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Scoping the application of primary care advanced clinical practice roles in England

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Abstract

Purpose

To scope the profile and application of advanced clinical practitioner (ACP) roles in primary care in the North of England, and how these roles meet the requirements of Health Education England's (HEE) ACP workforce capability framework.

Design

A 2 stage design was used. Stage 1 analysed health and social care workforce intelligence reports to inform scoping of numbers of ACPs working in primary care. Stage 2 used 2 surveys. Survey 1 targeted ACP leads and collected strategic level data about ACP application. Survey 2 targeted staff who perceived themselves to be working as ACPs. Survey 2 was in 3 parts. Part 1 collected demographic data. Part 2 required participants to record their perceived competence against each of the HEE ACP framework capability criteria. Part 3 required respondents to identify facilitators and barriers to ACP practice.

Results

Despite the introduction of HEE's ACP capability framework, there is inconsistency and confusion about the ACP role. Results indicated a need for standardisation of role definition, and educational and practice requirements. Results also suggested that some ACPs are not working to their full potential, while some staff who are employed as 'gap-fillers' to provide routine clinical services perceive themselves as ACPs despite not working at ACP level.

Originality/value

Although previous research has explored the application of ACP practice in primary care, few studies have considered ACP application in the light of the introduction of workforce capability frameworks aimed at standardising ACP practice.

Introduction

The increasing pressures on primary care services in England are well documented. Challenges include increasing demand on services to support an ageing population (European Commission, 2015; NHS England, 2019), escalating budgetary and organisational pressures (Fawdon and Adams, 2013), increased patient expectations (Williams, 2017), and staff shortages, particularly general practitioner (GP) shortages arising from struggles to recruit new partners and salaried GPs, and an increase in practising GPs leaving to work abroad (Barton *et al*., 2012a; Peckham *et al*., 2016). Imison *et al*.'s (2016) report for NHS Employers, the *General Practice Forward View* (NHS England, 2016), and the *NHS Long Term Plan* (NHS England, 2019) acknowledge these challenges, setting the strategic direction for an effective primary health care system with the aims of mitigating GP shortages, improving efficiency and improving patient care. Strategies include investing in the generation of 5,000 additional GPs, extending the skills of registered professionals, and developing advanced clinical practitioner (ACP) roles. The recent *Update to the GP Contract Agreement 2020/21-2023/24* (NHS England, 2020) confirms GP shortages are an ongoing challenge, and recommends further expansion of advanced multi-disciplinary team roles to release GP capacity.

Within this context, Health Education England (HEE) commissioned a study to gain insight into how ACP is specifically applied in primary care within the North of England. This paper presents the results of phase 1 of this study - scoping the profile and application of ACP in primary care.

HEE is an executive non-government departmental public body sponsored by England's Department of Health and Social Care. Its function is to provide national leadership, planning, coordination and commissioning for education and training, within the health and public health workforce in England.

Literature review

Barton *et al*. (2012a) and Williams (2017) track the development of ACP in the United Kingdom (UK), suggesting that the origins lie with the introduction of a nurse practitioner role in primary healthcare in the late 1980s. Williams (2017) proposes evolution of ACPs in the UK is associated with medical staff shortages resulting from difficulties in the recruitment and retention of GPs. These authors note that ACPs provide a set of services that might otherwise be performed by doctors (for example, being the first contact for people with minor illness, providing routine follow-up of patients with chronic conditions, prescribing drugs or ordering tests). To a large extent, this involves a substitution of tasks from doctors to ACPs, with the main aim being to reduce demands on doctors' time, that in turn, improves access

to care, and reduces costs. Participants in Clay and Stern's (2015) study estimated that 27% of GP appointments were potentially avoidable if operational systems were transformed, for example, by using ACP consultations instead of GP consultations where appropriate.

A number of systematic reviews have been undertaken that investigate the effectiveness of the ACP role in primary care. Laurant *et al*. (2018) suggest ACP care improves patients' functional, health and psychological status; improves rates of patients' goal achievements, and increases levels of family-expressed satisfaction. Begley *et al*. (2013) found a clear difference between clinical specialist and advance practitioners with advanced practice roles providing improved service delivery, and greater clinical and professional leadership. Swan *et al*. (2015) found that ACPs in primary care settings perform as well as medical staff in terms of clinical outcomes and patient satisfaction, but at a lower cost. Donald *et al*. (2013) found ACP care improves the health status of older adults living in long-term care settings, and family satisfaction with care.

