Surfacing the tensions in the advanced nurse practitioner role in a secondary care hospital: a situational analysis study

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Marianne Jenkins

Summary

Advanced Nurse Practitioner roles have developed over the past thirty years in response to changes in healthcare services and lack of medical staff. Despite an increasing body of evidence regarding advanced nurse practitioner roles there remains challenges and misunderstanding regarding training, skills, scope of practice and safety. The aim of this study is to increase the understanding of this role (Advanced Nurse Practitioner) within an organisation (secondary care hospital). In recognition of the complexity of healthcare systems a method and methodology that can capture this complexity has been applied. Situational analysis is an evolution of grounded theory and uses a cartographic approach to illustrate the situation being examined, there are three types of maps produced from data analysis to provide an in depth understanding of the situation:

- Situational map – sets out the major discursive human, nonhuman, and any other elements in the situation of inquiry.
- Social world/arenas map – a meso-level interpretation of the negotiations that the collective actors and key nonhuman elements are engaged in.
- Positional map – lays out the positions taken or not taken in the data as per key axes of contention within the situation of inquiry and its identified issues.

A post-modern lens was applied to analyse data gathered from focus groups, interviews, and discourse within the organisation. The positional maps laid out the points of tension regarding the advanced nurse practitioner role in secondary care with the overarching concept of professional identity recognised as the source of this tension. The tension was underpinned by a lack of career pathway and conflicts between scope to practice and barrier to practice. This study has laid out the advanced nurse practitioner role in a secondary care hospital to better understand the tensions in this role. This new knowledge can better inform higher education institutes to ensure concepts of professional identity are addressed during advanced practice training. It will also inform workforce policies by providing more understanding of the Advanced Nurse Practitioner role, scope of practice and need for visibility of the role. The results of this study will provide a foundation for further research into the professional identity of Advanced Nurse Practitioners.

Conference Presentations

The following conference presentations were undertaken during the process of completing this study:

Jenkins, M. Capturing complexity – how to surface the tensions in the advanced nurse practitioner role. *Royal College of Nursing International Nursing Research Conference* Online 7th – 9th September 2021

Jenkins, M. Who am I? Surfacing the tensions in the advanced nurse practitioner role in secondary care – A situational analysis. (Poster) *Royal College of Emergency Medicine Advanced Clinical Practitioner Conference* 18th May 2023

Acknowledgments

At times this study has felt like the loneliest experience in the world but in fact it is the culmination of a 36-year career from student to consultant nurse that has been full of people. Starting out as a student nurse in 1987 I was part of the certificate in nursing era where learning was experiential, and I was salaried to work while training. It was not recognised as studying to be a nurse. Experiencing the changes in nurse education, professionalisation and increasingly challenging health service environment over the past 36 years, has been personally and professionally life changing. This thesis reflects the nurse I have become with all the influences of the amazing colleagues I have had the pleasure and honour of working with.

This was a self-funded study that started with a temper tantrum and was continued in stubbornness, and I am hopeful that the influence it has already had on advanced nurse practitioners will continue for the future. I am very grateful to my husband for letting me raid our savings and spend it on education instead of shoes for a change.

Recognition of those who have been instrumental in pushing me over the finish line and completing this work is needed. I am incredibly grateful to those who gave their time during a global pandemic to participate in this study, without whom this would never have been written. I am grateful to those colleagues who have become friends, their encouragement, support, and tolerance has kept me sane, and I am indebted to them.

I have been lucky enough to have the best supervisors ever in the form of Dr Jane Harden and Dr Sarah Fry. Their good humour, dog stories and ability to challenge and support me simultaneously will never be forgotten.

This doctoral journey represents the last six years of my life where I have changed jobs (three times) and experienced the life trio of births, deaths and marriages. I dedicate this work to my darling Dad, who did not get to see me finish writing my essay.

Glossary, explanation of terms and abbreviations

There are numerous terms and abbreviations used in this thesis and I have endeavoured to explain them in the text. This glossary has been written to assist the reader in easily identifying the definition or explanation of terms or abbreviations, supporting consistent use, and understanding through the thesis.

ACCP/advanced critical care practitioner: This is the title for an advanced practitioner who works in critical care and has completed the ACCP training programme developed by the Faculty of Intensive Care Medicine (FICM).

ACP/advanced clinical practitioner: The Health Education England (HEE) definition of advanced clinical practice has been used:

> 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. (HEE, 2018 p8)

ANP/advanced nurse practitioner: The National leadership and innovation agency for healthcare (NLIAH) has been used:

> A role, requiring a registered practitioner to have acquired an expert knowledge base, complex decision-making skills and clinical competencies for expanded scope of practice, the characteristics of which are shaped by the context in which the individual practices. Demonstrable, relevant Masters level education is recommended for entry level (NLIAH, 2010 p21).

Cased based discussion: this is recognised assessment method to identify a healthcare professionals' clinical knowledge. The individual formally discusses a patient history, examination, investigations and treatments and identifies their current knowledge as well as acknowledging learning to be completed.

Clinical nurse specialist: this is a recognised nursing role that reflects a clinically expert nurse in a specialist area of practice such as diabetes, heart failure. The role develops to meet service needs and they have a level of autonomy and responsibility for patient care. This role reflects a specialism not a level of practice.

Diagnostic imaging – this is term to encompass all aspects of radiology investigations to assist the healthcare practitioner in formulating a diagnosis. This covers plain film imaging, commonly known as X-rays, non-plain film imaging which includes CT (computer tomography) USS (ultrasound scans) and MRI (magnetic resonance imaging). The positive or negative findings are used as part of the history taking and clinical assessment to provide a diagnosis for patients.

FICM/faculty of intensive care medicine: this is the professional and statutory body for the specialty of intensive care medicine. Its membership includes the doctors who lead and working in intensive or critical care as well as Advanced Critical Care Practitioners and Critical Care Pharmacists

Independent prescriber or non-medical prescriber (NMP): The Royal Pharmaceutical Society definition has been used:

> A prescribing healthcare professional who is responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing
> (RPS, 2021 p21).

Job plan – this is an agreed division of working hours across the contracted weekly hours. Advanced Nurse practitioners should have a split of 80% clinical hours and 20% non-clinical hours. The clinical hours would be service delivery and non-clinical would be to engage in teaching, service improvement, research or audit.

Junior doctor – this refers to any doctor below a consultant. Junior doctors are qualified doctors in clinical training, having completed a medical degree and foundation training. They would have up to eight years' experience working as a hospital doctor, depending on their specialty, or up to three years in general practice, they all work under the supervision of a senior doctor (British Medical Association, 2022).

Micro-level: for the purpose of this study this refers to the interpersonal level of interaction based upon Clarke et al (2018) definitions.

Meso-level: for the purpose of this study this refers to the social, organisational and institutional interactions based upon Clarke et al (2018) definitions.

Macro-level: for the purpose of this study this refers to the broad historical patterns such as industrialisation, transportation or globalisation based upon Clarke et al (2018) definitions.

Multidisciplinary team: this term is a commonly accepted term to describe the wider group of healthcare professionals working in conjunction to deliver patient care. This team would usually be a combination of nurses, doctors and allied healthcare professionals according to the needs of the patient.

Nurse practitioner – this is a nebulous title that sometimes reflects a shortened version of advanced nurse practitioner. It can also refer to an experienced nurse with an expanded scope of practice but without underpinning Masters level education in advanced clinical practice. The role is often clinically focussed only without any evidence of the other three pillars being met

Tier two – this refers to a level of seniority on the medical workforce rota associated with a doctor who has completed foundation and core training and is now on a speciality training programme. It refers to someone who is a senior decision maker at a level below a consultant.

Tier one – this refers to newly qualified doctors undergoing their foundation level training on a medical rota, and they would be on a tier one rota until foundation and core level training has been completed. Doctors at this level would have limits on whether they can discharge a patient independently.

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Chapter 1 – Introducing the study.

1.1 Introduction

As a professional group, Registered Nurses and Midwives account for almost two thirds of the healthcare workforce across Europe (World Health Organisation, 2022). Despite the overwhelming numbers of nurses and midwives, they have historically been misrepresented as 'handmaiden' to doctors (Garcia and Qureshi, 2021). However, over the past four decades there has been a slowly developing role that reflects an experienced nurse with additional skills that overlap with the medical model of assessment and care (Hill, 2017) titled advanced nurse practitioner (ANP). ANP roles have evolved and developed to meet changing patient and service needs, with experienced nurses applying a senior level of autonomous patient care with advanced skills in clinical assessment, diagnosis, and decision-making. The individual also possesses equivalent advanced skills in education and teaching, research and audit, as well as leadership and management to fulfil the four pillars of advanced level practice. Initially these roles evolved organically to meet the bespoke needs of the individual service with the main driver being to address inequalities in healthcare provision (Griffin and Melby, 2006). Hanson and Hamric (2003) notes that, historically, nurses set the foundations for this by previously taking on clinical tasks where there was a lack of doctors or doctors did not want to perform the task.

Subsequently, changes in medical and nursing careers and training, combined with a political focus on developing nursing and allied health professionals' roles, changed the drivers and contributed to the blurred professional boundaries (Dalton, 2013). This blurring of the boundaries and a lack of clarity about the role has meant these advanced practice roles have developed against a background of variety and confusion. The past decade has seen an attempt to define, understand and standardise the role across the UK with Wales (National Leadership and Innovation Agency for Healthcare (NLIAH), (2010), Scotland (Scottish Government, 2008), England (Health Education England (HEE), 2017), and Northern Ireland (Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC), 2016) having their own national frameworks for advanced level practice. Despite these frameworks, there remains inconsistency with how the roles are created and there is ongoing confusion about what advanced level practice is. This confusion extends

across departments and organisations, and it influences the experience of the advanced nurse practitioner in their day-to-day role.

This study reflects a personal response to organisational requirements to be able to fulfil the job I was appointed to. My journey as an advanced nurse practitioner started twenty years ago with extended skills and delegated responsibility for discharging patients in my role as a nurse practitioner in acute paediatrics. The lack of vision and support from the nurse manager restricted the development of the role at the time so I moved into a management role until I returned to clinical practice over a decade ago. As an addition to an MSc in Nursing Studies, I successfully completed an Advanced Clinical Practitioner MSc programme, which included Independent Prescribing. I am registered with the Nursing and Midwifery Council (NMC) as both an adult and children's nurse, having completed both training programmes at the beginning of my career. My advanced clinical practice portfolio holds evidence of advance practice skills in both adults and children. I have worked as an advanced nurse practitioner (ANP) in Adult (General Surgery) and Paediatric (General Medical Paediatrics) and in Emergency Medicine (Adult and Children) and my current role is Consultant Nurse Practitioner in Emergency Medicine (Adult and Children).

It was in my ANP role in paediatrics that the concept of competence was identified as a challenge in the ANP world. I had to demonstrate competence in autonomously discharging patients from the children's assessment unit, which involved being supervised and assessed managing children with a defined list of clinical conditions. Approval was given by my supervising consultant once I had the requisite number of cases. However, for the two years prior to this, I was autonomously discharging the same group of children with the same clinical conditions in my role in the emergency department. Both jobs had the same core job description, title and banding, and were in the same organisation. This triggered a reflection on the concept of competence – if I was competent to discharge a patient in one department, how did I lose my competence to do it in another? The desire to understand and articulate this as a challenge to being an advanced nurse practitioner in a secondary care hospital was the spark for this study.

It should be acknowledged that this study was undertaken during the global pandemic caused by the COVID-19 virus and the influence of the pandemic on the study is recognised in the limitations section as well as in text, where required.

1.2 What is advanced nursing practice?

The International Council of Nurses (ICN) defines the global version of advanced practice nursing as being:

> An Advanced Practice Nurse (APN) is one who has acquired, through additional education, the expert knowledge base, complex decision-making skills and clinical competencies for expanded nursing practice, the characteristics of which are shaped by the context in which they are credentialed to practice.
>
> (ICN, 2008)

Following on from the international work on advanced nursing practice, NLIAH (2010) was commissioned by the Welsh Government to develop the Framework for Advanced Nursing, Midwifery and Allied Health Professional Practice in Wales. This framework was based on similar work from Scotland (Scottish Government, 2008) and was widely recognised as a framework that influenced and established advanced practice roles in Wales (Hill, 2017). NLIAH (2010) gave a definition of advanced practice as:

> A role, requiring a registered practitioner to have acquired an expert knowledge base, complex decision-making skills, and clinical competencies for expanded scope of practice, the characteristics of which are shaped by the context in which the individual practices. Demonstrable, relevant master's level education is recommended for entry level (p21)

To demonstrate the senior level of experience and responsibility, the advanced nurse practitioner is required to develop and maintain a portfolio of evidence across the four pillars of advanced practice:

- Clinical
- Education
- Research and audit
- Management/leadership

It is accepted that the individual job plan would not require equal time for all four pillars, with some advanced practitioners having a dominant clinical pillar while others may have a dominant research pillar. However, the ANP is required to demonstrate the same advanced level of practice in all four pillars (NLIAH, 2010).

The advanced practice definitions and frameworks developed and used across the UK are consistent in the principle that advanced practice is a level of practice, and that masters level education is a minimum requirement (Scottish Government, 2008; NLIAH, 2010; NIPEC, 2016; HEE, 2017). To support the autonomy of the role, the master level education includes an independent prescribing qualification which is registered with the Nursing and Midwifery Council (NMC) (2023) alongside the existing professional registration. Requesting diagnostic imaging is another key skill and requirement of ANP roles (Royal College of Nursing (RCN), 2021). Traditionally these skills (prescribing and diagnostic imaging requesting) have only been held and owned by medical staff. Conducting a 'medical interview' and making a diagnosis has historically been the purview of doctors, however, the blurring of professional boundaries has seen this key interaction with patients transition notably into the domain of advanced clinical practitioners (Diamond-Fox, 2021).

ANPs have an expanded scope of practice which reflects a broad skill set and this is evidenced in a portfolio in which they demonstrate their competence in the skills to meet their role (Cooper and Lidster, 2021). However, there is a lack of consensus as to what being competent in this context signifies, and this concept of competence was part of the impetus for the study.

1.3 Competence

The concept of competence was identified as potential reason for the challenges with the ANP role when I had to prove existing abilities because of a change of department. Conceptually competence has evolved from the early 1970s approach of using education and training as a means of improving skills and knowledge of the workforce into the higher-level approach of corporate strategic development, human resources and innovation (Weigel et al, 2007). The Oxford English dictionary (online 2023) defines competence as a '*sufficiency of qualification; capacity to deal adequately with a subject*'. This implies adequacy, not excellence or expertise, which is the language used for the level of practice required as an ANP. Simple definitions such as this are reductive to the complexity and context that competence is measured in the secondary care setting.

There is a dichotomous aspect to competence as one is either competent or not (otherwise recognised as incompetent) (Erault, 1994). This is reductive when contextualised with the development of skills, knowledge, and experience over time,

and on a continuum, as recognised by the novice to expert approach widely accepted in nursing. Benner et al (2009) identified the stages of skill acquisition in nursing and NLIAH (2010) applied this to the portfolio for advanced practice as a means of assessing levels of skills as part of self-assessment. This does not align easily with advanced clinical practice given the years of experience required to apply for an ANP role, combined with a three-year MSc in Advanced Clinical Practice qualification. Benner (1984) identifies competence at two years in a role, however, an ANP would have at least eight years' experience and training, and still be questioned about competence.

Defining competence has remained elusive and nebulous (Yanhua and Watson, 2011), with the repeated attempts to define it adding to misunderstanding and inconsistency (Levy-Malmberg and Hilli, 2014). Accepting that competence is contextual, there have been various approaches to develop profession-specific definitions. Epstein and Hundert (2002) explored doctors' professional competence, identifying personal attributes and recognising the developmental, transient, and contextual dependence of competence. This led to the development of multi-modal assessment strategies to capture professional competence over several domains, noting that competence relies on an ability to apply expert scientific, clinical, and humanistic judgement in the context of clinical reasoning (Epstein and Hundert, 2002). Brockmann et al (2011) applied this multi-dimensional approach to competence in the wider workforce market as well as occupational groups.

This reinforces competence as a more complex concept, not the simplistic concept of adequately dealing with a subject. Weigel et al (2007) argue that the inconsistency in definitions of competence, professionally and globally, does not reduce the validity of it as a concept. The increasing need for higher levels of education, in conjunction with an ability to function independently and responsively to the fluctuating challenges and changes in the modern workplace, has broadened the understanding of what it means to be competent in the workforce (Weigel et al, 2007).

An alternative approach using capability instead of competence has been explored. Gardner et al (2008) undertook a series of qualitative research studies into the concept of capability regarding the abilities of an ANP. The argument was that capability reflects an ability to act effectively and with confidence in both predictable

and unpredictable situations, making judgements and decisions (Gardner et al, 2008). Despite the ambiguity regarding the meaning of competence, which is compounded with it being used interchangeably with the term's competency and competencies, it is found throughout the multi-professional frameworks for advanced clinical practice.

Associated with the concept of competence is the challenge of measuring or assessing it so it can be demonstrated in whatever context it is required. Nursing often takes a behaviourist approach and assesses abilities in relation to skills and tasks (Garside and Nhemachena, 2013). Gardner et al (2008) recognised this as a reductive approach, especially when assessing highly complex practice enacted by an ANP with an MSc in advanced clinical practice. A reflection of this reductive approach is noted in work exploring the benefits of a competency framework. Stanford (2016) describes competency as the combination of skills, knowledge, attitude, and leadership that form capabilities. Coupled with this is a competency framework which reflects a group of defined behaviours to guide a structured approach to identification, development, and evaluation (Stanford, 2016). This is again an oversimplification of the complexity of the ANP role.

Key work by Erault (1994) talks of competence being the intersection between professional knowledge, skills, and personal attributes. ANPs have a foundation of nursing knowledge to underpin the overlaying of the advanced practice knowledge which is developed in the context of experience and formal academic work. As part of the ANP role, there is development of shared skills with doctors, notably clinical patient assessment and diagnosis. However, the medical training approach to assessment of competence is based on the understanding that the doctor has a degree in medicine. This makes for a poor fit when assessing the abilities of a nurse, physiotherapist, or any other advanced practice professional. Applying the medical model of assessment advocated by Royal Colleges can further fuel the perception that ANPs are a replacement workforce. This has been seen in the development of the Royal College of Emergency Medicine (RCEM) Advanced Clinical Practitioner (ACP) curriculum (2022) and credentialing process. In the world of ANPs, the requirement is masters level education to provide the transition to qualification process, with successful completion of the course and a portfolio to evidence skills,

knowledge, and abilities. In essence the portfolio reflects competence, however, the mandate and licence to practice is variable and unclear.

Associated with this concept of competence is who approves the competence of the ANP – doctors, nurse managers, higher education institutes are all involved in the training and supervision of ANPs. This now situates competence in a power play, where someone has power over the ANP to declare them competent or not. This study is concerned with the tensions in the role and if it is shown that competence is a reason for the discomfort in the role, it could be suggested that power is the source of the tension.

1.4 Secondary care hospital as a complex adaptive system

Secondary care hospitals are often part of wider organisations – health-boards or trusts and reflect both local and organisational policies and culture. ANP roles in secondary care settings encompass several different services and specialities such as acute oncology, general surgery, paediatrics, emergency medicine, critical care (adult and paediatric), neonatal intensive care. The aim of this study is to identify and articulate the challenges of the ANP working within a large organisation in a role that is poorly understood. This setting is comprised of a physical space where 24-hour 7 day a week care was being provided to patients across multiple wards and departments. Hospitals and healthcare are increasingly recognised for the intricacy of organisations they are and, while exploring concepts such as chaos theory and complexity, the concept of complex adaptive systems theory was identified. This theory describes complex adaptive systems as self-organising, non-linear, responsive systems working across multiple layers towards a shared goal, without the need for singular direction (Kernick, 2004). This struck a chord with the ANP role weaving in and out of services and departments to provide patient care. To explain this in simpler terms the analogy of bees in a beehive is used as it reflects the shared goal of a self-directed responsive system that is complex in its nature.

Work by Strauss et al (1997) explored the social organisation of medical work and describes further the interplay of staff and systems in healthcare. This resonated with my experiences and influenced the choice of a whole hospital being the focus of the study rather than a single service or department. It is noted that ANPs self-organise in their roles, responding to competing service demands and needs of patients, moving fluidly across the nurse-doctor boundary (McDonnell et al, 2015). Using a

whole hospital approach this study of the ANP role allows for the social organisation of the work to be identified, and the influence of that on the ANP role revealed. It is in this seminal work by Strauss et al (1997) that the differentiation in the roles and work of doctors and nurses was articulated with the concept of 'negotiated order' being identified. It could be suggested that the ANP role disturbs this negotiated order of work between doctors and nurses. Is this the source of tension?

1.5 History of advanced nurse practitioner role.

To understand the current challenges in the ANP role, it is necessary to understand the evolution of the role. The following section identifies the key moments in the history of nursing and development of the ANP role to help set the scene for this study. These key moments mark critical junctures representing moments in time where change occurs because of alignment of previously unrecognised factors. Hogan (2019) comments that a critical juncture recognises the influence of the past in clarifying the present, emphasizing the importance of having a broad historical perspective. A comprehensive history of nursing is unnecessary, instead recognition of the key changes that have influenced and moved the nursing role forward, or held it backward sets the scene for this study.

To avoid a positivist linear approach to history a Foucauldian genealogical approach was taken to expose the critical junctures that influence nursing development and reveal the positions of influence within a concept. The concept is situated in the 'history of the present', which should help reveal the relationships in the ANP world, particularly since a genealogical lens explores a problem, not a linear timeline. This is achieved by de-normalising recognised roles, organisations and the accepted thoughts and actions. Foucault challenges us to be free beings by applying critical ontology to perception of self and look beyond confines of the present (Kendall and Wickham, 1999). It is the ultimate 'outside the box' thinking approach.

Based on Hallett's (2007) overview of nursing history as a social context the following simple figure was developed to identify the key concepts and historical junctures that influenced nursing.

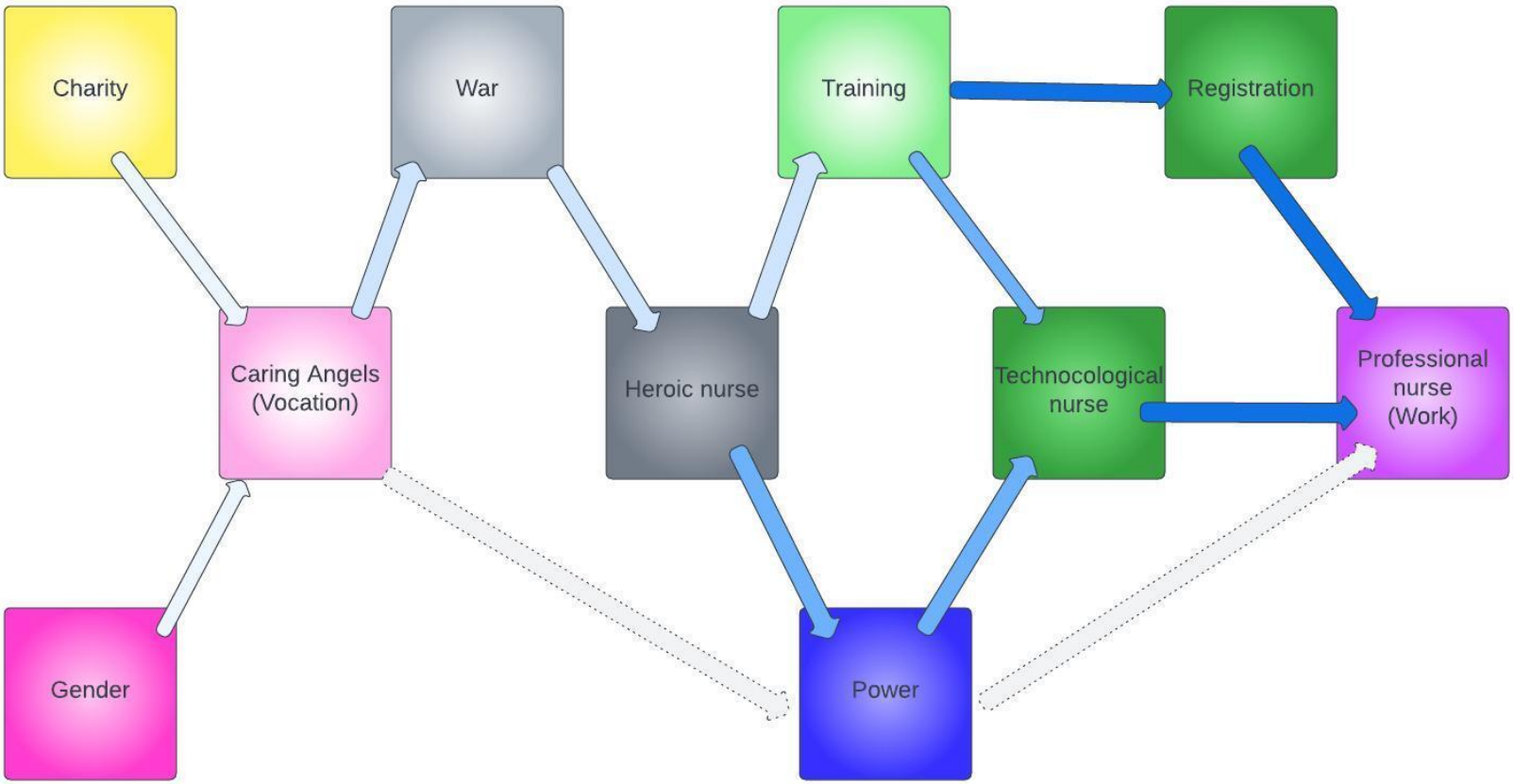


Figure 1 – The above represents the beginning of nursing as a charitable role where women were ‘caring angels’, this led to the vocational view of the role. The influence of war on the role moved the view to one of heroism which influenced the power balance in the role between doctors and nurses. This aligned with the formalisation of training and subsequent registration there was a move towards the concept of a professional nurse. Increasing formalisation of training (now degree level across the UK) has led to a perception of nursing as work not vocation.

1.6. How it started.

Much of the literature exploring the development of the ANP role picks up the history in the 60s, 70s or 80s depending on the country and the focus. Gloster and Leigh (2021) note ANP roles in the United States of America in the 1960s with a leap forward to the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) in 1993 first defining advanced practice in the UK. Crouch and Brown (2018) focus on the emergency medicine experience of advanced clinical practitioner development from 2011 onwards. Hill (2017) picks up the story in the 1970s with recognition of clinical nurse practitioners in the community in the late 1980s. However, to truly understand the ANP role and explore the tensions within it then the evolution of nursing needs to be understood. This is represented in Figure 1 (p9) and the foundational tension of gender is noted.

The male versus female power struggle which represents the doctor-nurse game as described by Stein (1969) is still evident in healthcare culture today. Darbyshire and Thompson (2018) explore the modern-day impact of the doctor-nurse game and the detrimental impact of power imbalance that now permeates healthcare hierarchy, not just between doctors and nurses. Exploring this in depth is outside the scope of this study, however, understanding the underpinning social constructs and discourse that influence the role of the nurse will allow for better understanding of the ANP tensions. Gender has and continues to be influential regarding the recognition of nursing as a profession, with nursing being viewed as a domestic task (Choperena and Fairman, 2018) and society considers domestic work to be women's work. This is likely founded on the earlier European development of nursing based on an ethos of charity (Hallett, 2007) which has shaped the ongoing perception of nursing as caring. Collectively nursing is sensitive to the influence of gender and feminisation of caring work, and the impact this has within the hierarchical organisations that nurses work within (Carter, 2014).

It was the influence of war on the nursing role that started shifting perceptions, with the nurse being seen as 'heroic' for being willing to care in situations of danger (Hallett, 2007; Choperena and Fairman, 2018). Social constructs and the influence of the media has perpetuated the subservient female only version of a nurse, with men as powerful doctors (Garcia and Qureshi, 2021). At the beginning of the 1900s there was a drive to improve and standardise training, with Ethel Gordon Manson pushing

this forward and championing registration of nurses, in opposition to Florence Nightingale (Lloyd Jones, 2012). Ten Hoeve et al (2014) identified that despite increasing education around the world for nurses, from diploma to doctorate level, there remains a lack of public awareness of how scholarly nursing has become.

Emancipation from medicine has been sought by nurses and nursing to gain recognition of their own professional identity (Ten Hoeve et al, 2014). However, ANPs share core skills with doctors, including making a diagnosis, so emancipation from a profession with shared skills seems conflicting. While the concern regarding the medicalisation of nursing is valid, the potential for the ANP role to be seen in a 'handmaiden' role will not help with the struggle to professionalise (McMurray, 2011). The challenge of this being seen as a substitutive role compounds the situation further. Applying a Foucauldian (2002) lens of discourse not just reflecting language but knowledge and context then the discourse associated with the work of ANPs demonstrates a lack of knowledge regarding the role, with a language that speaks to managers. It was reported that ANPs would be able to undertake between 20–70% of a doctor's work (Workforce education and development service, 2013). However, there was no context to this statement – what work, where and when? There are numerous studies supporting the concept of ANPs' providing equivalent or better care than doctors (Laurant et al, 2005; Easton et al, 2004; McDonnell et al, 2015; Barton and Mashlan, 2011). However, the tension between the ANP role being service driven, substitutional or a professional development role is recognised and ongoing (Paul et al, 2015).

Exploration of contingencies, not causalities or a concept, is suggested by Foucault (Kendall and Wickham, 1999) and, in the context of the ANP role, this allows for wider influences to be realised. There was a neo-liberal approach taken by the New Labour government led by Tony Blair (Hoskins, 2012), which focused on increasing staffing levels in combination with improved pay and conditions (Thorlby and Maybin, 2007). Measuring work through the introduction of targets and empowerment of primary care groups to commission services (Department of Health, 1997) allowed for governmental monitoring of medical work from a distance. This process, though widely welcomed, was part of wider work that started the erosion of power and hierarchy in the National Health Service (NHS).

The individual and collective power of doctors and has been noted with further exploration of this power and authority by Foucault who labelled this as ‘disciplines’ (Hardin, 2001). The development of this medical discipline aligned with societal development of other powerful institutions such as education, the military and healthcare (Hardin, 2001). This gave doctors power and authority and resulted in their dominance over other professions such as nursing and pharmacy (Pritchard, 2017). Self-regulation and standardisation of behaviours were recognised by Foucault as the source of disciplinary power of medicine (Forbat et al, 2009). In essence you can only have the power if you meet the regulatory requirements of education to enter and complete medical school and then medical training. The ‘normalisation’ of this process and behaviours is recognised as means of maintaining the power associated with medicine, which still reflects white male dominance (Zaidi et al, 2021). The NHS Plan (Department of Health, 2000) recognised this power and challenged the selectiveness of it. This was a critical juncture that opened the possibility of advanced and consultant practice roles that could challenge the medical dominance. The subsequent development of advanced practice roles moved nurses into a position where their skills and experience could be developed further.

1.7 Summary

Questioning why there are tensions and challenges with the ANP role in secondary care has led to this academic work being completed to understand the situation. Exploring the background of the role has revealed the historical influences on its development as well as exposing the foundation of tensions within the nursing role itself. Being competent and having competence is recognised as a key aspect of developing ANP skills, notably because of the move into the medical domain of diagnosis and treatment. The following chapter will provide further insight into the ANP role through a tripartite review of evidence:

- Policy
- Portfolio
- Literature

This will be used to develop the research question and study method in later chapters.

Chapter 2: Evidence reviews.

2.1 Introduction

Literature reviews provide a foundation for research studies by laying out the current knowledge and understanding of the concept being explored. A broader approach to literature was taken for this study to acknowledge wider influences and aspects of the advanced nurse practitioner (ANP) role in a secondary care setting. The previous chapter has set the scene through identifying the critical junctures of ANP role development. To continue the scene setting, this evidence review will follow the principles of a narrative synthesis review. Narrative synthesis is a recognised approach to literature reviews that allows for development or advancement of theoretical models, exploration of perspectives associated with complicated or contentious topics, identification of knowledge that can progress 'best' practice and the demonstration of new perceptions on key or developing topics (Booth, Sutton and Papaioannou, 2016). It facilitates the mapping of the key concepts associated with a phenomenon, which, at this stage of the research study provides a foundation to build the creation of new knowledge upon.

For completeness this review of the evidence has three sources:

- A review of contemporary policies that impact on the ANP role
- An ANP portfolio
- Review of current evidence-based literature regarding the ANP role in a secondary care setting with a focus on the concept of competence.

The purpose of this is to provide an understanding of the current practice of ANPs in secondary care, and to identify gaps in the picture to be explored in the research study. This chapter will address the search strategies and outcomes for the policy and literature review, as well as a descriptive review of the advanced practice portfolio. All the evidence will be discussed, concluding with a table of the key elements pertinent to the ANP role in secondary care as it is currently understood.

2.2 Policy review

A policy review has been completed to identify the wider influences on the development of the ANP role, the purpose being to situate the review of the ANP portfolio and the current literature in the context of local and national workforce strategies and professional bodies discourse associated with advanced practice. Government and professional organisations represent power and influence, and

taking a Foucauldian perspective it is important to acknowledge the control this will have on the development of ANP roles. Professional organisations and national institutes that are key to workforce development within the NHS were identified either from the literature or from existing knowledge. These were searched extensively for any policies that directly or indirectly addressed issues associated with advanced practice in general or ANPs specifically.

2.2.1 Search strategy

The following table identifies the sites searched and the terms used. The study site is in Wales where there is devolved responsibility for the NHS, therefore the policy review was focused on Welsh policies, not United Kingdom ones. Overarching national organisations that influence the Welsh NHS were included such as the Nursing and Midwifery Council (NMC), Royal College of Nurses (RCN). The following eligibility criterion was applied:

- Current (or still in use) policies regarding the development, governance, training/education, assessment, or supervision of advanced (nurse) practitioners, including position statements and consultation documents.

These documents are generally written generically for nurses, midwives and allied health professionals with some specific documents addressing nursing only. Briefing or scoping papers were excluded as they summarise policies or review positions of policy but do not have any influence or mandate.

Sites searched	Terms used
NMC RCN Health Education and Improvement Wales (HEIW) Chief Nursing Officer for Wales (CNO) Association of Advanced Practice Educators UK (AAPE) Council of Deans of Health Welsh Government	Advanced nurse practitioner Advanced practice Advanced clinical practitioner Advanced clinical practice

Table 1: Search terms for policy review

There were eight papers found that were included in the policy review. This reflects a paucity in current high level organisational discourse regarding advanced nurse practitioner roles.

The papers are listed in table 2:

Organisation	Document Title	Key Themes
Royal College of Nursing	Standards for Advanced Level Practice (2018)	Registration (including Independent Prescribing) Education Job plan Portfolio to evidence autonomous practice
Health Education and Improvement Wales (HEIW)	Framework for Advanced Nursing, Midwifery and Allied Health Professional Practice in Wales (2010)* *originally written by National Leadership and Innovation Agency for Healthcare (NLIAH) who have now become part of HEIW.	Terminology & definition Pillars of practice Role impact analysis Education Workforce planning Governance
	A healthier Wales: our workforce strategy for health and social care (2020)	32-point strategy – action 12 focused on extended and advanced practice
Nursing & Midwifery Council (NMC)	The Code (2018)	Prioritise people Practise effectively Preserve safety Promote professionalism and trust
	NMC response to the Department of Health consultation 'The regulation of medical associate professions in the UK' (2017)	Key message: *'No legal or statutory limitation on the scope of practice of a nurse therefore development of advanced nurse practitioner role is in response to changing patient needs. Regulation of these roles should be considered by the government if deemed necessary to increase public protection and confidence in those undertaking these roles' p2*
	Strategy 2020-2025	Consultation on regulation of advanced practice nursing
Chief Nursing Officer for Wales (CNO)	Priorities 2016-2021 Priorities 2022-2024	Increase advanced and consultant level roles Commission review of advanced practice frameworks as part of career frameworks Consistency of roles and titles across Wales
Department of Health and Social Care	Regulating healthcare professionals, protecting the public – Consultation (24th march 2021 – 16th June 2021)	Consultation concerned with four areas: • Governance and operating framework • Education and training • Registration • Fitness to practise

Table 2: List of policies included in the policy review.

