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Uptake of advanced clinical practice roles in the health service in England: Perspectives at the micro level

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ABSTRACT

Health care organisations in many countries are developing advanced clinical practitioner roles to address workforce shortages and growing demand for services. Even in countries where advanced practice roles are more established there are low numbers, clustered in a limited range of professions, mostly nursing specialities. Successful implementation of national policies encouraging increased advanced practice roles and from a broader range of professions, requires attention to all levels of the health system. There is a lack of evidence as to the motivation to take-up these roles at the micro, individual actor level. This study explored the motivations important at the micro level in influencing a range of health professionals to undertake advanced practice roles. The study used an interpretive methodology with thematic analysis and was framed by theories of motivational domains in the work environment. Semi-structured interviews were undertaken with eighteen advanced clinical practitioners working in health care organisations in England. The motivators for role take-up were found to be predominantly intrinsic reflecting participants' desires for advancement, both personal and for their profession, and improved efficiency of patient care. Participants described experiencing limited organisational support and sometimes discouragement from other professionals. There is potential for health organisations at the meso level of health care systems to support national growth of advanced practice roles by giving attention to the motivations of diverse health professionals. We propose a new theoretical framework of motivators for advanced clinical practice role uptake at the micro level.

1. Introduction

Health care organisations in many countries globally are considering strategies to address workforce shortages, particularly of doctors, and increasing patient demand for services (World Health Organization [WHO], 2016a). These problems are more prominent in consequence of the COVID-19 pandemic (Fraher et al., 2020). One organisational approach, advocated by the WHO (2016b, 2020a), is to introduce or expand the number of mid-level providers, more recently known as advanced practice providers (APPs), who are educated to a level to be able to undertake some of the medical activities of doctors within a prescribed scope of practice (WHO, 2018). APPs originate from two different pathways (Drennan, Collins, Allan, Halter, & Taylor, 2021). One being direct recruitment of individuals with further or higher education qualifications onto non-physician clinician training courses, such as physician assistants/associates. The second group, the focus of our study, are individuals with an existing health profession qualification and licence motivated to undertake further education and credentialling to an advanced clinical practice (ACP) level, such as nurse practitioners and extended practice physiotherapists. These types of health professionals exist in some but not all countries (WHO 2020b; Cawley & Hooker, 2018).

The presence of any professional group in a health care system and their jurisdiction in the provision of diagnosis, treatment and care is shaped by factors at the macro, meso and micro levels. Deriving from social science theory and analysis (Ritzer, 2011) and applied to health systems, the macro level refers to the overarching national system, structure and cultures, the meso level to organisational structures and cultures, and the micro level to the individual and their immediate work interactions (Fulop et al., 2001). Although there is international evidence

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of the influence of macro and meso level factors on the introduction, expansion or otherwise of ACP roles in health systems (Delamaire & Lafortune, 2010; Jokiniemi, Pietilä, Kylmä, & Haatainen, 2012), there is limited investigation at the micro level as to the motivations influencing the uptake of such roles. This paper reports on one study that focuses at the micro level on the motivations for uptake of an ACP role. We contextualise our work with an overview of the mediators operating at different levels of health systems on the development, scope of practice and uptake of advanced practice roles. We situate our study aim in this context before presenting the theoretical framing for the data analysis and interpretation, the methods, and study findings. We also propose a new theoretical framework of motivators for advanced practice role uptake at the micro level.

2. Background

It has long been recognised that the implementation of national policy is not simply the instruction from central government to the periphery (Pressman & Wildavsky, 1973). Actors (individuals and groups) at the micro and meso strata of the health system have agendas - frames of reference informed by different contexts - which impact on the extent of enactment (Gilson et al., 2014). The influence of the individual actors at the micro-level ('the street level bureaucrats') on the interpretation and enactment of policy is also widely understood (Lipsky, 2010).

Many commentaries note the influence of national health workforce policies on the development and number of ACP posts (OECD, 2016), but these in turn are dependent on the extent of support or opposition of other professional groups, most notably medicine (Cawley & Hooker, 2018; Eyal et al., 2015). It is not unexpected that new or extended practice roles might be contested. Health professions are part of an inter-dependent system (Abbott, 1998) in which activities and developments of one occupational group impact on others and are linked with issues of power, status and control. Accomplishing professional status is a strategy of limiting entry to and defending jurisdictional boundaries, supported by state legislation to ensure the highest financial and social rewards; medicine being the most successful exemplar (Larson, 1979). Consequently, development of any new roles for healthcare professionals represents a challenge since they may threaten existing professional jurisdictions and identities (Freidson, 1988, 2001). Abbott (1988) suggested that professions are shaped by three types of interaction: contests for jurisdiction between professions (inter-professional), the stratification and creation of hierarchies within a profession (intra--professional), and the influence of societal changes and state agency. Nancarrow and Borthwick (2005) further conceptualised inter-professional shifts as vertical or horizontal substitution between occupations in a hierarchical pyramid with medicine at the apex.