In spite of the advantages ACP can bring to primary care, the development of the role has been largely reactionary. This has led to difficulties in defining, and further developing the role. The Royal College of Nursing (RCN) (2010) recognised that title variation hindered the public's understanding about what levels of care ACP nurses can deliver. In addition, variation in titles impedes judgements, scrutiny and understanding of practitioners' knowledge and competency to practice at an advanced level. The Department of Health's (2010) report *Advanced level nursing: A position statement* agreed, acknowledging that the terminology associated with advanced level practice had been applied inconsistently to a number of different roles, which has led to confusion about the scope and competence required at this level of practice. Surveys and studies exploring ACP and advanced nursing practice (ANP) job titles, job descriptions and levels of competency have identified considerable variation (Begley *et al*, 2012; Elliot *et al*., 2015; East *et al*., 2015). These authors argue that such role inconsistency and confusion leads to inefficiencies in care, inconsistencies in levels of competency, duplication in care activities, and ineffective professional relationships.

In order to address inconsistencies in ACP roles and competence, suggestions have been made to develop a standard definition of the role, describe expected practice levels, and determine minimum educational standards, although these definitions have tended to focus on nursing practice (for example; Department of Health, 2010; Pearce and Breen, 2018; RCN, 2018). In 2017, Health Education England (HEE) published *Multi-professional framework for advanced clinical practice in England* (2017) - a workforce capability

framework designed to guide development of ACP roles in a consistent way. The framework offers a standard definition of ACP that is applicable across all professions, provides clarity about the nature of expert knowledge and skills, and directs the educational requirements and governance processes required for the effective planning and development of the ACP workforce:

> *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.*

Despite the publication of ACP definitions and standards, some professional staff propose that consistency will be difficult to achieve without registration of the ACP role. From a nursing perspective, the RCN (2010) called for consultation a decade ago, and the recent Blake Stevenson (2019) review of standards of specialist post registration education, commissioned by the Nursing and Midwifery Council (NMC), acknowledged the need for further consultation. However, advanced practitioner level as part of the NMC and Health and Care Professions Council registers has remained unrealised. Barton *et al*. (2012b) propose advanced practitioners represent no greater public risk than new registrants, therefore, a separate part of the register would hold little benefit. Nevertheless, concerns about lack of registration remain. This has resulted in suggestions about how to regulate the role in the absence of national registration. East *et al*. (2015) suggest that UK NHS Trusts should develop registers. However, it would be difficult to include staff working outside of the NHS. The RCN (2018) has developed the notion of 'credentialing', where nurses can apply to be recognised as ACPs via an on-line application, but this is not universally recognised as a means of regulation.

Although previous research has explored the application of ACP practice in primary care, few studies have considered ACP application in the light of the HEE ACP capability framework. HEE commissioned this study to gain insight into how ACP is specifically applied in primary care within the North of England. The objectives of the study were to: phase 1) scope the profile and application of ACP roles in primary care and how they meet the requirements of HEE's ACP framework; phase 2) identify any specific developments required to support ACP is to be effectively maximised 'at scale' within primary care. This paper reports on phase 1.

Methods

The study location was the three HEE regions in the North of England (North West, Central North, and North East). For the study as a whole, a mixed methods approach was used. As

phase 1 focused on scoping the profile and application of ACP, two approaches were used: stage 1 was an analysis of primary care services tables relating to staff numbers; stage 2 used a survey approach.

Stage 1 method: Analysis of service tables

The following public records were accessed:

- NHS Digital's GP medical service tables
- NHS service tables for nurses and direct patient care
- Skills for Care social care workforce intelligence reports

Information from these documents relating to the 3 study locations was used to inform the scoping of the application of the ACP role in primary care.

Stage 2 method: Surveys

Sample

Due to the potential for variability in definitions and perceptions about what constitutes advanced clinical practice, a mixture of purposive and snowball sampling was used. Purposive sampling was used to target personnel with knowledge of the scope of ACP practice within their work areas, and staff perceived by themselves or colleagues to be ACPs. Snowball sampling allowed these respondents to refer others to the study. Although this approach can have negative impacts on research in terms of selection bias, it an appropriate method of identifying participants in circumstances where the target population is not clearly defined.

Survey data collection: Online survey tools were developed by the research team. The tools were adapted from workforce development survey tools developed by McNall (2012), and used in a number of workforce scoping and application studies (for example, Thompson *et al*., 2018 workforce caring for older people with complex needs; McNall *et al*,. 2016 workforce caring for people with learning disabilities; McNall and Atkinson, 2014 primary care workforce). Before circulation, the adapted tools were piloted by two ACPs working in the study location (a clinical quality lead and an advanced nurse practitioner lead) for appropriateness of content, structure and clarity. Survey 1 was distributed via a weblink to clinical commissioning group (CCG) leaders, training hub leaders, ACP leads, directorates of nursing, allied health profession (AHP) service leads, care home and home care providers, and voluntary sector service leads working into primary care services across the HEE (North) region. The survey collected data on number, background and roles of ACPs in their region; use of the ACP framework to inform job descriptions; professional development opportunities and support provided for ACPs; barriers to developing ACP roles.