2.2.2 Policy review discussion

Reviewing the policies chronologically, the original work by National Leadership and Innovation Agency for Healthcare (NLIAH) (2010) remains the key paper for the development and maintenance of advanced practice roles in Wales. This framework was based on original work from NHS Scotland (Scottish Government, 2008) who developed an Advanced Practice Toolkit which introduced the concept of four pillars of advanced practice:

- Clinical practice
- Research
- Leadership
- Education

Gloster and Leigh (2021) note that, although the framework is simplistic, it has demonstrated resilience with its adapted version being established in Wales and England. The [Welsh] framework provides clarity regarding role definition and terminology as well as providing guidance on workforce and role impact, regulation and governance, and education (NLIAH, 2010).

The Chief Nursing Officer (CNO) for Wales published their priorities for 2016 to 2021 which detailed the need to increase the number of advanced and consultant nurses in Wales (Welsh Government, 2016). The appointment of a new CNO for Wales in 2022 has led to an updated list of priorities for nursing and midwifery in Wales. The tone of the document is influential in terms of advanced practice, with a focus on professional development, leadership, research, and a call for clarity regarding role titles in nursing and midwifery. ANPs are not explicitly mentioned, but consultant nurses are this may reflect the position of the Nursing and Midwifery Council (NMC, 2017) where they consider advanced nursing practice to reflect professional development.

The NMC has three core responsibilities as the regulatory body for nursing in the United Kingdom. Primary responsibility is regulation of nurses with specific focus on professional standards via ‘The Code’. They are responsible for the regulation of the pre/post registration education to support the standards. A secondary responsibility is the registration of nurses, and the final responsibility is to investigate concerns, these relate to less than 1% of the 758,000 registrants (NMC, 2022).

In 2017, the NMC held the position that advanced practice roles were reflective of professional development and therefore regulation was only required if it was considered essential in providing public protection and reassurance (NMC, 2017). However, the NMC strategy 2020 to 2025 plans for a wide-reaching review of the ANP role which will also address whether there is a need for regulation for these roles (NMC, 2019). This remains a contentious issue, with the Department of Health and Social Care completing a national consultation on regulating healthcare professionals (Department of Health and Social Care, 2021). The final report is awaited but the consultation paper notes the focus being on:

- Governance and operating framework
- Education and training
- Registration
- Fitness to practise

While advanced level practice is not a specific focus of the consultation, the tone of the paper is about a more responsive approach to changes in healthcare practices and the need to provide public safety and assurances.

In response to the ongoing debates regarding regulation of advanced level practice, the Royal College of Nursing (RCN) (2018) developed a process of credentialing and recognition of advanced level practice through the achievement of competencies. The purpose of this is to provide guidance and consistency in the development and benchmarking of these roles for employers, nurses developing their careers (RCN, 2018). The RCN (2018) also developed this process of credentialing to guide:

- policy makers for service development
- higher education institutions providing advanced practice education
- researchers of advanced level nursing practice
- to provide clarity for patients and public who need to understand the level of nurse who cares for them

The document details the standards for practice as well as the requirements to be credentialed as an advanced nurse practitioner, which when completed, provides some recognition for individual nurses that their knowledge, skills and job role fulfil the criteria for advanced level practice (RCN, 2018). For many ANPs this is the only route for recognition of their level of practice. Health Education England (2022a) has developed multi-professional credential frameworks for some specialities, but Health

Education and Improvement Wales (the Welsh equivalent organisation) has not developed their advanced practice workstream to a comparable level.

There is an ambitious and visionary workforce strategy for health and social care in Wales, with seven key themes (Health Education and Improvement Wales (HEIW), 2020). These intersect with advanced practice roles by virtue of them being workforce themes with theme 3 action 12 detailing the need for a competency and capability framework for multi-professional advanced practice roles (HEIW, 2020). The document uses terms such as '*top of license*' (HEIW, 2020, p23) to reflect the scope of the ANP. This is not a phrase associated with the registration or regulation of nurses, midwives, or allied healthcare professionals in the UK and reflects a lack of understanding of professional registration and regulation. Despite these roles being first documented over 20 years ago in the NHS Plan by the Department of Health (2000), there is still a lack of clarity. There is a paucity of documents at a strategic level that directly address ANP roles and an absence of consensus as to whether these roles are 'natural' professional development or a 'new' professional role. It could be suggested that the high-level policy documents have an expectation that organisations will take on the responsibility for developing ANP roles themselves. This lack of clarity regarding direction and ownership has contributed to individual services developing the roles in isolation rather than a strategic organisational approach. This has essentially created a 'bottom up' driver for change not a 'top down' one.

In summary, the policy review has identified multi-professional frameworks written to support the development and recognition of advanced nurse practitioner roles, however, current (2020 onwards) policies reflect limited acknowledgement of the role in the workplace.

2.3 Portfolio review

Using a portfolio as a repository of evidence to demonstrate an individuals advanced practice skills is a well-established process; it is also a requirement as part of the Framework for Advanced Nursing, Midwifery and Allied Professional Practice in Wales (NLIAH, 2010) as a means of demonstrating impact. In 2010 NLIAH developed a portfolio, alongside the framework for advanced practice, that details the evidence required across all four pillars of advanced practice and the level of practice the evidence should reflect. An adapted version of Benner's (1984) model of

skill acquisition in Wales, which was based on the Scottish Government Advanced Practice toolkit (Scottish Government, 2008), is used in the portfolio to enable the advanced practitioner to map their level of practice across each aspect of the four pillars. For ease of understanding these can be found in table 3 below which has been adapted from the NLIAH (2010) Advanced Practice – The Portfolio.

	Novice (Beginner with no experience)	**Advanced beginner** (Demonstrates acceptable performance)	**Competent** (Typically, 2-3 years' experience of role in same area)	**Proficient** (More holistic understanding with improved decision-making)	**Expert** (Intuitive grasp of clinical situations, not reliant on principles, rules, or guidelines)
Management & Leadership					
Identifying the need for change, leading innovation, and managing change, including service development					
Developing case for change					
Negotiation and influencing skills					
Networking					
Team development					
Education (either within clinical practice or education sector)					
Principles of teaching and learning					
Supporting others to develop knowledge and skills					
Promotion of learning/creation of learning environment					
Service user/carer teaching and information giving					
Developing service user/carer education materials					
Teaching, mentorship and coaching					
Research					
Ability to access research/use information systems					
Critical appraisal/evaluation skills					
Involvement in research					
Involvement in audit and service evaluation					
Ability to implement research findings into practice- including use of and development of policies/protocols and guidelines					
Conference presentations or publications					

	Novice (Beginner with no experience)	**Advanced beginner** (Demonstrates acceptable performance)	**Competent** (Typically, 2-3 years' experience of role in same area)	**Proficient** (More holistic understanding with improved decision-making)	**Expert** (Intuitive grasp of clinical situations, not reliant on principles, rules, or guidelines)
Advanced Clinical Practice					
Decision making/clinical judgement and problem solving					
Critical thinking and analytical skills incorporating critical reflection					
Managing complexity					
Clinical governance					
Equality & diversity					
Ethical decision-making					
Assessment, diagnosis, referral, discharge					
Developing higher levels of autonomy					
Assessing and managing risk					
Non-medical prescribing in line with legislation					
Developing confidence					
Developing therapeutic interventions to improve service user outcomes					
Higher level communication skills					
Service user focus/public involvement					
Promoting and influencing others to incorporate values-based care into practice					
Development of advanced psycho-motor skills					

Table 3: Adapted competencies and level of skill acquisition from NLIAH 2010 advanced practice portfolio.

For this study, I examined my personal ANP portfolio in the context of the policy and literature review. This served two purposes, firstly to align the influence of the policies with my professional development as evidenced in my portfolio. Secondly, it allowed personal assumptions and tensions to be reflected upon and addressed to limit any personal influence on this study. Further details and examples of my portfolio and this process of review are found in Appendix A. Key themes within the portfolio reflect my professional development as an ANP over the past decade:

- Imposter syndrome (section 2.3.1)
- Role recognition (section 2.3.2)
- Difference in diagnosis (section 2.3.3)
- Brick walls (section 2.3.4)

2.3.1 Imposter syndrome

The phenomenon known as 'imposter syndrome' is recognised in expert to novice transition (Murphy and Mortimore, 2020) which is a key change in role for expert nurses to become novice (trainee) advanced practitioners. Fleming and Carberry (2011) identified this as a challenge in the role transition for trainee to qualified advanced practitioners with some considering leaving the role and returning to their previous one. The challenge of transition and consolidating the role for myself is evident in the volume of assessments as well as the reflections on my development and practice. Despite completing the academic and employment requirements to more than fulfil the ANP role I still doubted my abilities and felt uncomfortable in my role.

2.3.2 Role recognition

Reviewing reflections and assessments in my portfolio there is a consistency in my understanding of the ANP role and where it sits within the multi-professional team. The reflections also demonstrating a wider understanding of the role by others within teams over time, notably with the junior tier of doctors who worked closely with myself and other ANPs. There was a frustration with the appraisal process where nursing line managers would challenge aspects of the role such as non-clinical time for teaching. The value of this was not universally recognised.

2.3.3 Difference in diagnosis – approaches to clinical reasoning.

There were two challenges noted in my portfolio associated with making a diagnosis and evidencing my clinical reasoning which is a key requirement of the ANP role.

HEE (2017) identified that advanced practitioners underpin clinical reasoning with expertise and decision-making abilities to manage complex situations with differentiated and undifferentiated individuals by synthesising information from multiple sources to make evidence-based appropriate decisions. In short form this means ANP's need to be able to make a diagnosis for a patient based on a variety of clinical information. This was traditionally a doctor's role and so as a nurse practicing at an advanced level I needed to demonstrate that I could do the same. This skill of clinical reasoning is a foundation of clinical practice (Young et al, 2020) and it is broadly split into two approaches, that of the novice – hypothetico-deductive reasoning, and that of the expert – pattern recognition (intuition). Brush et al (2017) acknowledge the influences of experience and expertise on clinical decision making and diagnosis. As an expert nurse working as an ANP I had the experience to apply pattern recognition to my clinical reasoning and diagnosis, but I needed to demonstrate through my assessments that I was applying a stepwise reasoning approach. This was challenging as intuitively I knew what was wrong with the patient but initially lacked the medical terminology to explain why I knew that.

Another challenge was recognising times when there were differences in opinions of diagnosis and an unspoken 'competition' of who was right, the doctor or myself. Initially, where there was a difference in initial diagnosis of a patient between myself and a doctor (not at consultant level) there was a wider consensus that the doctor had made the correct diagnosis, and I had not. It became apparent that the opposite was usually the case, and while there was not widespread recognition that I had been correct, I was able to internalise that I was making correct diagnosis and plans, and this added to the development of confidence in my skills.

2.3.4 Brick walls

Radiology was a notable challenge in my ANP portfolio with the numerous forms completed over the decade to be afforded permission to refer for diagnostic imaging. Despite being in the same organisation and working as an ANP on the same job description and banding, any change in department or service area required new forms to be completed. These forms then went through an approval process before being allowed to refer for the same tests that I had previously been given permission to refer for. The forms required supporting evidence and signatures by departmental clinical, nursing and management leads as well. Doctors are not required to do this

and there is no formal oversight to their radiology requesting and interpretation. My portfolio contains not only the work I have done to meet these requirements, but it also reflects my frustrations with this process, and reflects this as a ‘brick wall’ as despite multiple efforts to rationalise this process it remains the same.

2.3.5 Summary

A review of the policies associated with advanced level practice and my advanced practice portfolio has revealed a lack of clarity and direction with the roles and their development. To widen the understanding of advanced nurse practitioner roles in secondary care a literature review has been undertaken. The purpose being to add to this understanding and to situate this study in the current context of advanced nurse practitioner roles.

2.4 Literature review

Popay and Mallinson (2010) define a literature review as a process of summary and interpretation of evidence that is not limited to quantitative or qualitative data but includes, non-research-based evidence. The type, timing and purpose of literature reviews vary according to the research methodology and method, reflecting the researchers' epistemological lens and their current experience of the field of study (Giles, King and de Lacy, 2013).

Although the research methodology and method to be applied in this study will be discussed in subsequent chapters, it is timely to acknowledged that the literature review in the context of this study is to set the scene and a narrative synthesis of the current literature is appropriate. In opposition to a systematic review where the focus is on configuration and aggregation of data (Phillipson et, 2016), a narrative synthesis is an alternate approach that affords reassurance as a middle ground between a narrative literature review that is descriptive in nature and a systematic review which is rigorously structured and analytical (Booth, Sutton and Papaioannou, 2016). This is the approach taken for this study.

2.4.1 Search strategy

A research question needs to be developed to support the search strategy; this thesis does not pose a clear question, as the advanced nurse practitioner role is being explored in a defined context (secondary care). To facilitate the topic of study being extrapolated into a 'question', key frameworks are available to the researcher known by the mnemonics of PICO, SPICE and, more latterly, SPIDER. Richardson et al (1995) developed PICO as an approach that constructed high-quality questions, the letters representing:

- P – population
- I – intervention
- C – comparison
- O – outcome

As this framework was developed with quantitative studies in mind there has been a longstanding assumption that it is not appropriate for qualitative studies (Methley et al, 2014). Lockwood et al (2015) recognised the application of PICO to qualitative study questions with the adaptations in table 4 below:

Quantitative question	Qualitative question
Population	**P**opulation
Intervention	phenomena of **I**nterest
Comparison	**C**ontext
Outcome	**o**utcome *

Table 4: comparison of PICO headings for quantitative and qualitative studies.

*not a requisite of qualitative studies

SPICE was offered as a solution by Booth (2006) for formulating the right question as it recognises the subjective nature of qualitative research – setting, perspective, interest/phenomenon, context, evaluation. Further iterations by Cooke et al (2012) developed SPIDER as a further option for qualitative research and 'tested' this against the widely established PICO framework. Table 5 below compares the two (PICO & SPIDER):

Population	**S**ample	Covers both qualitative and quantitative participants
Intervention/phenomena of **I**nterest	**PI –** phenomenon of interest	Reflects the aim of qualitative research to understand the how and why as well as being able to be applied to quantitative studies
Comparison/**C**ontext	**D**esign	Recognises the influence of theoretical frameworks applied in qualitative studies
Outcome/**o**utcome	**E**valuation	Covers the output from both qualitative and quantitative studies
	Research type	Opens up searching for the three research types – quantitative, qualitative and mixed methods

Table 5: this table identifies the similarities between the PICO and SPIDER acronyms for developing a research question.

Consideration was paid to both SPICE and SPIDER but further work by Methley et al (2014) showed higher sensitivity in PICO when applied to qualitative systematic reviews than previously recognised. PICO was therefore chosen and was applied to all subsequent literature searches in this thesis. Table 6 below details the review question using the PICO framework and associated search terms:

PICO Framework for question development.		Search terms
Population	Advanced nurse practitioners	Advanced nurse practitioner Advanced practitioner Nurse practitioner Advanced clinical practitioner
Interest/phenomenon	Competence	Competence Capability Assessment
Context	Secondary care	Hospital care Acute care Emergency care
Outcomes	All	Clinical skills Patient care Leadership Diagnosis Clinical assessment Clinical decision-making Service development Education Teaching Role identity.

Table 6: PICO framework used in this study to develop the literature review question.

A systematic approach to the literature search was taken using key words and search terms from known literature regarding advanced nurse practitioners working in a secondary care hospital. An eligibility criterion was identified for inclusion and exclusion of studies to be used for the narrative synthesis. O'Connor et al (2011) comment that a fundamental difference between a systematic review and a literature review is the use of an eligibility criteria, with it being needed for a systematic review only. It can be equally argued that all reviews need an eligibility criterion as even the most sensitive search strategy may identify unsuitable literature which needs to be excluded.

2.4.2 Inclusion & Exclusion Criteria

Table 7 below identifies the inclusion and exclusion criteria for papers:

Inclusion	Exclusion
• Primary research publications since 2000, including systematic reviews. • Written in English • From or about UK hospitals • Any research method (quantitative or qualitative) • Primary research publications investigating, evaluating, or comparing aspects of ANP roles in secondary care. This would include papers where the ANP may be compared to other advanced practice roles.	• Research publications prior to 2000 as the role was not defined prior to this. • Research publications from outside the UK or regarding non-NHS services • Opinion papers • Research publications investigating, evaluating, or comparing aspects of roles other than advanced nurse practitioners in secondary care such as clinical nurse specialists or advanced allied health professionals.

Table 7: Inclusion and exclusion criteria for literature review

2.4.3 Search results

Search engines CINHAL and MEDLINE were used, and the searches were initially attempted using Boolean logic with advanced nurse practitioners AND hospital OR competency. However, this was not effective at identifying key known literature. Therefore, the search strategy was modified to search for the key topics separately and then combine the results. This proved more effective at retrieving pertinent literature and it is recognised that there is variation in the process and guidance given regarding a literature search and review and the robustness required can be overlooked (Rethlefsen et al, 2021). There are several processes available for reporting the searching and appraisal for systematic reviews, with PRISMA 2020 (Preferred reporting items for systematic reviews and meta-analyses) being one of the most well-known (Page et al, 2021). To support the literature search aspect of this process Rethlefsen et al (2021) developed the PRISMA-S checklist to provide a structured approach not only to the literature search process but to its reporting. The principles of this were employed in this literature search as far as applicable and a summary flow chart is displayed below:

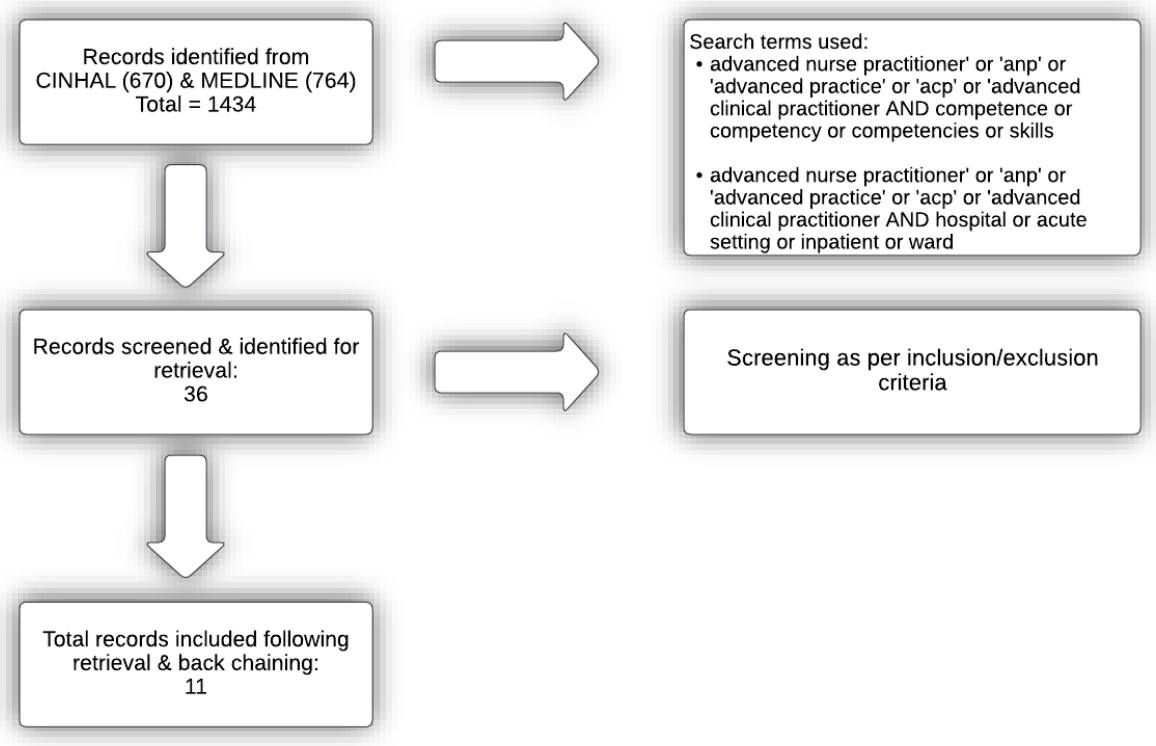


Figure 2: PRISMA-S adapted for this literature review.

The retrieved articles are set out in table below with the key themes from each one identified in the final column.

Authors	Date	Title	Methods	Themes
Norris, T. Melby, V.	2006	The acute care nurse practitioner: challenging existing boundaries of emergency nurses in the United Kingdom	Descriptive, exploratory design Questionnaires n=98 Interviews n=6	*Three main themes:* 1. Autonomy of the role 2. Inter-professional conflict 3. Perceived need for ACNP (acute care nurse practitioner – now ANP/ACP) role
Fleming, E. Carberry, M.	2011	Steering a course towards advanced nurse practitioner: a critical care perspective	Grounded theory – interviews n=25 comprising of 9 trainee ANPs 5 consultant intensivists 3 critical care nurses 4 critical care managers 3 junior doctors 1 divisional nurse director	*Main theme:* steering a course towards advanced nurse practitioner. *Sub themes:* 1. Finding a niche 2. Coping with the pressures 3. Feeling competent to do 4. Internalising the role
Williamson, S. et al	2012	An ethnographic study exploring the role of ward-based advanced nurse practitioners in an acute medical setting	Ethnographic Observation of 5 ANPs in practice with 24 interviews (including the 5 ANPs, 14 ward nurses of various levels and 5 patients)	*Main theme:* the ANP as a lynchpin *Sub themes:* 1. Enhancing communication and practice 2. Acting as a role model 3. Facilitating the patient's journey 4. Pioneering the role
Dalton, M.	2013	Perceptions of the advanced nurse practitioner role in a hospital setting	Qualitative cross-sectional study Focus groups and one to one interview (6 junior doctors; 6 ward nurses; 6 advanced nurse practitioners)	Four major themes: 1. Diverse definitions of the ANP role 2. Role vagueness and ambiguity 3. Communication and educational needs 4. Constraints and barriers
McDonnell, A. et al	2015	An evaluation of the implantation of advanced nurse practitioner (ANP) roles in an acute hospital setting	Collective case study Strategic stakeholder interviews n=13 Three individual case studies (medicine, surgery & orthopaedics) included interviews n=32 and non-participant observation of practice.	Three main themes with sub themes: *Impact on patients:* 1. Impact on patient experience 2. Impact on patient outcomes and patient safety *Impact on staff members:* 1. Impact on competence of staff members 2. Impact on quality of working life

Authors	Date	Title	Methods	Themes
				3. Impact on workload or distribution of work 4. Impact on team working *Impact on the organisation:* 1. Impact on organisational priorities and targets 2. Development of policy
Cowley, A. Cooper, J. Goldberg, S.	2016	Experiences of the advanced nurse practitioner role in acute care	Qualitative case study Interviews n=8	*Main theme:* 'Is it a nurse? Is it a doctor? No, it's an ANP' *Sub themes:* 1. The missing link (bridging the gap, establishing role identity, clinical skill set) 2. Facilitating and leading holistic care (understanding and valuing team contributions) 3. Safe, high-quality care
Stanford, P.	2016	How can a competency framework for advanced practice support care?	Qualitative cross-sectional design Questionnaires & reflective exercises n=8	*Main themes:* 1. Identifying strengths and weaknesses 2. Setting clear goals and targets 3. Improving how practice is organised 4. Potential to limit practice
Halliday, S. Hunter, D. McMillan, L.	2018	Ward staff perceptions of the role of the advanced nurse practitioner in a 'hospital at day' setting	Descriptive phenomenological Interviews n=10	*Main themes:* 1. Effectiveness of the role (clinical effectiveness and organisational effectiveness) 2. ANP as a 'constant' 3. De-skilling 4. Role confusion
Hooks, C. Walker, S.	2020	An exploration of the role of advanced clinical practitioners in the east of England	Case study – interviews N=22	*Main themes:* 1. Role purpose (6 sub-themes) 2. Role impact & evaluation (5 sub-themes)

Authors	Date	Title	Methods	Themes
				3. Role barriers and facilitators (10 sub-themes) 4. Role regulation (5 sub-themes)
Puravady, S. McCarthy, R.	2021	Evaluating a competency assessment framework for ANPs	Descriptive qualitative – interviews N=10	*Main themes:* 1. A guidance tool 2. Ensuring competence and effective professional development 3. Facilitation through principles of teaching and assessment 4. Transferability for standardisation
Cooper, J Lidster, J.,	2021	Perceptions of competency in advanced clinical practitioners	Cross-sectional qualitative study N=6	*Main themes:* 1. Value of trainee advanced clinical practitioner status 2. Skills, training and experience 3. Meaning of competency 4. Complexity of term advanced clinical practitioner 5. Experience of assessment 6. Self-directed portfolios 7. Work based assessments

Table 8: List of articles included in the literature review in date order.

2.4.4 Discussing the current evidence.

The limited number of suitable research papers reflects the paucity of evidence exploring the ANP role in secondary care and the associated concept of competence. The research methods are predominately qualitative with small numbers of participants, and this limits the generalisability of the individual studies. However, the commonality of the themes identified lends weight to the evidence in totality. Combining these themes with those already identified in the policy and portfolio review they have been distilled into two broad themes: The role of the advanced nurse practitioner, and the challenges of the advanced nurse practitioner role.

2.4.5. The role of the advanced nurse practitioner

The literature addresses key aspects of the ANP role from the perspective of the ANP, the patient, the multi-professional team, and the organisation. The literature spans fifteen years and it is interesting to see the discourse change. Early work by Norris and Melby (2006) addressed the boundaries and opinions of the newly developed acute care nurse practitioner role in emergency departments. Invitations were sent to seven out of 18 emergency departments and minor injuries units in Northern Ireland targeting the medical and nursing staff. Ninety-eight (47%) responded to the questionnaire with six of these participants recruited for further engagement in semi-structured interviews (four nurses and two doctors). Norris and Melby (2006) identified inter-professional conflict as a major concern, describing it as an inevitable result of blurred boundaries, close proximity working in a high stress environment and an imbalanced of power. Nurse participants felt that the doctors were perceived to have power over the nurses and did not value them. The doctor participants recognised the value of the nurse experience in the department and reported them as an underused resource that would benefit from the advanced role. However, the study is limited in generalisability due to the low response rate to the questionnaire and potential for bias with the purposefully sampled participants for interview. Additionally, there was limited representation across the healthcare staff who would work with an ANP, and Norris and Melby (2006) acknowledge the results reflect the views of a small group of doctors and nurses not a consensus view.

Studies in secondary care also found that healthcare staff compared the advanced nurse practitioner role with that of a junior doctor (Fleming and Carberry, 2011;

McDonnell et al, 2015) and it is these studies where the concept of competence is mooted. Fleming and Carberry (2011) used a grounded theory approach with 25 participants (listed in table 8), who were theoretically sampled. This study followed the principles of grounded theory and provides sufficient detail to support the development of the conceptual model. The focus was the transitional experience of expert critical care nurses into the advanced nurse practitioner role. A conceptual model was developed to articulate the transition experience (Fleming and Carberry, 2011). However, the transferability of the model to other specialities to reflect the transition of nurse to ANP has not been tested and to date the model has not been used by others. Fleming and Carberry (2011, p71) identified that the feeling of competence was underpinned with participants commenting regarding '*coming to terms with the role'* which recognised the need for professional identity. This was important for the individual trainee advanced critical care practitioners (tACCPs – the critical care equivalent for ANP), as well as for the wider multidisciplinary team who needed to understand the role. As part of the tACCP journey the '*doing the job'* theme identified by participants reflected how they internalised the role and it was at this stage that the benefits of the constancy of the tACCPs were identified; it was acknowledged that integrating their nursing background with the advanced practice training provided the unique added value to patient care (Fleming and Carberry, 2011, p71).

To further explore the ANP role, an ethnographic approach was taken by Williamson et al (2012) which provided insight into the ward based working experience of an ANP and expanded participants to include ward-based nurses and patients. Five ANP's working in the same organisation across acute medicine wards were observed in their daily work environment, they were also interviewed along with 14 ward-based nurses and five patients. A nurse participant described the ANP role as a '*lynchpin*' for patient care, with patient participant noting they acted proactively not reactively to patient's needs (Williamson et al (2012 p 1582 – 1583). Williamson et al (2012) acknowledged the small study size and the inherent limitation of generalisability as a result. However, as each ANP was based on a different acute medicine specialist ward, the findings characterise core similarities representing the ward-based experience of an ANP, which supports generalisability through the homogeneity of the findings. The similarities identified were:

- Enhancing communication and practice
- Role model
- Facilitating the patient's journey
- Pioneering the role

The ANPs in this study recognised their skills in communication between the multidisciplinary team and with patients, which facilitated all aspects of the patients journey by proactively managing care (Williamson et al, 2012). They also reported their responsibility as role models and the need to pioneer the role (Williamson et al, 2012). This notion of core shared experience influenced the development of my study as I am seeking to understanding the ANP's experience in an organisational setting (secondary care hospital).

McDonnell et al (2015) evaluated the implementation of ANP roles in an acute hospital setting. This study influenced the development of my study as it was the first in depth UK study exploring the ANP role in an acute/secondary care hospital environment. Using a collective case study approach in three key clinical specialities – medicine, surgery and orthopaedics, McDonnell et al (2015) demonstrated the positive impact of the ANP role on patient experience. It was recognised that the ANPs provided a holistic and thorough approach as reported by patients, and the staff felt that the constancy of the ANP enhanced patient safety and improved patient outcomes (McDonnell et al, 2015). McDonnell et al (2015) acknowledge that using a single site for the study was a limitation and recommend further studies to include more organisations to increase the generalisability of the findings. However, there were no multi-site studies exploring the ANP role in an acute or secondary care setting identified in the literature search.

A further study by Cowley et al (2016) evaluated the impact of the advanced nurse practitioner role in an older person's frailty service. This study sought to explore the ANP role in more depth and although there were a limited number of participants (n=8), they were representative of the multidisciplinary team (MDT), which provided a broader insight into the understanding and experiences of the ANP role within this team. There is limited information on the analytical approach taken, although the themes – the missing link; facilitating and leading holistic care; safe, high-quality care

are similar to Williamson et al (2012), the size of the study is small and limits generalisability and transferability.

Stanford (2016) reflects the changing understanding of the ANP role and explores the influence of a competency framework. Using Interpretative Phenomenological Analysis (IPA), eight nurse practitioners were purposefully recruited using a non-probability, convenience sampling approach. Sanford (2016) used three stages to data collection using a mixed approach: questionnaires for demographic data and experience of competency framework; written reflective exercises on participants experience and understanding of the positive and negative aspects of a competency framework; focus groups to explore perceptions and attitudes regarding using a competency framework (Stanford, 2016).The authors have not made it clear why the focus groups were carried out or if the reflective diaries informed the topics discussed, but four clear themes for further consideration:, which have relevance to the current research:

- Identification of strengths and weaknesses
- Setting clear goals and targets
- Improving how practice is organised.
- Potential to limit practice.

Stanford (2016) concluded competency frameworks would be useful in supporting the development of nurse practitioners into ANPs as they provide structure to the development. However, the concern was that frameworks could become restrictive to professional development over time (Stanford, 2016). The size of study while appropriate for an IPA study, is a limiting factor in transferability and generalisability of findings, although the findings are of interest to the current national approach to defining advanced practice with a competency framework.

Halliday et al (2018) also took a phenomenological approach in exploring staff perceptions of ANPs in a ‘hospital at day’ setting. Hospital at day in this study site reflected the expansion of the ANP role from the hospital at night team. The role was initially introduced to augment and support the medical team at night but had been expanded into ward-based roles during the day. To better understand the ANP role during the day, this descriptive study explored the role of ANP’s and Halliday et al (2018) acknowledged his place as insider researcher as he was conducting research in a service where he worked as an ANP. A ‘bracketing’ approach was used to

distance himself from his preconceptions based on his lived experience as an ANP in the service being investigated. This insider researcher approach is present in several of the studies included, which may reflect that ANP's are driving the research into their roles as others are not. Although Halliday et al (2018) acknowledge the insider researcher status, the influence and bias of interviewing staff he works alongside has not been addressed. The use of direct quotes to support the themes identified infers credibility but the language used reflects that the participants knew the researcher well and this will bias the findings. There are four themes given as findings – effectiveness (clinical and organisational); ANP as a constant; de-skilling (doctors); role confusion. These are not dissimilar to other studies but the discomfort from the closeness of the researcher to the participants makes these findings less reliable.

Although the literature notes role confusion and conflict (Norris and Melby, 2006; Fleming and Carberry, 2011; Williamson et al, 2012; Dalton, 2013; Cowley and Cooper, 2016; Halliday et al, 2018), there is increasing understanding of the requirements of the role; themes of the '*ANP as a lynchpin*' (Williamson et al, 2012 p1582), '*ANP as a constant'* (Halliday et al, 2018 p94) have emerged over time. The most recent papers by Hooks and Walker (2020) and Cooper and Lidster (2021) indicate that, although the impetus for the ANP role was lack of medical staff, there is now a greater recognition that these roles are not substitutive but are complementary.

Hooks and Walker (2020) provide insight into the regional experiences of Advanced Clinical Practitioners (ACP), which include professionals other than nurses in advanced practice roles. This research was undertaken on behalf of Health Education England (HEE) as part of the ongoing work regarding Advanced Clinical Practitioners following the publication of the HEE Multi-professional framework for advanced clinical practice in England (2017). Hooks and Walker (2020) used a focussed case study approach which purposively recruited an ACP, their line manager, and where possible a colleague across both primary and secondary care settings. Twenty-two interviews were carried out and thematically analysed, participants were:

- ANPs (n = 6)
- Consultant level doctor (n = 8)

- Manager (physiotherapist, nurse, radiotherapist and occupational therapist) (n = 5)
- Allied Health Professional (Paramedic, physiotherapist and radiographer) (n = 3).

The findings reflecting less conflict between the professions and more support for the role. Hooks and Walker (2020 p866) identified that:

> Medical colleagues…expressed the added value that they perceived ACPs provided, noting that years of clinical experience…brought unique skill sets…over and above those of the medical equivalence they were often replacing.

The study revealed differences between nurses and allied health professionals (AHPs) in advanced clinical practitioner roles. The nurses were more likely to be aligned to a junior doctor rota and covering junior doctor work, and AHP's were more likely to be undertaking the less complex consultant level tasks with an aim of freeing consultant time (Hooks and Walker, 2020). This implies that nurses in the ACP role are seen as replacements for a junior medical workforce but the AHP's in ACP roles substitute for consultants which are senior medical roles. This reflects nurses are subservient to medicine but AHPs are more equal and is an interesting aspect of the ACP role that should be further explored.

Cooper and Lidster (2021) explored the perception of competence and competency, investigating what the terms mean to ACPs and how they evidence it in practice. The study was small (n= six) with the potential for bias being addressed by the researcher through reflexivity; data was gathered through convenience sampling of students on an MSc in Advanced Clinical Practice programme. Participants included those new to the role and training for an ACP job, as well as those who were gaining the academic qualification to support the role they had been in for a long period of time. The paper does not give any information about the participants themselves, and it would have offered more insight to know average length of time in post; it is key to analysis of what the participants thought about competence and competency. The findings are in keeping with conceptual understanding of competency, with a lack of consensus in the literature on definition and subjective understanding. The lack of information about the participants limits generalisability to a wider ANP population.

However, participants in the research gave interesting insights into the understanding of competency (Cooper and Lidster, 2021, p853):

> There is comparison between the competency of junior doctors and ANPs. I do not feel they are comparable in any way…the whole basis of their training is different.

The participants also suggested using medical model style of assessment and a standardised curriculum to prove competency, which is at odds with wanting to be recognised for the differences they bring.

This was one of the three papers that sought to investigate the benefits of a competency framework and to identify what competence looked like for advanced clinical practitioners (the generic term encompassing all advanced practitioners regardless of base profession). Stanford (2016) identified that a competency framework would provide guidance on the strengths and weakness of an individual ANP. This was seen as helpful when training, and acknowledging the potential for practice to be limited and ongoing development curbed without a competency framework to describe to others what the individual can and cannot do. This was also found in subsequent work by Puravady and McCarthy (2021), and Cooper and Lidster (2021), with recognition that trainee ACPs (ANPs) have different needs to trained ACPs (ANPs). The benefit of a competency framework as a means of transferring skills was identified by Puravady and McCarthy (2021), with Cooper and Lidster (2021) investigating further the types of evidence and assessments that demonstrate competency.

Puravady and McCarthy (2021) developed a competency framework for ANPs working in acute medicine and published an evaluation of this framework. The framework was evaluated by ANP's (n=five) and Consultants (n=four). Semi-structured interviews exploring participants perceptions as well as a Likert scale was the data collection method. The Likert scale was used to measure experience of using the competency framework. The researchers state a phenomenological approach was taken to the interview data but there is no further information why this methodology was used, undermining the quality of the research. Additionally, the questions used for data collection do not reflect a phenomenological approach, asking for opinion of the framework not lived experience. The themes identified are reflective of the purpose and understanding of competence and competency

frameworks in the broader sense. For example, Puravady and McCarthy (2021) suggest that a competency framework is a guidance tool to ensure competence and professional development, which is enabled through principles of teaching and assessment, which in turn provides transferability through standardisation.