Healthcare role boundary disputes most commonly emerge between medicine and other non-medical professions seeking to acquire roles previously exclusive to medicine (King et al., 2015) and are particularly evident at the macro level of health systems. For example, reflective of differences in national level settlements between the professions of medicine and nursing, only a minority of countries legislate for nurses to have the authority to prescribe medicines (Kroezen et al., 2012). Additionally, at the meso level, there have been many studies in hospital and primary care settings of attempted changes between the work of doctors and other health professions, with evidence of negotiated, accepted and contested boundaries of jurisdiction (e.g., Allen, 1997; Borthwick, 2000; Drennan, Gabe, Halter, de Lusignon, & Levenson, 2017). There is also evidence at the micro level of confusion in role and professional identity among health professionals changing their role boundaries (King et al., 2015).

In this context, the presence of ACP roles varies greatly by country, region and professional group. In nursing specialities, ACP roles have a fifty-year history in Canada and the United States (US), and over thirty years in other countries including Australia, Belgium, South Korea, and the United Kingdom (UK) (Sheer & Wong, 2008). Over 70 countries worldwide have established or are exploring the possibility of introducing such roles for nurses (International Council of Nurses, 2022). Physiotherapy advanced practice roles have similar longevity, particularly in the US and the UK (Thompson et al., 2017). More recently ACP roles have developed across a wider yet still limited range of health professions including midwifery in the US, Europe and Africa (Goemaes et al., 2016), pharmacy in Australia, Canada, the UK and the US (Shalansky et al., 2019), and paramedicine in the UK (Jackson, 2012).

Regulatory advances or changes can potentially influence the motivation of individuals wanting to be in a profession (Gutacker et al., 2019). In response to regulatory and governance approaches the scope of ACP roles continues to evolve, with variation between countries and professions as to whether the roles are regulated by law (Maier, 2015). The nurse practitioner role, for example, is regulated in Australia, Canada, the Netherlands and New Zealand, but not in the UK (Carney, 2016). International studies also highlight that governance is crucial in implementing ACP roles effectively into the workforce. For example, regulation has been identified as an enabler to advanced practice if current with educational competencies (Maier, 2015).

England is one country in which there is policy support for health professionals to work at advanced practice level in its tax-funded National Health Service (NHS) and thereby to address medical workforce shortages and improve service delivery (NHS 2014; 2019). The policy is accompanied by workforce development finance for NHS provider organisations (known as trusts) to fund an increase in the number and range of health professionals trained as ACPs, including allied health professionals, health scientists and pharmacists, in addition to nurses and midwives (Health Education England [HEE], 2014; NHS, 2020). Underpinning the policy is a national framework for multi-professional advanced clinical practice which provides a definition and standards for the ACP role (HEE, 2018). Nevertheless, there remains no state regulation or licensing for ACP roles. The HEE framework specifies the ACP level of practice for health professionals already regulated by the Nursing and Midwifery Council or the Health and Care Professions Council. Responsibility for developing governance structures rests with each NHS trust resulting in inconsistent governance approaches and ACP competency arrangements. This has led to confusion around the role scope and expectations of ACPs (Fothergill et al., 2022), hindering workforce planning at scale (Evans et al., 2021).

Successful implementation of national level policies encouraging ACP role uptake across diverse health professions, not just nursing, requires attention to all levels of the health system. The motivation for health professionals to take-up new roles being influenced by factors operating at these different levels and how they interrelate (Köppen et al., 2018). However, there has been little attention at the individual actor level as to the motivation to undertake ACP roles, potentially in the face of contest from other professions. Our study addressed this evidence gap by investigating and reporting on the motivational factors that were important at the micro level in influencing a range of health professionals, working in English NHS health care services, to undertake advanced clinical practice. The research question addressed was: what are the motivations that influence health professionals at the micro level to take-up an ACP role?

3. Theoretical approaches to understanding health professional motivations at the micro level

In general terms, motivation within a work environment represents a psychological process that influences how personal effort and resources are assigned to work actions, including the direction, intensity, and persistence of such actions (Kanfer et al., 2008). Motivation is nevertheless complex, multifaceted, and multiply determined (Cerasoli et al., 2014). Workers have different kinds of motivation and vary in the orientation of that motivation (Ryan and Deci, 2000). Theories of how internal and external factors influence worker motivation are cumulative and multifarious, having evolved over decades from research across

different disciplines. Early theories include motivation-hygiene theory (Herzberg et al., 1959) that associates worker satisfaction with the intrinsics of what they do ('motivators') more than extrinsic environment ('hygiene') factors such as salary, supervision, working conditions and organisation policies. Herzberg et al. (1959) argue that while addressing 'hygiene' factors may remove the barriers to positive job attitudes, it is primarily 'motivators' that lead to work satisfaction by gratifying the individual's need for self-actualisation in their work. Hence, feelings of personal growth accompanied by a sense of increased responsibility, greater achievement of goals related to the doing of work, additional authority, and a collective purpose will help foster intrinsic motivation. Another early theory, Alderfer's existence, relatedness and growth theory (1969), centred on the motivating potential of jobs, and the relationship between engagement in stimulating tasks and the impetus to self-develop. Alderfer (1969) stressed that unlike Maslow's hierarchy of human needs from which this theory evolved, satisfaction of lower-level needs is not a prerequisite to drive efforts to achieve higher-order self--development needs.