The invitation to participate in survey 1 included a weblink to survey 2, and survey 1 participants were requested to cascade survey 2 to nurses and AHPs in their locations. In addition, permission was sought from the Queen's Nursing Institute to circulate the weblink for survey 2 via their social media and twitter sites. To maximise response rates, reminder emails were sent on a weekly basis. Survey 2 was a 3-part survey. Part 1 collected data on demographic, experience and educational backgrounds of participants; current role; professional development opportunities and support available. Part 2 required participants to record their perceived competence and confidence against each of the capability criteria within the HEE ACP framework. Responses were captured using a 4-point Likert scale: 1= not at all; 2 = not very; 3 = somewhat; 4 = very. Part 3 requested respondents to identify facilitators and barriers to ACP practice, and suggest recommendations about future role development.

Data analysis: Data from the completed surveys were imported into Statistical Package for the Social Sciences (SPSS) software, and data from the hardcopy observation tools were entered manually into SPSS in preparation for analysis.

Descriptive frequency analysis was used to provide an overview of the data. Additional analysis was carried out as follows:

- Survey 2 required participants to self-rate their capabilities against each individual capability of the ACP framework. Mean capability ratings were then calculated for each individual capability, and total capability for each of the four pillars.
- Spearman rho correlation calculations were used to determine possible relationships between highest academic level and capability, and band (job grade) and capability.

Only results addressing the scope and application of ACP are reported in this paper.

Research ethics approval to undertake the study was secured from the Faculty of Health and Life Sciences, xxx University.

Results: analysis of service tables

NHS Digital's (2018a) GP medical services tables for nurses and direct patient care were accessed. Information from electronic staff records informs these tables. The tables showed that 1,287 GP ANPs were employed across the 3 HEE North of England regions. The basis for these numbers was labelling staff according to staff employment records i.e. job titles determined by employers.

GP service tables also showed numbers of AHPs working in GP practices. The tables did not indicate how many of these were working as ACPs. In order to capture information about numbers of ACPs working in primary care, but not in GP practices, NHS Digital's (2018b) NHS services tables for nurses and direct patient care were accessed. With regard to nurses, the tables showed that across the three HEE northern regions 40 community nurse consultants and 342 community matrons were employed by the NHS. These results may indicate the number of senior nurses that may be working at ACP level in primary care outside GP practice. However, numbers for senior AHPs show the total number employed by NHS services. Information about whether these staff work in or into primary care was not provided. The Skills for Care (2018) workforce intelligence report provided detailed information on the state of the social care workforce. Numbers and demographics for registered health and social care professionals was provided, but the report did not indicate level of practice.

In summary, available information gives some indication of nurses working at ACP level in GP practices and the NHS but results rely on assumptions. Results show there is insufficient information to calculate numbers of AHPs working as ACPs, or nurses in social care working as ACPs.

Results: analysis of surveys

Participants were drawn from a wide range of locations across the North of England. In total, there were 116 respondents to the surveys, 45 responding to survey 1. As survey 1 was primarily a scoping exercise to determine numbers of ACPs working throughout the North of England, service leads completed the survey, as these individuals were most likely to have access to this information. For the purposes of this study, these respondents are entitled 'ACP leads'. Survey 1 ACP lead respondents were as follows: 67% ANP leads; 6.7% directors of quality and safety (nurses): 4.4% CCG lead nurses; 4.4% GP federation managers; 4.4% education lead (nurse); 4.4% community matron leads; the remaining were service lead nurses for frailty, respiratory, dementia or workforce services. As ACP leads were commenting on the workforce, rather than on their own experiences as ACPs, it was unnecessary to present any further demographic data.

Table 1 provides details of survey 2 respondents' characteristics.

INSERT TABLE 1 HERE

Table 1: Survey 2 respondents

Survey 1 asked ACP lead respondents to provide details of numbers and professional backgrounds of ACPs working in primary care in their area of practice. The valid response rate for this questions was 84.4%. Of these, 26.3% provided definitive numbers, and 73.7%

were unsure. Of respondents that were unsure, 17.9% provided explanatory comments on the survey, or emailed members of the research team to explain why these questions could not be answered fully. After analysis, 100% of these comments were coded: 'there is no registration or standard definition of an ACP, so it is not possible to ascertain numbers of staff working as ACPs'.

Total mean capability per pillar for all survey 2 respondents was calculated from valid responses. Valid response rates were: clinical skills capability questions 79.3%; L&M capability questions 72.4%; education capability questions 71.5%; research capability questions 71.5%. Total mean capability for clinical skills was: clinical skills 3.58 (SD 0.61); L&M 3.24 (SD 0.74); education 3.34 (SD 0.69); research 2.86 (SD 0.81). If a mean capability of 3 is taken as a minimum ACP capability level (3 = somewhat capable), then the results suggest that the ACP workforce in general has highest levels of capability in clinical skills practice, followed by education, then leadership and management. The workforce in general does not meet minimum capability levels in research.