Across the three papers it was apparent that the definition of competency was challenging and elusive, Stanford (2016, p1118) described competence in a quantifiable manner, talking of '*performance of tasks'* as means of observing competence and that the use of a competence framework can link organisational and personal objectives to provide clarity for the ANP regarding their role. Cooper and Lidster (2021) identified in their descriptive study a lack of cohesive understanding of competence by the trainee and qualified ACPs they interviewed; comments regarding competency as successful performance of a task or performing a task to the same standards of others (p854) were noted. Puravady and McCarthy (2021) evaluated a competency assessment framework and identified it provided guidance and transferability of skills and did not limit ANP development, which has been a concern in the other studies.

The positive impact on patient care is noted in Williamson et al (2012); McDonnell et al (2015); Cowley et al (2016); Halliday et al (2018). A key factor is the constancy on the ANP in the service or ward, Cowley et al (2016) noted the ANPs used their nursing knowledge and experience to ensure appropriate investigations were requested and the practicalities of undertaking investigations were considered in the context of the patient's condition. This was seen as beneficial by both the nursing staff and the patients.

2.4.6 The challenges of the advanced nurse practitioner role

In contrast to positive patient outcomes where there were ANPs in a team, it was the lack of clarity and understanding of the role contributing to the confusion. Dalton (2013) focussed on the hospital at night experience of the advanced nurse practitioner role in another small qualitative cross-sectional study using an interpretive lens. There were 18 participants (six of each – doctors, nurses, and ANPs), with data being collected using focus groups and semi-structured interviews. The limited discussion provided from the published data reflects four seemingly negative findings associated with the experience of the role, with a focus on task

shifting (doctor to ANP) rather than valuing the professional expertise of the ANP. As with the many of the other papers this author is an ANP working in the area of investigation, which can introduce bias to the research findings. This was not addressed by the author, so analysis of the data may have been heavily influenced by the researchers' own experiences and perceptions.

Hooks and Walker (2020) identified the diversity of experience, training, qualifications, and the lack of consistency in the use of the ANP title as contributing factors to the ongoing challenges. A consistent challenge across the studies is the institutional and professional barriers applied to advanced practice roles with a mismatch between scope of practice and permissions to fulfil that scope being restricted by institutional 'brick walls'. Hooks and Walker (2020 p867) report issues with requesting investigations particularly radiological investigations, prescribing and access to 'medical' IT systems. This was reported in earlier studies, notably Norris and Melby (2006), who found radiologists were a significant barrier to the ANP being able to request investigations. There was a perception that ANPs would not be able to interpret the x-rays and a reluctance from radiologists to engage in a dialogue to resolve this. This was reflected in the review of my portfolio, and the policy review did not reveal any strategic or high-level policies/frameworks or papers addressing this. Further searching identified work between the Royal College of Nursing and the Society of Radiographers (RCN, 2021) regarding non-medically qualified radiology requesting which has gone some way to address this disparity. However, it remains in the gift of individual organisations to adopt this guidance rather than it having any enforcement power. No research papers were found specifically addressing radiology requesting as an ANP.

There is wide variation in knowledge, skills and experience that nurses bring to the advanced nurse practitioner role (Norris and Melby, 2006; Dalton, 2013; Halliday, Hunter, and McMillan, 2018; Hooks and Walker, 2020) which adds to role confusion and uncertainty about the purpose of the role as there is disparity in skills and knowledge (Dalton, 2013; Cowley and Cooper, 2016). Stanford (2016) identified the lack of consistency in supervision and assessment would also have contributed to role ambiguity. The need to standardise core practice through a unified educational pathway was identified (Dalton, 2013) and subsequent work on competency frameworks has contributed to greater consistency in the advanced practice role.

Puravady and McCarthy (2021) identified the benefits and transferability of a competency assessment framework for advanced practice roles, and this is in keeping with the work from Health Education England (HEE, 2022b) regarding speciality specific multi-professional advanced practice competency frameworks.

2.5 Summary

The policy, portfolio, and literature review cover twenty years of the advanced nurse practitioner role in Wales. The paucity of up-to-date policies specifically addressing advanced practice in Wales exposes the lack of strategic ownership and investment in the role. However, my portfolio reflects operational experience of the role that identifies greater understanding and acceptance of the role within the teams where ANPs work.

The evidence-based literature shows the evolving change in how these roles are understood by the ANPs themselves as well as the wider multi-professional teams. Nonetheless, combining the discourse from the policy review, portfolio review and literature review there are key issues to explore further in this study. From this broad review the key areas to explore are:

- Role transition – from nurse to advanced nurse practitioner
- Role identity – what is the individual, team, and organisational understanding of the advanced nurse practitioner role?
- Role challenges – what barriers are still in place and why?

Chapter 3 – Situational analysis – a post-modern methodology

3.1 Introduction

To meet the study aims a methodological approach that would capture the complexity of the ANP role within the whole hospital system was needed. My philosophical outlook reflects a postmodern position, and situational analysis was identified as the methodological framework to achieve the study aim. Situational analysis (SA) is a methodology, and method, developed from grounded theory (GT) by Adele Clarke and reflects postmodern influences on grounded theory. This chapter will briefly examine my philosophical paradigm and why situational analysis fits as the research methodology. To understand situational analysis more fully, its evolution from grounded theory will be briefly explored, with further detail about GT and SA found in appendix B.

3.2 Philosophical paradigm

The professional experiences that have influenced my personal outlook have been laid out in the previous chapters and the following reflects how my philosophical paradigm was identified and applied to this thesis.

3.2.1 Postmodernism

Exploring the various philosophical paradigms, I recognised that my worldview fits with that of postmodernism. Postmodernism is a 20th century theoretical movement, which challenges the established views across philosophy, social sciences and the wider cultural domains, including architecture and cultivated journalism (Capovin, 2020). The value of formal theory is contested, with a particular friction between an inherent need to create guidance to get things done and a postmodern view that acknowledges that the complexity of life cannot be truly captured by any theory (Kearney, 2011). The table below details the core philosophical beliefs of postmodernism:

	Ontology	**Epistemology**	**Axiology**
Postmodernism	Discourse reflects objective and subjective realities, 'things' exist only if there is language to make them exist	Truth and knowledge are known only through discourse; no absolute truth; knowledge has power	Value the question more than the answer (in relation to research and knowledge generation)

Table 9: the philosophical beliefs of postmodernism (Adapted from Trivedi, 2020)

The research positionality of postmodernism supports a philosophical stance whereby no method can deliver a universal truth, although some research methods are more suited for questions of human social constructs, ultimately it is the validity of interpretation that answers the question being asked (Lincoln et al, 2018). Giacomini (2010) describes the postmodern researcher as seeking to explore, analyse and neutralise grand theories. Grand theories, or metanarratives, are deconstructed and all possible connotations, alternative interpretations and propositions are afforded this postmodern lens of analysis, with findings being presented as problematic (Giacomini, 2010).

This paradigm will allow for previous narratives regarding the ANP role to be re-examined in the context of this study. A postmodern lens allows for an openness to the complexity of the ANP role being enacted in a secondary care hospital. The policy, portfolio and literature review has exposed gaps in discourse associated with the ANP role and applying the ontological position of a postmodern lens would allow for discourse regarding the ANP role to be created. The value of the question being asked is seen as greater than the outcomes in postmodern research paradigms (Giacomini, 2010). Contemplating the value of this study in my professional life, the influence has been greater than anticipated.

The following section explores the research methodology that best fits my philosophical paradigm and identify the most suitable approach to explore the tensions in the advanced nurse practitioner role in secondary care.

3.3 Methodology

Grounded theory is one of the most widely used qualitative methodologies (and method) in sociology and health research and is regarded as the most popular sociological methodological export (Pawluch and Neiterman, 2010). It has responded to the influences of the social world with several evolved versions; one such evolution is situational analysis, developed by Adele Clarke (2005). Situational analysis is a qualitative research methodology suited for social world research where there is a need to explore and understand the deep complexities of a ‘situation’ broadly envisioned; the situation then becomes a pivotal component of analysis (Clarke et al 2018).

3.3.1 Grounded theory

Grounded theory (GT) was developed by two sociology researchers, Barney Glaser and Anslem Strauss, in 1967, with the aim of producing an illustrative theory aligned with shared social life patterns (Annells, 2010).

Glaser and Strauss (1967) identified the fundamental process of traditional GT as being an ongoing inductive, iterative process of data analysis through constant comparison. Figure 3 below reflects the research process of traditional GT:

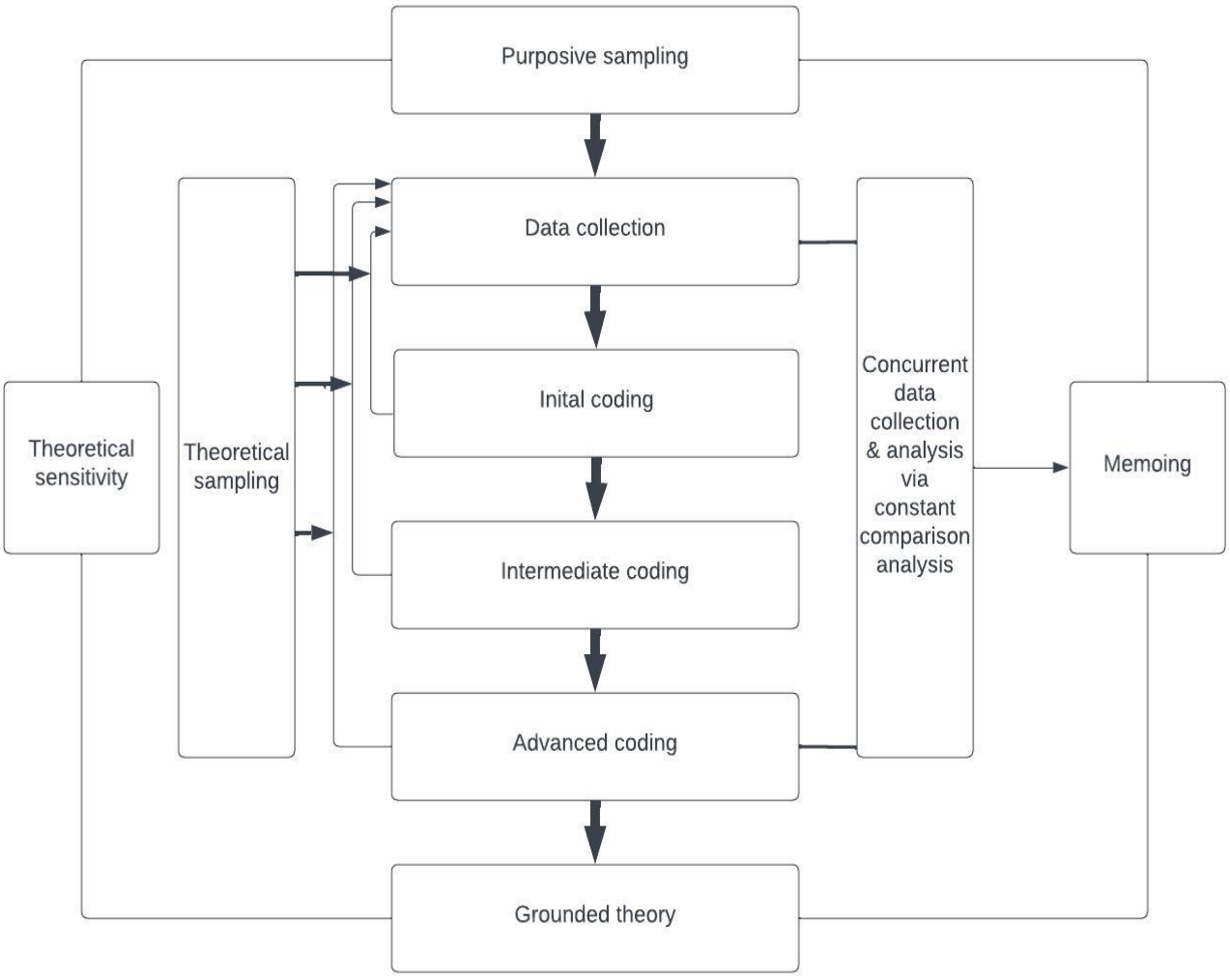


Figure 3 : research process chart for grounded theory, adapted from Chun Tie et al (2019).

Philosophical influence, and ultimately, arguments, have been instrumental in creating the three core versions of GT as recognised today – traditional (Glaserian) GT, Straussian GT and constructivist GT (Rieger, 2019). Situational analysis is the fourth and most recent approach with the development of maps to represent the

situation, social world, and positions of the points of discord. Figure 4 below reflects the genealogy of GT from discovery to today:

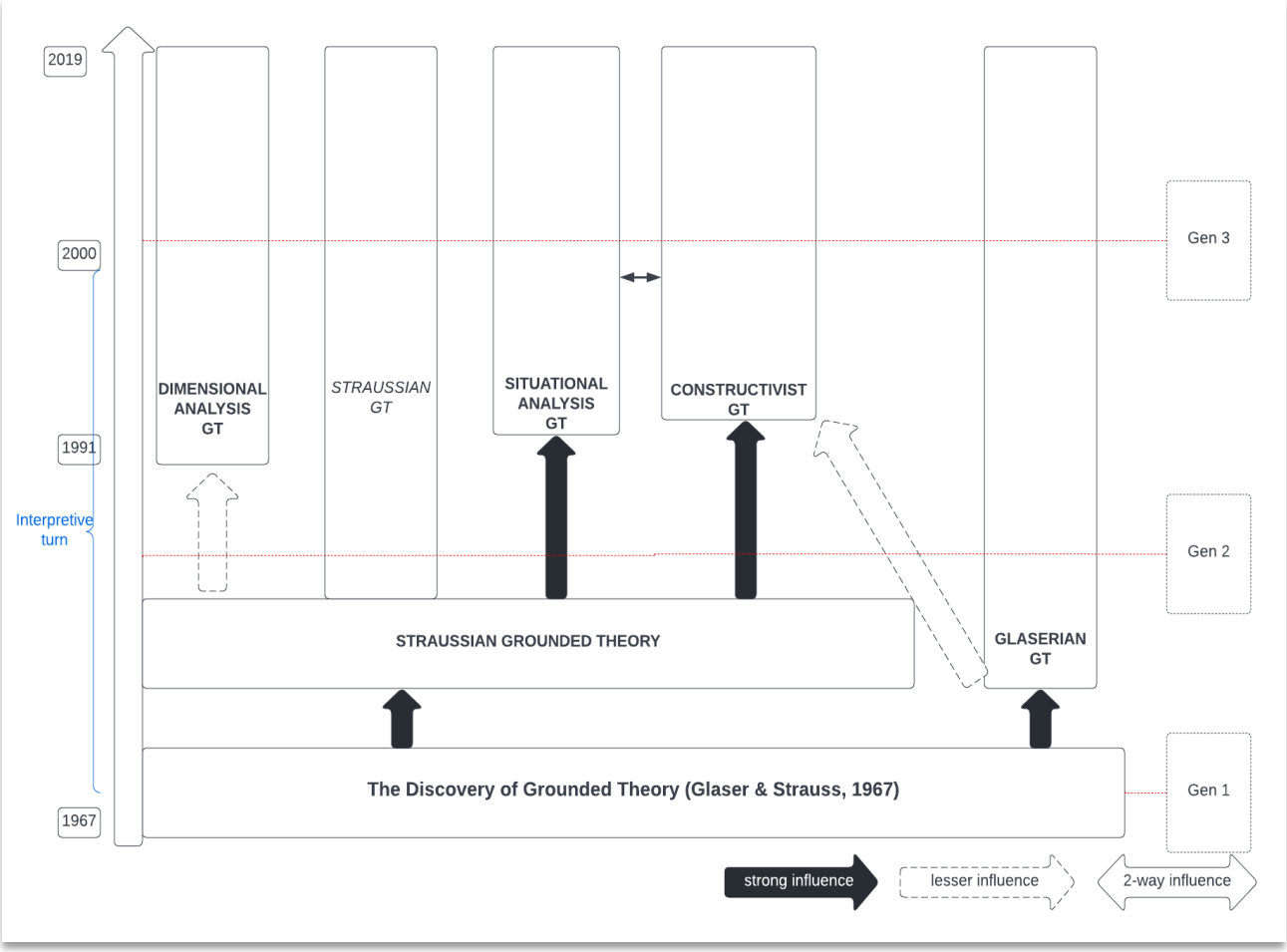


Figure 4: Evolution of grounded theory, adapted from Clarke (2019, p18)

It is the varying philosophical views that influence how the methods of grounded theory are applied, how the data is collected and analysed, how theory is created (or not) and the position the researcher takes in the process (Pawluch and Neiterman, 2010). The table below identifies the key philosophical stances of each of the current versions to date, position of the researcher, coding, and development of theory.

	Traditional GT	**Straussian GT**	**Constructivist GT**	**Situational Analysis**
Philosophical influences	Pragmatist Symbolic Interactionist	Symbolic interactionist	Constructivist	Postmodernist
Position of researcher	Distant observer	Interactive	Co-constructor	Active participant

	Traditional GT	Straussian GT	Constructivist GT	Situational Analysis
Coding	Constant comparisons Incidents Categories	Open coding Axial coding Selective coding	Initial Open Focused Varied Axial Theoretical	Open Axial Situational maps Social worlds or arenas maps Positional maps
Process of theory development	Inductive emergence	Induction	Constructed	Induction & Abduction

Table 10: Key philosophical stance of the 4 evolutions of ground theory.

Situational analysis is rooted in GT with the original iteration being a response to a postmodern lens being applied to GT. Clarke (2005) identified vulnerabilities in traditional GT that did not meet the needs of social world research in a postmodern world: a lack of reflexivity, the position of the researcher, oversimplification, and lack of situatedness.

3.3.2 From Grounded theory to situational analysis

GT in all its versions, remains the most popular and widely used qualitative research method (Clarke, 2007). However, Ralph et al (2015) recognise that GT, as a methodology, is inherently influenced by the epistemology and ontology of the researcher using it. Allen (2010) challenges that Clarke (2005), in her version of situational analysis, assumes tensions or conflicts that have not been identified or proven. However, postmodernism is reconciled to acknowledge silences and tensions in discourse, particularly with the lack of a grand narrative. It is not assumptive to accept that discourse also reflects the unsaid, situational analysis provides a means to explore the silence and expose its place and influence within the situation.

3.4 Situational Analysis as methodology

Clarke (2005) took a cartographic approach to exploring complex situations of inquiry, using three maps to represent the intricacy of the situation and the analysis of the data:

1. Situational map – this sets out the major discursive human and nonhuman and any other elements in the situation of inquiry. This initiates analysis of the relationships between these actors and elements.

2. Social world/arenas map – this is a meso-level interpretation of the negotiations that the collective actors and key nonhuman elements are engaged in. It also includes the arena(s) of discourse and commitment.
3. Positional map – this lays out the positions taken and not taken in the data as per key axes of disparity, concern, and controversy within the situation of inquiry and its identified issues.

(Clarke, 2005 pxxii)

This is a simple description of what is on closer examination a significant and innovate approach to research that allows for complexity to be captured. Perez and Canella (2013) note that situational analysis challenges the narrow and inhibiting traditional methods of researching concepts. In the first iteration of situational analysis Clarke (2005) identified six strategies applied to move GT from a symbolic interactionism paradigm to postmodernist one. The strategies are summarised in table 11 below, and address the limitations and lack of reflexivity that Clarke (2005) felt that traditional GT lacked:

1 – **Acknowledging embodiment and situatedness**: This means the acknowledgement of the position of the researcher in the research process, their interactions with the participants and data, analysis and in the generation of knowledge.
2 – **Grounding in the situation**: this addresses a broadening of the phenomenon under research to include the situation as broadly conceived and accepting situations as fundamental units of analysis
3 – **Acknowledging differences and complexities**: this addresses the inherent drivers of the 'normal' curve and allows for the 'differences' to be included and where indicated given meaning
4 – **Sensitizing concepts, analytics and theorizing**: this is a move away from grand theories and accepting Denzin (1992: p23) that '*it makes no sense to write a grand theory of something that is always changing'*. Clarke seeks to increase the analytical sufficiency of sensitizing concepts, analytics and theorizing rather than creating a substantive theory.
5 – **Doing situational analysis**: creating empirical analytical maps of situation(s) and doing situational analyses, accepting that the contextual elements are within the situation itself and are constitutive. Maps allow for alternative ways of working, opening up knowledge spaces and supporting temporal and spatial narratives.
6 – **Turning to discourse(s):** taking Foucauldian approach to discourse(s) and including narrative, visual and historical discourses to address '*narrative machineries'* (p31)

Table 11: 6 strategies applied to Grounded theory by Clarke, 2005 p19 – 31

Clarke et al (2018) continued the evolution of situational analysis towards the interpretive paradigm and by acknowledging that this turn has occurred globally and across scholarly divides, it recognises the need to reconceptualise the social world as being heterogenous and co-constitutive across all levels of organizational complexity. This further evolution widened the analytical abilities of situational analysis and cemented it as the methodology of choice for this study. The full

exploration of a secondary care hospital with all its complexities and the ANPs that work and move within this situation was now possible.

3.5 Situational analysis as method.

Situational analysis starts with memoing and preliminary mapping to outline the boundaries of the situation and answer the question of what the situation is (Clarke et al, 2018). Clarke (2019) continues to contest that the context is within the situation (or phenomenon) under investigation and the contextual elements create the situation. The principle of developing the three maps (situational, social world and positional) implies three single maps produced in a linear fashion. However, the essence of situational analysis is for multiple maps to be developed, either in isolation or in conjunction with each other, representing the inception of a research study through to its completion and publication.

3.5.1 Situational map

The situational map sets the foundation of the research process as it is used in unfettered form to set out the researcher's knowledge and understanding of the situation to be investigated. Messy map versions, using the principles of the situational map, start the process, and through memoing and analysis an initial situational map, will be developed to inform the research study. Clarke et al (2018, p117) define a situation '*as an enduring arrangement of relations and includes a number of events over at least a short period of time and can endure considerably longer'*. The situational map also presents the data from the study with the analysis being applied to identify key actors, actants, discursive and sociocultural elements as well as the silent or implicated actants.

For this study the policy, portfolio and literature review were initially reviewed in a traditional systematic approach. With the identification of the methodology and method for use in this study, a situational map will be created from the data and discourse discussed in chapter 2. Situational analysis allows for data to be gathered and analysed in a wider sense by including present and historic discourse and acknowledging the influence of non-human and silent actants (Clarke et al, 2018). This approach allows for initial emergence of the situation to be mapped and provided the early guidance for the study design (see chapter 4).

Clarke et al (2018) notes that undertaking research on a personal topic requires the researcher to be particularly reflexive, and my positionality will be formally addressed in chapter 4. This initial messy map, which evolves into a situational map, is recognised as a valid process. Martin et al (2016) noting that indiscriminately 'dumping' descriptors on paper allows the researchers to focus on ideas not structure, as well as stimulating thinking it can facilitate patterns and connections when applying it to data. The messy map remains throughout and is preserved as a point of reference for the researchers, Clarke et al (2018) maintains they should be messy, accessible, and malleable throughout supporting ongoing analysis. Figure 5 identifies the key elements that are required on an initial messy map:

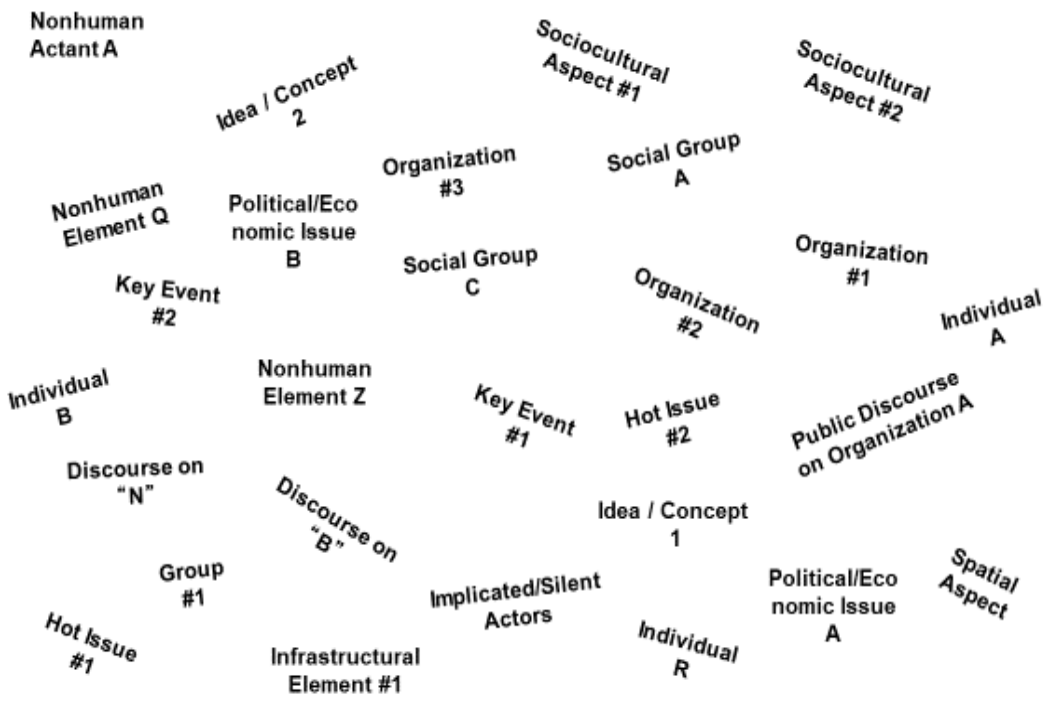


Figure 5: template messy map (Clarke, 2005 p88).

The ordered version of the abstract situational map reflects Clarke's experience and the negotiated/processual ordering framework of Strauss (1993). Clarke et al (2018) acknowledge that this may feel prescriptive but encourage the researcher to add categories to as needed to meet the needs of their research. A template of this ordered situational map is found in Figure 6 below:

Individual Human Elements/Actors	***Nonhuman Elements/Actants***
e.g., key individuals and significant (unorganized) people in the situation, including the researcher	e.g., technologies; material infrastructures; specialized information and/or knowledges; material "things"
Collective Human Elements/Actors	***Implicated/Silent Actors/Actants***
e.g., particular groups; specific organizations	As found in the situation
Discursive Constructions of Individual and/or Collective Human Actors	***Discursive Construction of Nonhuman Actants***
As found in the situation	As found in the situation
Political/Economic Elements	***Sociocultural/Symbolic Elements***
e.g., the state; particular industry/ies; local/regional/global orders; political parties; NGOs; politicized issues	e.g., religion; race; sexuality; gender; ethnicity; nationality; logos; icons; other visual and/or aural symbols
Temporal Elements	**Spatial Elements**
e.g., historical, seasonal, crisis, and/or trajectory aspects	e.g., spaces in the situation; geographical aspects; local, regional, national, and global spatial issues
Major Issues/Debates (Usually Contested)	**Related Discourses (Historical, Narrative, and/or Visual)**
As found in the situation; see positional map	e.g., normative expectations of actors, actants, and/or other specified elements; moral/ethical elements; mass media and other popular cultural discourses; situation-specific discourses
Other Kinds of Elements	

Figure 6: abstract situational map: ordered version (Clarke et al, 2018 p131).

Clarke et al (2018) recognises the impact of the non-human actants on the situation from previous life science research and asks the researcher(s) to consider '*what nonhuman things really matter in this situation of inquiry? To whom or what do they matter?*'(p129). The researcher(s) are also challenged to consider what beliefs, discourses, symbols, notions, points of dispute and issues of culture are in the situation as well as asking the more challenging question of what is taken for granted? This tasks the researcher to uncover that which is invisible due to its deep naturalisation (Clarke et al 2018). This situational lens has not been applied to the role of the ANP in the evidence identified thus far, and it is anticipated that this novel

approach with reveal unknown silences and tensions in the role. Despite all this abstraction in developing the messy and ordered situational maps, Clarke et al (2018) make it clear that these maps are not conceptual or analytical, they are intended to open the elements of the situation for the researcher to gain clarity of the whole. Once completed then the relational connections between the elements can be identified so that individuals can be targeted for further investigation. The purpose of this process is to enhance later analysis of the data by providing a clear map of the situation, thus allowing the relationality of the elements to be revealed.

Messy and then ordered situational maps were completed at the outset of the study, with an example of an early messy map in appendix C and the ordered map that informed the study design can be found in chapter 4.

3.5.2 Social worlds/arenas map

The development of the social world and arena maps reflect key concepts initially recognised by Clarke (2005) that reveal the influences of both Strauss and George Mead on her creation of situational analysis. Clarke et al (2018) gives a description of social worlds as being groups of fluctuating sizes that create a life of their own, citing examples of a profession, a hobby group, an academic tradition, or a discipline. There is an associated commitment to act collectively through shared viewpoints that support both individual and collective identities. It is anticipated they will reveal the complexity of the relationships both within and between social worlds, and associated negotiations that the ANP experiences to enact their role within a secondary care hospital. Context can be studied through mapping causal process and the complexities of the resulting relationships gaining insight into the circumstances that produce effects (Martin, 2016). A template of a social world and arena map is represented in Figure 7 below:

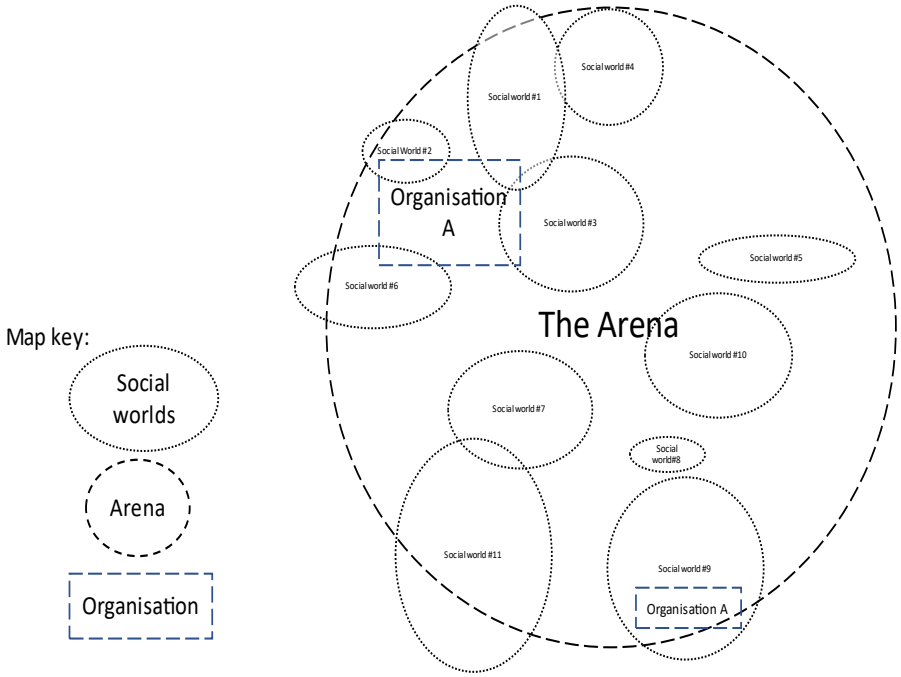


Figure 7: template of the social world and arena map (Clarke et al, 2018 p150)

3.5.3 Positional maps

The data informs the positional maps by identifying the foundational issues within the situation of inquiry (Clarke et al, 2018). The positions are usually points of contention or tension within the situation, though this is not always the case. Two relational axes are identified, and the major positions are mapped rather than the micro-level refinements within a wider position (Clarke et al, 2018). Table 12 notes the key questions that Clarke et al (2018 p168) suggests the research asks to identify the axes.

- What is X about?
- Why is it being talked about?
- Why is it important?
- Who or what is Y arguing against in the data?

Table 12: identifying positions taken in the data Clarke et al (2018 p168)

An example of how this is represented in map form is found in Figure 8:

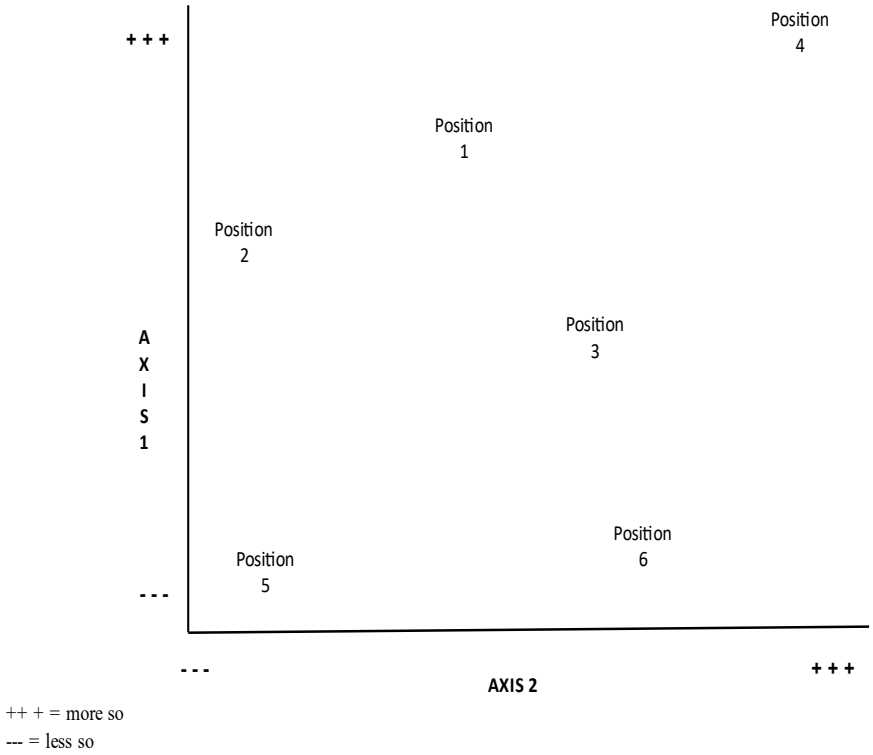


Figure 8: template positional map (Clarke et al, 2018 p165)

Numerous positional maps will be produced during a study as it allows for multiple positions to be explored through various aspects though ultimately the contentious issues will be presented more fully in the completed study (Clarke et al, 2018). It is anticipated that this will be a key map in this study, being able to represent the tensions in a such a clear format would add to the knowledge and understanding of the ANP role in secondary care.

3.6 Summary

Accepting one's philosophical lens and applying it with the right research methodology to answer a question or to investigate a social situation brings a validity to the new knowledge created. Situational analysis fits with the postmodern lens being applied while also embracing the complexities of the role (advanced nurse practitioner) in the identified context (secondary care hospital). The following chapter discusses the study design using situational analysis.

Chapter 4 – Study design using situational analysis.

4.1 Introduction

This qualitative research study applied both the methodological framework of situational analysis as well as using the methods of this cartographic approach to data analysis. The philosophical methodology has been addressed in Chapter 3, this chapter will lay out the study design and methods to be applied.

4.2 Situational map to inform research process.

The aim of this study is to surface the tensions in the advanced nurse practitioner (ANP) role within a secondary care setting. Since Kernick's (2004) early work on the complexity of healthcare organisations, there has been increasing recognition of this concept. More recent challenges are to adapt qualitative research to better explore and capture this complexity (Long et al, 2018). As an evolved form of GT, situational analysis (Clarke et al, 2018) provides the framework to capture this intricate web of social interaction in a healthcare organisation. The literature review encompassing portfolio and policy review identified current themes and silences to be addressed in this study. This evidence provided the study foundation and developed the initial messy map which informed the first situational map. This has been labelled as Figure 9: study design situational map. This does not reflect any analysis at this stage, it is a representation of the evidence about the advanced nurse practitioner role in secondary care.