Subsequent theories include self-determination theory (Deci & Ryan, 1985; Ryan and Deci, 2000) that draws distinction between different types of motivation based on the different innate psychological needs that drive action. Distinction is made particularly between intrinsic motivation, behaviours that are enjoyable and inherently interesting, and extrinsic motivation, behaviours undertaken because of consequences external to the individual such as obtaining a tangible reward. Deci & Ryan (2000) identified that individuals whose behaviour is internally regulated are more motivated, have more interest and persist longer in their efforts than those who are externally motivated. Intrinsic motivation is achieved when three fundamental and universal psychological needs are satisfied: autonomy - feeling a sense of choice or freedom from compulsion; competence - feeling effective and capable; and relatedness - feeling reciprocally respected and cared for in interrelation with others. Subsequently, Franco et al. (2002) developed a conceptual framework demonstrating that while intrinsic and extrinsic motivational processes in the work context operate at the level of the individual, determinants of these motivations originate at different levels: the internal individual, the organizational work context, and the broader societal and cultural context.

More recently, Pink's drive theory (2009) distinguishes three drivers of intrinsic motivation - autonomy, mastery, and purpose - that tend to operate once workers receive pay sufficient to meet their needs. Pink's theory suggests that in essence workers want to direct their own lives to progress and improve in areas that matter to them, but also to serve something with purpose and vision at a higher level than themselves.

Phipps-Taylor and Shortell (2016) recognised commonality across this broad theoretical context in that many of the theories attempt to categorise motivation into discrete domains. They identified overlapping concepts from nine such theories (including those described above), developing an overarching framework for conceptualising motivation for health professionals that encompasses six core motivational domains: mastery, autonomy and power, relatedness, social purpose, potential demotivators or hygiene factors, and financial motivators. In our study, we drew on the spectrum of theories around worker motivation at the micro level, considered in this section, to guide our data analysis and interpretation.

4. Methods

Qualitative semi-structured interviews were undertaken in the interpretive tradition (Crotty, 1998). The strength of the methodology was that it enabled exploration and understanding of the individual-level determinants motivating ACPs to undertake their role, and consideration of context in understanding their motivations; perceptions and behaviours being essentially linked to context in respect of location, time, and the work environment of the participant (Holloway & Wheeler, 2010, pp. 4–5). Guidance for ensuring quality when undertaking qualitative research (O'Brien et al., 2014) was used to assess transparency in methodological approach. The study was undertaken in NHS organisations in Greater London (population nine million) providing acute secondary and tertiary, community, and urgent and emergency care services, that self-identified as employing ACPs. Initial contact with these organisations was established by the study investigators, mainly with education leads or directors of nursing, to inform them about the study. The lead contact in each responding organisation was asked by the study investigators to forward an email invitation to all ACPs employed in the organisation. There was no predefined range of specialities. The email invitation included details about the study and the researcher contact details if the ACP was interested in participation. ACPs expressing interest were sent a study information sheet outlining the study purpose and what participation would involve, and a consent form. Participants could choose to be interviewed by telephone or face-to-face. A total of 21 ACPs expressed willingness to participate in the study and 18 (86%) from six organisations consented to be interviewed. Three ACPs withdrew before consenting due to work pressures. The study was undertaken between August and October 2019. Ethical approval for the study was received from Kingston University (FREC2019-05-007) and Middlesex University (H&SCS-CREC7075).

The interviews lasted 21–47 min (median 34). They consisted of open-ended questions with supplementary prompts to enable key issues to be explored without being prescriptive about content and direction (Pope et al., 2000). A topic guide was developed based on the study aims and informed by input from patient and public involvement representatives who were advisors to the study, and the literature on ACP role uptake and health professional motivations considered in earlier sections. It included questions on what the participant's current role involved and their perspective of what made the role advanced; their reasons for taking up the role; any personal and/or organisational motivating factors at the micro level; their role expectations; and their perception of what was needed and/or required of them to undertake the role. All interviews were audio-recorded and professionally transcribed verbatim, with transcripts proof-read against recordings.