Table 2 shows total mean capability per pillar by job. Intermediate care leads (occupational therapists), community emergency care practitioners (paramedics), and extended scope practitioners (physiotherapists) were not included as numbers were too small to provide meaningful results. Standard deviations (SDs) highlight that capability variation occurs between individual practitioners within the same job group. Results suggest that, if a mean capability of 3 is taken as a minimum ACP capability level (3= somewhat capable), then care home manager and district nurse respondents are not working at ACP level; trainee ACP respondents are only working at ACP level in clinical practice and education, and only nurse consultant respondents are working at ACP level in research. Total mean capability per pillar rankings for total participants were (from highest to lowest) clinical practice 3.58 (SD 0.61), education 3.34 (SD 0.69), leadership and management 3.24 (SD 0.74), and research 2.86 (SD 0.81). This is reflected in all jobs except for care home managers, for whom rankings were (from highest to lowest) leadership and management, education, and clinical practice/research. This is to be expected because this staff group are employed specifically in a management role, are responsible for ensuring their staff are adequately trained, and delegate clinical practice to clinical lead nurses and registered nurses in their employ.

INSERT TABLE 2 HERE

Table 2: Mean capability per pillar by job

Figure 1 and table 3 show total mean capability with regard to the ACP framework by band.

INSERT FIGURE 1 HERE

Figure 1: Total mean capability (by pillar) by band

INSERT TABLE 3 HERE

Table 3: Mean capability per pillar by band

Findings suggest that, if a mean capability of 3 is taken as a minimum ACP capability level (3= somewhat capable), then band 6 practitioner respondents are not working at ACP level. Only respondents of band 8b and above are working at ACP level in research. Capability level rankings for total participants are (from highest to lowest) clinical practice, education, leadership and management and research. This is reflected in all bands except for band 6, for whom rankings are (from highest to lowest) research, clinical practice, education, and leadership and management. Research capability level for band 6 is higher than band 7 and band 8a. It is unclear why this is the case.

Spearman rho correlation calculations were used to examine relationships between band and mean capability in the 4 pillars. Significant correlation was found between band and capability levels for all 4 pillars, suggesting that higher band is associated with higher capability levels:

- Clinical skills – $rho(54)=0.583$, $p<0.05$
- Leadership and management - $rho(54)=0.548$, $p<0.05$
- Education - $rho(54)=0.530$, $p=0.05$
- Research - $rho(54)=0.432$, $p<0.05$

Analysis of survey responses showed inconsistencies in minimum education qualifications required for the role, and qualifications attained by ACPs. Survey 1 asked ACP leads whether a minimum academic qualification was required for ACP roles. The valid response rate to this question was 68.9%. While 80% of respondents said yes, 20% said there was no minimum requirement. Of those that said a minimum qualification was required, 30.5% (24.4% of the total valid responses) required a Master's degree; 43.4% (34.7% of the total valid responses) a Bachelor's degree, and 4.4% (3.5% of the total valid responses) a diploma/certificate. The remaining did not specify a degree/diploma level, but required non-medical prescriber (NMP) module accreditation (13%; 10% of the total valid responses) or advanced clinical skills module accreditation (8.7%; 6.9% of the total valid responses). In survey 2, ACP participants were asked what their highest academic qualification was. The valid response rate to this question was 86.2%. Responses were: 4.7% doctorate; 41.8% Master's degree; 48.8% Bachelor's degree; 4.7% diploma/certificate.

Findings suggest that, if a mean capability of 3 is taken as a minimum ACP capability level (3= somewhat capable), then practitioner respondents with diploma/certificate education

level were not working at ACP level in clinical practice or research. Respondents with doctorates were most likely to work at ACP level in research. Capability level rankings for total participants were (from highest to lowest) clinical practice, education, leadership and management and research. This is reflected in Bachelor's and Master's degree levels. Certificate and diploma level competency rankings are leadership and management, education, clinical practice and research. One explanation is the inclusion of care home managers in certificate/diploma category. Research capability for staff educated to certificate/diploma level is higher than that for those educated to Bachelor degree level. It is unclear why this is the case. Doctorate level competency rankings are research, clinical practice, leadership and management and education. This is to be expected as staff qualified to doctoral level are likely to be research active.