Individual Human Elements/Actors	***Nonhuman Elements/Actants***	***Discursive Constructions of Individual and/or Collective Human Actors***
Advanced nurse practitioner Nurse Trainee doctor Consultant Researcher Patient Medical supervisor	Paperwork IT Uniform Rotas Radiology	Job description Scope of practice Portfolio Job plan Reflections Work based assessments Feedback
Collective Human Elements/Actors	***Implicated/Silent Actors/Actants***	***Discursive Construction of Nonhuman Actants***
Advanced nurse practitioners Medical teams Specialty teams Chief nursing officer team Nursing & Midwifery council Department of Health & Social Care Higher Education Institutes	Patients Pharmacy Radiology Governance Lead nurse manager	Public safety
Political/Economic Elements	***Sociocultural/Symbolic Elements***	***Major Issues/Debates (Usually Contested)***
Advanced practice framework Royal College of Nursing Royal College of Emergency Medicine Royal College of General Practitioners Workforce planning Welsh Government Department of Health & Social Care Health Education England	Gender Age License to practice (permission) Difference in diagnosis	Recognition & governance (regulation) Advanced practice or professional development Assessment & measuring Substitutive or complimentary
Temporal Elements	**Spatial Elements**	**Related Discourses (Historical, Narrative, Visual)**
Novice to expert Professional development Imposter syndrome Self-awareness Competence	Hierarchy in practice Welsh workforce Role model Perceived need for the ANP role	Patient care Curriculum Credential
Other Kinds of Elements	Time Motivation	

Figure 9: study design situational map

This map provides the foundation for the study; individual and collective human elements will inform who the human participants should be, and this will be discussed in the sampling strategy. The questions used in the data collection strategy will be informed by the other elements in this map to surface tensions in the advanced nurse practitioner role.

4.3 Positioning the researcher.

In the original version of situational analysis, Clarke (2005) acknowledged that researchers cannot approach studies without prior knowledge, which influences and affects them and the research process. This reflects the concept of positionality and this needs to be addressed with sincerity to provide the reader with reassurance as to the truthfulness of the findings. The dynamic and contextual nature of positionality is widely recognised (Soedirgo and Glas, 2020); therefore, my positionality will be addressed at this preparatory stage of the study and throughout as needed during analysis and discussion.

My work identity is multifaceted: I am a nurse, an experienced advanced nurse practitioner, a novice doctoral researcher. Piedra (2023) recognised that the concepts of positionality, identity and reflexivity apply to the participants of the study as well as the researcher. This is important to acknowledge as my identity in my workplace, which is also the study site, will potentially influence those who do or do not participate. Associated with identity there are elements of social capital and influence, and I acknowledge that this was a key consideration in relation to the participants of the study. At the time of the study, I represented the ANPs in the organisation at the nursing and midwifery board meetings, which are high level professional nursing meetings chaired by the executive nurse director. As a result, I was not only actively campaigning and championing the ANP role in the organisation, but I had created a network of contacts amongst advanced practitioners.

Although my identity in the organisation carried some social capital and influence, acting as researcher did not. I acknowledge that this placed me as an insider researcher which carries with it benefits and challenges. Insider-researcher status is not a settled place and requires a reflexive approach to successfully negotiate the research process and engage the participants (Adu-Ampong and Adams, 2020).

Reflecting on the issues of bias noted in the literature review with insider-researchers, I recognised the need for the transparency regarding any aspect where my place in the organisation could influence my actions or interpretations. This was discussed openly with supervisors and is acknowledged in the introduction that one of the sparks for the study was frustrations with radiology department. To avoid influencing data collection and analysis I will examine and address my personal responses to any aspects, such as radiology, that trigger an emotional reaction. It is anticipated that taking a broader, organisational approach to the study site and setting will further reduce any bias. I am not studying my individual role or service but the collective ANP roles and multiple services within a secondary care hospital.

Reflexivity requires the researcher to look outwards, questioning and addressing assumptions associated with the research subject matter, design, and process (Wilson et al, 2022). As previously stated, my main assumption is that the tension in the ANP role is linked with a perception of competence by others (organisationally as well as individually). To address this and to maintain an open-minded approach I spent time gaining a better understanding of the concept of competence, through reading various expert sources and debating it at length with my supervisors and colleagues. The purpose being to be able to recognise where and when the concept of competence truly exists in the study and to provide assurance it is not implied by any bias that I held prior to the study. Clarke et al (2018) developed situational analysis to allow deeply naturalised aspects of the situation to be made visible. In preparation for undertaking this study I have addressed assumptions, completed a policy, portfolio and literature review which has allowed for a broader macro-level view of the subject matter. As a subject matter expert with lived experience as an ANP, I can recognise the nuance and language in the situation that can identify the invisible deeply naturalised aspects of the situation in the data analysis.

Clarke et al (2018) advocate for memoing throughout the whole research process not just during data analysis, and taking this approach allows for ‘in the moment’ reflexivity. Using voice note memos allowed for articulation of thoughts as it facilitates a dialogue to explore and challenge assumptions. Being reflexive in planning and completing the research process has ensured that consideration has been paid to aspects that could be viewed as limitations in the study from the outset.

Reyes (2020) notes the advantages of researchers recognising and strategically applying their positionalities in both positive and negative ways. One such positive positioning is undertaking this study in my employing organisation. This affords access and insight to the influences and barriers to the ANP role that might not have been available in other settings.

It is the acknowledgement of the influence of my identity and positionality on the analysis that is key to the validity of the findings. My openness to reflexivity will allow for the constant questioning of the analytical process, with the analytical approach guided by Clarke et al (2018) supporting transparency of analysis. Drawing this together, my positionality in this study reflects the identity of a curious doctoral researcher with extensive ANP experience, and an ability to openly challenge my thoughts, opinions and assumptions shining a light on the truth of the tensions in the ANP role in secondary care.

4.4. Sampling strategy

The objective of sampling in qualitative research is to illuminate the concept of interest and although flexibility in approach is required, there needs to be clarity of purpose when inviting participants and gathering data (Morse and Clark, 2019). The study design situational map, created from the evidence review, identified the individual and collective human actors to be included in the study in its primary stages. A purposive sampling approach was taken for the initial phase of the study with the focus being on recruiting ANPs across the secondary care hospital. The inclusion criteria in section 4.4.2 clarifies the characteristics of the ANPs included. This commonly used approach is appropriate as it is a defined occupational group under investigation. Purposive sampling allows those who have the required knowledge, information, or experience to be targeted (Campbell et al, 2020). ANPs were a key data source to set the foundation for the study as the focus is on their experience and enactment of role within the secondary care setting. However, the study design situational map identified other actants and data sources to be collated and analysed to give the whole picture view that was being sought. To provide clarity regarding data sources for this study an inclusion and exclusion criteria has been written based on the study design situational map.

4.4.1 Inclusion criteria

The preliminary purposive sampling inclusion criteria focuses on identifying and recruiting ANPs either in training or qualified. There is ongoing confusion and variety regarding the titles given to the role of an ANP (Imison et al, 2016) and the study site is no exception, with numerous titles in use:

- surgical nurse practitioner
- trauma nurse practitioner
- advanced paediatric nurse practitioner
- advanced critical care practitioner
- clinical nurse practitioner
- polytrauma nurse practitioner

Using the title ANP alone would not have been enough to identify and recruit to the study, therefore the National Leadership and Innovation Agency for Healthcare (NLIAH) (2010) definition of advanced practice was used:

> a role, requiring a registered practitioner to have acquired an expert knowledge base, complex decision-making skills and clinical competencies for expanded scope of practice, the characteristics of which are shaped by the context in which the individual practices. Demonstrable, relevant Masters level education is recommended for entry level
>
> (NLIAH, 2010 p21)

Following initial data analysis, an ongoing purposive sampling strategy is applied. The study design situational map suggested that the inclusion criteria would reflect:

- Line managers of ANPs
- Medical supervisors of ANPs
- Medical, nursing, or allied healthcare professional staff who work daily with ANPs
- Staff whose role impacts or influences the ANP role through governance or policy (such a radiology or pharmacy).

Data collection using situational analysis follows an emergent process based upon the principles of grounded theory data collection (Clarke et al, 2018). Therefore, it is acknowledged that not all the sources of data are known at initial stages. Data collection process is discussed further in section 4.6 of this chapter.

4.4.2 Exclusion criteria

The exclusion criteria included those who would be unable to give data on the ANPs role within the secondary care hospital through virtue of their role, responsibility or contact with ANPs. This would also include:

- Clinical nurse specialists (due to differences between roles)
- Advanced practitioners from others allied health professionals (the focus of this study is on advanced nurse practitioners only).
- Employees without experience of working with advanced nurse practitioners.
- Employees whose roles does not influence the governance or practice of advanced nurse practitioners.

4.4.3 Secondary data sources

As situational analysis encompasses the discursive elements of a situation, secondary data sources were identified and gathered. Pertinent documents within the organisation that impact on the day to day working of ANPs were included to provide a wider picture of where ANPs are situated within the organisation. The discursive data was collected in conjunction with the focus group and interview data to reflect the situation at that time. The study design situational map identified non-human actants and discursive constructions for inclusion such as:

- Hospital policies
- Hospital guidelines
- Intranet/internet webpages
- Forms and documentation that are used in clinical practice.

Any further data sources identified during data analysis will be included as required. However, policies and discourse regarding ANPs from outside of the organisation will be excluded and have been addressed in the policy and literature review in chapter 2.

4.5 Study site

The study site chosen is a secondary care hospital which includes an adjacent children's hospital. The hospital provides aspects of tertiary care to both adults and children. However, the main function is providing assessment, investigations, care, and management to the local population within a hospital setting at a secondary care level. There are established ANP teams in several departments within this hospital. Consideration was given to carrying out this study in alternative organisations however this study site had the largest number of ANPs in Wales.

4.6 Data collection

Clarke et al (2018) challenges researchers to ensure they collect data that addresses the pertinent issues within the situation, in particular the silences that are notably associated with gender, race, or power. The literature review and study

design situational map allude to tensions within the role; however, these are silent and unseen. This study seeks to reveal these tensions through exploring how the role is enacted within a secondary care setting. Koro-Ljungberg et al (2018) remind us that data is a nebulous concept, as is it does not exist until it is created or gathered. Analysis changes it from data to evidence. This perception aligns with Clarke et al (2018) appreciation of the silences in a situation whereby they do not exist until they are revealed. The initial data collection via purposive sampling identified ANPs as being the preliminary data source, and as this study seeks to explore the ANP experience in a whole hospital not a single department or speciality, then their collective experience was sought. Exploring various approaches to data collection, focus groups were identified as an effective process to gather this data. This is discussed further in section 4.6.1. The other human actants once identified, were offered interviews as a means of identifying the wider experience, understanding and opinion, of the ANP role, this is discussed in section 4.6.2.

4.6.1 Data collection – focus groups

Focus groups are recognised as a method for investigating and examining issues of importance to a group of individuals. It allows for what they think, how they think and why they think that way, to be explored without any pressure to make decisions or reach an agreement (Liamputtong, 2015). There is a need for homogeneity within a focus group to allow for open and comfortable discussion and a moderator is recommended to support the free flow of dialogue during the limited time (Acocella, 2012). This homogeneity was a guiding reason for using focus groups for the ANPs but not for the other participants. The purpose being to identify the group experience of ANPs within the hospital by gathering them together and sharing their journey. Focus groups provide an opportunity for the individuals to explore, reflect and problematize their taken for granted behaviours and positions (Barbour, 2010). The aim of this process is to allow the ANPs to openly discuss their experiences and question each other's enactment of the role, revealing silences and tensions.

Acocella (2012) recommend that focus groups are seen as group discussions rather than group interviews, so to facilitate the discussion the study design situational map was used. Researcher expectation is recognised as influencing the imagining and enactment of the focus group, particularly the flow of conversation from tightly scripted to unrestrained dialogue (Kamberelis et al, 2018). This was a serious

consideration when undertaking a focus group as an insider-researcher. I used memoing pre- and post-focus groups to facilitate reflexivity regarding the focus groups. This allowed for acknowledgment of the duality of my position as participant and researcher, given my situatedness in the study. When using situational analysis, Clarke et al (2018) acknowledge and accept the experience and the situatedness of the researcher as an investigative resource not a corruption.

Digital recording via voice recorders and an online video conferencing platform were used for data collection from the focus group. These recordings were stored securely on an encrypted platform. The recordings were transcribed verbatim by a third party using the video and digital recordings. Greenwood et al (2017) recognise this as a standard approach with interview and focus group data but note that transcriptions alone are one-dimensional. There is benefit from both voice and video recordings as it provides a three-dimensional data source that can be analysed both independently and simultaneously to provide validity to the analysis. Collins et al (2019) demonstrated the benefit of hearing as well as reading the data from focus groups and encourage a reflexive attitude to transcription. The video recording allowed for the group interaction to be captured, creating another source of data in conjunction with the transcribed focus group recordings. Eaton et al (2019) demonstrated that transcriptions of video interviews produced equivalent quality data as voice recordings. Although verbatim transcription is recognised as the conventional approach (Greenwood et al, 2017) it is labour intensively and costly (Eaton et al, 2019). Omitting transcription and using audio/video recordings and field notes only for analysis has been explored but it was recognised that some of the nuance and interaction within a group can be missed (Greenwood et al, 2017).

There is ongoing debate regarding the number of participants for a focus group. Gill et al (2008) suggest between six and eight participants is suitable, too few make it more like an interview and too many can make it difficult to manage and to hear everyone’s response. Carlsen and Glenton (2011) identified a lack of transparency and accountability in published qualitative research where focus groups have been used. They noted little explanation regarding the number of participants as well as the number of groups (Carlsen and Glenton, 2011). For transparency this study had two focus groups with four and five participants, lasting 55 minutes and one hour six minutes respectively. A third focus group was planned however, with the impact of

the COVID-19 pandemic it had to be abandoned. Initial mapping of the data from the two focus groups revealed the homogeneity of the role in a secondary care hospital. Although a further focus group would have added to this evidence it is not anticipated that the lack of a third group had a significant impact on the validity of the data. This limitation is explored further in chapter 7.8.5.

To mitigate bias an open questioning approach was used to encourage the participants to interact and discuss with each other. The study design situational map was used to guide the questions. Barbour (2010) notes the effect of the environment on the dynamic of the focus group advising a comfortable room without distractions, as well as moderator to support with the discussion and interaction. A large seminar room away from the clinical areas was used for the focus groups. However, as these were held at the beginning of the Covid-19 pandemic accessing a suitable moderator was not possible. Tausch and Menold (2016) explored the moderator role and identified key factors that facilitated a positive outcome for a focus group:

- Introductions to create open atmosphere.
- An awareness of the influence of status within the group.
- Smaller group size was more beneficial (4-8).
- Adaptable structure to the discussion, depending on the topic.

This was taken into consideration when arranging, preparing, and facilitating the focus groups without a separate moderator. The number of people able to gather in a room together and an individual's willingness to meet with others outside of their usual social 'bubble' was affected by the global pandemic. Participants were given an opportunity to join the meeting either online or face to face. Using webcams and an online meeting platform the online participants and those attending in person were able to interact and the whole session was recorded digitally. A backup digital recorder was used in case there were any recording issues. Barbour (2010) reminds the researcher to be familiar with and confident using the recording equipment. The equipment had been used for hybrid teaching sessions and I was practised at managing any challenges with equipment or internet failures. Managing a focus group in this hybrid way was challenging but not unique. Woodyatt et al (2016) explored the potential for differing quality in data collection using online versus face-to-face focus groups. It was demonstrated that although there are differences with the data gathered, the content generated was comparable (Woodyatt et al, 2016).

Preliminary review of the focus group data revealed homogeneity of experience which was mapped onto a messy map to be further analysed. The messy map identified the staff to be recruited for individual interviews as well as the non-human and discursive elements to be included in the study.

4.6.2 Data collection - interviews

While homogeneity was sought regarding the advanced nurse practitioner experience, the heterogenicity of the supervisors (medical and nursing), managers, colleagues and other identified participants was explored in individual interviews. Using interviews as a method of '*knowledge production'* has become widely accepted and of the three approaches – structured, semi-structured and unstructured, semi-structured is the most widely used (Brinkmann and Kvale, 2018). The purpose of interviews is to elicit individual opinions, beliefs, experience, or motivations of the phenomenon under investigations (Gill et al, 2008) and Kelly (2010) reminds us that it is the interviewees construction or perspective of reality that is being sought, not the interviewers. This is in-keeping with the postmodern philosophical lens used in this study. Interviewing is a conversation with purpose and should be conducted with an aim for concrete descriptions rather than theorising from the interviewee (Brinkmann and Kvale, 2018). Semi-structured interviews offer a framework for the dialogue without being too rigid by reciting a questionnaire, or so open that the conversation is completely unfettered and there is too much data to analyse. For the purposes of this research the semi-structured interviews were based on the preliminary analysis of the focus groups. The interviews were recorded via an online videoconferencing platform, again with a backup digital recorder in case of equipment failure. All the interviews were carried out online. These interviews were transcribed verbatim in the same way as the focus groups, analysis of the interviews will be addressed in chapter 5: analysis and findings – making maps.

There was a nine-month gap between the focus groups being carried out and the interviews completed. This was due to limitations in the workplace associated with the Covid-19 pandemic. The restrictions regarding staff contact within the workplace that were at a higher level than the national restrictions associated with 'lockdown'. The IT system required urgent updates to facilitate online meetings and staffing levels were reduced in many areas. It took this nine-month period to gain sufficient

stability and resilience in the workplace to recruit and interview the participants. The potential effect of this on the study outcomes are discussed in chapter 7.8.4.

4.6.3 Data collection – discourse

Discourse is understood as the assigned representations, principles and practices of language used to place meanings in their specific fields of society and history (Brooker, 1999). Jaworski and Coupland (2014) recognise the broad opinion that discourse is 'language in use' but acknowledge that discourse is more than that and should be seen as 'beyond language in use'. This reflects discourse as language use intertwined with the influences of societal, political, and cultural constructions and it both shapes and is shaped by these influences (Jaworski and Coupland, 2014). It should not be limited to language or words but should include graphical representations, symbols, nonhuman and material things, as well as any other modes of interaction (Clarke et al, 2018). These elements are required to complete the context of the situation and reveal the silences and tensions as these factors have not been explored in other studies.

The initial situational map identifies the discursive constructions of human and nonhuman actants to be investigated as part of this study. These were gathered during the data collection period from the organisational intranet, via email requests to appropriate departments such as workforce for job descriptions, senior management groups for minutes of meetings. Discourse should not be limited to analysis of language used and Clarke et al (2018) challenge that the concept of discourse should be '*writ large'* as it is constitutive of the how people view and comprehend the world around them.

The principles of analysing discourse have been set out by Clarke et al (2018) and are found in table 13 below:

Discourse analysis	Discursive materials collected
• Why did you choose these materials? • Who in particular produced them? • Who were they produced for – for what audience? • For what purposes, what work were these materials intended to do in the world? • With what goals and intended us	• Minutes of nursing and midwifery board meetings • Nurse practitioner job descriptions that were in circulation during the time of the data collection • Documents relating to non-medical prescribers or non-

• What else seems important? (Clarke et al, 2018 pp247)	medical referrers for diagnostic imaging • Workforce strategy

Table 13: principles of discourse analysis and discursive materials collected in this study.

This was the analytical approach taken in this study and the discursive elements collated will be discussed further in Chapter 5.

Aspects of the ANP role are governed by departments external to the service they work within; for example, pharmacy hold the register of non-medical prescribers. The pharmacy and radiology sites on the intranet were searched for any policies, guidelines or other discourse associated with the ANP role. These documents from radiology and pharmacy reflect the governance process for non-medical staff to request radiology investigations or to prescribe medications for their patients. Appendix E has detailed information regarding these processes.

The minutes of the nursing and midwifery board meetings reflect the discussions and approvals of high-level nurse or midwifery governance, professional or operational issues. Attendees at the meeting are:

- nurse director representatives from each of the clinical boards
- consultant nurses and midwives
- lead for professional standards
- nurse director lead for workforce (whose portfolio includes advanced practitioners)
- advanced nurse practitioner representative
- senior nurse for learning, education, and development

These meetings reflected the professional vision and culture within the organisation. The Nursing and Midwifery framework for 2017 – 2020 was included in the discourse data as it shared the vision the of nursing and midwifery workforce.

4.7 Recruitment of participants

Established ANP groups were contacted via email with participant information and dates for focus groups. The focus group participants all met the inclusion criteria as ANP, two of the participants were in the final year of training/studying. The remaining participants had been working in ANP roles in the organisation from two to seventeen years.

Following the focus group, a messy map of the data was created to identify participants to be interviewed. Emails were sent to senior nursing and medical teams

across clinical boards along with emails to the senior management teams in radiology and pharmacy. This allowed for a wider spread of participants across the hospital. This recruitment phase was repeated five times as one staff group identified from the focus group analysis consistently did not respond – lead nurse group. This group became a silence in the data analysis and will be discussed further in Chapter 5. There were 12 participants recruited and interviewed. One interview was excluded as the participant did not meet the inclusion criteria which did not become apparent until the interview was completed. They had volunteered to participate to discuss radiology processes associated with ANPs. However, it became evident during the interview that they were not able to provide the insight required, they were a staff nurse working in radiology not an advanced practitioner nor someone responsible for the governance of radiology referrals. The absence therefore of any 'human' data from a radiological perspective became a 'silence' in the human data, but the discourse from the department was included and provided valuable understanding from a discursive perspective.

The participants are identified in table 14 below:

Pharmacist	Lead for non-medical prescribing governance
Consultant	Surgeon, Adult Intensivist, Paediatric Intensivist, Neonatologist, Emergency Medicine, Paediatric Trauma and Orthopaedics
Trainee doctors	Registrar level (speciality training year 4 or above) Foundation level (year 2 of Foundation training)
Nurse	Deputy Executive Nurse Director Senior nurse for a specialist service

Table 14: participants interviewed for this study**.**

4.7.1 Ethical considerations

Ethical approval for this study was sought and given by Cardiff University School of Healthcare Sciences ethics committee on the 18th September 2019. The study was subjected to approval via a Research Ethics Committee which was given via the Integrated Research Application System on the 9th March 2020. Further permissions for the study were sought with the local research and development office before commencing on site recruitment. This was received on the 4th May 2020.

4.7.2 Informed consent

Informed consent is a founding principle of any research study, and the participant information sheets addressed the information required for participants to make an informed choice. There were two participant leaflets, one for the ANPs and one for the other participants. These can be found in appendix F. Consent was obtained by

all participants after they were invited to participate and were given the appropriate participant information leaflet. At the start of focus groups and interviews participants were also given an opportunity to confirm verbally they were giving consent to participate in the study.

4.7.3 Confidentiality (including anonymity)

Iphofen and Tolich (2018) discuss the difficulties of maintaining confidentiality and controlling information with focus groups and recognise the inability to meet ethical requirements with groups that know each other from the same organisation. This was a notable concern, and the participant information leaflet sought to address this vulnerability by including a statement about respecting confidentiality inside and outside of the focus group, while also encouraging free dialogue in the focus groups. The principles of Chatham House rule were followed within the focus groups. One to one interview's are recognised as allowing for confidentiality to be maintained and the individual being entitled to alter or retract any dialogue (Iphofen and Tolich, 2018).

Anonymity could not be maintained in this focus group as participants work in the same organisation and are closely linked with each other. It was also an aim of the focus group to identify the homogeneity of experience of the ANP role in the organisation. It was therefore necessary to ask individuals about their role to start the conversations about shared experience. Although this would have removed any anonymity should individuals not know each other, each individual maintained control of what they shared and how much they engaged. Barbour (2010) notes this as a strength of focus groups when anonymity cannot be maintained.

4.7.4 Professional issues

Participant information sheets addressed the process of managing any professional concerns raised during the focus groups and interviews. This proved not to be an issue as no information shared or discussed fell outside of the requirements of the codes of conduct for any of the professionals who participated.

4.7.5 Data protection and management

Both the focus groups and interviews were recorded digitally by online meeting programmes, these were password protected and stored securely within Cardiff University IT system. Third party transcription was used with data protection guidelines adhered to throughout. All digital data was given an anonymous code

before transcription and the university IT system was used for storage and transfer as the transcription was carried out by an employee of Cardiff University. To further meet data protection requirements the hard copies of transcripts were also stored securely in a locked facility within Cardiff University.

4.8 Data Analysis

Data was analysed using an abductive analytical approach. Clarke et al (2018) advise an analytic focus of laying out the human and nonhuman elements by asking questions of the data: 'Who and what are in this situation? Who and what else matter in this situation? What other elements make a difference in this situation?' (Clarke et al, 2018, p127). As these elements are identified they are added to the situational map and with each addition of data the map will be revised. There is a perpetual movement between the empirical data and the abstract concepts created by analysing the data (Clarke et al, 2018). This process will continue throughout the data collection and analysis contributing to the development of the situational, social world and positional maps. This is more fully addressed in Chapter 5.

4.9 Summary

The aim of this study is to surface the tensions in the ANP role within a secondary care hospital. Homogenous data was gathered from advanced nurse practitioners via focus groups, with heterogenous data from those who supervise, manage, or provide governance for ANPs collected via individual interviews. Discursive data was also gathered to map a fuller picture of the advanced nurse practitioner role in secondary care. Ethical principles were maintained throughout the study and legal requirements for the management of data adhered to. Following the tenets of situational analysis, the data was abductively analysed and represented cartographically in the situational, social world/arena and positional maps. This analysis and the subsequent findings will be addressed in the following chapter.

Chapter 5 – Analysis and findings: making maps.

5.1 Introduction

This chapter lays out the analytical process applied to the data collected with the findings cartographically presented. Situational analysis is an abductive analytical process (Clarke et al, 2018) and although the study design guided initial data collection, it is the analytic process that guided wider situational data gathering. Data collection and analysis were intertwined, and this chapter will demonstrate the influences they had on each other. Clarke et al (2018) developed the three maps (situational, social world and positional) to give the researcher a structure to present findings following investigation of a situation. It is the researcher's choice regarding which of the maps are presented in the completed study but Clarke et al (2018) recommend fully developing all three maps as part of the analytical process. Ahmady and Khani (2022) talk of the levels of the maps with the situational map being macro-level, social world at meso-level and the micro-level of a situation reflected in the positional map. This approach was in-keeping with the maps developed in this study. The situational map not only reflected the organisational influences and experiences of the advanced nurse practitioners, but also the external, wider political, social and temporal elements. All three types of maps have been used to present the findings from the data analysis in this study. The tensions in the advanced nurse practitioner role will be presented in the form of two positional map with the situational and social world maps demonstrating the situation that creates the tensions.

The following chapter discusses data collection and preparation for analysis, analytical process and concludes with the findings being laid out in the maps. Prior to discussing these maps in chapter 7, there is a return to the literature, with an updated review of the concepts identified in the analysis.

5.2 Data collection and preparation for analysis

Data collected comprised two focus groups, eleven interviews, and 157 pages of written documentation associated with the ANP role in the study site. Although preliminary messy maps were created as part of the data collection process, it was only when data had been more fully gathered that analysis started in earnest. The following section describes the practical aspects of the analytical process to the point of messy map development. An in-depth description of analysis from the messy map

to developed situational map will follow. A reflexive approach to data collection and analysis was taken using the memoing approach advocated by Clark et al (2018).

The focus groups and interviews were transcribed verbatim. The text in isolation was sometimes difficult to follow but listening and watching the overlapping conversations allowed for the nuance of emotion and inference of tone to be appreciated. The power of participants words or silences could be better identified by watching and listening to the recordings. This added depth to the analysis giving a situational element to what participants said and how they said it. Transcribed data was printed twice, initially with black ink for first round analysis as it allowed for notes to be made while watching and listening to the focus groups and interviews. The second printing was in coloured ink so that text could be cut out and put together with similar responses to develop the data for the situational and social world maps. The colour coded ink allowed for convergences and differences to be identified between the participants. Data from the two focus groups was read, watched, and listened to several times before a messy map was started. This map was overly messy with less focus on concepts or themes and more focus on recognising pertinent comments from the participants. This initial map is shown in Figure 10 below with further examples of the messy map process previously noted in appendix C:

Figure 10: first messy map from data analysis

It became easier to collate the data under the headings of the situational map as the messy map was reviewed and added to over time. Clarke et al (2018) advocate putting everything the researcher thinks might be relevant on this messy map as the analytical relevance of this raw data might not be known until further into the study. Memos were important at this stage to record why something was mapped, so that the perspective and the cognitive process associated with this decision was recorded. Adding in colour to the text also helped recognise the associations between the data as the analysis progressed. The key colours are identified in table 15 below:

Advanced nurse practitioner	
Researcher	
Consultant and medical mentor	
Trainee doctor or doctor	
Radiology	
Pharmacy and prescribing	
Medical professional organisations	
Nursing professional organisations	
Other barriers to role	
Silences	

Table 15: key colour chart used for the participants and themes in the study.

To explain the colour allocation shades of blue have been used for nursing participants, the darker the shade the more senior the nurse. As an ANP researching advanced practice I have acknowledged my place and presence with a shade of blue. Doctors are shades of yellow, barriers are red and silences silver to allow them to stand out, Pharmacy is green. Combining the use of colours and the memoing allowed for the decision-making to be reviewed as the data analysis progressed. There has been debate about the approach to be taken with memos and what style or method is best (Birks et al, 2008), but Clarke et al (2018) advise the researcher to memo in whatever way or style suits them. To better suit my cognitive process, I used the voice note application on my phone for memoing as well as making short notes in a notebook. These were easy and accessible options and allowed for reflexivity. This was important for validity as I was able to demonstrate the analysis was of the data and not my opinion, some examples of these memos can be found in appendix C.

Clarke et al (2018) talk of ‘wallowing’ in the data, which was an aspect of the analysis that I was afforded by the challenges of the data collection. The two focus

groups took place in close succession and the data transcribed quickly. It was nine months before the interviews were started which gave a good ‘wallowing’ period with the focus group data. There were multiple readings, listening and watching of the focus groups, which contributed to the ongoing development of the messy map. It afforded some time to further sharpen and consolidate my analytical skills.

The focus group participants identified key stakeholders that influenced or impacted on their roles, these were purposively recruited to be interviewed. The key relationships identified were consultant supervisors, nurse managers, junior doctors, radiology, and pharmacy. The participants interviewed are as noted in table 14 in chapter 4 and for ease it is presented again below:

Pharmacist	Lead for non-medical prescribing governance
Consultant	Surgeon, Adult Intensivist, Paediatric Intensivist, Neonatologist, Emergency Medicine, Paediatric Trauma and Orthopaedics
Trainee doctors	Registrar level (speciality training year 4 or above) Foundation level (year 2 of Foundation training)
Nurse	Deputy Executive Nurse Director Senior nurse for a specialist service

Table 14: participants interviewed for this study.

Other non-human concerns with uniforms, job descriptions, scope of practice, rotas, portfolios, training programmes, faculties and Royal College influences, job plans were noted in the situational map developed from the focus group data. The non-human elements did not easily lend themselves to being colour coded in the same way as the human elements. Therefore, colour has been applied where possible to show linkage, but much remains as black ink. This does not imply inferiority or superiority; it reflects the challenge of assigning further meaning and value to non-human elements. Documents, policies, reports, and any other accessible text related to these issues was gathered. The circumstances of the discourse gathered needs to be recognised as influencing what was gathered and as a limitation in the study. The Covid-19 pandemic impacted on the routine meetings in the organisation and therefore workforce groups, advanced practice network groups, lead and senior nurse meetings were all stood down. The organisational intranet and external internet were searched to gather any written data associated with advanced practice roles with the specific focus on advanced nurse practitioners. The organisational data was discursive in the form of policy documents, job descriptions and minutes of meetings.

To summarise prior to discussing the analytical process in more detail: two focus groups, eleven interviews, and 157 pages of documents associated with advanced nurse practitioner roles were collated and prepared. An initial messy map was developed and added to, providing the foundation for analysis, memoing was used to support reflexivity as well as recording decision-making. The following section discusses the analysis of the data in detail, followed by the findings and the developed maps.

5.3 Analytic approach

The abductive analytical approach advocated by Clarke et al (2018) is described as a repetitive process of moving in and out of all the study data to analyse and theorise it abstractly, developing broad assertions about the phenomenon. It is recognised as a method of reasoning through which unforeseen or unusual observations are related to other observations by identifying the context of a credible relationship (Tavory and Timmermans, 2019). The ability of abductive analysis to reveal and relate actants within a situation was a key factor in choosing this method. Literature regarding advanced nurse practitioners alludes to challenges with role recognition and variability with role enactment but the reasoning behind these challenges has not been articulated to date. Abductive analysis facilitates the revealing of the unexpected and allows for development of explanations of these surprises through adapting known theories or developing new ones (Tavory and Timmermans, 2019). This analytical process with the subsequent mapping has allowed for a more situational understanding of the advanced nurse practitioner role.

Underpinning abductive analysis Clarke et al (2018) advocate either an integrative analytical approach or comparative mapping and analysis, with a recommendation to identify early in the analytical process which approach to take. Consideration of the comparative approach was given, especially with data collection comprising three parts – focus groups, interviews, and organisational data. It was assumed that comparing the data would reflect the silences and confluences better. However, once data collection started and progressed it became more apparent that an integrative approach was a better fit. This study aims to map the whole situation regarding the ANP role in a secondary care setting. An integrative analytical approach allows for the moving in and out of the various influences on the role. This technique allowed for the issues raised in the focus group to be explored in the

interview data and organisational discourse, and vice versa. The core question in this integrative analytical approach is '*what do all of these data sources together have to say about the phenomenon of interest?'* (Clarke et al, 2018 p235) with the resultant maps representing the situation as found in the collective data. Below is a flow chart of this whole process for clarity (Figure 11):

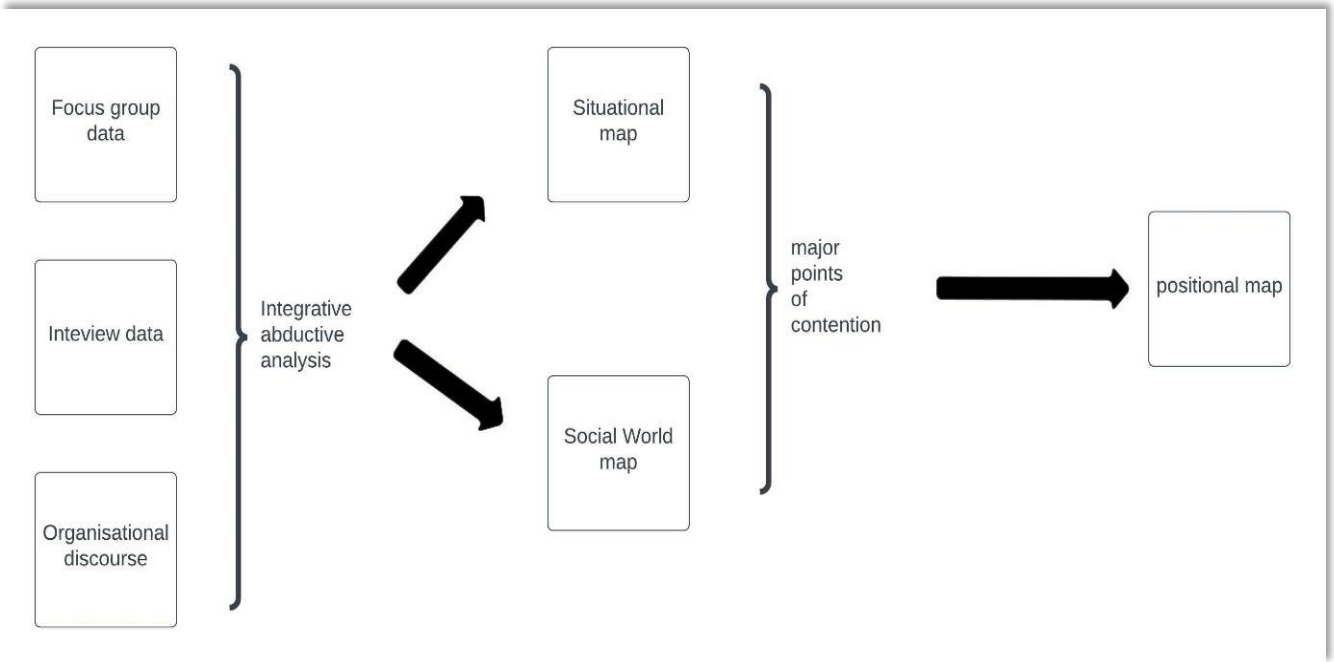


Figure 11: Representation of analytical process and creation of situational, social world, and positional maps**.**

5.4 Analysis

The abductive approach of moving in and out of the data was applied across all aspects of the analysis. The focus group data was repetitively reviewed and then the organisational data was explored to identify if it supported the experiences expressed in the focus groups by the ANPs. This action was repeated with the interview data, moving in and out and across the collective data. This became an immersive experience which then required some time stepping away from the data to cognitively process it. Returning to the data it then became easier to identify findings for mapping under the headings of the situational map. This was an evolving process and took several weeks and extensive memoing. Analysis was non-linear and occurred without a recognisable pattern. Reading one interview would lead to reviewing a document which would lead to a paragraph from a focus group transcription, and so on. To demonstrate the interconnectivity of the analysis, Figure 12 below is a representation of this process:

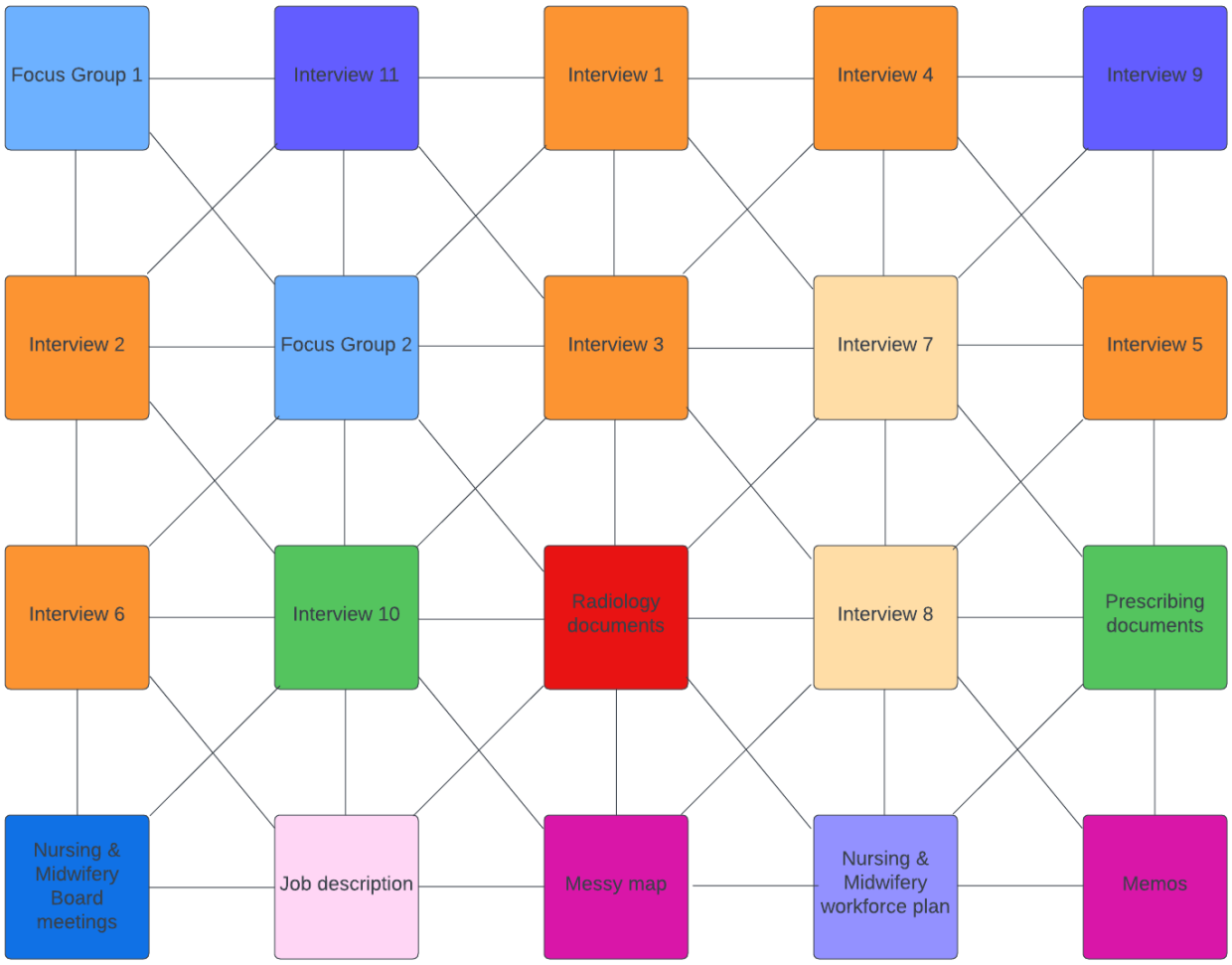


Figure 12: Visual representation of the integrative analytical approach across the data sources. The colours reflect the source of the data, and the interconnecting lines represent the moving back and forth between the data during the analytical process.