Interview data were coded and analysed using thematic analysis (Boyatzis, 1998). An inductive approach to the thematic analysis was informed by the topic guide and extant theories on health professional motivations at the micro level considered in the previous section. Data were initially broken-down using line-by-line coding by three researchers (FT, HA, LC) and the codes clustered manually to identify preliminary categories. These were scrutinised and discussed with two other researchers (VMD, MH) who read transcripts from a sub-sample of interviews. Differences between researchers in how they coded the data were resolved by discussing the relevant sections of the transcripts and the conflicting codes until agreement was reached. A framework of themes was developed from the analyses, together with a code book, and used to structure verbatim responses onto a spreadsheet. Where data did not fit existing themes, new codes were developed or existing ones revised. This reflexive process of allocating data into themes (Koch and Harrington, 1998) was undertaken by one researcher (FT), supplemented by discussion with a second researcher (VMD) before full research team discussion. A further stage of analysis was undertaken (FT, VMD) to consider and interpret our inductive themes, in the context of existing concepts and frameworks on motivations for health professionals, before confirmation of themes.

5. Results

Eighteen ACPs participated in interviews. Ten participants were allied health professionals, seven participants were nurses, and one was a health scientist. They were employed across six study sites including two acute teaching hospitals, an urgent and emergency care service, two community care centres, and a district general hospital. The participants also worked across different medical/surgical specialities (Table 1). Twelve of the participants were female and six participants were male.

Table 1
Study participants by medical/surgical speciality.

Speciality	Number of study participants
Urgent and emergency care	2
Acute internal medicine	3
Other adult medical services	6
Musculoskeletal	5
Paediatric care	2

Seven participants were interviewed face-to-face and eleven by telephone.

Following data analysis, ten sub-themes were identified and grouped into three different motivational dimensions: (1) Personal and interpersonal motivations (career advancement; niche personal roles; greater control over decision making; improving patient care; strength of motivation); (2) Professional and institutional motivations (recognition; advancing the status of their profession; professional boundary conflicts), and (3) Structural influences (financial benefits; constraining factors).

5.1. Personal and interpersonal motivations

5.1.1. Career advancement

The desire to undertake an ACP role was closely associated for many participants with perceived career advancement opportunities. Some participants talked about these motivations in the context of ambitions to assume more senior responsibilities within their medical/surgical team, by advancing their learning and developing new skills. Other participants reported the attractions of an ACP role in terms of offering career progression within their chosen speciality; there often being few perceived opportunities to advance without leaving their organisation.

> *"One of the reasons I wanted to do this is that I was quite frustrated with the lack of opportunities for people to progress within the* [name] *service … and they then have to leave."* (ACP 13*)*

The attraction of being able to develop their career in new professional areas within their speciality was described by some participants. For example, one participant talked about the appeal of teaching a range of different health professionals, including doctors up to registrar level, by moving into an advanced role. Another participant reported that the opportunity to lead clinical research trials in their team was a key motivational factor. Additionally, a few participants described their ACP role as a stepping-stone to a longer-term career goal of becoming a consultant.

> *"I looked to develop within some of these advanced roles, so prescribing or injecting … I was already the 8A* [high-level NHS grade and salary scale], *but if I wanted to go on and become a consultant* [non-medical], *then these sort of skills are really important."* (ACP 8)

A few participants recounted feeling encouraged to follow an advanced practice route because they wanted to progress their career but were not attracted to a management role.

> *"I know as a clinical person I definitely want to stay in a clinical role. Because if you want to move up the banding* [NHS word for salary scales] *in the NHS historically and traditionally, it's been management and I don't want to do management … so when the ACP came up, I thought 'oh this is more me'."* (ACP 3)

Participants frequently mentioned putting themselves forward for opportunities to develop their careers rather than following a clearly defined career pathway. The absence of any career guidance and direction permeated many participants' accounts. They seemed to have forged their own individual career routes to often undefined ACP roles, reliant on self-direction.

> *"There is no set guidance of how the training has to go, nobody sat with me and said this is the expectation, this is how the role is going to be."* (ACP 9)

5.1.2. Niche personal roles

Being motivated to develop a niche or specialist role at an advanced level, subsequently integrated into a service pathway, was also reported by some participants. They individually seemed to have identified and developed a specific role associated with personal interests and/or clinical skills. For example, one participant talked about setting up a nurse-led cancer treatment clinic:

> *"The role that I'm in was developed because I came here and set up services and then everybody went, 'oh, that is like an advanced practice role' … but it was very much about doing it for me."* (ACP 10)

5.1.3. Greater control over decision-making

The opportunity for more authority over clinical decision-making was reported as an important stimulus to undertake their ACP role by several participants. Some talked about the attractiveness of independent clinical decision-making and being able to apply their knowledge directly to patient care without having first to get approval.