Spearman rho correlation calculations were used to examine relationships between highest academic level and mean capability in the 4 pillars. These correlational comparisons showed positive relationships in all areas, and significant correlation was found between highest academic level and clinical skills, leadership and management, and research, suggesting that having high academic qualifications is associated with higher capability levels in clinical skills, leadership and management, and research:

- Clinical skills – $rho(53)=0.395$, $p<0.05$
- Leadership and management - $rho(53)=0.369$, $p<0.05$
- Education - $rho(53)=0.31$, $p=0.055$
- Research - $rho(46)=0.488$, $p<0.05$

INSERT FIGURE 2 HERE

Figure 2: Mean capability (by pillar) by highest qualification

INSERT TABLE 4 HERE

Table 4: Mean capability per pillar by highest qualification

After completing their self-reported capability scores, survey 2 asked participants to report any challenges and facilitators to practicing at ACP level for each pillar. The valid response rate to this question was 52.3%. This was an open question, and responses were analysed and coded. None of the responses identified facilitators. Identified challenges were: no requirement or opportunity to practice in the current role as other staff in the workplace carry out those roles/tasks; lack of interorganisational support of the role (for example, primary care providers requiring ACPs to make referrals to secondary care, but secondary care

providers not accepting referrals from ACPs); lack of understanding about the ACP role remit (for example, employers not understanding the advanced level of practice ACP roles are capable of, which results in restricted or limited opportunities to practice at an advanced level); demands of the routine clinical role restricting opportunities for advanced level practice and development; limited access to appropriate and relevant study programmes and courses to support ACP capability development and maintenance; lack of funding for study programmes and courses; lack of access to clinical mentorship and supervision to support ACP capability development and maintenance. Table 5 shows the percentage of valid responses per ACP practice challenge for each pillar and as a total.

INSERT TABLE 5 HERE

Table 5: Percentage of responses per ACP practice challenge for each pillar and as a total

The first four challenges listed in the table refer to job and organisational factors relating to work allocation and interprofessional and interorganisational relationships. In total, 73% of challenges to ACP practice emanate from these. The final 3 challenges listed, totalling 27%, relate to access to education to support ACP practice development and maintenance.

Discussion

Workforce intelligence documents for the NHS and social care do not record ACPs with the exception of GP ANPs. However, the recording of GP ANPs may not be reliable as some ACP lead respondents suggested as there is no registration or standard definition of ACP, it is not possible to accurately determine the scope and application of ACP, or which staff are working at ACP level. Staff from a range of job groups responded to the invitation to participate, demonstrating that either they or their employers identify them as ACPs. Results show differences in capability between job groups, and standard deviations highlight that capability variation occurs between individual practitioners within the same job group. Despite the existence of the HEE capability framework, these results show that a standard definition and agreed standards for ACP practice are not widely acknowledged or implemented, which means the title of ACP, or being identified as ACP, may offer limited insight into the capability level and practice of the practitioner. The inconsistency and confusion about ACP practice highlighted by Begley et al. (2013) and Elliot *et al*. (2016) appears to remain. This suggests that in order to achieve consistent and standardised ACP practice, regulation or registration of the role may be required because guidance in the form of definitions and capability frameworks are not universally implemented. This is in accord

with the Blake Stevenson (2019) review. However, other studies and consultation reviews propose that much more analysis is required to ensure the benefits of registration outweigh the challenges arising from costs, staff requiring multiple registrations, and the potential for causing public confusion about professional registration.

Results show positive correlation between mean capability levels and band, and mean capability levels and qualifications, demonstrating that the capabilities of senior staff and staff with higher academic qualifications are more likely to align with the HEE capability framework. Staff with qualifications less that Master's degrees have a mean capability level for research that is less than 3. Staff working at lower levels than band 8a have a mean capability level for research that is less than 3. This is reflected in the HEE definition of ACP, which describes ACPs as 'experienced practitioners…characterised by a high degree of autonomy and complex decision making…underpinned by a master's level award'. This is demonstrated in the findings regarding capability by job group. The nurse consultant job group had the highest mean capability score than other job groups in all pillars, and was the only job group to have a mean capability score over 3 in research. The NHS job specification for nurse consultants requires post holders to work at band 8b level or above, and be qualified to Master's degree level or above (NHS Employers, 2020). It must be acknowledged however, that the data is collected from self-reported capability. There may be an expectation that senior, highly educated staff are more likely to practice at ACP level, and this expectation may have influenced their self-reported scores. Nevertheless, these results demonstrate that a number of staff working below the HEE ACP standards perceive themselves as, and/or are called ACPs/ANPs, or are perceived, and/or called this by their employers.