Data was analysed from single words(micro) to phrases (meso) to whole sections(macro) of text and back again. Taking this micro, meso and macro view of the data allowed for connections to be identified which in turn exposed gaps or silences. An example of the data can be found in appendix D; this it is part of the whole transcript of an interview with the deputy executive nurse director. Differing options for managing data were considered; coding either by hand or using an electronic system was a possibility, however, coding felt as though the data was being quantified. As the volume of data increased it became a more intuitive process to move in and out of the various data sources and to look at the wider literature to identify the high-level concepts being identified. I recognised a need to keep a focus on the aim of the study and not cognitively wander or theorise. To do this I wrote the

title of the study on the messy map and used the memoing process to keep focussed. Once the analysis had progressed sufficiently the first situational map was completed.

5.4.1 Developing the situational map.

As previously noted, the initial messy map contained pertinent comments and phrases representing the data from the focus groups and interviews. This map was illustrative of the general comments and issues raised in the focus group discussions and became the foundation for the data analysis with the discursive organisational data adding to it. As the messy map became filled with these comments, it became easier to identify collections of comments and to start grouping them in the headings on the situational map. The headings used by Clarke et al (2018) have remained the same since the inception of situational analysis in 2005 and are noted in figure 6 on page 53-4.

Clarke et al (2018) acknowledge that not all these elements will be present in every situation and study, reminding the researcher to adapt the framework accordingly. This framework was used to organise the data from the messy map, tacking in and out of the data allowed for the high-level concepts to be identified and moved on the situational map. Using an example to explain this more clearly – the phrase 'jumping through hoops' was used in the focus groups and interviews. However, the underlying meaning changed according to the situation it was used in and who said it. Consultants used the phrase to recognise a rigorous process of assessment to achieve a standard. The ANPs and trainee doctors both perceived it as unnecessary onerous assessments, especially the trainee doctors who compared the processes applied to them with those applied to the ANP's. When mapping this from the messy map to the situational map it was acknowledged as a '*discursive construction of individual and collective human actants*' and recorded as 'achievement', 'standards' and 'barriers'.

The abductive analytical approach advised by Clarke et al (2018) reflects her view of the art of the researcher, acknowledging the abductive gestalt that researchers develop during analysis. This mirrored my experience of tacking into the data and out to high level concepts to recognise the structure of what was being said in the data. To support this analytical process, I regularly returned to the questions that Clarke et al (2018) highlighted as key to the analytic aim of the situational map:

> Who and what are in this situation? Who and what else may matter in this situation? What other elements may make a difference in this situation?' (p127)

As the aim of the study is not to theorise the ANP role, it was important when analysing the data not to develop participants responses into grand theories. This is reinforced by Clarke et al (2018) who remind the researcher that situational maps are not intended to be conceptual and should not contain analytical codes. The purpose of the map is to lay out the major elements in a situation to provide clarity. The mapping process was reviewed and refined numerous times, with elements being added, removed and position changed as the data is perpetually analysed. Reflecting on this process, the development of my analytical skills was visible in the evolution of the analysis. Initial maps feel simplistic and superficial in comparison with the final situational map and there is now a satisfaction that the tensions in the advanced nurse practitioner role in secondary care have been captured and mapped. Knowing when the map is complete is a challenge, and in true grounded theory style, Clarke et al (2018) talk of saturation. In this study the situational map was deemed complete when no new elements had been added or removed over a two-month period. There was a temptation to map elements which were variations of the same concept, for example diagnosis, decision-making, and responsibility are all interlinked and so responsibility became the element mapped as it carried more of the essence of what was being said. The completed situational map is presented in section 5.7.

5.4.2 Developing the social worlds and arenas map.

The social worlds and arenas map requires the researcher to initially take a meso-level view of the situation recognising where the study is placed in the phenomenon under investigation (Clarke et al, 2018). It was the social world map that originally sparked the beehive analogy for the secondary care hospital. The organisational work of the hospital was representative of multiple levels of activity occurring simultaneously, with an overarching purpose of delivering healthcare. This is analogous to the colony work of bees where there are self-organising responses to the need of the hive. The ANP role is a relatively new 'worker bee' role and while it fits into the work of the colony, there is a lack of acknowledgement of this new 'bee'. The social world mapping is an opportunity to identify the influences on the ANP role across a secondary care hospital, as well as the influence the role has on the organisation. Social world maps symbolise the interests of key stakeholders and the

effect they have on the situation, with the sizes of the arenas and organisations being representative of relative power (Clarke et al, 2018). The template of a social world map is noted in Figure 7 on page 56.

The analysed data was used to populate this map with the size of social worlds, overlap and relational position used to demonstrate the influences of the social worlds and arenas that exist in the world of an advanced nurse practitioner in secondary care. Colours and sizes of the dots or lines of the circles are also used to represent the function and influence of the group. Martin et al (2016) comment that the social arenas demonstrate the intricacy of the situation, reflecting a holistic lens and interlinking worlds and actors.

It was during the development of the social world map that my position as insider-researcher became more apparent, and the reflexivity applied in the analysis became more important. An example of this relates to the minutes of a nursing and midwifery board meeting where there was reference to ANPs because I had raised the issue. I recognised that in my ANP role I had created the data that I was now analysing as researcher. For transparency, and to provide validity in the analytical process, this was discussed at length with my supervisors, I also reviewed Clarke et al (2018) position in such circumstances. I recognised that the minutes of the meeting I was analysing did not fully reflect the circumstances of the conversation, as I was present at the meeting. The discussion was regarding a new job description for a nurse practitioner, I queried as to how this role fitted with the ANP roles, to be told that there were no ANPs in the organisation (this was digitally recorded but not documented in the minutes). The response revealed the misunderstanding of the ANP role in relation to other practitioner roles.

Social worlds and arenas reflect the collective social action of a group and there are distinctive group characteristics displayed (Clarke et al, 2018). Analysing data from the focus groups the collective characteristics of ANPs were identifiable, as are the overlapping characteristics with the medical team. However, the differences in characteristics between the two social worlds meant the actual overlap was small. The completed social world and arena map is presented in section 5.9.

5.4.3 Developing the positional maps.

Of the three types of maps, it is the positional ones which I regard as providing an accurate reflection of the tensions in the ANP role. For the positional map, the focus of the analysis is to examine the discursive data and identify the major positions taken on issues in the situation, including silences in positionality (Clarke et al, 2018). In analysing data, it is important to accept that there is not a 'normal' position and a corresponding 'opposite' one, the positionality is reflective of the analysis of the data and does not have an additional value inferred. The purpose of the analysis at this stage is to present the major positions as communicated in the materials (data) in the situation they are produced. A template of an abstract positional map is displayed in Figure 8 page 53.

Although the situational map identified major issues and debates, the analysis for the positional maps required a focussed analysis of the non-human and discursive materials. A renewed approach was needed with this analytical process as exploring the discourse without the circumstances of the interview and focus groups data was challenging. The human data provided such rich perspective to the situation, the organisational discursive data initially felt one-dimensional and cold. Clarke et al (2018) reassures the researcher that this is a recognised challenge when starting to analyse discourse but encourage the researcher to engage with the materials more deeply. This process required some reflexivity and reflection as I recognised my positionality in relation to some of the documents could affect the analysis. The process of completing and adhering to the requirements in some of the documents had been stressful, therefore, to analyse them for this study I needed to compartmentalise my emotional reaction to them. Time was given to reading the materials in detail and then re-reading and making notes while starting to ask – what is being talked about and why does it matter? Comparing the materials was the next stage in the approach taken and it started to become apparent that there were differences in positions taken in materials even though the purpose of the documents was the same.

To explain this in relation to the analysis, the documents associated with non-medical referral for diagnostic imaging and non-medical prescribing were both concerned with governance of these processes. These processes are fundamental aspects of the ANP role contributing to the diagnostic and treatment part of clinical

patient assessment. The language used in these documents has differing tones reflecting the culture of each department. These documents were the impetus for first positional map, situating them with the focus groups data allowed for the points of contention to be identified. Analysing the radiology document, the language was 'aggressive' in manner with reference to removing requesting privileges until all requested evidence approved and using terms such as 'breach of contract' if the process is not adhered to. The prescribing document had a 'softer' tone using words like 'enabling'. Nursing and Midwifery board (NMB) meeting minutes reflect these differing approaches with a reference to challenges for community based advanced nurse practitioners being denied permission to request radiology imaging. The NMB minutes also ratified the governance process for non-medical prescribing, the radiology process was agreed within the radiology directorate.

Applying a postmodern lens to the discourse allowed for issues associated with power to be explored and the phrase 'non-medical' resonated through the discourse. The situational use in the documents associated with providing permission to practice (non-medical referrer for diagnostic imaging and non-medical prescribing) could reflect that there are multiple professionals, notably nurses, physiotherapists, pharmacists, paramedics, to whom these documents apply. However, my postmodern lens sees this discourse as having negative connotations, 'not a doctor' implying something lesser. This is more apparent when as part of the analytical process the national documents that these organisational ones are based on were reviewed and a different language is used. Royal Pharmaceutical Society (2021) refer to prescribers collectively, not separating out 'non-medical' professionals. The Ionising Radiation (Medical Exposure) Regulations (2017) reference the 'referrer' for diagnostic imaging and again does not delineate doctors from other healthcare professionals. This analytical process was reviewed and refined until I was confident that the two positional maps developed reflected the positions taken regarding scope of practice and barriers to practice, and professional identity and visibility. The completed positional maps are presented in chapter 5.10.

5.5 Summary of analytical process

The integrative, abductive analytic approach advocated by the situational analysis method has been followed and has allowed for the tensions in the advanced nurse practitioner role in secondary care to be revealed and mapped. Analysis of data in

this study has been a lengthy and immersive process to develop and evolve the three versions of maps -situational, social world/arena and positional. The situational map has set the circumstances for the tensions in the ANP role in secondary care. The collective behaviours influencing these tensions have been represented in the social world and arenas map. The first positional map shows the tensions between what an ANP can do (scope of practice) compared with the influences that limit that practice (barriers to practice). The second positional map reflects the positions taken regarding professional identity and visibility. The analytical process has been laid out and now the findings will be presented.

5.6 Introducing the findings.

The following section will present the findings in cartographic form to provide clarity and understanding regarding the tensions identified in the ANP role in secondary care. Clarke et al (2018) gives the researcher the freedom to present the pertinent maps for their study, acknowledging that not all maps need to be presented in the published work. In this study the interconnectivity of the tension is better represented by displaying all the maps, signifying the depth of analysis, and providing a more complete view of the situation. For clarity the maps are presented in a linear manner – situational, social world, and the two positional maps but as previously discussed they are not developed in a sequential manner. The maps and their relationship with the findings are presented in this chapter with detailed discussion developed in chapter 7. The analysis identified key actants across all the maps and the colour coding introduced in the glossary and earlier in this chapter was used for consistency.

5.7 Situational Map

The completed situational map is displayed below:

Individual Human Elements/Actors	***Nonhuman Elements/Actants***
Researcher Advanced nurse practitioner Trainee advanced nurse practitioner Nurse practitioner Consultant Trainee doctor Medical mentor Line manager Patient	Titles Uniform Rota Geographical boundaries
Collective Human Elements/Actors	***Implicated/Silent Actors/Actants***
Consultants Doctors Multi-disciplinary team Nursing management Advanced nurse practitioners	Lead Nurse managers Directorate managers Radiology
Discursive Constructions of Individual and/or Collective Human Actors	***Discursive Construction of Nonhuman Actants***
Foundation of experience Responsibility for actions and decisions Autonomy – freedom to practice Value of ANP Anchor Advanced practice portfolio Barriers Validation Funding & cost Holistic nursing lens Support for junior doctors Support from consultants	Non-medical title (radiology and prescribing) Workforce plans All Wales nursing uniform Levels on rota Scope of practice linked with place of work
Political/Economic Elements	***Sociocultural/Symbolic Elements***
Agenda for change The NHS Plan (2000) Royal College of Emergency Medicine Royal College of Nursing Faculty of Intensive Care Medicine European working time directive	Recognition in hierarchy Gender Nurse equality with doctors
Temporal Elements	**Spatial Elements**
Career pathway Professional development Transition of nursing role Organisational memory	Wales England
Major Issues/Debates (Usually Contested)	**Related Discourses (Historical, Narrative, and/or Visual)**
Same/Different Broad scope/Limiting permissions Internal governance/External governance Advanced generalist/Advanced specialist Professional development/Service provision Personal identity/Professional recognition Ambiguity/Standardisation	Modernising nursing careers
Other Kinds of Elements	Time Loneliness Motivation

Table 16: completed situational map from analysis with colour coded elements.

Using the broad headings of nurse and nursing, doctor and medicine, regulation and restriction, the key findings will be laid out in the following sections to provide clarity regarding the placement of the findings on the various maps.

5.7.1 Nurse and nursing

This section will identify the findings associated with the broad themes of nurses and nursing, with the recognition of the lead nurse manager as a powerful silence in the study. This level of nurse manger was first noted in the focus groups, with reference to a lack of understanding of ANP role:

Focus Group 2
ANP 5 - I don't want to be negative about it but there's that lack of understanding of ANP roles in other nursing hierarchies and so that constant having to prove what it's all about, what level you work at, yeah, it's challenging. **ANP 9 -** the medics and the consultants that we work with know what we do, the nurses on the unit know what we do and they're all fine but it's the nursing management within our, you know, our team that don't really get what we do and yet we're the people that get moved and put everywhere, we're like a commodity because they can't fit us into a box, because they don't get it still, they still think they can move us around and do, oh the nurse practitioners will do that, oh the nurse practitioners will do that.

There was further reference in the interviews reflecting the lead nurse role as a deliberate barrier to development of advanced roles:

Interviews
Senior nurse manager – recently with the change of management I've found some of the previous documents haven't gone any further than immediate line managers and yet that wasn't the message that was coming back, it was very much 'oh this has gone to board and board have said no', you know that type of conversation and that's really frustrating as a manager to hear

Consultants also reported a push back from the nursing hierarchy regarding the pay banding for an ANP role:

Interviews
Consultant 4 - I argued against the nursing hierarchy [banding of role] and it was the nursing hierarchy that kicked back…which for me is not progressive.

The lead nurse managers have a key responsibility in the governance for non-medical prescribing, as the forms to be registered with pharmacy must be signed by them. They are not required to be prescribers themselves and this has, in some specialities, caused further challenges with them requesting the nurse prescriber to list each individual drug they will be prescribing. The interview data was reviewed with the non-medical prescribing documents, and it was identified that this is not a requirement of the non-medical prescribing guidelines and reflects a lack of understanding of independent prescribing. This was reflected in an interview response:

Interviews
Consultant 6 – that's what they're saying they need to do on intensive care which is like utterly ridiculous, I said we're not doing that, you are not writing down you are setting up 10 patients on lactulose today. No way. What I don't know is where the rules come from yeah but one of them [consultant colleague] said do you know what we just need to find where this rule came from and then we sit on that committee and we change the rules because this is nonsense

The lead nurse managers were recognised by the ANPs, senior nurse manager and consultants as having a negative impact on the role. They are present in influence but their role in the situation has not been fully understood, hence the recognition of the lead nurse role as a silence and transparent in the social world map and written in silver elsewhere. An executive level nurse recognised the potential for this perceived block, with their view being boundaries and limits should be reflective of individuals and roles:

Interviews
Deputy executive nurse director – Nursing is quite old fashioned…governed by traditional boundaries...should be about the individual's ability

The ANPs also reported challenges from the lead nurse manager level of nursing management where they (ANPs) were treated as commodities to move and fill gaps in services. However, they were not allowed to use the title advanced as the managers did not want to recognise that the role was that of an advance nurse practitioner:

ANP Focus Group 2
ANP 9 – Just to say that where [I work] I'm not [called] an advanced nurse practitioner, of course it's my job description and role, I'm just a surgical nurse practitioner, they're not keen to go down calling us an advanced nurse practitioner role but I have done the ANP … standalone module [portfolio] because I'd already had my Masters I didn't have to do the whole MSc so I finished that a couple of years ago and that was very, very challenging **ANP 5 –** I find…most frustrating is that you're okay to do some things when it suits them [lead nurse managers] but not to be as autonomous when it doesn't suit them

The consultants also reported frustrations in the variation regarding the management of the ANPs in relation to job plan and scope of practice. As previously noted, the application of organisational 'nursing' rules and regulations being applied to ANPs was seen as inappropriate. The ANPs noted the need to '*prove yourself*' (ANP focus group 1, ANP 2) if you have a clinical role but not having to do so in management roles:

ANP Focus Group 2
ANP 6 - there's some really rubbish managers and you know, if that was nurse practitioners it would be picked up on straightaway.

This reflects a tension with equality of seniority between ANPs and senior nurses, without parity of evidence to prove an ability to do the job.

The concept of advanced practice as a '*new way of nursing'* (ANP focus group2, ANP 6) is a reflection on the change in role from nurse to advanced nurse practitioner. It was consistently recognised in the focus groups and interviews that this is a nursing role, with the value of bringing a holistic nursing lens to the role being acknowledged:

Focus group 1 & 2
ANP 1 – Everything you do is still guided by your years as a nurse, and that was our kind of foundation…as a trainee doing someone's central line…the nurse who was with me said 'you did that in a very nursey way' **ANP 1 –** ANP's filling doctors gaps [during the Covid-19 pandemic] …really showed their massive breadth of skills whereas a junior doctor is a junior doctor…the ACCPs [Advanced critical care practitioners] were just doing everything

ANP 8 – For me its about giving the whole patient care to the patients, its being able to do everything I need to do for the patient in a sort of not having to wait around for other people to do stuff **ANP 9 –** It comes from the nursing background…we were taught slightly differently, and it wasn't all learning medical facts, it was how to read a patient and how to look at things slightly differently

ANP 1 was referring to how the ACCPs were not only covering the medical tasks and roles they were able to provide the nursing care required at the time with that patient. This ability to meet all the patients needs was part of the added value of advanced nursing practice. The foundation of nursing experience was also recognised by the doctors as a key reason for the success of ANP roles:

Interviews
Junior Doctor 1 - We sort of get taught, given a title then put into the role, whereas you guys do it because you've got all the experience in that area **Middle grade Doctor 1 -** They're so skilled in the practical skill set …they've been doing it for years…they also have that added skill set which really works in intensive care of being able to know about drugs, like they know how to make drugs up, check drugs and IV infusions

The doctors recognised and valued the extra skills that the ANP's brought to the patient they were caring for. Here, tensions were starting to be identified; the value of nursing in the ANP role was respected by the doctors and the ANP's but the nursing identity also brought with it restrictions and barriers.

From the ANP perspective in the focus groups it was their significant nursing experience and seniority which led them into the advanced practice world. This was borne out of frustration from teaching and supporting trainee doctors to carry out procedures or make decisions without being 'allowed' to do it themselves:

Focus Group 1
ANP 3 – I was actually supervising a lot of the younger medics in some doing, some of the procedures but I couldn't actually do the procedures myself [as a nurse] so I thought 'oh I've got to change that'

Personal motivation and drive were key characteristics that all the ANPs reported and the enormity of commitment to the role and training was a challenge for all the

participants. Supervising consultants noted these characteristics and recognised that this is a '*self – selecting'* (Consultant 4 & 5) role:

Focus Group 1 & 2
ANP 2 – If you're working with members of the [ANP] team who don't have the same drive or understanding of the role then I think it can be really difficult…you need a team around you who you trust **ANP 4 –** I knew it would be hard for sure but nowhere near as hard as it actually was. **ANP 3 –** It can consume your whole thought process…your thought process in that training is I've got to revise…you realise your life is on hold **ANP 5 –** So challenging, particularly when you work fulltime…the competency-based learning was quite difficult with all the OSCE's etc that were required on the course **ANP 9 –** very, very challenging because there was nothing, no sort of programme set up for it in surgery at all and I basically had to find my way through all of that, write my own competencies, you know set up my own assessments. **ANP 6 -** Just keeping my fingers crossed I survive the next three years of masters

When the ANPs discussed where they aligned themselves professional it was firmly with nursing. However, they also commented on all the aspects of being a nurse that impacted on their ANP role and recognised that the identity of being a nurse was a factor in limiting their role:

Focus Groups 1&2
ANP 1 – The rest of the world are not quite ready [to] let nurses do what they [ANPs] do. **ANP 4 –** There's still very much a nurse/doctor divide and this is what nurse does, this is what a doctor does. **ANP 2 -** [Initially…] nursing staff who didn't like the idea of the role, thought they could do the role and were quite dismissive of the role…over time they realised having a nurse practitioner on the unit was an absolute massive plus

The previously noted tension regarding the advanced nurse practitioner role and the imposition of nursing rules was countered by an argument for standardisation and clarity. One consultant wanted a '*core set [of skills] that defines that advanced level'*

(Consultant 4). This desire for clarity of definition of advanced practice was also noted in the interview with a deputy executive nurse director who felt the boundaries between advanced and specialist practitioner roles were blurred:

Interviews
Deputy executive nurse director – We've got lots of roles spanning from nurse practitioner to specialist practitioner to advanced nurse practitioner where you know for me the boundaries of definition between advanced, specialist, you know is blurred. We call practitioners out of hours particularly at night, we call a band 7 a nurse practitioner, are they a nurse practitioner or that just an old title that has been kept in the organisation or are they …in an advanced role so but there's not advanced in their title.

This reflected changes in the understanding of the roles of nurses over time with the introduction of advanced practice roles, without consideration of clinical nurse specialist roles and extended skills practitioner roles. Nurses have increased their knowledge and skills in multiple roles and settings to meet patients need and their drive to develop. This has created confusion about types of roles, levels of practice and autonomy, which has yet to be addressed in policy, workforce plans or professional guidance. A lack of understanding of the ANP role is apparent in the discursive data. The three job descriptions included in the analysis – nurse practitioner, advanced nurse practitioner and clinical nurse specialist, were all at the same pay band 7. The description of the role, level of responsibility and autonomy as well as the underpinning academic requirements were similar, and it was challenging to identify differences between the roles. The job summary on each job description reflects the four pillars of advanced practice although is it only the advanced nurse practitioner role that would have a requirement to meet this. All three require autonomous and accountable practice and as reflected in table 17 below:

Nurse Practitioner	Exercise clinical leadership through a higher level of independent judgement, discretion and decision-making
Advanced Nurse Practitioner	Highly developed specialist knowledge underpinned by theory and experience
Clinical nurse specialist	Providing expert clinical care using an extensive theoretical knowledge base

Table 17: core role definitions from three job descriptions for nurse practitioner, advanced nurse practitioner and clinical nurse specialist

All three job descriptions have prescribing as part of the role; however, it is the ANP job description that requires this to be essential in the person specification. Similar

discrepancies occur regarding the level of education, the ANP role requires a full MSc in Advanced Clinical Practice, the nurse practitioner role requires an MSc but doesn't specify which one, the clinical nurse specialist role requires an MSc or equivalent experience. Accepting that all three roles are on the same pay band and there are such similarities in the job descriptions it further reflects the ongoing misunderstanding of the ANP role, as well as the other roles. These would have been written by senior or lead nurse managers and further reflects their lack of understanding of the roles. This misunderstanding was also observed in the discursive data from the professional nursing and midwifery meetings where it was also noted the perceived similarity with the roles.

The discursive constructions of nonhuman actants were found in the use of the non-medical title for aspects of the ANP. This and the other discursive constructions contributed to the development of the second of the positional maps (figure 15 page 113).

5.7.2 Doctors and medicine

It is usual practice for an ANP to have a designated medical supervisor during their training and to maintain an ongoing medical mentor relationship as part of their professional development. It was clear from the focus groups and the interviews that this is a key relationship for both parties, and this is a key relationship on the situational map. From the ANP focus groups they talked about their mentor as being available and accessible to them reporting that '*they'll always make time for us'* (ANP focus group 1, ANP 3). This was recognised as a supportive and key relationship with the consultant being seen as endorsing their role and its value. Equally the consultants recognised the evolving aspects of supervision and mentorship according to the needs and stage of training the ANP is at.

Interviews
Consultant 4 – You know whatever level you're at, to have a friendly ear, then you can have a friend to actually, to you know advise you, a sounding board, you know whatever. So, mentorship supervision and again wellbeing I'm really conscious of

These relationships are also reflected in the social worlds. The language used by consultants demonstrated a supportive approach to their ANP. This was notable when they were training:

Interviews
Consultant 2 – You need to understand what they can do comfortably…and what they want to expand their role…you have to be mindful of what you're asking them to do and why have you employed them. **Consultant 1 -** Everybody [ANP's] has got a bit extra to give…more comfortable often being hands on…medical staff are perhaps lacking at times [these skills]

With the investment in the mentorship and development of the ANPs the consultant 3 and 6also identified tensions in the relationships with nurse managers. The consultants cited examples where the ANP they had trained and developed to have advanced clinical skills were then being measured against general nursing skills. The consultants recognised the challenges of being a registered nurse but practicing with advanced skills and working within a medical domain:

Interviews
Consultant 6 – There's a requirement of nurses to keep on proving that they are doing something which they do day in and day out, is a nightmare. **Consultant 3 –** what's always been difficult is them falling really between the medical camp and nursing camp…for example they don't have the study leave budget that junior doctors have so it harder for them to have either the time of the funding to do some of their CPD.

The consultants felt that the nursing structure did not work for the advanced nurse practitioners as any issues with patient care would require the medical team and consultants to '*defend'* (Consultant 6) the ANPs because of the work undertaken in the role.

The driver for developing an ANP role with a team was discussed in one of the interviews and demonstrates the 'extra' and the difference that a nurse with advanced skills brings to the role and team:

Interviews
Consultant 4 – I wanted somebody…to provide the care focus with advanced skills rather than task focussed with maybe being nice along the way

This ‘extra’ was also recognised by others and further interviews reflected this added value to having an advanced nurse practitioner within the wider medical team:

Interviews
Consultant 1 – They (ANPs) come with years of experience which being the clinical field… will allow them a, probably a different approach… with a valuable resource of knowledge. **Junior doctor 1 –** Another senior member of our team who was very capable of doing everything and because…skills are so good. **Consultant 4 -** Contribute to our teaching and training…involved in quality improvement … contribute to the research’

Previous findings identified the ANPs challenges with role identity, but the consultants and other doctors reflect a good level of understanding of the advanced nurse practitioner role with the clinical aspect of the role being the key point of explanation. However, recognising the value of the ANP role and where the role is situated within the wider clinical team was where some of the tensions started to surface. Funding of the role seemed to influence the focus of the role as purely service delivery or an augmented role to support the work of the whole team. One of the consultants recognised that the ANPs could have work inappropriately delegated to them by the junior/trainee doctors:

Interviews
Consultant 2 – We’ve made it clear …they are not somebody you just hand the file to at the end after the ward round…they’re not a dumping ground.

The focus on service provision was potentially related to the speciality the ANP worked in with one of the consultants’ placing limits on how far the ANPs should be developed:

Interviews
Consultant 1 – There’s no point in having aspirations whilst working at [hospital name removed] to be…a trauma team leader…its about understanding roles …and managing those expectations..

While other specialities were supportive of ongoing development beyond the original advanced clinical practice training:

Interviews
Consultant 3 – No, I don't think there should be a ceiling…would be really helpful if there was a much better-defined career pathway within the role…I think the consultant team…view the nurse practitioners more as tier two individuals.

Tier two relates to middle grade medical staff who are regarded as senior decision makers at a level below a consultant. This expanding and developing scope is supported at the highest level of nursing management in the organisation with an acknowledgement that underpinning competencies are the key to providing assurances:

Interviews
Deputy executive nurse director – Scope shouldn't have boundaries as long as…the individual is educated to a level where they can function.

However, this ability for the ANP to safely fulfil gaps in services and expand their skills accordingly can also lead them to being seen as a quick fix solution to workforce challenges was also noted:

Interviews
Deputy executive nurse director – I've seen it …where there's a gap in a service, they can't fill…oh we'll get a nurse practitioner to do that.

Discussion regarding the comparison between advanced nurse practitioners and doctors occurred in the focus groups and was also noted in the interviews. Comparison with what an advanced nurse practitioner is allowed to do and what a doctor is allowed was discussed in the focus group and reflected the frustrations with the advanced level of practice not being acknowledged. The theme of comparing ANPs with doctors permeated the data and although there was not a consistent view of who was better than the other, in general the ANPs were favourably compared to doctors in interviews:

Interviews
Consultant 5 – Actually, nurse practitioners are probably better than doctors, they are more thorough. **Consultant 3 -** They're really invaluable... they provide so much more than just support on …rota

The focus group data reflected that nursing staff would often overlook the medical staff and seek out the ANP to answer their concern or resolve an issue. This recognition of the value of the ANP was noted in the description of the ANP as an '*anchor'* (Consultant 5). The consistent presence of the ANP provided a stability to the service which was recognised by the medical staff:

Interviews
Consultant 2 – Constant part of the framework of the team and they're more…value…especially in this pandemic…' **Consultant 6 –** Essentially, we have migrant workers [this reflects the rotational nature of doctors training]…the ACCPs*…provide us with the continuity because there's someone to ask who knows, not somebody who makes it up

**ACCP = advanced critical care practitioner, the name for advanced nurse practitioners who work in critical care*.

An ANP described herself as '***a lynchpin'*** (ANP focus group 2 ANP 9), acknowledging the consistent approach to patient care and management that they were able to provide. It was the term '*anchor*' (Consultant 5) that was mapped as this best reflected the stability and security provided by an ANP as an individual as well as a team of ANPs.

This positive benefit carries with it a contrasting negative with expectations of filling gaps on medical rotas and only being job planned for service delivery. These negative connotations were more apparent when the role was funded by medical monies. This was where the silence of the directorate manager was noted. While the financial influence on the expectations of the role could not be fully explored it was clear from the data that there was tension between service provision and professional development. This influenced job plans and rotas with a recognition that the expectations of only clinical service delivery and responsibility is not sustainable in the long term:

Focus group 1
ANP 2 – working 100% clinical …it becomes exhausting…especially as you're getting older

There were opposing views on the relationship the ANPs had with the consultants in the clinical environment:

Interviews
Middle grade doctor 1– I think they, coming from a …different hierarchy…the ANPs will feel the need to challenge the consultant …as a senior nurse …you will challenge the consultant if you don't agree with what they're doing **Consultant 1 -** they have come from a nursing background, and I guess they've always…understood a certain hierarchy between nurses and doctors

These differing perspectives were revealing and placed them within the sociocultural and symbolic elements.

5.7.3 Regulation and restrictions

The seniority and experience that ANPs bring to the role is acknowledged and the training they undergo is recognised as thorough and of high standards. Supervising consultants commented that their training had not been as intense or strict, especially regarding the level of assessment the ANPs were exposed to:

Interviews
Consultant 5 – When [name given] was doing the prescribing course, I was thinking wow I never had such intense, strict training and I wasn't assessed as [much] yes I was told off and I made mistakes and I felt really bad when I made those mistakes

The potential tension in the ANP role and the regulatory body was recognised:

Interviews
Consultant 5 – They are regulated by nurses, by the nursing bodies and all they have to follow all the rules of the nursing bodies but they work alongside doctors so that may bring up some…issues, lead to some discontent

This discontent reflected the freedom to practice and make decisions afforded the doctors but not the ANPs. The consultants also shared the frustrations of ANPs who had completed their training but were still limited by departments such as radiology.

They recognised the experience, skills, and knowledge of the ANPs as being greater than the junior tier of doctors, yet the ANPs were not allowed to request x-rays without further training and scrutiny. This is also recognised by the junior doctors themselves:

Interviews
Junior doctor 1 – There's lots more barriers and hoops to jump through in the nursing profession … we, that doesn't really occur to us because we don't do any of that, we're just sort of let free to do everything… **Consultant 3 –** They can go through this exceptionally rigorous training, you know they are more experienced than most of our SHO's and yet aren't allowed to request an x-ray without doing some silly tick box exercise

This is mirrored in the exasperation of the ANPs in the focus groups; their roles meant they were providing a level of service on a rota as a senior decision maker but were not permitted to request radiology imaging for their patients:

Focus Group 1
ANP 2 – If someone comes in sort of who has neurological signs that you're thinking this could be a brain tumour, I'm not allowed to go and request a CT scan. So I'm allowed to examine, I'm allowed to you know decide all the differentials that could be going on with this child but I'm not allowed to request a CT scan because the radiologists don't accept that.