> *"I should be able to initiate* [clinical procedures] *without asking a doctor. That level of advanced work, more than a nurse … thinking advanced and then anticipating that there is a problem and working on it."* (ACP 2)

Others spoke about the appeal of being able to attend patients independently and without supervision. For example, a participant working in a neurological service had been spurred to undertake a non-medical prescribing course to be able to run patient outreach clinics without a doctor present.

Additionally, some participants described how expectations of being able to exert greater influence within their work environment had acted as a motivator. For example, one participant spoke about their anticipation that in an ACP role they would be working at a level where they could more effectively advocate on behalf of patients; their views on patient care being more likely to be listened to by colleagues. Another participant described the appeal of having greater influence on decision-making around service delivery:

> *"I think the motivation was to be able to have a bit more impact on services … the musculoskeletal services we operate and have some influence."* (ACP 16)

However, only one participant mentioned specifically seeking a formal leadership role; wanting to manage the work of their staff and be responsible for service developments.

5.1.4. Improving patient care

Having the opportunity to use their knowledge and capacity to improve the efficiency of patient care processes was integral to several participants' accounts of their motivations to pursue an ACP role. For example, one participant focused on the motivation of being able to use their knowledge of which patients would respond to physiotherapy and those who would need a different clinical pathway:

> *"Regarding the patients we see just improving the pathways that patients travel through, trying to improve the efficiency of their care."* (ACP 16)

Other participants reported being keen to meet more effectively the demands placed on their service because of increased patient volume. In this context, participants spoke about wanting to support medical consultants by taking on some of their clinical responsibilities and enabling more patients to be treated effectively and faster.

> *"They* [the consultants] *realise and are very respectful of the fact that if you can use and work alongside an advanced physio practitioner, that sometimes some patients are much better served to see us rather than them … that's why they created the role."* (ACP 12)

Addressing problems associated with the fragmentation of patient care had particularly motivated some participants. For example, the

motivation of one participant centred on delivering continuity of care in their medical speciality:

> *"Engaging women who would normally have fragmented care to have continuity of care … It was very much me seeing that those women weren't getting that holistic approach to their care and there were lots of gaps."* (ACP 14)

Another participant reported how awareness of ineffective support for the heavy symptom burden of cancer patients for whom they cared had prompted them to undertake a physical assessment and prescribing course. This enabled them to take-up an advanced practice position providing improved continuity of care for the management of patients' symptoms. Preventing patient use of inappropriate services had been a motivator for another participant who worked with musculoskeletal patients.

5.1.5. Strength of motivations

The strength of participants' personal motivation and commitment to advance to an ACP role was reflected in how they frequently talked about their behaviour and experiences. They variously described themselves as needing to be *"resilient", "bloody minded", "a fighter", "self-directed", "a pioneer",* and *"brave"*.

> *"It was completely self-directed. I didn't have a manager, a clinical manager above me to drive it* [the ACP role] *forward, so I had to do it myself."* (ACP 7)

5.2. Professional and interprofessional motivations

5.2.1. Recognition

Achieving recognition by their employing organisation for their skills and experience appeared to be an important contributory reason among some participants for taking up an ACP role. These feelings seemed especially salient for nurses. They often expressed frustration that their knowledge, sometimes built-up over many years, had been under-utilised in their previous role. Some participants talked about having had the capacity to undertake an advanced role for some time within their speciality, without this being acknowledged by their line managers.

> *"I felt I could offer more. I've been a nurse for 20 years, so I had a lot of experience from various different aspects of nursing, and I wanted to do more."* (ACP 1)

5.2.2. Advancing the status of their profession

Transcending the boundaries of their profession by taking on higher-status tasks traditionally performed by other medical/surgical professions was integral to some participants' desire to develop their ACP role, most notably nurses. They believed that demonstration and recognition of their capacity to undertake more advanced practice would raise the status of their profession. To illustrate their motivation for facilitating such change, some nurses, spoke about the incentive to take over roles and responsibilities previously medical consultant-led.

> *"I'm very specialised. Whereas before my role came into place, it would have been the* [medical] *consultants doing that work."* (ACP 1)

Other participants talked about pioneering a novel way of working within their profession, expanding the boundaries of care provided. One participant reported wanting to develop a new advanced role for a health scientist by undertaking clinical implant procedures; another had pioneered a novel remit for their profession:

> *"It's not within the [profession]'s remit … Rather than seeing a succession of different doctors and no one really understanding them or what's been going on for them, that whole journey is shared and that's a whole new way of working."* (ACP 14)

5.2.3. Professional boundary conflicts

There were also reports of role boundary tensions. In some cases, predominantly in nursing, participants' motivations to expand the boundaries of their profession were reported to conflict with the views of medical/surgical team colleagues who preferred to retain the traditional remit of their profession. Resistance and opposition from colleagues were described in different forms, overt as well as covert actions. For example, one participant reported encountering some passive resistance from nursing staff to their advanced role:

> *"If it's a doctor, they often help but if it's a nurse doing independent work, they're not for it … For example, a doctor finishes a consultation, they come, they take the patient out. But if I finish a consultation, I have to push the wheelchair out of the room. They won't help."* (ACP 2)

There were also reports, mainly from allied health professionals, of role boundary tensions with other professions. One participant, for example, described experiencing variable responses from the nursing and medical professions to *"pushing into their areas."* Whereas they talked about receiving the support of consultants and nurse colleagues *"where traditionally from a* [name of speciality] *perspective we've had strong roles,"* they mentioned in another speciality experiencing "*quite a lot of conflict … nurses are saying 'well we've always done that job' and it can cause quite a bit of friction because ultimately you're going to be competition for the future workforce."* (ACP 3).