Capability level rankings for total participants in relation to job group, band, and qualifications are (from highest to lowest) clinical practice, education, leadership and management, and research. Results regarding challenges to practice may go some way to explaining this overall ranking. While 27% of valid responses referred to difficulties in accessing education to support development or maintenance of ACP capability, 73% referred to organisational factors. A major challenge was 'no requirement to practice in the current role', particularly with regard to leadership and management, but also the other pillars; another major challenge being 'demands of the routine clinical role' which hindered practice in all pillars, but particularly in education and research. Lack of understanding about the role remit and lack of interorganisational support where also challenges. Phase 2 of this study (reported in XXX *et al*., 2019), in which 22 practitioners were interviewed about their experiences as ACPs suggested that the absence of a standard definition of ACP, or what the remit of ACP actually is, can lead the role being used as a 'gap filler' i.e. used by employers to address

specific local gaps due to shortages of medical staff. While, for example, this acknowledges the role of ANPs in 'freeing up GPs', as intended by the *GP Forward View,* findings from XXX *et al*.'s (2019) study suggested ANP participants often took on routine clinical activities, while leadership, education, research and complex clinical practice become the remits of GPs. This, together with the results from phase 1 reported in this paper, suggest either ACPs are not being used to their full potential, which restricts their scope of practice, or they are perceived/called ACPs although they are not actually employed to, or capable of, working at ACP level.

These explanations are reinforced by differences between the qualifications required by employers regarding ACP, and what is achieved. Results demonstrate that participants were more highly qualified than required by employers. Of note is that 20% of valid ACP lead responses did not require a minimum qualification level, while 21% of valid ACP lead responses requiring a minimum qualification (16.9% of total valid responses) required module accreditation in NMP or advanced clinical skills. These results suggest that ACPs and employers value qualifications differently. Where employers are looking for 'gap filling', they may value experience, and/or qualifications that specifically focus on clinical activities, more highly than higher academic attainment (so that ACPs can act as substitute clinicians for routine clinical activities), while ACPs themselves regard higher academic attainment as integral to ACP practice.

Limitations

The study has a number of limitations. The small sample size recruited in one area of England limits generalisability. Snowball sampling may have introduced selection bias. Respondents to survey 2 self-assessed their competency against the HEE framework. As such expectations about competency regarding higher band staff and staff with higher qualifications may have influenced their self-reported scores.

Conclusion

Despite the introduction of HEE's ACP capability framework, inconsistency and confusion about the role remain. Results indicate that in order to enable scoping of the application of ACP, and ensure standardisation of educational and practice requirements and consistency of ACP capability, a standard role definition is required. Results also suggest there is a mismatch between the HEE ACP capability framework requirements and the requirements of some employers. This can lead to ACPs not working to their full potential, or staff being employed as 'gap-fillers' to provide routine clinical services perceiving themselves and being perceived as ACPs despite not working at ACP level in some or all pillars. Standardisation of

ACP role definition and capabilities is required to distinguish ACPs to prevent inconsistencies in practice and confusion about ACP role, and to maximise the effectiveness of the role. As guidance via capability frameworks does not appear to achieve this, regulation or registration may be required, although further analysis with regard to the benefits/challenges of registration is necessary.

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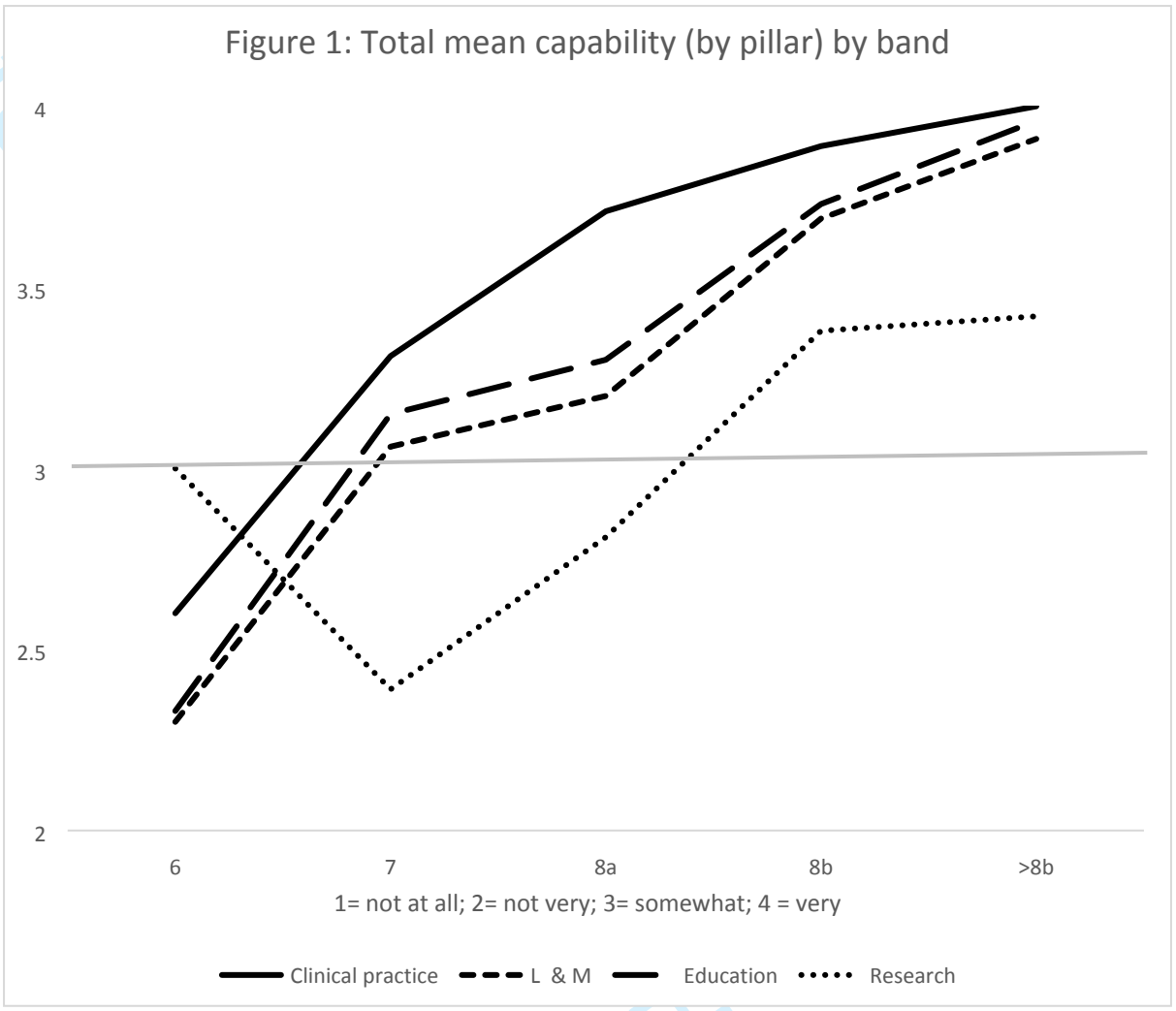