This tension between the senior clinical decision-making role the ANPs were trained and employed to provide and the barriers to fulfilling that role was the foundation for one of the positional maps. The frustrations felt by the ANPs were, in some situations, due to the speciality they were in and there being a lack of understanding of the service arrangements. For example, radiology requesting within the Ear, Nose and Throat (ENT) speciality was consultant led as the imaging required was associated with complex patient conditions and the consultant should be making those decisions:

Interviews
Consultant 2 – For us in ENT its very rare that we do plain x-rays nowadays so where those are concerned and that usually a CT scan or MRI and that then usually is by the registrar, or a decision taken by the whole team

This added to the recognised tensions and frustrations with the ANPs seeking a role that provided freedom to practice, yet there were still significant limitations placed on what they were permitted to do. To counter these restrictions, it was the newfound autonomy that the role provided that was the source of satisfaction for the ANP's. When asked about what they liked most about their role it was apparent that taking responsibility for their decisions and actions was a key driver for the ANPs:

Focus groups 1&2
ANPs 5, 6, 7, 8 & 9 – Autonomy **ANP 2 –** it was the autonomy and the extra skills that it brought as well, that was one of the main attractions sort of early on and obviously because it was an evolving role around that time because there really wasn't that many in secondary care at that time, especially in Wales, then I sort of realised they were leading the way in the way that the role would be developed. **ANP 7** - I think the autonomy, which I probably had a bit of in my last role, like it wasn't really safe because I was on my [own], so it's nice to have the safety of [a team] **ANP 6** - enjoy the learning and enjoy the first bit and don't try and push the autonomy too quickly, absorb as much as you can early on **ANP 8 -** for me it's about giving the whole patient care to the patient, it's being able to do everything I need to do for the patient in a sort of not having to wait around for other people to do stuff, do you know what I mean?

Learning to think and analyse in a new way to be able to make a clinical diagnosis was also recognised as an aspect of developing this autonomous role, with one of the ANPs describing it as '*terrifying'* (ANP focus group 2, ANP 8). The consultants also recognised that moving into a clinical decision-making role with the responsibility that goes with the role takes some adjustment time. This learning a new way of thinking and to make decisions they would not have been required, or allowed, to make before is recognised as a significant part of developing into an advanced nurse practitioner:

Interviews
Middle grade doctor 1 – They found it quite tricky, like, transitioning from this, like, nursing structure to this more medical structure

Consultant 1 – medics have always taught to think outside of the box as it were and the nurse practitioners come from the nursing very protocol driven and sometimes when you get past a certain, you know protocols are great, they're great for junior staff…but sometimes you need that ability to think outside the box…and I guess that would perhaps be something that perhaps a nurse prac [practitioner] may have to develop as they go on and they're developing that later in their medical training perhaps than a more traditional medical practitioner **Consultant 6 –** What I was taught is you have to live with uncertainty so at some stage you just have to make a decision…so what I've realised is one, nurses are not very good at making decisions but we have always said we have to try and take people who will be able to learn to do that…

Perceptions that the ANP role is a new one that has yet to be normalised, was seen as contributing to restrictions associated with the role. If other healthcare staff are still unaware of the role unless they have an opportunity to meet or work with one then it will remain a challenge to their ability to make decisions and fulfil the ANP role.

The pharmacy participant noted risks associated with prescribing were linked with the individual rather than a professional group as a whole:

Interviews
Pharmacist – It's a risk for any prescriber whether they're a nurse, a doctor or a pharmacist…individual level of professional responsibility…governance is in place for us to be assured…each individual is aware of their own responsibilities

They did highlight a particular risk within the ANP role that was unique to nurses in the role. Nurses usually administer medications prescribed by others, however, with the advancement of the nurse as an ANP and independent prescriber, they need to transition with the role to prescriber and stop being an administrator:

Interviews
Pharmacist – I think a nurse (is) a more risky prescriber…if they are administering that drug or dispensing that drug because if what they've prescribed is an error

This was acknowledged as a risk, but the pharmacist also recognised this was not a common problem regarding drug errors and that nurse prescribers were a safe prescribing cohort.

Restrictions in fulfilling all aspects of the ANP role were noted in discussions about job plan. There was disparity amongst the ANPs where some had a 70% clinical to 30% non-clinical split of working hours with others having an 80% to 20% split and some having ad hoc non-clinical time. The non-clinical time is to allow for teaching, learning, service improvement work, audits, and research, as well as maintaining a portfolio of evidence of their skills and knowledge. The findings reflect a tension amongst the ANPs themselves due to this disparity with one speciality (neonatology) having more non-clinical time allocated than in the other specialities:

Focus group 1
ANP 3 – 70/30 and the reason we want to or need it is because of the four pillars and for the clinical support and for the research to be able to fit all that extra stuff in on the side, that 30% is actually quite vital because maybe actually only 15% we're not physically on the shop floor so that's in negotiation at the moment ANP 2 – We're 80/20 and I think that's pretty standard UK wide really for advanced practice.

It was noted that at times of increased service demand the non-clinical time was reduced or removed and the service needs put ahead of any professional development:

Focus group 1
ANP 3 – we're the retainers on the rota we just step up when we need to, but we think they sort of take advantage of us sometimes in that way, so we have to touch back to base again and remind them what our actual role was and what we have to do and achieve. **ANP 8 –** We fill gaps on the rota when needed, we're seen as an extra layer so and that's quite good I think.

This was particularly noted when the impact of COVID-19 on their roles and job plan was discussed:

Focus group 1
ANP 3 – We did have like an emergency rota put in place with people put on back up shifts in case, we worked really well, and I think we showed it that at this stage. **ANP 2 –** our junior doctors did go to the covid wards which left us with a sort of skeleton of registrars left and consultants and then us (ANPs)… we all stepped up… we didn't have any non-clinical time, so we were sort of working 100% clinical

5.8 Major issues and debates

The findings in the situational map lay the foundation for the binary oppositions developed further with positional maps and explored in more detail in chapter 7 – the tensions discussed. The oppositions are represented clearly in the major issues and debates section of the map where the tensions in the advanced nurse practitioner role have been distilled into seven points of contention. The findings that support these points of contention have been noted in the previous sections of this chapter with additional findings being included as needed for clarity.

5.8.1 Same/different

The findings demonstrate that ANP's have some of the same skills as both doctors (through their additional training) and as nurses (as its their foundation profession). However, the differences in the ANP role between doctors and nurses despite the sameness is a tension. The findings reflect a comparative approach between the ANP and doctor roles but there are several findings that reflect the differences: the 'extra' of experience, caring, and organisational memory. The lead nurse manager saw the ANP role as being the same as a nurse and required the same regulation and restrictions as applied to nurses. There was a silent lack of recognition of the difference between an ANP and a nurse. The 'extra or different' aspect of the role recognises that the ANP enhances the wider medical team and bridges into the nursing team (section 5.7.2).

5.8.2 Broad scope/limiting permissions.

The tensions found where the abilities of the advanced nurse practitioner reflected in their scope of practice was limited by others are noted as broad scope and limiting permissions. The lead nurse manager role (section 5.7.1) was influential with this tension as well as radiology (section 5.7.3). The ANP's noted the autonomy (section 5.7.2) of the role being a source of job satisfaction and a driver to take on the training for the role. This has led to the tension of developing a broad scope of practice but having limits on permissions to practice.

5.8.3 Internal governance/external governance

This tension is explored and is further recognised in the internal governance and external governance. Internal governance refers to the individual and departmental

governance arrangements whereas external governance refers to the governance applied to the advanced nurse practitioner by agents outside of the department. External governance is applied by in the main by radiology and to a lesser extent pharmacy. The advanced nurse practitioner (ANP), their medical mentor and the senior nurse manager provide assurances regarding the safety of the ANPs practice through training, supervision, support, and portfolio review, this is internal governance. The study findings revealed the individual ANP maintains a portfolio of evidence of their skills, knowledge, and level of expertise across all four pillars of advanced practice:

Interviews
Consultant 3 – They were working…sharing clinical shifts, seeing patients, trying to get their skills up so they were wanted on things like supervision, doing lumbar punctures, case-based discussions, mini-CEX's, collecting their evidence to go towards their portfolio.

Internal governance is also maintained by consultant supervisors and senior nurses, who as part of supervision and annual appraisal ensure there is maintenance and development of advanced level skills:

Focus group 1
ANP 3 – We have a yearly portfolio that we have to keep up to date which is then reviewed at PADR*…on a day-to-day basis it's a peer review thing that keeps me confident that I'm doing things effectively and properly and competently is probably the best way on a daily basis…' .

*Personal appraisal and development review

The consultants and senior nurses are the staff who have employed the advanced nurse practitioner and work with them so there is understanding of the role. Peer review and this appraisal process has been mapped under discursive constructions as validation on the situational map (p98). External governance refers to the agents outside of the advanced nurse practitioner's area of practice and how they control the practice of the practitioner. Radiology (section 5.7.3) has previously been identified as a department that imposes external governance on advanced nurse practitioner roles for which they have no direct operational or employment responsibility for. Whereas pharmacy have a more administrative approach with governance requirements that are not punitive. These documents can be found in appendix E but there is a short extract below:

Discourse data	
Radiology – Rationale is needed for each body area that is being requested in the scheme of work, detailing why this service is needed (e.g. nurse led clinics), what type of patients will be being referred and under what circumstances. Every NMR requires a GMC Consultant who takes clinical and financial resource responsibility and support. Individuals are required to review and audit referral practice on a minimum yearly basis. The review process should asses the quality and appropriateness of requests made by non medical referrer's An ongoing review programme by the radiology directorate will be undertaken, where compliance against authorisation is assessed. Authorised NMR's will be requested to submit evidence of their practice reviews and ongoing Radiation Safety learning. If evidence is not submitted or cannot be shown; requesting privileges will be removed until verification of audit and review practice is demonstrated and	**Pharmacy –** The UHB register is held and maintained by pharmacy. Registration is enabled through the submission of a Scope of Practice (SoP) form (appendix 4). An updated Scope of Practice form must be submitted every three years as a minimum and if there is a change to any of the elements. There may be circumstances whereby an NMP would benefit from an additional period of supervised practice with a DPP e.g. a. A change in role which requires a significant change in SoP b. A lapse in prescribing activity which lasts 12 months or more c. Concerns regarding prescribing competence d. An established prescriber joining the UHB – to enable effective induction to the UHB's policies, procedures, prescribing practices etc. The length and form of supervision should be decided through discussions with the DPP, line manager and the individual and approved by the Lead Nurse/Department Head.

5.8.4 Advanced generalist/advanced specialist

The findings reflect contention in the form of advanced generalist/advanced specialist where the academic education and training is for an advanced generalist. However, the role is more often one of advanced specialist as the foundational knowledge and experience the ANP brings to the role is based in a specialism. ANP participants in this study worked in distinct clinical areas:

- acute child health
- critical care
- paediatric intensive care
- acute oncology
- paediatric trauma and orthopaedics
- neonatology
- general surgery

The generalist skills and specialist knowledge need to be reconciled as part of the advanced nurse practitioner development and the findings note this change in responsibility and decision making is challenging.

5.8.5 Professional development/service provision

The rub between this role being recognised as professional developmental one with agreed job planning that meets the four pillars of advanced practice, and a clinically focussed service delivery role was evident in the findings. The need to provide evidence across the four pillars of advanced practice was recognised and the findings reflected challenges with rotas and a lack of job planning to allow for the non-clinical pillars of advanced practice to be fulfilled.

The doctors recognised there was more to the advanced nurse practitioner role that the clinical assessment and diagnostic skills they applied to patients with section 5.7.2 and 5.7.3 identifying the service delivery aspect of the role more fully.

5.8.6 Personal identity/professional recognition

Personal identity and professional recognition as a tension reflected the challenges reported with being an experienced nurse transitioning into a novice advanced nurse practitioner before becoming an expert advanced nurse practitioner. This evolution is not smooth and the absence of a professional career pathway that maps out this progression leaves ANPs and medical mentors unsure regarding where the end point of training is. The relationship between the ANP and supervising consultant (section 5.7.2) is key to the successful transition from nurse to ANP and the validity provided by the consultant supervisor endorses professional recognition.

5.8.7 Ambiguity/standardisation

There was a drive from some of the consultants for core training for the advanced nurse practitioner roles to provide standardisation, with the ambiguity of the role adding to the tension. This ambiguity was notable in the discursive data particularly

in relation to job titles and job descriptions. Although the need for standardisation to training was recognised, there was an acceptance by the consultants that there is variability within the ANP role as the experience of each one is different. This is a lack of standardisation of the role which creates a tension with those outside of the ANP world not knowing the skills and abilities of the individual. Ambiguity of the role is an opposing tension which will be discussed further in Chapter 7.

5.9 Social world and arenas maps

The social world and arenas map lay out the relational aspects of the situation being studied. The map developed from the findings in this study reflects the advanced nurse practitioner world in secondary care, and the relationship of their world within the arena of the wider hospital and organisation. Figure 13 is the completed social world and arenas map developed from the analysis and is displayed below:

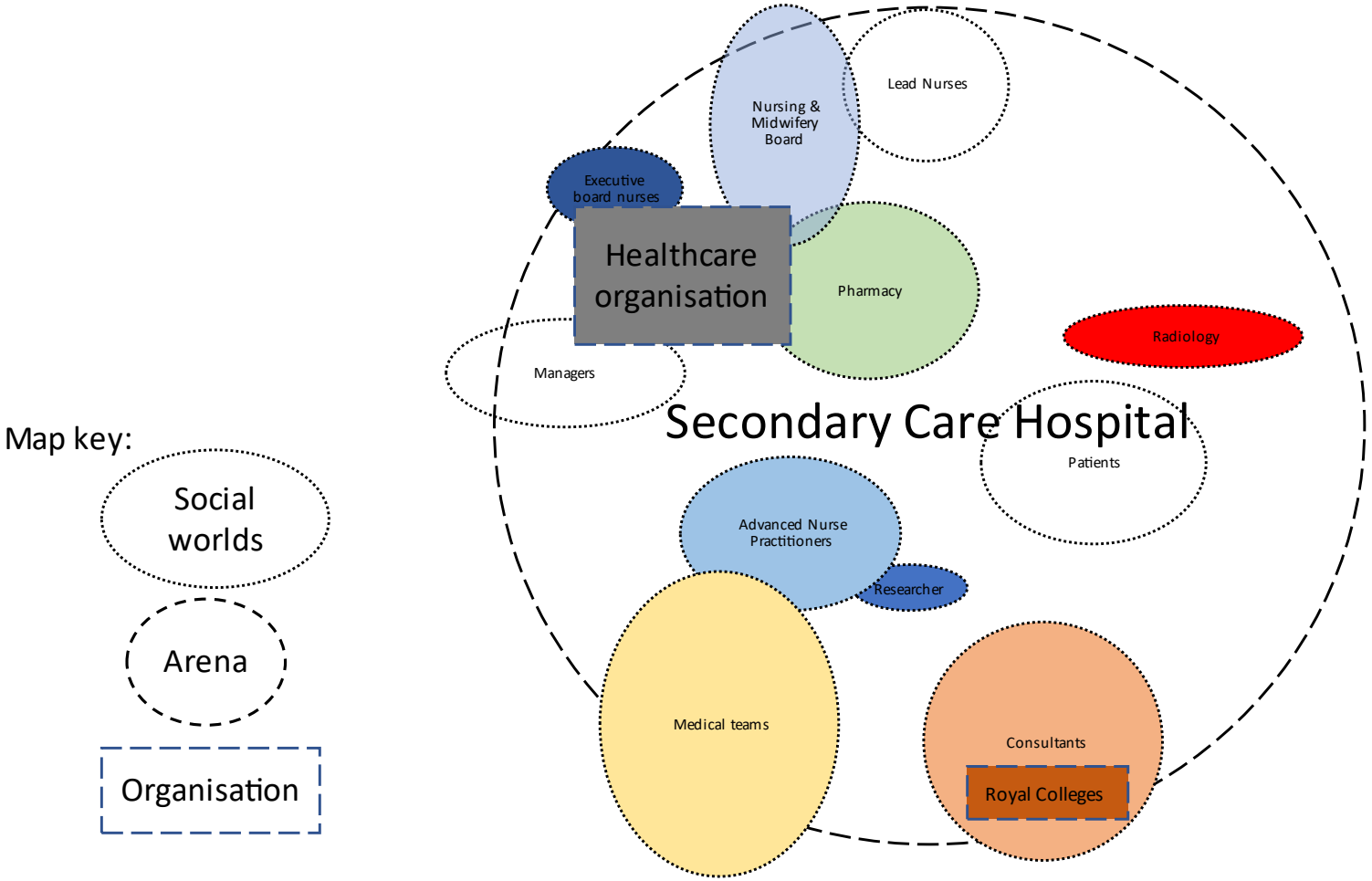


Figure 13: this is the completed social world and arenas map developed from the analysis

This social world map provides a visual narrative of the social collective groups and their interactions and influences on the situation. The healthcare organisation was core to the management and culture of the hospital and its relationship to advanced nurse practitioners is reflected in the distance from them. The nursing and midwifery board group overlaps with the healthcare organisation at a strategic level; lead and executive board nurse managers attending this group. These worlds intersect with the organisation and overlap with each other in part, representing the levels of influence identified in the data analysis. Pharmacy intersects the nursing and midwifery board as they collectively agree and guide the governance for non-medical prescribing. However, as this is the only aspect of collective overlay recognised from the analysis then the overlap is small. ANPs and medical teams intersect to reflect the shared skills in patient assessment, investigation, diagnosis, and treatment. However, data analysis recognised the core nursing skills and identity that the ANPs maintained, which is reflected in the scale of intersection of the worlds. The medical team's world overlays the ANP world to represent the dominance of the doctors as the organisation is designed to favour the medical model, and it has not adapted to accommodate the ANPs in an equal way.

The situational map acknowledges the importance of the relationship between the ANP and the consultants both in general terms as well as the closer medical mentor relationship. However, regarding social worlds there is a distance (or tension) between the ANPs, and consultants associated with the career pathway and professional identity. This is reflected in the separate social worlds as the ANPs intersect with the consultants for supervision infrequently even though it is a key relationship. Analysis of the data revealed that the ANPs and consultants float in and out of each other's worlds but do not have a fixed intersection, unlike the medical teams where there is daily connection. The influence of the professional bodies – Royal College of Emergency Medicine, Royal College of Surgeons, and Faculty of Intensive care medicine, was identified in the analysis and lives within the consultant social world.

From the analysis, and supported by the associated memos, the position of the researcher was placed with the advanced nurse practitioners. There was a shared language as well as shared experiences which made this a natural relational world. Data analysis noted the influence of the patient on the ANP and patient care is the

core business of the secondary care hospital, which is why there is a social world for patients within the hospital world. However, as the study has not explored or revealed the patient voice this world was set apart from others, it is in essence a reflection of a silence in the social worlds. This is discussed further in section 7.7.5 research into the patient experience of ANP's in managing their health needs.

Given the position that radiology plays in the tensions of the advanced nurse practitioner role it has been isolated from the other worlds. The evidence from the analysis showed that radiology did not have a collective view that overlaid with any of the other social worlds. It was referred to as if it was an entity which was curious, radiology is a non-human actant and is not sentient. Radiology is an actant that is present across all the maps and consideration was paid to separating it out and discussing it in isolation, however this would narrow the focus of the study.

The situational and social world maps set the scene regarding the advanced nurse practitioner role in a secondary care hospital, but it is the positional maps that reveal the positions of power and points of contention, this is explored in the following section.

5.10 Positional maps

There were two positional maps developed from the discursive data and refined in the perspective of the human data. The first positional map has the axes – scope of practice and barriers to practice and is presented below as Figure 14.

Figure 14: Positional map 1: axes barriers to practice and scope of practice.

One of the major debates placed on the situational map was broad scope versus limiting permissions as that reflected the experiences of the advanced nurse practitioners and consultants. Developing this point of contention further in the discursive data influenced the development of the first positional map. The minutes from the nursing and midwifery board meeting, the non-medical prescribing governance framework, and the non-medical referrer for diagnostic imaging documents were influential in developing this map. The axes of 'scope of practice' and 'barriers to practice' represented the positions taken in the data with the discursive elements being mapped accordingly. The findings from the focus groups and interviews were reviewed as part of developing this positional map to ensure the tensions were situated accurately. The inconsistent view of advanced nurse practitioners from the nursing and midwifery board meetings resulted in it being mapped twice, initially as supporting expanded practice giving it low power as a barrier and mid-point power to support the scope of practice. The discourse from the meetings places value on the nursing role in the organisation and reflects a view of empowerment for nursing staff in general. There was a drive for maintaining and developing nursing roles and skills and a celebration of successes when nurses showed initiative and drive to improve patient care or services. By extension this should reflect on the advanced nurse practitioner role where initiative and motivation are key to success. However, discourse relating to job descriptions and role developments revealed the lack of understanding regarding advanced nursing practice. This led to the second placement on the positional map as a powerful barrier to advanced nurse practitioner role development. There is still a mid-point for scope of practice as the job descriptions discussed at the nursing and midwifery meetings had an expanded scope and autonomy regardless of the title given to the role.

The influence of the discourse regarding non-medical referral for diagnostic imaging reflects a significant barrier that limits the scope of practice the ANP can independently fulfil. This is indicated with non-medical referral for diagnostic imaging being positioned as a significant (+++) barrier to practice and a limiter (---) of scope of practice. Conversely the non-medical prescribing framework is less of a barrier and supports the expanding and developing scope of practice of an ANP. Both these policies are local interpretations of national professional and regulatory bodies which

were explored as part of the analysis to set the scene for the discourse. The professional and regulatory bodies support a broad scope of practice, hence the high-power placement. The requirement to achieve competence in this scope is a mid-point barrier as this reflects time, money, and motivation to attain the necessary academic qualifications and advanced practice portfolio.

Findings from the focus groups identified the drivers for individuals to become advanced nurse practitioners. There was homogeneity regarding the drive to expand their scope of practice from the boundaries of nursing and to take more responsibility for patient care. As nurses they recognised the limits on their role, however with extensive knowledge and experience in their specialist areas they were relied upon to teach and support doctors in training to make decisions and carry out tasks that the nurses were not allowed to do. Their hope was that by developing into advanced nurse practitioners they would be allowed to make these decisions and carry out these tasks themselves. It is an unfortunate outcome that what was a key driver for experienced nurses to become advanced nurse practitioners remained an issue in a different form. Data reflected barriers to the advanced nurse practitioner fulfilling their scope and this was recognised as a significant frustration in the role. These barriers and the impact on the advanced nurse practitioner role are evident in this positional map.

Positional map 2 was the final map from data analysis and reflects the key themes of professional identity and visibility. These axes were drawn from the findings and further analysis of the major issue of personal identity and professional recognition. During data analysis it was recognised that professional identity was a lead concept, accurately reflecting the tension in the role. The focus groups revealed the vulnerability the ANPs felt not having a recognised professional identity as an ANP. This was also a tension with the attachment to their nursing foundations while acknowledging that it was the nursing identity that was limiting their role. Analysing the discursive data, from the perspective of a lack of professional identity, was impactful and the visibility as well as the invisibility of the role was recognised. Consideration was paid to whether visibility or invisibility was as better fit as a concept. The ANP’s collectively felt they were not visible outside of their department or within the organisation. However, reviewing the analysis of the interview data reflected that the ANPs were very visible. The discursive data often refers to ‘non-

medical’ rather than ANP, and although this label has negative connotations, it is a clumsy attempt to be inclusive. There is a breadth of healthcare professionals that prescribe and request radiological imaging, not just those from a nursing background. Overview of the analysis better supports the term visibility, so this was applied to the second axis in opposition to professional identity. This positional map is displayed below as Figure 15:

Figure 15: Positional map 2: axes professional identity and visibility.

This second positional map reflects key concepts revealed in this study. The findings from the interviews and focus groups identified opinions and experiences that were in opposition regarding the recognition of the professional identity developed as an ANP. The ANPs remained attached to their identity as a nurse and had not reconciled this in the '*new way of nursing*' (ANP focus group 2 ANP 6) nor fully developed a professional identity as an ANP. A key point of discussion in the focus groups was the identity the ANPs held. While identifying as nurses, they felt that the nurses uniform they were required to wear held them back and did not reflect the senior and autonomous role that they had. These discussions led to the tension of personal identity and professional recognition being acknowledged in the findings (section 5.8.6). The identity as a nurse was a personally held view held by the advanced nurse practitioner and they were clear about not denying their nursing roots (section 5.7.3). However, there was discomfort with being identified as a nurse by others, with uniform and restrictions on their practice being key factors contributing to this tension:

ANP Focus Groups 1 & 2
ANP 8 – The uniform is a big thing and I know some of my friends on PICU who are nurse practitioners…one of them point blank refuses to wear the uniform, the other two do but they've got a big issue with it…because by night their registrars see them as acting as on like reg level on the reg rota but they're still seen as practice educators or ENT nurse specialists **ANP 1 –** Ready to intubate the patient and at the other end [of the bed] you've got a bed manager whose responsibility is not a clinical role… and they're both in the same uniform and you know patients and staff are going to be really confused because they're not going to accept a nurse suddenly sticking a tube down somebody's throat if they don't know who they are... **ANP 5 –** uniforms, love them or hate them, has a huge impact on how you're perceived initially
Interviews
Consultant 4 - Don't get me started on nurse uniforms…uniforms are just one of those things which again makes no sense to me whatsoever, you know you can look at this sea of blue, have no idea of the level of experience of that individual and I think it must be really hard for patients myself so yeah don't get me started on it. They (ANP) should absolutely have their own uniform that is recognised and acknowledgement for their role yeah. **Deputy executive nurse director –** The uniforms don't help because yes you know, you look at a myriad of people in a room, you think I assume you know that the majority of them are tending to be a clinical nurse specialist or a band 6 type role rather than an advanced nurse practitioner

This combination of nursing identity and the artifacts associated with that, namely uniform, was a curious tension. The ANPs positively valued their nursing background but were equally negative about holding a nursing identity as an ANP as they recognised this as holding them back in their role. It took a period of wallowing in the data to identify that this tension is part of the deep-rooted conditioning associated with being a nurse, given the historic foundation of nurses being in a subservient role. This concept is explored in more depth in chapter 7.

These tensions with nursing identity and nursing artifacts contributed to frustrations and within the role that had not been resolved. In parallel ANPs found it difficult to acknowledge when they had completed training and were on an ongoing development route. The consultants and trainee doctors recognised and articulated their view of the role clearly albeit by using their training and experience as a benchmark. The consultants could identify when the ANP had finished training and was now on a pathway of ongoing development, and maintenance of skills and knowledge, the ANPs could not. This is reflected on the positional map with the placement of trainee doctor and supervising consultant who recognise the professional identity and visibility of the ANP.

The nursing and midwifery workforce framework, valid at the time of the study, referred to advanced practice roles twice in the fifty-page document. The situation of these references was regarding robust governance arrangements for nurses and midwives who take on advanced roles and impact of these roles on patient outcomes. The professional identity and visibility of ANPs who are already working in the organisation was not recognised in a key workforce framework. The lack of identity and visibility was most noticeable in the uniform policy where there is no reference to ANP roles. There is no specific uniform for advanced practice roles which was recognised in the findings from the focus groups with ANPs wearing the generic specialist nurse royal blue colour. The consultants also recognised the impact of uniform on professional identity and recognition of a role, this was a tension for them as the lack of recognisable uniform impacted on identifying seniority and skills associated with the role.

Job descriptions were another discursive source of confusion with limited visibility regarding the ANP role given the similarities with other job descriptions. This also

limited the professional identity of the role at a level below nursing and midwifery board on the positional map. The nursing and midwifery board reflects a midpoint on the map with meso-level recognition of professional identity and visibility. However, this felt like a fluid position not a static one as the position taken in the discourse from the group was variable.

Alongside the supervising consultants it was the discursive content from professional bodies, nursing, medical and governmental but not organisational, that gave clarity to a professional identity for ANPs as well as visibility. This is reflected in discourse related with independent prescribing which is why these three elements were mapped with high professional identity and visibility regarding the ANP role. High visibility but low professional identity was applied to service delivery from analysing the nursing and midwifery workforce framework. There was a focus on developing skilled staff to meet changing service needs, but the ANP contribution currently and in the future to meet these service needs was not acknowledged. In effect ANPs were invisible.

5.11 Conclusion

Recognising the ANP role as a '*new way of nursing*' was a significant quote in this study and reflects the change in professional identity needed to have ownership of the role. The findings reveal that the ANPs have not fully achieved this even when their colleagues recognise this professional role. The positional maps have exposed this and the other three tensions in the ANP role - scope of practice, barrier to practice, visibility.

Professional identity is the linking concept across these tensions and to be able to explore and discuss this further there is need to return to the literature. The following chapter discusses these concepts in relation to this study and wider literature.

Chapter 6 Reviewing the literature – situating the concepts.

6.1 Introduction

The findings have laid out the key concepts that reflect the tensions in the advanced nurse practitioner role in a secondary care hospital. The purpose of this chapter is to review the current body of knowledge associated with these concepts and to facilitate further discussion of the concepts in the context of the findings of this study. Professional identity is recognised as the overarching concept that reflects the tensions in the advanced nurse practitioner role, with visibility, scope of practice and barrier to practice being associated concepts.

This chapter will lay out the approach to literature searching and inclusion in this study, to provide a transparent approach to the discussion in the next chapter. Unlike grounded theory, situational analysis allows the researcher to find the key concepts in situations without having to develop a theory to explain them (Clarke et al, 2018). The aim of this study is to surface tensions not to theorise them. Therefore, a return to the literature at this stage is appropriate as it allows for the concepts to be tested against the wider evidence and understanding of them. It also facilitates ongoing analysis and refinement of the key concepts from this study.

6.2 Search strategy

There was a focussed approach to this search strategy as the findings indicated the concepts to be explored:

- professional identity
- visibility
- scope of practice
- barrier to practice

As the purpose of this literature review is to explore the current understand of these key concepts rather than ask or develop a research question then a less rigid approach has been taken.

Table 18 below identifies the search terms that were used as singular terms as well as in combination:

Terms used in combination and in isolation	
• Advanced nurse practitioner or ANP or advanced clinical practitioner or ACP • Nurse or nursing or nurses	• Professional identity • Visibility – Invisibility – being seen • Scope of practice • Barriers to practice

Table 18: search terms used for secondary literature review to facilitate further analysis and discussion.

Various combinations of the terms were used, and searches of databases CINAHL and MEDLINE completed. Articles based on empirical research, including literature or narrative reviews, were retrieved, and read. Conceptual papers were also included as they contributed to the discussion, this was particularly noted in papers exploring professional identity and applying a sociological theory. Opinion articles were excluded, and a ten-year search period was used to situate this study's findings in the current understanding of the concepts. Initially a total of fourteen were included to facilitate discussion regarding the identified concepts. However, a further fourteen articles and one textbook were added via back-chaining and reviewing grey literature, to add to the understanding of the main concepts for discussion.

It was apparent in the literature that not all these concepts have recognised definitions, and the concepts are not always associated directed to the advanced nurse practitioner role. For example, much of the work on professional identity is related to becoming a doctor or a nurse but there is limited work on becoming an advanced nurse practitioner. This led to wider reading as influenced by the references from the included articles. The primary literature search in Chapter 2, was focussed on developing the research question and meeting the research aims. This secondary literature search has broader objectives and therefore studies associated with primary care or non-UK studies have been included as they provide a wider platform for discussion.

Table 19 below identifies the key papers used in the discussion. The remainder of this chapter will briefly layout the current knowledge and understanding of the main concepts in this study.

Authors	Date	Title	Methods	Themes
Willetts, G. & Clarke, D.	2014	Constructing nurses' professional identity through social identity theory	Concept paper using social identity theory	Concepts • Group belonginess as a consequence of the interpersonal-intergroup continuum • Group identity salience • Complexities of individuals and their multiple social identities • Situational relevance and subjectivity of these identities
Jones, A. et al	2015	Realising their potential? Exploring interprofessional perceptions and potential of the advanced practitioner role: a qualitative analysis	Qualitative study with focus groups n = 9 (focus groups) 67 participants in total	Themes • Demand, policy context and future priorities • AP role clarity and standardisation • Lack of agreed understanding • Interprofessional working:benefits and challenges
O'Keeffe, A.P., Corry, M. and Moser, D.K	2015	Measuring the job satisfaction of advanced nurse practitioners and advanced midwife practitioners in the Republic of Ireland: a survey	Survey using Misener Nurse Practitioner Job satisfaction scale Descriptive statistical quantitative n=47 (80% response)	Themes • Job satisfaction • Challenge and autonomy • Professional growth and development • Intra-practice partnership and collegiality • Ability to negotiate resources
Kennedy, C. et al	2015	Fluid role boundaries: exploring the contribution of the advanced nurse practitioner to multi-professional palliative care	Qualitative evaluation study n=21	Themes • A unique contribution • Fluid role boundaries • Delivery of person-centred care
Elliott, N. et al	2016	Barrier and enablers to advanced practitioners ability to enact their leadership role: a scoping review	Systematic scoping review	Identified 13 barriers and 11 enablers and rated them according to one of four levels: • Healthcare system-level • Organisational-level • Team-level • Advanced practitioner-level

Authors	Date	Title	Methods	Themes
Pennbrant, S.	2016	Determination of the concept's 'profession' and 'role' in relation to 'nurse educator'	Concept determination using etymological and semantic analysis of the concepts 'profession' and 'role'	Concept of profession – 15 synonyms Concept of role – 13 synonyms
Leary, A. et al	2017	Variation in job titles within the nursing workforce	Secondary analysis of data set n= 17,960	595 job titles used in UK in 17.960 specialist posts. Main titles • clinical nurse specialist • nurse specialist/specialist nurse • advanced nurse practitioner • nurse practitioner
Kluijtmans, M. et al	2017	Professional identity in clinician-scientists: brokers between care and science	Phenomenological qualitative study using semi-structured interviews n=14	Themes • professional identity • boundary-crossing experiences
Medina Ruiz, L.	2018	Multidisciplinary team attitudes to an advanced nurse practitioner service in an emergency department	Mixed-methods questionnaire n= 60 (53% response)	Themes • Participants understanding of the role and scope of practice • Previous experience, educational preparation, and accreditation • Protocols and autonomy • Working practices, and effect on nursing and multidisciplinary team
Laurant, M. et al	2018	Nurses as substitutes for doctors in primary care	Cochrane systematic review	Themes • Nurse practitioners can provide equal or better quality of care for defined conditions • Nurses can provide equal or better health outcomes • Nurses achieve higher levels of patient satisfaction
Thompson, J. et al	2019	Whole systems approach. Advanced clinical practitioner development and identity in primary care	Qualitative part of mixed methods study. Semi structured interviews n=22	Themes • Role definition

Authors	Date	Title	Methods	Themes
				• Access to/availability of quality educational and professional development opportunities • Support and supervision • Organisational culture and infrastructure • Career pathway
Cooper, M. et al	2019	The similarities and differences between advanced nurse practitioners and clinical nurse specialists	Systematic literature review	Similarities • Added value • Autonomy – referral rights • Patient care • Leadership • Education • Research, guidelines, audits • Resource Differences • ANP generalist • CNS specialist • ANP medically focussed • CNS nursing focussed • ANP evaluates patient satisfaction • CNS evaluating patient quality of life • CNS leadership within team • ANP strategic leadership influence
Laird, E. et al	2020	'The lynchpin of the acute stroke service' – an envisioning of the scope and role of the advanced nurse practitioner in stroke care in a qualitative study	Qualitative study interviews n=18 (healthcare staff and patients) qualitative content analysis	Themes • Lynchpin of the acute stroke service • An expert in stroke care • Person and family focussed • Preparation for the role
Mannix, K. & Jones, C.	2020	Nurses experiences of transitioning into advanced practice roles	Qualitative study – 8 semi-structured interviews with trainee ANPs	Themes • Transition (what this feels like) • Professional identity (perception of medical colleagues)

Authors	Date	Title	Methods	Themes
				• Training (need for more structure) • Job satisfaction (what nurses find most rewarding about the role)
Kerr, L. & Macaskill, A.	2020	Advanced nurse practitioners (emergency) perceptions of their role, positionality, and professional identity: A narrative inquiry	Qualitative narrative inquiry using Bourdieu (1990) thinking tools of habitus, field and capital. 10 interviews with ANP's purposively sampled to reach data saturation.	Themes • Participants career pathways • Personal and professional transitions • Role dimensions and core concepts • Position within the organisation • Emergent professional identity
Anderson, H., Birks, Y., & Adamson, J.	2020	Exploring the relationship between nursing identity and advanced nursing practice: an ethnographic study	Ethnographic study – participant observation and semi-structured interviews n=9 ANPs, nurses n=5 in two primary care organisations	Themes • Conciliating nursing • Vertical discounting • Lateral othering
Thirtle, S.	2021	Identity and learning experience of non-traditional students undertaking the specialist practitioner	Narrative inquiry n=3	Themes • Academic self-doubt • Student identity challenges • Past learning experiences
King, R., Sanders, T. & Tod, A.	2021	Shortcuts in knowledge mobilisation: an ethnographic study of advanced nurse practitioner discharge decision-making in the emergency department	Ethnographic study – observation n=5 and semi-structured interviews n=13	Themes • Boundary blurring in ANP discharge decision-making • Shortcuts in boundary blurring work
Wood, E. et al	2021	Sources of satisfaction, dissatisfaction and well-being for UK advanced practice nurses: a qualitative study	Qualitative study n=22 semi-structured telephone interviews	Themes • Advanced nurse role and professional identity • Feeling exposed • Support for the advancement of the role • Demonstrating impact

Authors	Date	Title	Methods	Themes
York, R.	2021	Perceptions and beliefs about the regulation of advanced nurse practitioners	Interpretative phenomenological study n=2	Themes • Managing ANP identity • Professional credibility • Ensuring safety • Other people's attitudes • Fear and uncertainty
Batty, J.	2021	An evaluation of the role of the advanced nurse practitioner on an elective orthopaedic ward from the perspective of the multidisciplinary team	Qualitative evaluation study N=10 (4 doctors, 6 nurses)	Themes • Role identity • Valued member of the team • Value-added care
Lewis, R.	2022	The evolution of advanced nursing practice: gender, identity, power and patriarchy	Modern sociological theory	Concepts • Power and social control • Dominance of medicine within healthcare • Closure theory • Professional knowledge • Division of labour • Occupational imperialism • Professional identity • Working in a pink collar profession
Lockwood, EB., et al	2022	An exploration of the levels of clinical autonomy of advanced nurse practitioners: a narrative literature review	Narrative literature review with 19 critically appraised research papers	Themes • ANP stepping up • ANP living it • ANP bounce back ability • ANP setting in motion
Thompson, W., McNamara, M.	2022a	Constructing the advanced nurse practitioner identity in the healthcare system: a discourse analysis	Discourse analysis of 7 interviews and 4 focus groups with ANPs, doctors, nurses and allied health professionals	Themes • The value adding nurse practitioner • In search of the nurse • The educated taskmaster • Negotiating a place in the healthcare system • Supervision or control?