Nevertheless, many participants describing tensions seemed prepared and motivated to manage the process rather than becoming demotivated.

> *"You can impinge on historical people doing particular roles … There can be disputes around who should be doing it, whether it is a nurse etc … And you have to take people on that journey with you."* (ACP 7)

5.3. Structural influences

5.3.1. Financial benefits

A small number of participants mentioned that securing a higher salary had been a contributory motivator to undertake their ACP role, although very few reported having had organisational commitment to support them with a funded ACP post. Some talked about financial benefits in relation to being able to stay in a clinical role and not needing to become a manger to advance their pay. Others mentioned the attractions of increased salary alongside career progression.

> *"I think there is also the financial aspect, so there is the opportunity to go into the higher pay grades with these roles. So sometimes you are capped in terms of if you stay as a general* [name of profession], *whereas if you move into advanced practice roles, obviously there is the pay progression as well as the career progression."* (ACP 11)

Receiving increased financial remuneration commensurate with their advanced skills and training was also reported as an incentive. One participant described having been prepared to leave their organisation for a better paid role after completion of their ACP training if not rewarded with a higher salary:

> *"Just to try and make that decision, I had a chat with the person who is now my line manager, who was responsible for bringing the role in. They gave me a guarantee that it would be a Band 8* [high-level NHS grade and salary scale] *role, so I would be paid what I felt I needed to be paid."* (ACP 4)

Furthermore, many participants - including those for whom financial benefits had not been an individual-level motivation - expressed a belief that if appropriately remunerated ACP roles were not available in an organisation, future advanced clinical practice graduates would likely leave to take-up such roles in other organisations.

> *"The training and education, they're all for supporting people to do these modules, but then retaining the staff at the end of it, because they'll go off*

and get an 8a job somewhere else, unless they're promised an 8a job here." (ACP 3)

5.3.2. Constraining factors

For some participants, their experiences were considered personally stressful, particularly in respect of finding the time and financial resources to study. The considerable time commitment required to complete their master's and/or specific ACP training modules was reported by several participants. Some talked about the pressures on work-life balance because of the need to study while working full-time and not always allowed study days. Others reported having to put in clinical practice time outside their assigned working hours.

"I worked a few Saturday nights, you know, as extra for free, just to try and get all the [clinical] *work done … a huge, huge commitment."* (ACP 1)

Another participant described the difficulties of self-directed training without wider professional support:

"This was like an individual thing that I was doing, rather than a group of professionals that are all doing the same … all of the coursework, essays, independent reading is all done in your own time, so it was challenging." (ACP 11)

Experiences of financial sacrifice were also reported by several participants because of the need to self-fund all or part of their training in the absence of funding support from their organisation.

Other challenges and difficulties reported by participants related to being a pioneer ACP in their profession or speciality. Examples included problems accessing clinical skills training opportunities, and challenges faced in sorting out role content and making it happen.

"It has been very challenging for me within my speciality. That there isn't a specialist pathway for me to follow." (ACP 15)

Furthermore, there was a sense from many participants that despite their personal continued motivation, and being passionate advocates for the ACP role, the challenging path they took to reach this position was one they would not readily recommend. They also stressed that organisations should consider how to mitigate these issues to avoid the demotivation of others.

6. Discussion

This study is the first to explore the motivational factors at the micro level influencing advanced practice role uptake, from the perspective of health professionals working across a range of health services, medical/surgical specialities, and professions. Our study participants strongly emphasised motivating drivers that were intrinsic to the individual. Their ACP roles seemed often to have developed in a non-strategic manner with individuals on a self-selection and self-driven basis putting themselves forward to pursue advanced practice; indicating limited encouragement for role take-up from the institutional (meso) level of the health system.

