Systematic Review,* 10, pp. 1-22.

Taylor, F., Drennan, V. M., Halter, M., Allan, H. T. and Collins, L. (2022) 'Uptake of advanced clinical practice roles in the health service in England: Perspectives at the micro level', *SSM - Qualitative Research in Health,* 2, pp. 100141.

Teddlie, C., and and Tashakkori, A. (2012) 'Common "Core" Characteristics of Mixed Methods Research', *American Behavioral Scientist,* 56(6), pp. 774-788.

Tee, S. R., Jowett, R. M. and Bechelet-Carter, C. (2009) 'Evaluation study to ascertain the impact of the clinical academic coaching role for enhancing student learning experience within a clinical masters education programme', *Nurse Education in Practice,* 9(6), pp. 377-382.

The Centre for Advancing Practice (2022)*: Advanced Practice workplace supervision-minumum standards for supervision*. https://advanced-practice.hee.nhs.uk/resources/supervision-and-assessment-resources/: Health Education England. Available at: https://advanced-practice.hee.nhs.uk/resources/supervision-and-assessment-resources/ (Accessed: 15.12.23).

The Nursing and Midwifery Council (2023) *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.* . https://www.nmc.org.uk/standards/code/: Nursing and Midwifery Council. Available at: https://www.nmc.org.uk/standards/code/ (Accessed: 27.11.23 2023).

Thompson, J., McNall, A., Tiplady, S., Hodgson, P. and Proud, C. (2019) 'Whole systems approach: Advanced clinical practitioner development and identity in primary care', *Journal of Health Organisation & Management,* 33(4), pp. 443-459.

Timmons, S., Mann, C., Evans, C., Pearce, R., Overton, C. and Hinsliff-Smith, K. (2023) 'The Advanced Clinical Practitioner (ACP) in UK healthcare: Dichotomies in a new 'multi-professional' profession', *SSM - Qualitative Research in Health,* 3, pp. 100211.

Timonen, V., Foley, G. and Conlon, C. (2018) 'Challenges When Using Grounded Theory', *International Journal of Qualitative Methods,* 17(1), pp. 160940691875808.

Tong, A., Sainsbury, P. and Craig, J. (2007) 'Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups', *International Journal for Quality in Health Care,* 19(6), pp. 349-357.

Torjesen, I. (2022) 'Number of NHS staff taking pension benefits hits record high', *BMJ,* 377, pp. o1390.

Tracy, S. J. (2010) 'Qualitative Quality: Eight "Big-Tent" Criteria for Excellent Qualitative Research', *Qualitative Inquiry,* 16(10), pp. 837-851.

Tsiachristas, A., Wallenburg, I., Bond, C. M., Elliot, R. F., Busse, R., Van Exel, J., Rutten-van Mölken, M. P. and de Bont, A. (2015) 'Costs and effects of new professional roles: Evidence from a literature review', *Health Policy* 119, pp. 1176-1187.

Tufte, E. R. (2021) *The Visual Display of Quantitiatve Information: Second Edition.* 2nd edn. Cheshire, Conneticut: Graphics Press, p. 7.

Tukey, J. W. (1977) *Exploratory data analysis.* Reading, MA: Addison-Wesley.

University of Essex (2023a) *Research participant information and consent*. https://www.essex.ac.uk/staff/research-governance/research-participant-information-and-consent: Research governance. Available at: https://www.essex.ac.uk/staff/research-governance/research-participant-information-and-consent (Accessed: 27.11.23 2023).

University of Essex (2023b) *Research risk assessment*. Available at: https://www.essex.ac.uk/staff/research-governance/research-risk-assessment (Accessed: 27.11.23 2023).

Verbeek, J., Ruotsalainen, J. and Hoving, J. L. (2012) 'Synthesizing study results in a systematic review', *Scand J Work Environ Health,* 38(3), pp. 282-90.

Walsh, B., Fogg, C., Harris, S., Roderick, P., de Lusignan, S., England, T., Clegg, A., Brailsford, S. and Fraser, S. D. S. (2023) 'Frailty transitions and prevalence in an ageing population: longitudinal analysis of primary care data from an open cohort of adults aged 50 and over in England, 2006–2017', *Age and Ageing,* 52(5).

White, M. and Mackenzie-Davey, K. (2003) 'Feeling valued at work? A qualitative study of corporate training consultants', *Career Development International,* 8(5), pp. 228-234.

Williams, K. (2017) 'Advanced practitioners in emergency care: A literature review', *Emergency Nurse* 25(4), pp. 36-41.

Williamson, G. R., Webb, C., Abelson-Mitchell, N. and Cooper, S. (2006) 'Change on the horizon: Issues and concerns of neophyte advanced healthcare practitioners', *Journal of Clinical Nursing* 15(9), pp. 1091-1098.

Wilson-Barnett, J., Barriball, L., Reynolds, H. K., Jowett, S. and Ryrie, I. (2000) 'Recognising advancing nursing practice: evidence from two observational studies', *International Journal of Nursing Studies,* 37(5), pp. 389-400.

Wong, A., Ho, S., Olusanya, O., Antonini, M. V. and Lyness, D. (2021) 'The use of social media and online communications in times of pandemic COVID-19', *Journal of the Intensive Care Society,* 22(3), pp. 255-260.

Woods, L. P. (1998) 'Identifying the practice characteristics of advanced practitioners in acute and critical care settings Leslie R Woods', *Intensive and Critical Care Nursing,* 15, pp. 308-317.

Wu, M.-J., Zhao, K. and Fils-Aime, F. (2022) 'Response rates of online surveys in published research: A meta-analysis', *Computers in Human Behavior Reports,* 7, pp. 100206.

Yang, F. M. and Kao, S. T. (2014) 'Item response theory for measurement validity', *Shanghai Arch Psychiatry,* 26(3), pp. 171-7.

Zhou, Y. (2019) 'A Mixed Methods Model of Scale Development and Validation Analysis', *Measurement: Interdisciplinary Research and Perspectives,* 17(1), pp. 38-47.

ZoomHelpCentre (2021) *Enabling and managing closed captioning and live transcription*. Available at: https://support.zoom.us/hc/en-us/articles/207279736-Enabling-and-managing-closed-captioning-and-live-transcription (Accessed: 19 July 2021).