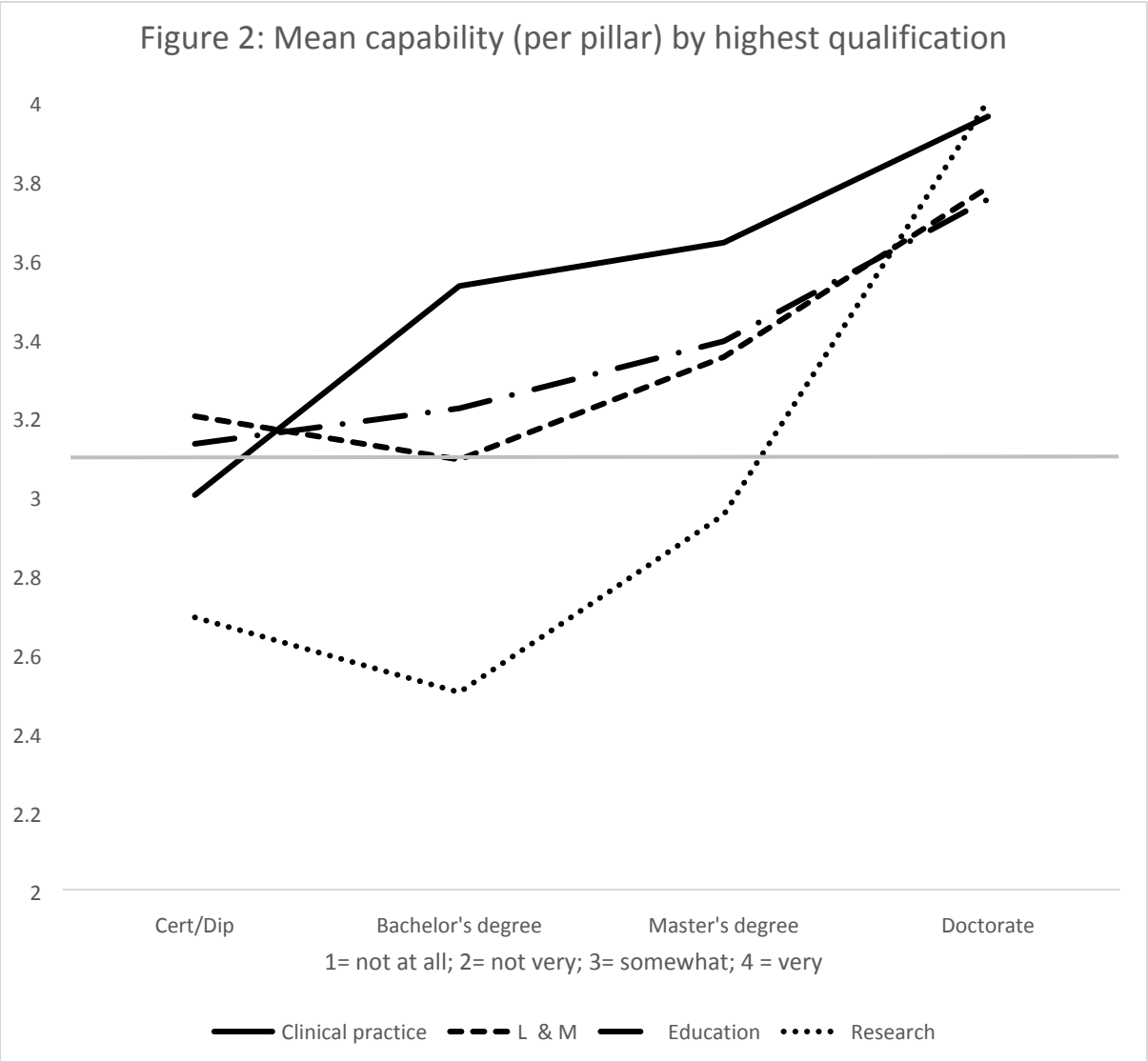

Table 1: Survey 2 respondents

Participant characteristics	Percentage	Mean (SD)
Gender:		
female	91.5	
male	8.5	
Age		47.1 years (SD=8.4)
Job title:		
care home manager	5.6	
GP ANP	59.2	
trainee GP ANP	8.5	
nurse consultant	7	
community matron	5.6	
district/community nurse	8.5	
intermediate care lead (occupational therapist	1.4	
community emergency care practitioner (paramedic)	1.4	
extended scope practitioner (physiotherapist)	2.8	
Years as a qualified professional		24.5 years (SD=9.4)
Years working as an ACP since qualification		10.5 years (SD=6.2)
Band (role grade):		
6	9.9	
7	28.2	
8a	31	
8b	23.9	
>8b	7	

Table 2: Mean capability per pillar by job

ACP pillar	Care home manager	GP ANP	Trainee ANP	Nurse consultant	Community matron	District/ community nurse
Clinical practice: mean (SD)	2 (0)	3.78 (0.35)	3.15 (0.36)	3.94 (0.05)	3.73 (0.72)	2.39 (1.21)
Leadership & management; mean (SD)	3 (0.71)	3.39 (0.6)	2.82 (0.42)	3.87 (0.11)	3.42 (0.7)	2.33 (1.32)
Education: mean (SD)	2.5 (0)	3.46 (0.5)	3.04 (0.26)	3.88 (0.13)	3.58 (0.72)	2.29 (1.12)
Research: mean (SD)	2 (0)	2.96 (0.82)	2.67 (0.94)	3.59 (0.61)	2.92 (0.5)	2.19 (0.44)

Table 3: Mean capability per pillar by band

ACP pillar	Band 6	Band 7	Band 8a	Band 8b	>band 8b
Clinical practice: mean (SD)	2.6 (1.33)	3.31 (0.65)	3.71 (0.26)	3.89 (0.16)	4 (0)