The desire to progress their career and self-develop by gaining new skills or utilising existent skills were key motivators for many participants. These motivations accord with the motivational influence of mastery, the desire of individuals to improve, gain experience and get better at what they do (Pink, 2009). Evidence suggests that individuals with intrinsic motivational tendencies will naturally be inclined towards independent masterly-related behaviour (Ryan and Deci, 2000), being driven to apply comprehensive knowledge and skills to see personal improvement (Phipps-Taylor and Shortell, 2016). This is exemplified in our study where participants were sometimes motivated to advance their clinical skills while staying in their chosen specialist area of practice, or in connection with a niche role to fit distinct medical/surgical team or local service needs. Similarly, advanced nurse practitioners in the UK have been identified as being motivated to advance their nursing career while staying clinically focused (Kerr & Macaskill, 2020). Although advanced clinical practice is viewed in policy as a level of practice rather than a specialist skill in England (HEE, 2018), it seems that in this study some participants were driven to work in more specialist as opposed to generalist roles.

Our findings showed that many participants were motivated to exercise their initiative and utilise their skills more constructively, by developing roles to improve patient care through increased effectiveness of care delivery. There was anticipation of greater personal satisfaction as they could perceive reason and value in what they would be doing for patients. These motivations are closely related to concepts of purpose (Phipps-Taylor & Shortell, 2016; Pink, 2009), characterised in the healthcare context as the joy and satisfaction of doing what matters to patients by helping and supporting their quality of care. These findings suggest that more attention to this important intrinsic motivator for health professionals may help support initiatives to improve the care quality and efficiency of health systems (WHO, 2016a).

Autonomy, through having control over the content, direction and setting of your work has also been identified as a core intrinsic motivational domain (Deci & Ryan, 1985; Pink, 2009); associated with "a feeling of volition" rather than independence or individualism (Deci & Ryan, 2008). Advanced practice is characterised by a high degree of autonomy (HEE, 2018) and during the COVID-19 pandemic ACPs often worked with increased autonomy (Morley et al., 2022). Some participants in this study described perceived opportunities for more personal authority and influence over decision making as an important component of their motivation to undertake an ACP role. Gaining of the ACP role was considered a reward in terms of recognition of their skills and experience by several participants, in particular nurses. Others expressed their motivation for more autonomy and power from a professional rather than individual context. Advancing the status of their profession by undertaking responsibilities previously led by other disciplines was shown to be a significant motivating influence for these participants. It is well established in the literature that nurse practitioners in advanced practice roles can experience jurisdictional boundary disputes and protections (Allan & Barber, 2004, 2005; Carney, 2016). Our evidence suggests that in some cases study participants perceived doctors as accepting a move into their traditional jurisdiction, content to retain only supervisory control because the ACP role was thought to contribute to medical/-surgical team efficiency. However, there were other participants, particularly nurses, who appeared to experience what Abbott (1988) referred to as dynamic inter-professional tension in jostling to provide vertical substitution (Nancarrow & Borthwick, 2005), as well as some evidence of the 'professional project' (Larson, 1979) whereby professions protect themselves from 'outsider' competition by exerting control over the education, regulation, work status and ideology of their profession. Insights from these worker motivations at the micro level arguably provide an additional lens through which to understand not only the evolution of ACPs but professions in general, and the boundary-linked behaviour engendered.

Most participants were motivated by new or existing ACP roles within the medical/surgical team of which they were already a part. This is likely a result of the undertaking of their ACP roles being mainly individual - rather than organisation - led. Hence the strength of participants' association and loyalty to their employing organisation appeared quite weak. Some participants mentioned that they or colleagues were prepared to leave their organisation to achieve their motivation of undertaking an ACP role. This is in line with existing evidence that shows intrinsically motivated health professionals have greater commitment to their organisation if it is viewed as instrumental in helping them achieve their professional goals (Cardador et al., 2011).

The motivations underpinning a participant's take-up of an ACP role had frequently stimulated considerable personal commitment, tenacity, and drive to succeed. Significant levels of time and financial investment were reported. Many participants also described work-related stress and

compromised work-life balance. These findings suggest that the conditions surrounding the 'doing' of an ACP role, the 'hygiene' factors, were not a core motivational influence for our participants. Of more value was the performance of the role; "an actuating approach rather than avoidance behaviour" (Herzberg et al., 1959, p. 114). Research has found that the extent to which something is intrinsically motivating will fuel the direction, intensity, and persistence of work motivated behaviour even under inhibiting conditions (Kanfer et al., 2008, p. 163). Intrinsically motivated behaviours are inherently purposive and provide sufficient reason to persist (Pinder, 2011). Such motivational-inspired persistence will encourage staff to engage on their chosen behaviour for longer periods of time beyond the point at which they are rewarded (Deci & Ryan, 1985). More negatively, our findings revealed reports of stress among some participants because of the extent of their commitment. Evidence suggests that while strength of purpose is strongly associated with health professionals, intrinsically motivated clinicians can risk burnout if they feel their work environment inadequately supports their goals and values (Norton, 2018), although burnout may be reduced by fostering an environment that supports intrinsic motivation and improves work hours (Tung et al., 2020).