Authors	Date	Title	Methods	Themes
Thompson, W., McNamara, M.	2022b	Revealing how language builds the identity of the advanced nurse practitioner	Critical discourse analysis of 7 interviews and 4 focus groups with ANPs, doctors, nurses and allied health professionals	Themes • The uniquely holistic identity • The controlled identity • The medicalised identity • The independent powerful identity
Sheehan, D. & Wilkinson, TJ.	2022	Widening how we see the impact of culture on learning, practice and identity development in clinical environments	Conceptual framework of learning environment	Concepts • Organisational culture • Practice culture • Identity • Revealing culture
Wang, H. et al	2022	The roles of physician associates and advanced nurse practitioners in the National Health Service in the UK: a coping review and narrative synthesis	Systematic scoping review	Themes • Competency (education and key skills) • Career (employment, career progression, and job satisfaction) • Effectiveness (patient outcomes and cost-effectiveness) • Perceptions (by colleagues, employers, and self-identity) • Regulations (policy and governance structures)
Fothergill, LJ. et al	2022	Nationwide evaluation of the advanced clinical practitioner role in England: a cross-sectional survey	Mixed-method online survey n=4365	Themes • Lack of standardised governance structures and role regulation • Diversity in education, supervision and support • Working in accordance with the Health Education England framework
Kidner, M.	2022	Successful advanced practice nurse role transition	Book	International council of nurses commissioned work on the advanced practice nurse role. Explores transitional processes from nurse to advanced practice nurse.

Table 19: literature included in secondary search for discussion

6.3 Overview of the literature

The literature included in at this stage of the study has been purposefully sought to test the validity and robustness of the findings. Reviewing references from the papers there would have been further suitable literature available for the discussion from more than a decade ago. However, given the volume of relevant studies published in the past five to ten years it was decided that focusing on this contemporary literature would be more suitable. Professional identity was recognised as a key concept and reviewing the current literature there are now increasing studies recognising this as a challenge with the advanced nurse practitioner role. There are less studies addressing the visibility of the advanced nurse practitioner role directly however lack of recognition for the role is a notable theme in the initial literature and evidence review. The scope of practice and barrier to this scope is again not a clear research question in the literature, however it is recognised in the findings in the literature.

The following is a short summary of the literature findings under the key concepts of this study's findings. This is to set the scene prior to a more detailed discussion in the next chapter.

6.3.1Professional identity

Professional identity was either part of the research question or the findings in thirteen of the papers and was the focus of the book authored by Kidner (2022). Construction or development of professional identity in nursing (Willets and Clarke, 2014), nurse educators (Pennbrant, 2016), clinician-scientists (Kluijtmans et al, 2017) and specialist practitioner qualification students (Thirtle, 2021) was included to provide insight to understanding changes in professional identity in other professional roles in nursing. Kidner (2022) discusses professional identity as part of role transition from registered nurse to advanced practice nurse and brings an international perspective to this. An consensus definition of professional identity is not used in the literature, however there are core themes in the development of a professional identity, with socialisation being a key factor (Willets and Clarke, 2014; Kluijtmans et al, 2017; Thompson et al, 2019; Mannix and Jones, 2020; Kerr and Macaskill, 2020; Anderson, Birks and Adamson, 2020; Wood et al, 2021; Lewis, 2022, Kidner, 2022). The importance of personal values, attributes and ethics and aligning this with the professional group within which the individual would work is

recognised (Kidner, 2022). These aspects will be discussed further in the discussion chapter linking with the findings from this study.

6.3.2 Visibility

Although visibility was not a clear question or outcome from the papers included, aspects associated with being seen or recognised were noted. Role recognition and the contribution of the role to patient care or services was noted by Kennedy et al (2015), Laird et al (2020), Kerr and Macaskill (2020) and Batty (2021). Associated with visibility, Lewis (2020) and Thompson and McNamara (2022a) identified the dominance of medicine and the need for advanced nurse practitioners to negotiate their authority and place in the healthcare system. Being recognised for the role they provide is key to this, however a large study by Fothergill et al (2022) identified a lack of standardisation in governance and recognition of the advanced clinical practitioner role across England. This is despite the introduction of the multi-professional framework for advanced clinical practice by Health Education England in 2017.

6.3.3 Scope of practice

The literature does not provide a consensus opinion on whether advanced nurse practitioner roles are advanced specialist or advanced generalist roles which gives variability in the scope they are expected to fulfil. O'Keefe et al (2015) identified professional growth and development as key themes affecting the job satisfaction experienced by advanced nurse practitioners. Associated with this was an ability to effectively negotiate resources to fulfil their role (O'Keefe et al, 2015) which implies this professional growth can support a broad scope but the inability to negotiate to fulfil this is a potential barrier. King et al (2021) explored how advanced nurse practitioners used knowledge to fulfil their requirement of discharging patients safely from the emergency department. Wood et al (2021) was able to demonstrate the scope of practice by identifying the impact of the role and recognising the support for advancement of the role. Medina Ruiz (2018) noted the departmental understanding of the role and its associated scope of practice and recognised the autonomy required to fulfil the role. A description as an expert and a lynchpin was applied by Laird et al (2020) in their study exploring the advanced nurse practitioner role in developing stroke services.

6.3.4 Barrier to practice

The evidence reviewed in chapter 2 recognised the theme of ‘barrier to practice’ and the findings in this study have identified this a tension in the advanced nurse practitioner role in secondary care. Both O’keefe et al (2016) and Medina Ruiz (2018) noted radiology was not the only barrier to fulfilling the advanced nurse practitioner (ANP) role, but other professions also refused to accept referrals from ANPs. Anderson et al (2020) identified behaviours that created barriers to fulfilling the role not just between nurses and advanced nurse practitioners but between ANPs themselves. Laurant et al (2018) provided medium quality evidence in their Cochrane review that nurses (notably nurse practitioners) could provide equal or better levels of care for patients in defined situations. This could imply there are limits to the abilities of nurse practitioners to provide broad scopes of care and is a potential barrier to the acceptance of the role. Thompson and McNamara (2022a) explored the issue of supervision being supportive or controlling. This raises another potential barrier to practice, control by the supervisor rather than support.

6.4 Summary

To summarise, a focused review of current literature was undertaken using the key concepts found in this study as search terms. The purpose of this was to identify the current knowledge and understanding of these concepts and to situate the findings in this knowledge. Clarke et al (2018) recognise this process as sensitising concepts and acknowledge it as a means of facilitating theorising but not a process of generating formal or grand theories. In this study I have theorised that professional identity, visibility, scope of practice and barrier to practice are the tensions in the advanced nurse practitioner role in secondary care. The following chapter provides a discussion to demonstrate that these are valid concepts in the context of the wider literature associated with advanced nurse practitioners.

Chapter 7: The tensions discussed.

7.1 Introduction

The aim of this study has been to surface the tensions in the advanced nurse practitioner role in secondary care hospital. Situational analysis as methodology and method has provided a means to capture and analyse all elements in the situation revealing the complexity of the ANP role in a secondary care hospital. Clarke et al (2018) recognise that situational analysis creates numerous interesting and new findings which is challenging to the researcher who then needs to focus on what should be highlighted as '*big news´* (p209). In this study the findings have been laid out in the situational, social worlds and positional maps with all the concepts associated with the advanced nurse practitioner role in the secondary care hospital visible. The major issues and debates on the situational map and the axes of the two positional maps identifying the key concepts.

Revealing the tensions in the ANP role was the aim of this study. These tensions have been identified as concepts with underpinning theoretical backgrounds and those backgrounds will be discussed to demonstrate that the analysis has identified true concepts in the study. The major issues from the situational map will be discussed initially as this lays the foundation for the points of contention used as the axes in the positional maps, this linearity of discussion should not be seen as inferring hierarchy to the tensions. All these concepts are interlinked and represent the co-constitutive tensions found in this study.

7.2 Major issues and debates in binary opposition – situational map.

Taking an overview of the findings in the situational map the connectivity of the elements is apparent and the tensions in the relationship of the elements emerge. Exploring these contested concepts with a postmodern lens identifies the overarching binary opposition of structure and agency as the most accurate reflection of the role in secondary care. Binary opposites are interlinked opposing aspects of a concept or philosophical lens whereby one of the factors has power, however limited, over the other. Other binary opposites of licence and mandate as well as political and personal represent aspects of the tensions and contribute to the overall binary opposition of structure and agency.

7.3 Structure/agency

Structure and agency are recognised sociological terms and although they can reflect individual philosophical paradigms, they also represent social theory views on human social behaviour. George Herbert Mead (1934) argued for the agency of human beings, taking a now established view that they are not reflexively reactive to the world around, but create the structures for their agency through their interactions (Pawluch and Neiterman, 2010). Foucault's work 'discipline and punish' identifies how agency can also create structures that are given power over individuals which limits agency, this is reflected in the concept of panopticism (Rabinow, 1984). Within the situational map there are seven major issues that collectively reflect the tensions of structure and agency:

- Broad scope and limiting permissions
- Internal governance and external governance
- Ambiguity and standardisation
- Advanced generalist and advanced specialist
- Professional development and service provision
- Same and different
- Personal identity and professional recognition

7.3.1Broad scope and limiting permissions.

The ANPs have a broad scope of practice reflecting their experience and the further academic training to fulfil the role. In this study the consultant and middle grade participants recognised there was a high degree of motivation in the ANPs. This trait reflects the agency of the ANP to develop their role to the fullest and there was an acceptance in the study that limits or boundaries (structures) to the ANP role should not be applied. This opinion was notably held by the most senior nurse in the organisation, who acknowledged that professional development is ongoing, evolving and provided the ANP maintained underpinning competencies then boundaries should not be enforced. Kennedy et al (2015) identified ANPs had an extensive foundation of highly developed skills and knowledge that were invaluable to service development and patient care. Competency assessment frameworks can be used to demonstrate these core generalist skills to support transferability (Puravady and McCarthy, 2021). This was the aim of the multi-professional framework for advanced clinical practice produced by Health Education England in 2017 (Fothergill et al, 2022). However, applying these frameworks (structures) has not increased the

transferability (agency) of the role as the ANP role reflects an advanced specialist more than an advanced generalist.

This drive for recognising the broad skill set of the ANP is in part a response to the limitations that are placed on the role from other sectors of healthcare. This limiting of permissions was a tension to the broad skills; an analogy in practice would be a world class tennis player from whom someone keeps taking the balls away. In this study it was radiology and lead nurse managers that kept taking the balls away. Frustrations with these limiting permissions is noted throughout the literature with radiology being a main source of angst, Medina Ruiz (2018) reporting that the radiographers in their study did not agree with ANPs requesting diagnostic imaging. This was also reflected in the experiences of the ANPs in this study, when asked about challenges in their role, radiology was a notable source of tension. These limits on broad scope of practice are frustrating and are also seen in the tensions of internal governance or external governance, which is in keeping with the overarching structure and agency opposition. It is in this tension that the influence of power on the ANP role is also seen. Power/knowledge is recognised as being truly integrated concepts (Foucault, 1980) with the relationships between the ANPs and lead nurse managers reflecting the power/knowledge imbalance and the limitations that structure then places on agency. ANPs hold specialist knowledge and associated power over the patient through diagnosing and treating illness. However, the increasing knowledge and associated power of the ANP role is a potential threat to the power of the lead nurse manager as the ANP now possesses knowledge that they do not have. This was questioned in the study by consultant participants, but with the silence of the lead nurse manager there is only evidence of absence, and nothing can be substantiated or inferred without their engagement.

Although the literature has identified the influence of the lead nurse manager role on ANPs, the tensions found in this study have not been found elsewhere. This may reflect a local culture and attitude towards ANPs, however, without their participation in the study, it is difficult to identify the rationale for their perceived restrictions on the role. The lack of engagement of nurse managers in developing leadership skills in ANP roles is recognised in the literature (Elliott et al, 2016). Kerr and Macaskill (2020) identified that ANP roles were not acknowledged by senior or lead nurses for the senior level they are because of the clinical focus. It was interpreted that

management skill and responsibility carried more value than the high-level clinical skills of the ANP, this was reflected in an attitude of '*who do you think you are?'* towards the ANPs (Kerr and Macaskill, 2020 p1207). The wider literature does not reflect all the challenges found in this study where ANPs were subjected to unnecessary levels of scrutiny and limitations. However, as this study has used situational analysis methods, which has not been applied previously to this subject matter then it is not unexpected to have new findings.

Jones et al (2015) when exploring perceptions of the ANP role, found that some nurse managers did not trust the education from higher education institutes (HEI) and required further training within organisations to provide them with assurances. The rationale was a lack of trust in the education and training (Jones et al, 2015) and this has not been the experience of the ANP's in this study. In the context of comments made in the focus group regarding nurse managers not being subjected to the same levels of scrutiny about their skills and abilities, there seems to be an imbalance in what is accepted for advanced clinical roles and what is required for similar level management roles. Without the opportunity to explore this with the lead nurse managers in this study, this remains an unanswered question and a silence.

7.3.2 Internal governance and external governance

This conflict of broad scope and limiting permissions is reflected further in the internal governance and external governance tension. Internal governance refers to the governance placed on the ANP role by the ANP and the department or service they work within. This is governance that can be negotiated according to the skills, experience and knowledge held by the ANP and there is an opportunity to manage or control these governance arrangements. External governance refers to the governance placed on the ANP role by the wider organisation and specialities within the organisation who indirectly control aspects of the ANP role. Notably radiology is one such department that imposes external governance on ANP roles for which they have no direct responsibility. It should be acknowledged that radiologists are doctors with specialist training in diagnostic imaging and interpretation. Exploring the wider literature does not provide the clarification for why this department imposes restrictions on ANPs roles that limit their ability to fulfil their role. The legislation regarding Ionising radiation for medical exposure (IR(ME)R) (2017) reference 'referrer' and define it as:

> ‘a registered health care professional who is entitled in accordance with the employer’s procedures to refer individuals for exposure to a practitioner’
>
> (IR(ME)R, 2017)

A registered health care professional is a member of a profession regulated by a body listed section 25(3) of the National Health Service Reform and Health Care Professions Act 2002 (Government UK, 2002), which includes the Nursing and Midwifery Council. There is no distinction between medical and non-medical referrers in the Ionising radiation for medical exposure regulations (IR(ME)R) (2017) and it is unclear as to where or when this distinction started. Hughes et al (2022), on behalf of the British Institute of Radiologists, have produced a position statement regarding governance for non-medical referrers and this provides an insight in this professional body’s view of healthcare professionals other than doctors. The statement refers to an increase in number of non-medical referrers and an increasing regulatory and administrative responsibility on radiology departments to ensure hospitals meet their requirements. However, as there are no regulatory or administrative responsibilities specifically reported for medical referrers, it is unclear as to why non-medical referrers would add to this. There is a paucity of studies exploring the radiology referring aspect of the ANP role. Kerr and Macaskill (2020) attributed the additional governance from radiology on the ANPs as being due to the newness of the role in Ireland. However, O’Keefe et al (2015) noted challenges with radiology in an earlier study and given that the study was undertaken in 2009 it would suggest that the situation has not improved eleven years later when Kerr and Macaskill (2020) undertook their study.

Taking a Foucauldian view, this punitive approach taken by a medical speciality is an example of hierarchical values applied to differentiate individuals through limiting conformity. Rabinow (1991) reports Foucault’s concepts of the power of the norm, in this case doctors have power (the norm). Applying this to the ANP role, the increasing number across the various specialities challenges the power of the norm as the ANP’s need the same power and freedoms to carry out their role. Policy and practice reflect an acceptance that all doctors can refer for any diagnostic imaging by virtue of a degree in medicine, with a requirement for other healthcare professionals (notably nurses) to provide additional evidence and assurances. As with the Lead nurse manager silence, without the opportunity to explore this with those who

represent radiology, meaning cannot be inferred into why this process and situation exists.

7.3.3 Ambiguity and standardisation

The third major issue and debate from the situational map that underpins structure and agency is the tension between ambiguity and standardisation. The differences in foundation experience and subsequent scope of practice for each of the ANPs contributed to variation in how the ANP role was fulfilled. This fed the concept of ambiguity for those working with the ANPs unsure of who could do what. There was a wider lack of standardisation regarding the post across the organisation, including banding and job plan. This echoes the findings in the literature, Williamson et al (2012) attributed role confusion to the development of a role that was ill-defined. This was also found by Dalton (2013) who explored the perceptions of the ANP role in a hospital setting, a key theme identified was role vagueness and ambiguity. Stanford (2016) evaluated the influence of a competency framework for ANPs and identified that it facilitated a more standardised approach to training and mentorship. Wang et al (2022) identified the variation in roles and titles for ANPs, particularly when compared with physicians' associates. However, they recognised ANP roles developed within specialities in response to service and patient needs and this was viewed as a positive aspect of the ANP role (Wang et al, 2022). Findings from the medical participants in this study noted an acceptance and recognition of different skills and experience owned by the ANP.

7.3.4 Advanced generalist and advanced specialist

This tension reflects the challenges with how the ANP role is perceived, do they have advanced generalist or advanced specialist skills? The study findings reflect commonality in the skills attained as ANPs notably with clinical patient assessment. However, the ANP participants were from a range of specialist clinical areas where they worked using these advanced generalist skills. It was recognised, in this study, by the ANP participants that they needed to evidence expertise across all four pillars of advanced practice, and this may reflect local culture regarding ANP portfolio management. All the ANPs had completed higher education at master's level which included developing and maintaining a portfolio. Cooper and Lidster (2021) found variation in portfolio management in their study and although Health Education England (2017) recommend a portfolio of evidence there remains inconsistency and

a lack of engagement in this process. Fothergill et al (2022) acknowledge the impact of the variation in education, adherence to frameworks and the impact this had on recognising the advanced generalist skills of the ANP. Current frameworks for advanced practice across the four nations have a consistent structure implying a generalist approach to the role with core skills, standards, and scope of practice. However, there is concern that such frameworks could limit the ongoing development of advanced practice roles by being prescriptive and restricting abilities for cognitive creativity (Stanford, 2016).

The specialist areas ANPs work within and the specialist experience that underpins the role can limit the transferability of the role and supports the opposing position of advanced specialist. In this study the ANPs worked in critical care, paediatric surgery, acute child health, paediatric trauma, neonatology, and acute oncology. All the participants shared the core skills of clinical patient assessment and diagnosis, but it was their specialist experience which limited transferability across services at the same expert level.

Hooks and Walker (2020) noted the broad generalist skills of the advanced clinical practitioner, with an ability to manage patients autonomously and holistically with undifferentiated conditions. Broad generalist skills of ANPs that are underpinned with a depth of specialist knowledge is a uniqueness of this role. Cooper et al (2019) recognise the generalist skills of ANPs particularly in comparison with the specialist skills of clinical nurse specialists. Hooks and Walker (2020) identified this lack of transferability as a barrier and felt that the absence of standardisation of credentials limited movement and recruitment of advanced practitioners. It was noted that this was more of a challenge in primary care and that the advanced clinical practitioners in secondary care shared more of the core skills (Hooks and Walker, 2020).

This generalist/specialist tension also contributes to role confusion and is explored further in section 7.3.6.

7.3.5. Professional development and service provision

One of the challenges reported in the study was the friction regarding the ANP role being a role focussed on professional development or service delivery. This tension fits with what is the mandate of the role: care? cure? It is also another reflection of the structure and agency challenge and echoes the Foucauldian paradigm of

power/knowledge. The ANP's recognise the professional development that this role affords, and the increasing knowledge should reflect an increasing power with the role. However, the structure within which the ANPs work limits agency and with service provision being imposed as the priority and a heavy focus on clinical work limits any increasing power.

In practical terms professional development aspect reflects a job plan for 7.5 hours (or pro rata equivalent) to fulfil the other pillars of advanced practice (RCEM, 2021). This supporting professional activity (SPA) is valued for allowing protected time to maintain an advanced practice portfolio that evidences the four pillars as well as enabling ongoing development. This approach to job planning (clinical and non-clinical time) is a key difference recognised between the ANP and clinical nurse practitioner job descriptions noted in the data analysis. Service delivery only would reflect a purely clinical role without protected time for the other pillars which ultimately limits professional development. Fothergill et al (2022) found that this tension between job planning for professional development or service need was widespread with the education, research and leadership pillars being overlooked and the clinical pillar constantly prioritised.

This focus on the clinical contribution of the ANP is reflected in the literature with Halliday et al (2016) identifying that in addition to the clinical aspect of the role, ANPs provide education for the nurses and doctors. Cowley et al (2016) has similar findings with the clinical and education value of the role being recognised not research or leadership. This focus on clinical skills would support a service delivery view of the role rather than a professional development role. Kerr and Macaskill (2020) noted the '*big brother is watching you'* (p1206) feeling where there was a focus on quantity of patients seen, not the quality of care provided. This reflects earlier findings by O'Keefe et al, (2015) where there was a focus on quantity of patients seen with lack of resource being cited as an excuse for not supporting professional development especially research. The balance between meeting service needs and maintaining the professional development of the role is a tension that reflects the disparity and lack of consistent approach to the understanding and recognition of these roles.

7.3.6. Same and different

Same and different reveals the ANP experience of being compared to both doctors and nurses but ultimately being different to both. The comparison to doctors reflects the critical juncture where these roles began expanding exponentially. Fleming and Carberry (2011) note that although changes in healthcare provision was a driver for the development of ANP roles, it was the reduction in junior doctors' hours (Council Directive, 2000) that had the biggest impact on the development of ANP roles. This set the foundation of the view that advanced nurse practitioners were there to be *'gap fillers on the rota'* (ANP focus group) or replace the doctors that were now not working excessive hours as part of their training. This is noted in the findings from the focus groups where the ANP cited the reduction in medical staff as an opportunity for them to develop into the space this left in the medical team. Although there is now shared knowledge and skills between doctors and ANP's, the tensions in the role reflect that the agency and freedom to practice afforded doctors is not automatically shared with ANPs working in the same teams. Interviews with the doctors in this study demonstrate their frustrations with structural imposition which limits ANP agency.

Nursing is predominately a female and feminine profession (O'Connor, 2015) which perpetuates the perception of subservience to medicine and doctors. In the context of ANPs, this is a group of experienced nurses moving into the medical domain and applying nursing expertise through a medical model. This tension is increased when the ANPs themselves simultaneously cling to and resist their nursing identities. This was evident in the focus groups where the unanimous identity the ANP's held was that of a nurse, while recognising the limitations (lack of agency) placed on them by the wider organisation (structure).

Historically ANP development occurred to fulfil unmet service or population needs. Lewis (2022) acknowledges nurses have been taking on medical work to fill gaps in the patient care which paved the way for ANPs to develop in the space where the doctors were missing. However, it is apparent that both the data and the wider literature recognise the more recent substitutive reason for ANP role development. Laurant et al (2018) completed a systematic review specifically comparing nurses, nurse practitioners and practice nurses with GPs in primary care, concluding that nurse practitioners were the same or better than GPs at managing certain patient

conditions. While the literature over time reflects a change where the ‘extra’ of the advanced nurse practitioner role was recognised, there is still comparison with other professional groups. This is noted in the scoping review by Wang et al (2022) where ANPs were compared with physician associates, describing them both as mid-level practitioners. This is an interesting approach given that ANPs are autonomous, registered professionals and physicians associates are a dependent occupational workforce without professional recognition, registration, or regulation. Cooper et al (2019) looked for similarities and differences between ANPs and clinical nurse specialists (CNS) and acknowledged that clinical nurse specialists reflect a specific role not a level of practice. While there is much crossover between the roles, the specialist (CNS) versus the generalist (ANP) perspective appeared to represent the point where the roles diverged (Cooper et al, 2019).

It could be considered that these challenges and tensions in the wider literature reflect the need to establish the history of the ANP role and situate it in the known history of healthcare roles. Foucault talks of ‘historical a priori’ in The Archaeology of Knowledge (p143) and applying this concept in principle to the ANP role, the lack of shared, known history with common language is reflected in this study notably within the organisational documents. Despite this comparative approach there is wider literature recognising the differences and benefits the advanced nurse practitioner brings to teams and patient care. Dalton (2013) reported on the complexity of the ANP role, while McDonnell et al (2014) identified the positive impact of the role notably providing a means to ‘bridge the gap’ (p795) between professional teams and as well as patients. ANPs were recognised for their ‘unique contribution’ (p3300) to a specialist service by Kennedy et al (2015). Batty (2021) found ‘value-added care’ (p4) as one of the themes in their study and demonstrated the difference that advanced nurse practitioners brought to the service.

This was the first of the tensions recognised in this study and is represented in the social world map with the minimal overlap in social worlds of the ANPs and doctors. The size of the overlap reflects the sameness in the skills of clinical patient assessment and diagnosis but the differences between the roles is reflected in the larger separate social worlds each profession occupies. The medical world overlapping the ANP world reflects the dominance that remains of medicine over nursing. This theme is discussed further as part of the discussion of the key

concepts as this power hierarchy is influential in the success of the ANP role. Individually the power of the doctor is used to support and highlight the ANP role, however, the collective historical power afforded to doctors/medicine is applied by others to suppress the role.

The doctors in this study acknowledged that the position of the ANP in the team was more than the space occupied by a doctor. This extra that the ANP had was recognised as their experience, organisational memory, caring paradigm, and constancy. The study findings reflected that viewing ANPs as substitutes for doctors was a narrowminded approach, and that the value of all the additional skills should not be overlooked. Although a substitutional view was taken, Hooks and Walker (2020) identified the added value of years of clinical experience and expert communication skills brought to the role by the advanced clinical practitioner was greater than that of the doctor they were often replacing. McDonnell et al (2014) had previously reported the added value of the ANP to the team. Bringing extensive experience and knowledge the ANPs enhanced the training of the junior doctors and nurses and were recognised as a dependable source of expertise (McDonnell et al, 2014). Batty (2021) identified that the ANPs sat within the medical team but brought a nursing perspective to the team which gave a holistic approach to patient care that was lacking in the medical model. Halliday, Hunter and McMillan (2018) reported the lack of understanding of the four pillars of practice influenced medical and nursing colleagues in comparing the clinical skills between ANPs and doctors only. In the primary care setting the ANP role is often regarded as substitutive, and this may reflect the different ways of working as an ANP in primary care where there is a defined caseload of patients and more isolated working (Laurant et al, 2018).

This same/different tension is also reflected in the nomenclature ‘non-medical’ and although it is not clear in the literature when this was adopted, it adds to the ‘different’ aspect of the tension. The ‘not a doctor’ label implies something lesser and ANP roles have been viewed by some as providing something less to patients. The hierarchical power held by doctors by having medical knowledge is recognised and considered in part a cause of the doctor-nurse power game (Lewis, 2022). This reflects the power/knowledge influence on structure and agency. Doctors are not traditionally limited to a scope of practice, there is a general acceptance that they hold all the skills and knowledge to make a wise decision, to do the right thing.

Nurses, however, in advanced roles are required to define the boundaries or limitations of their roles and there is no automatic right given to practice, as is seen in medicine. Given that ANPs now share, in part, this medical knowledge and apply it autonomously to patient care, the counterargument could be given that medical power is being eroded and patients are getting something more from an ANP through the application of both medical and nursing knowledge. This is more in keeping with the findings of this study where the additional skills and knowledge gained by becoming an ANP were recognised as a new way of nursing and not a step towards becoming a doctor. It was both the ANP's and doctors who recognised this benefit for patients.

Cowley, Cooper and Goldberg (2016) reported in their study potential confusion patients could experience seeing a nurse instead of a doctor and this was noted as a '*cop-out*' by the participants (p33). However, there is little evidence to support this in the literature with studies reporting patients increased satisfaction with the care from ANPs. Kennedy et al (2015) noted the person-centred care delivered by ANPs; Medina Ruiz (2018) reported timely and efficient holistic patient care, with Williamson et al (2012) identifying the crucial impact on patient care that the ANP provided with enhanced communication and consistent presence on the ward.

ANPs are not only compared with doctors, but literature also reflects comparisons with nurses and nursing. This was a notable tension in the study with the ANP's holding firm their nursing identity and foundations but finding the limitations placed on nurses challenging at advanced level practice. It was not only the ANPs in the study that experienced this tension, but consultants also reported frustrations with nursing restrictions being placed on ANPs. This has not been noted in the wider literature. The medical consultant experiences of limitations on ANP roles is a new finding and important contribution to understanding the tensions in the ANP role. The medical consultants identified and articulated the restrictions placed on the ANP roles because they were nurses and were able to challenge these restrictions due to their position in the healthcare hierarchy.

The same and different tension permeates through the comparison of ANPs with doctors and nurses, by themselves and others. The ANPs recognised the value of their nursing background and how it enhanced their advanced practice role.

However, there were increasing differences between the ANP role when compared to traditional nursing roles. Constant comparison with nurses was a limiting factor in the ANP role and is seen as a thread throughout the other tensions. The ANP participants in this study described their role as a 'new way of nursing' (ANP 6 Focus group 2). Similar comments have been noted by ANPs in other studies: 'I believe I nurse better as an advanced nurse practitioner' (Williamson et al, 2012 p1583); 'I see it as a role as a mega-nurse, not a mini-medic.' (Hooks and Walker, 2020 p 15). This adds to the tension of ANPs developing into the role as part of an evolution of nursing care but being restricted because they are nurses. It is in this tension that the either/or of the contested issue is recognised. Has the ANP role developed to meet patient needs instead of doctors or as well as them?

The sameness with doctors is noted in the clinical skills and decision-making but the differences are more than the sameness, which may be where the source of tension lies regarding limitations on scope and practice are noted. The social world map provides a visual representation of these worlds, with the overlay of within the medical world and distance from senior and lead nurse managers. However, taking a more macro level view of the professional groups of doctors, nurses and ANPs, figure 16 represents the same, difference and unique aspects of all these roles:

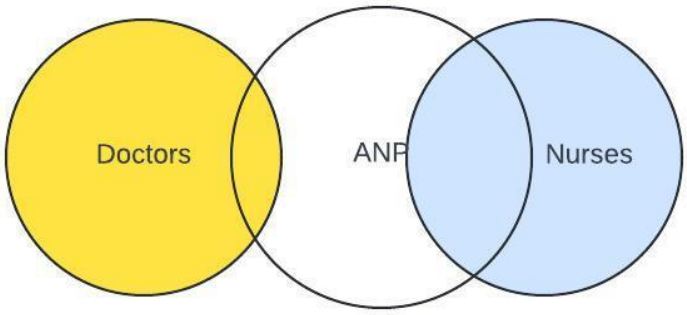


Figure 16: macro representation of professional intersection

For the ANPs there is greater overlap with the nursing profession than the medical representing the perceptions of participants in this study. The ANP circle is clear to represent the difference of the role in comparison with doctors and nurses and it is this uniqueness that is the tension they have struggled to articulate in this study. This tension provided a foundation for the major concepts in the positional map of professional identity and visibility.

7.3.7 Personal identity or professional recognition

The ANPs in this study resolutely claimed nurse as their identity, but this is at odds with the expressed frustrations associated with being recognised as a nurse. The challenges with a nursing identity were noted in the introduction and the study findings identified that is restricted or regulated what they could do as ANPs. They were resentful of this but still wanted to hold a nursing identity. There was a strong drive for clear and consistent professional recognition as an ANP not as a nurse which was also at odds with the personal view of being a nurse. The wider use of the advanced clinical practitioner (ACP) title in England may have allowed for acceptance of this as a professional role with a personal root in the foundational profession: nursing, in the case of this study. York (2021) noted that regulation may better support the professional nature of the role with an acknowledgment of the recognition that this would bring to these roles*(see footnote).

Foucault (1980) talks of the self-construction of power associated with structure and agency. Applying this to the expert nurse who becomes an ANP, they have structure and agency in their nursing role, with power associated with this. However, this changes in the ANP role as the structure and agency associated with that role has not been fully recognised nor given any power. This represents the personal identity and professional recognition tension and is also reflected in the confusion created by the variety of job titles and job descriptions found in the data. Other studies have found varied and inconsistent titles associated with advanced practice roles, which was further compounded by unclear job descriptions (Fothergill et al, 2022) However, this study has demonstrated this as a tension and recognised the influence of power in this tension.

*Footnote: at the time of writing the NMC have now completed consultation on the regulation of Advanced nurse practitioners and are proceeding with the next stage of work.

The lack of clarity in the job descriptions in this study, contributed to more misunderstanding with the similarities between three different roles – advanced nurse practitioner, clinical nurse specialist and clinical nurse practitioner. They would all wear the same uniform as required by the All-Wales NHS dress code (Welsh Assembly Government (WAG), 2010) which was intended to provide clarity and consistency regarding nursing roles. However, the rapid development of ANP roles increased after this dress code was introduced and it has not been updated. Doctors are not included in the All-Wales NHS dress code (WAG, 2010) nor in any other such policy document in Wales.

Cooper et al (2019) explored similarities between the advanced nurse practitioner (ANP) and clinical nurse specialist (CNS), concluding that ANPs are generalists and CNSs are specialists. However, the evidence from this and other studies does not support this dichotomous view, and it is both the advanced generalist and advanced specialist skills that are noted with generalist referring to core advanced practice skills and specialist being their area of practice. Advanced Practice reflects a level of practice whereas a clinical nurse specialist is a role in a specialist area of nursing not a level of practice (Cooper et al, 2019). Uniform is key aspect of professional recognition for all healthcare professionals and historically has reflected a sense of belonging and respectability (O'Donnell et al, 2020). With the ongoing confusion regarding ANP and CNS roles, the fact they wear the same colour uniform in Wales does nothing to provide any clarity regarding roles or belongingness for ANP's who have identified vulnerabilities with their professional identity. There is a paucity of research exploring uniform and identity and as it was acknowledged in this study as a source of confusion and invisibility regarding the advanced nurse practitioner role.

7.4. Professional identity and visibility

The concept of professional identity was recognised from the analysis as a means of providing a relatable explanation of the internal and external struggles regarding the acceptance and understanding of the ANP role. It was evident from the situational, social worlds, and particularly the positional maps that professional identity was closely associated with visibility, being seen was intertwined with acknowledgement and recognition of what the role is. Strauss' work on the social worlds organisation in medicine identified the negotiated order of healthcare work (Strauss et al, 1997). The ANP role with a hybrid skill set disrupts this accepted order and with the challenges

of professional identity and visibility, they [ANPs] need to re-negotiate where they are within the accepted order to function in their roles. The ANP participants identified that outside of their workspace, where they are known, they are not recognised as being a healthcare professional who can lead on aspects of patient care that would have traditionally been led by a doctor (section 5.7.1 and 5.7.2). The medical consultant participants who supervise ANP's recognised the need to re-negotiate the position of the ANP within the team and hierarchy (section 5.7.3) and to re-negotiate the restrictions that being a nurse placed on the role (section 5.7.1).