Leadership & management; mean (SD)	2.3 (1.17)	3.06 (0.65)	3.2 (0.76)	3.69 (0.31)	3.91 (0.16)
Education: mean (SD)	2.33 (1.2)	3.15 (0.54)	3.3 (0.72)	3.73 (0.5)	3.96 (0.07)
Research: mean (SD)	3 (0.66)	2.39 (0.45)	2.81 (0.88)	3.38 (0.8)	3.42 (0.4)

Table 4: Mean capability per pillar by highest qualification

ACP pillar	ACP pillar	Diploma & certificate	Bachelors degree	Masters degree	Doctorate
Clinical practice: mean (SD)	CS Mean	3 (1.41)	3.53 (0.36)	3.64 (0.74)	3.96 (0.06)
Leadership & management; mean (SD)	LM Mean	3.2 (0.62)	3.09 (0.59)	3.35 (0.89)	3.78 (0.06)
Education: mean (SD)	Ed Mean	3.13 (0.88)	3.22 (0.51)	3.39 (0.88)	3.75 (0)
Research: mean (SD)	Res Mean	2.69 (0.98)	2.5 (0.63)	2.95 (0.82)	4 (0)

Table 5: Percentage of responses per ACP practice challenge for each pillar and as a total

Challenge to ACP practice	Clinical practice %	Leadership & management %	Education %	Research %	Total %
No requirement or opportunity to practice in the current role	10.5	58.8	20	13	25.5
Lack of interorganisational support of the role	10.5	16.4			6.7
Lack of understanding about the ACP role remit	15.8				3.9
Demands of the routine clinical role	21.1	23.5	46.7	56.5	36.9
Limited access to appropriate and relevant study programmes and courses	15.8		23.3		9.8
Lack of funding for study programmes and courses	10.5	11.8		30.4	13.2
Lack of access to clinical mentorship and supervision	15.8				3.9