Many study participants identified themselves as pioneers and early adopters of the role and expressed concern that the next generation of health professionals inspired to undertake ACP roles may become demotivated by some of the negative factors they experienced, particularly time and financial pressures. Although only a few participants mentioned financial incentives in wanting to take-up an ACP role, some believed that the health professionals currently training in advanced clinical practice would leave their organisation if there were not suitably remunerated ACP roles available for them at graduation. Existing evidence suggests that monetary incentives and intrinsic motivation are not necessarily antagonistic; they can co-exist persuasively (Cerasoli et al., 2014; Chandler et al., 2009), enhancing intrinsic motivation if the interpersonal context is informational and supportive of autonomy (Deci & Ryan, 2008).

Consideration should be given to the generalisability of our findings. We investigated volunteer participants who were self-selecting rather than purposively recruited which may have introduced some partiality into the study sample. However, participants characterised diversity in both the health care organisations and medical/surgical services in which they worked. Although the inclusion of multiple study sites is likely to have minimised any partiality that may have arisen from local context, the study was undertaken in only one area of England, Greater London. We also reported the experiences of mostly early adopters of the ACP role and cannot rule out that factors motivating later adopters will be different. Additionally, there is value in future studies exploring any apprehension that ACPs had about the role and how they felt it might be different from their earlier role.

Nevertheless, a strength of this qualitative study is that theoretical framing supported data analysis and interpretation. Furthermore, the new empirical evidence offered by the study underlines the complexity at the micro level of health professional motivation to undertake an ACP role, and the need for a new, more comprehensive theory that encompasses the range of influential motivational factors across different professions. The insights provided suggest four primary intrinsic motivators at the micro level for advanced practice role uptake, three of which accord with those included in Phipps-Taylor and Shortell's (2016) framework of combined motivational domains – 'mastery', 'autonomy and power', 'social purpose' – and a fourth motivator, 'advancing the profession', associated with Abbott's (1988) theory of the system of professions with shifting professional boundaries linked to increased status. Additionally, we identified two secondary motivators: 'relatedness', also included in the framework of Phipps-Taylor and Shortell (2016), and 'financial benefits'. This proposed new theoretical framework of motivating drivers for take-up of advanced practice roles (Fig. 1) requires further investigation and testing in larger-scale studies across a wide range of health professional groups and involving both early and later adopters of the role.

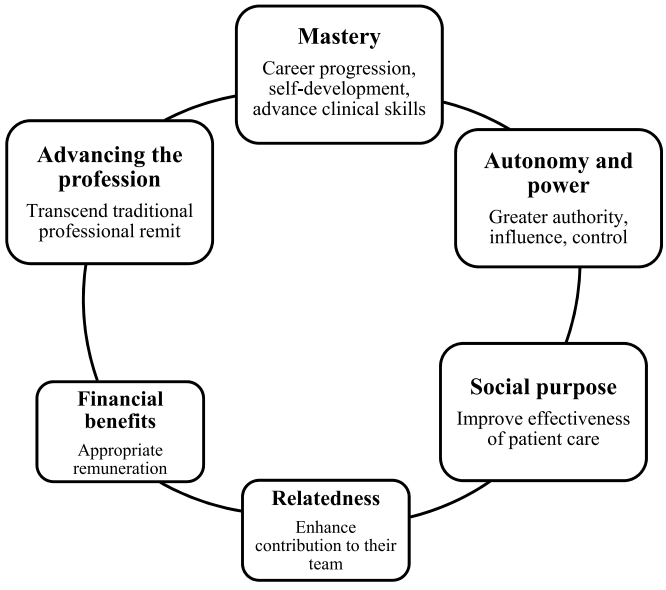

Fig. 1. Framework of motivators at the micro level for advanced practice role uptake.

7. Conclusion

Health care organisations in many countries globally are considering strategies to develop advanced practice roles, to address workforce shortages and the growing demand for services. Successful implementation of national or provider level policies encouraging advanced practice role uptake across diverse health professions, not just nursing specialities, requires attention to the motivations at the micro, individual actor level, to undertake such roles. This qualitative, multi-site study, the first to explore the motivational factors at the micro level influencing advanced practice role uptake, from the perspective of a range of health professionals, identified that early role adopters were predominantly motivated by intrinsic factors. These motivational factors reflected participants' desires for advancement, both personal and for their profession, and improved efficiency of patient care. Insights from our study suggest several primary and secondary motivators at the micro level for role uptake, brought together in a proposed new theoretical framework. Individuals seemed to have put themselves forward on a self-selection and self-driven basis to pursue advanced clinical practice, with limited organisational encouragement despite supportive national policies. There is the potential for health care organisations at the meso level of health systems to support national growth of advanced practice roles by giving attention to the motivations of diverse health professionals at the micro level.

Ethical statement

The study received ethical approval from Kingston University (FREC2019-05-007) and Middlesex University (H&SCS-CREC7075). Written informed consent was obtained from each interview participant.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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