7.4.1 Professional Identity

Nursing has had a stormy relationship with the concept of being a profession, with research focussing more on professional identity than what the profession is (Willets and Clarke, 2013). A profession is recognised as such by having a body of knowledge, professional authority, approval of the community, regulatory ethical code, regulatory or professional body to monitor conduct within the profession (Willets and Clarke, 2013). This description is in-keeping with the structure and agency binary opposition and the associated power and knowledge to provide agency within a structure. Using this description, nursing is a profession, but what of the various roles within nursing are they occupations or jobs or professional roles in their own right? Wider literature reflects that although nursing is the overarching profession, there are professional roles that develop under that title, nurse educators are one such professional role (Pennbrandt, 2016). Pennbrant (2016) used an etymological and semantic analytical approach to identify if nurse educators represented a separate professional role. Applying this approach to the ANP role then it too could be considered a separate professional role. There is a body of knowledge associated with the role as reflected in the evidence review in chapter 2 and chapter 6; there is authority and permission to practice (agency) from other professions and the community (patients), with regulation (structure) managed by the Nursing and Midwifery Council (NMC). Recognising ANPs as having a professional role allows for discussion regarding developing a professional identity.

Professional identity reflects a how an individual aligns their values, ethics, knowledge, and skills within a profession (Kidner, 2022). Development of a professional identify for nurses is achieved through a socialisation process of formal education combined with time spent in clinical practice and workplace experiences

(Kidner, 2022). The transition from nurse to ANP reflects how an existing professional identity of nurse is influenced by new education and socialisation. Lewis (2022) notes the work to professionalise nursing moved it from diploma to graduate level education and has cemented recognition for nursing as a profession. There is a strong sense of belongingness that underpins the professional identity of nursing (Wood et al, 2021). This sense of belongingness changes when the workplace socialisation changes in the transition from nurse to advanced nurse practitioner and it contributes to loneliness and isolation (Wood et al, 2021). In this study it is expressed as frustrations with the ANP participants reporting irritation at having to explain who they are and what they do, despite being in post for several years. All this combined will influence the identity developed by ANP, especially if they are the first or only one in a medical team.

The study findings (section 5.7.1) identified the challenges in developing a professional identity as an ANP with erosion of the recognition of the senior status that these roles should hold. The re-negotiation of social order is present not only within the medical social world but with the positioning of the ANP role within a nursing social world, particularly nursing management hierarchy. Challenges were identified by the ANP participants with a lack of understanding of ANP roles in nursing hierarchies, a requirement to constantly ‘prove yourself’. This study identified nursing management as holding the power to give or take away autonomy in the ANP role, despite the roles (nurse manager and ANP) often being the same banding (8a) implying parity not seniority of one over the other. Kerr and Macaskill (2020) noted similar issues with the implication that clinically focussed roles have a lower position than nursing management ones.

The power dynamic has been noted throughout this discussion and Anderson et al (2020) reflect the actions of the ANP’s aligning themselves with the medical model, seeking the associated power with medicine. Considering the attachment to their nursing roots the ANPs in this study are not aligning themselves with medicine for power and this may be contributing to the frustrations and tensions with their role. By not aligning themselves within the medical model of care and immersing themselves fully in that social world the ANPs are not accessing the power of medicine. However as previously noted (section 1.6) nursing has sought emancipation from medicine to gain recognition of their own professional identity (Ten Hoeve, 2014) so it does not

sit well with the ANPs in study to align themselves with doctors and medicine. As part of re-negotiating a new social world order the ANPs may need to develop and possess a professional identity as an advanced version of a nurse that is new and unique.

The complexity of developing a professional identity has been recognised and the wider body of knowledge exploring this concept acknowledges the various social theories associated with this process. Kluijtmans et al (2017) used dialogical self-theory to investigate professional identity of clinician-scientists (clinical academics in the UK) whereby clinicians (nurses and physiotherapists) also worked as clinical researchers. It was recognised that a 'dual-identity' (p649) was developed and the roles reflected boundary crossing which, when the duality was reconciled, a 'meta-identity' (p651) as 'broker' emerged (Kluijtmans et al, 2017). Applying this process of professional identity development to the findings of this study the ANPs have duality of skills but there is an imbalance – all nurse skills and partial doctor skills, as reflected in the social worlds map. Given the struggles identified in this study it could be argued that the ANPs have not fully formed the meta-identity to facility the duality of the role. This duality is also reflected in the perceptions of ANP as 'lynchpins' (ANP 9 Focus group 2) bridging both nursing and medical worlds for the benefit of patients (McDonnell et al, 2014; Laird et al, 2020). The space occupied by ANPs between these worlds is seemingly opaque and, in this study, there is a lack of ownership of the space. The size of the social worlds reflects this 'smallness' of the ANP arena. However, visibility is the opposing axis in this positional map, and it could be argued that it is the limited visibility of ANP in the organisation that had made their arena small and influenced their reticence at owning the space between nursing and medicine.

Sheehan and Wilkinson (2022) recognised the influence of organisational culture, clinical environment, and learning, in combination with the individuals place in the wider team on the development of professional identity. In the context of ANPs, they are in a unique position of overlaying a new professional identity on their existing nurse identity at a stage of expertise in their career. The literature review in Chapter 2 acknowledges this difficulty with Fleming and Carberry (2011) reporting the challenge of identity deconstruction and reconstruction as a process of development from nurse to advanced critical care practitioner. This process is noted in other

studies where there is a shift from experienced or expert nurse to adult learner (student) to specialist practitioner which is impactful on the individual's sense of self (Thirtle, 2021). The discourse from this study reflects an organisational culture that is not sufficiently supportive of ANP roles and there is a failure to recognise this role noted in high-level professional nursing meetings and is further contributed to by confusing job descriptions. This adds to the lack of visibility of the ANP role in the organisation under investigation.

7.4.2 Professional identity as advanced nurse practitioner or non-medical practitioner

A significant tension associated with professional identity in this study was the strongly held views the ANP participants had, identifying as nurses first but were then frustrated by the constraints being recognised as a nurse placed on their role. Taking Foucault's view of power as metaphysical and '*productive network which runs through the whole social body'* (Rabinow (ed), 1984 p61) then it could be argued that the ANP's have power that is unrecognised by them and therefore unused. It was a profound moment of reflexivity at the end of the first focus group when there was a personal realisation that the ANPs understood their role and motivations but did not 'own' an identity, acting as if powerless to effect any change in their world. Given their ownership of the nurse identity and the repressive power applied to the nursing role (section 1.6) then it is unsurprising that they felt powerless. However, the interviews with the doctors identified the power of the ANP within their speciality and supported their roles and the added value they brought to patient care.

This frustration was also reported by Thompson and McNamara (2022b) who recognised it as '*controlled identity'* (p2348) with the perception of freedom for doctors and control for nurses. This freedom versus control dichotomy was recognised by the doctors interviewed in this study where the medical participants recognised their freedom to practice based on their medical degree and struggled with the control applied to ANPs. This brings to the fore again the debate about the role being a professional one or an occupational one. Advanced practice reflects a level of practice and although this study addresses the nurse experience of the role, it is in general multi-professional using the advanced clinical practitioner title instead. It can be argued holding the nurse identity too firmly limits the development into the advanced practitioner professional identity. Anderson et al (2019) recognised the challenge of freedom versus control when a nurse transitioned from a role with

boundaries as a nurse to one with less-boundaries as an ANP. As an ANP there is increasing freedom to practice but not as much as is afforded the doctors. However, Anderson et al (2019) reports that the nursing participants did not recognise advanced nursing practice as nursing and saw the ANPs as moving into the medical domain. This attitude regarding ANPs no longer being recognised as nurses by nurses is not new and has been noted in other studies. Medina Ruiz (2018) reported a quarter of participants agreeing that becoming an ANP meant they moved away from their caring role as nurses. The alignment of the ANP role with medicine further compounds this issue of ANPs being seen as advanced nurses. Batty (2021) identified that the ANP was seen as having an extra doctor in the team, albeit a doctor who had additional nursing skills. In the context of this study the social world map (Figure 13: p106) has the medical world overlaying the ANP world, however it would be interesting to see if the doctors develop any of the advanced nursing skills over time and change the way the worlds overlap. The medical consultant participants in this study notably favoured the caring skills the ANP brought to the role, and one made the deliberate choice to seek an ANP for that skill set within the multi-disciplinary team. This reflects the value placed on caring and the role of the nurse.

7.4.3 Power in status

In this study there was a dichotomous view of the status of the ANP role within the organisation. There was ANP representation at high level professional nursing forums, implying power in status. However, it was in the same forum that comments about not having ANPs in the organisation were made, no status equals no power. Visibility aptly represents this contentious issue and was applied to avoid further negative, non, or lesser inferring concepts such as invisibility. This was the interconnected axis with professional identity and as organisational culture is important in developing a professional identity. Working in an organisation where you are not visible will impact on your sense of professional self and the power and control you feel you have in the workplace.

The medical teams in this study generally held the ANPs in high regards with an acknowledgment of their valuable experience and senior position in the wider multidisciplinary team. There was only one participant who raised the issue of hierarchy between nurses and doctors (Interview with consultant 1) and the impact

this could have on the nurse moving to an ANP role. The doctors acknowledge ANPs as a separate role from nursing, recognising they have added traditional medical skills to significant nursing expertise which creates this new professional – advanced nurse practitioner. Using Critical Discourse Analysis, Thompson and McNamara (2022b) also identified '*The Medicalised Identity'* (p2349), where the medical skills developed by the ANP were seen as greater than the nursing skills. It was challenged that they are no longer nurses, and the discourse reflected that medicine was favoured above nursing (Thompson and McNamara, 2022b). This attitude is reflected more subtly in the findings of this study with a challenge that the ANPs should not be managed or subjected to the same reviews as traditional nurses. There was a suggestion that these roles should be under the regulation of the General Medical Council (interview with consultant 5).

Mannix and Jones (2020) noted a status change where it was recognised that senior nurses were appointed to trainee ANP roles, the trainee roles were initially seen as a junior level clinician and so there was a loss of status. Kerr and Macaskill (2019) also noted this change in status from clinical nurse manager to trainee ANP and acknowledged that the senior nurse managers no longer afforded them the same respect and voice in the organisation. They were limited in negotiating rights, and disregarded in meetings which restricted their influence in organisational nursing forums (Kerr and Macaskill, 2019). Although there is a perception that ANP roles have a lower status because they are clinically focussed (O'Keefe et al, 2015), it may be the burden of clinically loaded role that limits their leadership influence (Elliot et al, 2016; Lockwood et al, 2021) and therefore their perceived status.

7.4.4 Powerless in status

The theme of the ANP role sitting between two professional groups is reflected in this study as well as in the wider literature (Williamson et al, 2012; McDonnell et al, 2015; Cowley et al, 2016). However, in this study the findings reflect that they feel they do not have a voice, they are something 'other' and this adds to the insecurities in the professional identity. This lack of professional identity is noted in the silences of the discourse data from this study, where there is little reference to ANPs. Being visible, being seen and being acknowledged as a professional with a senior role is reported by the ANPs as an important key to cementing the professional identity. The wider organisational discourse refers to a collective of non-medics, implying

there is a bi-professional option in healthcare – doctors or not doctors. This is another example of the binary opposition of the postmodern discourse found in this study, and given the high professional status afforded doctors, there is an implication that anything else is ‘lesser than’. Combining this with the recognised change in status associated with transitioning from a nurse to an ANP it is unsurprising that there is a crisis of professional identity.

7.4.5 Visibility

Visibility was reflected in the ANP focus groups with reference to not being recognised outside of their area of work with uniform impacting on this visibility and recognition (ANP1 Focus group 1). Reflecting on the social world map and considering the findings, visibility moves from an abstract concept to a tangible one with physical geographical placement influencing the visibility of the advanced nurse practitioner role. Notably the interviews reference the commonality of the ‘*sea of blue uniforms’* (interview with deputy executive nurse director). In this study the lack of visibility is in part reflected in the homogenous approach taken to nursing uniforms in Wales that does not reflect breadth of role and levels of practice that are outside of the traditional bedside nursing role. This breadth of roles is noted in the wide variety of titles applied to nursing roles by Leary et al (2017) with over five hundred different titles identified. Of greater concern is the more than three hundred jobs using the title advanced or specialist nurse practitioner that did not required professional registration with the Nursing and Midwifery Council (NMC) (Leary et al, 2017). Lack of visibility of the ANP role is in part a result of the poor development of the roles. Jones et al (2015) found that those in a specialist nurse role had developed into ANP roles over time without the recognition that that had happened. This led to confusion as well as frustration regarding recognition of the contribution of the role to the service (Jones et al, 2015).

Despite the feeling of not being visible the ANP’s also recognised the feeling of being watched or monitored. This links with Foucauldian description of the panopticon where power operates through a process of observation, in this case arrangements are in place to watch the actions of the ANP. For example, the structures applied for prescribing and radiology referral impacting on the agency of the ANP role when compared to doctors.

7.5 Scope of practice and barriers to practice

As discussed above owning a professional identity and being visible are key tensions that are also aligned and underpinned with extensive skills, knowledge, and experience to have a wide scope of practice and associated autonomy. However, this broad scope is restricted by barriers to the enactment of the role, and these barriers are often outside of the control of the individual or collective advanced nurse practitioner(s). Structure and agency as binary oppositions have been used to explore these tensions identified in the situational map. The following section discusses the tensions on the second positional map in more depth, seeking understanding of why the ANP does not have the freedom or jurisdiction to practice that the role requires.

7.5.1 Scope of practice

Scope of practice is described by the Health and Care Professions Council (HCPC) as:

> the limit of your knowledge, skills and experience and is made up of the activities you carry out within your professional role.
>
> (HCPC, 2021)

The Nursing and Midwifery Council (NMC) do not offer a specific description for scope of practice, but all registered nurses are required to work within their competence (NMC, 2018). Advanced nurse practitioners (ANPs) are therefore required to be competent in the scope of the role they are performing. As these roles have developed in response to the shortage of doctors following changes in training and working hours, then the ANPs will have a scope of practice and a requirement of competence in an area previously occupied by doctors. It is recognised in this study that the ANPs are required to define the scope of their practice (sections 5.7.1. & 5.7.2) when working in the medical space. Doctors do not (section 5.7.2) and they are surprised by the levels of scrutiny applied to the ANP role. The doctors respected the commitment and work of the ANPs to complete their training (section 5.7.3) and acknowledged that this training combined with their existing knowledge and experience places them at the higher end of the medical hierarchy. This caused frustrations with the doctors and notably the consultants when the ANP's were required to comply with the restrictions applied to nurses without acknowledgement of their advanced skills.

In this study the knowledge, skills and experience of the ANPs was significant which give them a broad scope of practice at an advanced level. The scope of practice held by an ANP is not standardised or regulated and as noted by Hooks and Walker (2020) this also limits the transferability of the role. In real terms this means that the scope of practice is both an enabler and a barrier to the ANP role. To fulfil this autonomy an acceptance of responsibility is also needed, Lewis (2022) describes this as jurisdiction, and this better reflects the tension reflected in the study with having jurisdiction to practice in their department but this jurisdiction not being supported out of a defined physical space. This is in-keeping with the agency discussion associated with the situational map.

The findings reflect that the ANPs had a broad scope of practice and were able to clinically manage a caseload of patients that would have been similar to doctor at a senior level of training (specialist training year five and above). Combining this with advanced level skills across the other three pillars (research, education, and leaderships) then arguably, the ANP would hold a set of skills and abilities that are unique. Batty (2021) identified that the scope of practice of ANPs provided an added value to the team and the care patients received. The autonomy that accompanies the role is a source of satisfaction for the advanced nurse practitioner (O'Keefe et al, 2013).

A key finding in this study was the enabling support and supervision of the consultants whereby they championed the ANP role within their teams and were appropriately protective of the roles, ensuring they were not 'a dumping ground' (Consultant 2) for work by junior doctors (section 5.7.2). Accepting the power that medicine (doctors) holds and that ANPs are working in medical teams the opposite might also occur where the power of the consultants limits the ANP role. This has been noted in the literature with consultant supervision being seen as both supportive (Fothergill et al, 2022) and limiting in practice (Kerr and Macaskill, 2020; Thompson and McNamara, 2022a). Thompson and McNamara (2022a) cited language reflecting control being applied by supervision particularly noting the assumption that a 'hierarchical physician' is the legitimate supervisor of ANPs. In this study the scope of the role and the support of the consultant in a supervisory role or in general is seen as supportive and enabling. This finding may reflect the culture of the organisation given the willingness of consultants to participate in the study. The

ANP's did not report that their medical colleagues or supervisors were limiting in the scope of the role.

7.5.3 Structure, agency, and scope of practice

In this study the ANPs expressed their freedom to practice in their workplace and the environmental influence on the scope of practice is likely related to the ANP developing their role in environments where they have worked for several years. The stability of the ANP in the work environment allows for more ownership of the service and as Thompson and McNamara (2022a) note this improves patients' outcomes. Lockwood et al (2022) talk of the environment enabling the clinical autonomy of the ANP identifying this as the theme of 'living it' in their narrative literature review. Evidence reflecting improved times to be seen, reduction in waste of resources, admission avoidance and stable workforce were associated with ANPs working within the medical team and service (Thompson and McNamara. 2022a). The permanency of the ANP in the service ensures the development of an organisational memory and it is recognised as an ability to 'get things done'. The consistent presence of the ANP role should also influence the structure and agency of their service and into the wider organisation, this is a key aspect that was not recognised by the ANPs in the focus groups, which may reflect their lack of belief in their power.

Williamson et al (2012) noted the 'get things done' ability of ANPs was identified as 'facilitating the patients' journey' (participant comment) through proactively anticipating the next stage in care (Williamson et al (2012). This was identified as a theme by McDonnell et al (2015) reflected in 'Impact on organisation' (participant comment) suggesting both the admission and discharge processes of patients being improved by the ANP.

7.5.4 Barriers to practice – structures to limit agency.

The findings of this study identified several barriers to ANPs fulfilling the agency of their role. Some barriers reflect power imbalance between the doctors and nurses, however this study also identified that there were two influential roles acting as barriers – the lead nurses and radiology. These roles were perceived as barriers by the participants (ANPs and doctors) and as the roles had an oversight aspect to them, they could be likened to the ANP's working in a panopticon. While lead nurses individually were silent non-participants in the study, collectively their voice was present in the documents analysed, notably minutes of professional nursing

meetings. This data reflected the organisational confusion about the ANP role and were a source of challenge and tension regarding the role.

Barriers due to poor understanding of the role is noted in the wider literature with reference to the lack of clarity and standardisation to the roles (Jones et al, 2015; Fothergill et al, 2022). This may be in part to the development of the role in services without clarity of purpose, which leads to a blurred boundaries making it challenging to articulate what the ANP does. This blurring of boundaries will contribute to barriers being placed on the ANP role as this role challenges the established balance of power and knowledge within healthcare. Kennedy et al (2015) identified fluid role boundaries as a positive aspect of the ANP role in palliative care, noting that the role complemented the medical workforce not to substitute it. Viewing ANP roles as complimentary not substitutive should provide clarity and reduce barriers, but the use of the non-medical title implies something other or lesser and this raises barriers. In this study the documents produced by radiology and pharmacy are title: non-medical referral for imaging and non-medical prescribing. This can be interpreted as not a doctor asking for radiology imagining or not a doctor prescribing implies someone is doing something they should not.

The impetus for the ANP role appears to influence the recognition and acceptance of the role and has the potential to reduce barriers. To identify the purpose of an ANP in stroke services, Laird et al (2020) explored in depth what the service and the ANP would need to fulfil the role, before developing the role in the service. This provided a clarity to the role and its development that is often lacking in other services where ad hoc role development has occurred. The tendency to use ANPs to fix a workforce problem was recognised in this study, notably by the deputy executive nurse director who acknowledge that ‘putting a nurse practitioner in’ was often seen as a solution to staffing less attractive posts or services.

Nursing management is hierarchical in nature and is recognised in this study and the literature as source of negative impact on the development of the ANP role. The reasons for this are poorly understood, Jones et al (2015) identified a lack of confidence in the education and training of the ANPs as a reason for increased scrutiny in the workplace. However, as noted in this study this scrutiny would not be placed on a nurse manager at an equivalent level (ANP 6 Focus group 2, section

5.7.1). Alongside the caring nature that nurses portray, there is a darker side where it is recognised that nurses at senior levels or who have been registered for a long time may actively work against junior nurses or ambitious nurses who are striving to develop themselves. Anderson et al (2020) noted this as ‘vertical discounting’ in their study exploring the nursing and advanced nurse practitioner relationship. The difference in value placed on higher level clinical skills and management skills of nurses has been identified and discussed previously. To resolve this then the value of the advanced nurse practitioner role needs to be identified and highlighted.

7.6 Summary

The discussion has situated the research findings from this work in the context of the wider literature and the theoretical concepts associated with the key tensions identified. Structure and agency encompass the major debates found on the situational map with the overarching concepts of professional identity and visibility being representative of the ANP role tensions. Knowing who they are and being seen for that role allows for clarity of scope of practice and reduces the barriers to practice. The complexity of the ANP role in a secondary care hospital has been revealed and the challenges of professional identity and the agency to fulfil the role are key to its ongoing establishment within healthcare. Considering these challenges and tensions the following section will explore recommendations to reduce or resolve these tensions.

7.7 Recommendations

The findings in this study have revealed and explored the tensions in the ANP role in a secondary care setting and have informed these recommendations. The overarching binary opposition of structure and agency is under pinned by tensions in professional identity and visibility and the recommendations seek to address these tensions.

To address the tensions with professional identity the following is recommended:

- Professionally neutral title.
- Advanced Practice uniform
- Support to transition from nurse to advanced clinical practitioner.

To address tensions with visibility the following is recommended:

- Organisational recognition of advanced practice roles
- Further research exploring the Advanced Nurse/Clinical Practitioner role.

7.7.1 Professionally neutral title.

Professional identity was a significant tension in the ANP role with the challenge of balancing a nursing identity with an advanced level of practice overlaid. The title nurse title and associated identity was seen as barrier and tension that limited the agency of the role. There are now national multiprofessional frameworks for advance clinical practitioners and an acceptance of the advanced clinical practitioner title in England as this better reflects the advanced clinical role that the ANPs and other professional fulfil. It is recommended that there is local and national adoption of a professionally neutral title as it will facilitate the development of a professional identity reflecting the advanced clinical practice role, not the foundational professional identity. Leary et al (2017) identified multiple role titles and the confusion they cause, however there is a definition and description of what the advanced clinical practitioner role is, which provides clarity. Moving to the professionally neutral title of 'Advanced Clinical Practitioner' should allow the nurses in these roles to move away from the limitations applied by virtue of being titled 'nurse'. The role is professionally neutral in England with the Health Education England (2018) multi-professional framework for advanced clinical practice and practitioners. Changing this within the organisation locally, as well as nationally across Wales would change perspectives on how the role is developed. It would recognise the role as autonomous enacted at an advanced level with core skills applied by a registered professional. Using a professionally neutral title would allow for clarity regarding the role as it would better reflect the purpose of the role and may also move away from limitations placed on development of these roles by lead nurse managers. Although the rationale for the barriers from the lead nurse managers has not been identify, professional jealously has been noted in other studies. Removing 'nurse' from the title might ease these tensions and allow for a more supportive relationship.

Using a professionally neutral title would also assist in moving away from using 'non-medical' in organisational discourse. This would be particularly beneficial in relation to radiology requesting where a neutral practitioner title is used in the IR(ME)R

(2017) regulations. This may reduce barriers that the ‘nurse’ title seems to raise when nurses expand their role away from the traditional expectations. The advanced practice roles have been developed to augment and compliment medical roles in services rather than it being a purely professional development. Therefore, a title reflecting the role not the profession, would better support its recognition and allow for a professional identity that is not rigidly anchored in nursing.

7.7.2 Advanced Practice Uniform

Recognition of roles in healthcare is often reflected in the uniforms worn. The Welsh approach for a standardised nursing uniform is being explored in England currently (NHS supply chain, 2021) and the advantages of easier recognition of the healthcare professional can only benefit patients. There is strong support from public and patients for recognisable uniforms that communicate the role of the person wearing it (NHS supply chain, 2021) and this is important when the role is concerned with assessing, diagnosing and treating patients. Pawlowski et al (2019) found a correlation in the published studies of patient’s perceptions of nurse’s uniforms and the level of professionalism and skills. This was previously noted by Palazzo and Hocken (2010) with regarding to doctors, uniform and credibility. The findings from this study identified the challenge of the ANP uniform and the impact it had on role recognition. Therefore, to develop the recognition and identification of advanced nurse practitioners, having a uniform that represents and unifies the role can only aid the ongoing development of advanced nurse (clinical) practice roles. Given the introduction of physician’s associates into the workforce then standardising uniforms would provide clarity for patients as to who has assessed them and provided care. The combination of a professionally neutral title and a standardised uniform would provide recognition of the role within the healthcare team and the wider NHS.

A standardised uniform would also support with the development of professional identity. Currently, in teams with multiple professionals working in advanced practice roles, they wear different uniforms despite doing the same job. A standardised uniform would allow all those in the role to be seen as a professional group and allow them to support the development of their professional identity through socialisation, role modelling and sharing of values. Adopting the recommendations for title and uniform would have a significant impact on how the role is perceived and recognised.

7.7.3 Support to transition from nurse to advanced clinical practitioner.

The findings in this study identified the tension in developing a new professional identity while being attached to the foundation profession. To reduce these tensions and challenges, it is recommended there needs to be a greater understanding of the transition process from foundation profession into advanced occupational role. Including experienced advanced practitioners in academic programme development to address this aspect and gap in training can only improve the experience of advanced clinical practitioners in training.

Those who supervise trainee advanced clinical practitioners should have guidance on the challenges of changing professional identity and the vulnerability that the trainee experiences. The power/knowledge influence on the trainee in this role should not be underestimated and this study has identified how the effect of the hierarchical power of lead nurse managers limits agency and causes tensions in the role. Supervisors of trainee ANPs should be empowered to lead on the development of these roles given the understanding and support identified in the findings of this study.

Experienced advanced clinical practitioners (ACPs) have increased in number and are now able to provide mentorship for trainee ACPs. This would enable support for the trainee through the transition into the ACP role and reduce tensions such as imposter syndrome. Providing the trainee ACP with more support and opportunity to develop their new professional identity will also provide clarity and understanding of the role. They will be more able to articulate and own their role if they understand and assimilate the professional identity in a more confident manner.

7.7.4 Organisational recognition of advanced practice roles

The study findings demonstrated a disconnect between those in the nursing hierarchy and those in advanced roles as well as their medical colleagues. To better support the visibility of the advanced practice role there should be leadership with responsibility for the role at an executive level, preferably with an advanced practice background. This is noted in recommendations from Health Education England (2022b) regarding the governance of advanced clinical practice (ACP) roles with the identification of a strategic lead at an executive level who had a background as an advanced practitioner. This has not been replicated in Wales, and this disparity as well as a lack of understanding regarding advanced practice roles was recognised as

a patient safety issue (Welsh advisory group for advanced clinical practice meeting, 28th September 2021). Developing an organisational governance framework would standardise the development and training of advanced practice roles (Health Education England, 2022b). Organisational leadership and ownership of the ACP role would reduce the barriers as it would provide the consistency and clarity to the core purpose of the role. It would also provide the visibility needed for the role to be fully recognised within the organisation. This would influence the barriers from services where the lack of understanding has limited the role, such as with radiology. Having executive leadership and recognition would ensure the role is visible in professional forums as well as within workforce planning.

In this study the lack of visibility within the organisational discourse has led to lack of recognition of the ANP role outside of the area they directly work. Having an organisational approach regarding role development, training, title, scope of practice and governance of the role would widen the recognition of the role. Recognition of this role and its place within services would provide validity to the role within an organisation. This study has identified that the ANP fulfils a role within a team that is different to the occupational space of a doctor and can offer more to patient care that the role of a doctor. Health Education Innovation and Workforce (HEIW) (2023) have published a Professional Framework for Enhanced, Advanced and Consultant Clinical Practice in Wales, to refresh and update the levels of clinical practice across healthcare professionals in Wales. There is a requirement for organisations to identify leads for advanced practice with reporting routes to executive level (HEIW, 2023). This is a step forward and may increase the visibility of advanced practice roles, however it falls short of the model in England. The importance of this level of executive responsibility of advanced practice roles is a key indicator in the governance maturity matrix for advance practice developed by the Centre for Advancing Practice (NHS England, 2023) as it recognises the influence this has on the visibility and safety of advanced practice roles.

7.7.5 Research exploring the Advanced Nurse/Clinical Practitioner role.

The focus of this study has been on the ANP and organisational tensions with the ANP role. However, given the ANP attachment to their nursing foundations and the evidence from the literature identifying the positive impact on patient care, the recommendation is that further research regarding the ANP role should be from the

patient perspective. Patient opinion and feedback is highly valuable and influential, and for ANPs who have struggled to find their professional identity the solution to reconciling it may be found in the patients experience and perception of the role.

The ANP focus groups reflected the ANP drive to provide the holistic care for the patient without having to wait for someone else to do work that they themselves knew how to do. Patient focussed research for the future could provide the evidence of whether this holistic approach met patient needs in the way the ANPs perceive that it does.

7.8 Limitations

7.8.1 Introduction

Research studies represent findings from a defined set of circumstances, or in this case situation. Although this places limits on the transferability of the findings to other circumstances or situations, it does not take validity from the generation of new knowledge. The following section will address the limitations, associated with this study and how this new knowledge can be used.

Recognising and acknowledging the limitations of any study is important to provide confidence in the work, and to situate the findings where they can be applied and where they should be used with caution. Reflecting on this study four key limitations were identified and are discussed in the following sections:

- Transferability to other settings where advanced nurse practitioners work
- Applicability of findings to other professionals who are advanced practitioners.
- Influence of Covid-19 pandemic on participants and organisation
- Advanced Nurse Practitioner as researcher in workplace

7.8.2 Transferability to other settings where advanced nurse practitioners work

Situational analysis as a method allows for the investigation and understanding of a defined situation, and although the size of the situation is not limited, the transferability of the findings can be. As the study site was in Wales, the tensions experienced by ANPs in secondary care settings in England, Scotland or Northern Ireland, may not reflect the same tensions as this study. However, this study has revealed high-level concepts of professional identity, visibility, scope of practice and barriers to practice which are individually reflected in wider ANP research. This not

only supports the potential transferability of these concepts to the ANP role in other settings but also the benefit of using a research method that can capture the complexity of a situation.

Single site studies are a recognised limitation for transferability of findings. However, the unique research method of situational analysis applied in this study has afforded a three-dimensional insight into the tensions of the ANP role, which has not been revealed in other methods. The influence of power and knowledge and its use to negotiate, both expanding and limiting the role of the ANP, is an important finding that should be considered in future studies.

7.8.3 Applicability of findings to other professionals who are advanced practitioners.

This study reflects the experience of the nurse as an advanced nurse practitioner; however, it is recognised that physiotherapists, paramedics, pharmacists, occupational therapists, and dieticians are all developing advanced practice roles. Other allied health professionals and clinical scientists are also developing advanced practice roles to support changes and challenges to healthcare services. The identification of professional identity as a notable tension, and the link to the underpinning profession as a nurse would make the findings less applicable to other healthcare professionals in advanced practice roles. However, the tensions surfaced in this study have a basis in the concepts of power and knowledge which is applicable across healthcare settings and roles. It reflects the power of the medical discipline within which nursing and allied health professionals have to negotiate their place in the accepted social order.

7.8.4 Influences of Covid-19 pandemic on participants and organisation.

It was acknowledged at the outset that this study was approved for recruitment in March 2020. This influenced the approach taken to data collection as well as the length of time to complete the study. The effects of the rapidly changing landscape of services to meet the challenges that Covid-19 place on the National Health Service cannot be underestimated. At this study site there were several ANP teams who were not able to participate in focus groups due to work pressures. Their roles had also been changed during this time and they were moved away from their ANP roles to the nursing rota to keep nursing staffing levels at a safe number. This did not happen in all areas where ANPs work, and it would be interesting to explore why

different departments used their ANPs in different ways during that time. This reduced the number of ANPs available to participate in the study and may be considered a limitation, potentially influencing the validity of the study. However, the homogeneity of the ANP experience across the six specialities represented in the focus groups should give confidence that the tensions identified are truly reflected of the ANP role in secondary care.

While the pandemic influenced the ability to expand the focus groups for the ANPs, it conversely facilitated access to medical participants as by the time the interviews took place there were online platforms which made interviewing more accessible. This allowed participants to be interviewed in their own homes and at more flexible times to suit their needs, which was beneficial to the study. The reduction of organisational and professional meetings that were deemed 'non-essential' influenced the development of workforce plans, planning of new jobs for ANPs during this time.

7.8.5 Advanced nurse practitioner as researcher in the workplace

The positionality of a researcher as insider has been addressed early in the study, and it is recognised as both a limitation and a strength. Researching in one's own organisation is challenging and acknowledging the influence of my experience as an ANP on the study was key to avoiding that influence, particularly during analysis. Clarke et al (2018) are accepting of the fact that researchers are not *tabula rasa* and acknowledge that by the time data is collected and analysed, most researchers are subject matter experts. A strength being that as an expert in the ANP role, whether researching in my own organisation or not, ensured that nuances and pertinent aspects of the role were explored as I have awareness of the issues, and an understanding of the language used. The abductive analytical approach allowed space in the analytical process to review, revise, and check findings for validity to reduce the chance of bias. The constant tacking in and out and checking the data against itself allowed for the truth of the tensions to be revealed and subsequently mapped.

While being an insider-researcher can be a limitation due to potential bias and undue influence, transparent reflexivity has been provided to demonstrate that this was not the case in this study. Exploring and identifying assumptions at an early stage and returning to them during the analysis to avoid early closure of decision-making

regarding findings, allowed for the voice of the participants to be heard throughout the study.

7.9 – Conclusion

The role of a nurse is evolving and developing to meet the ever-changing needs of healthcare services and the ongoing needs for care of patients. The advanced nurse practitioner (ANP) role has developed as a workforce solution for vulnerable services where the skills to deliver the service has been limited by a depleted medical workforce. Nurses with significant experience and additional skills, knowledge, and autonomy are now working in a traditional medical space in healthcare. This caused challenges and tensions that were palpable but difficult to articulate. This study has sought to expose these tensions using a postmodernist lens and a research method that captures complexity. Through the evolution of Grounded Theory into Situational Analysis, Clarke et al (2018) provided the means to capture the intricacy of the ANP role within the secondary care setting. This has allowed for the tensions to be surfaced, articulated, and cartographically represented.

As situational analysis is concerned with all aspect of the situation under investigation, it has facilitated a three-dimensional exploration of the ANP role in secondary care. Applying an abductive analytical process to the data from focus groups, interviews and organisational discourse revealed the actants and tensions in the situation. These were laid out in the situational map to surface the major issues of: Same/Different; Broad scope/Limiting permissions; Internal governance/External governance; Advanced generalist/Advanced specialist; Professional development/Service provision; Personal identity/Professional recognition; Aambiguity/Standardisation, which underpinned the overarching binary opposition of structure and agency as a tension in the role.

The social world map represents the collective social worlds within the secondary care hospital and the influence and intersection of these worlds on the advanced nurse practitioner. It was notable that there was a disconnect with the various levels of nursing worlds and a limited overlap with the medical world. This contributed to the development of the positional maps, and it is in these maps that the key tensions are laid out, with the positions of associated power providing the most insight into the challenges of the role. Professional identity and visibility represent the challenges for

an advanced nursing role with shared medical skills, as well as being seen for the uniqueness of the role within the wider workforce and organisation. Scope of practice and barriers to practice link to the situational tensions of structure and agency but in the positional map reveals the power influences. Those who enable the role – consultants and supervisors and those who limit the role – lead nurses and radiology.

The analytical process dispelled the early assumptions that the tensions were aligned with the concept of competence. Situating the findings in the wider literature has provided a deeper understanding of the surfaced tensions. Understanding one's professional identity and then assimilating a new one at a later stage of a career is challenging. Recognising the work needed to support the transition from nurse to advanced nurse practitioner is key to reducing the tensions and fully establishing the role in the healthcare system. Providing support through training to develop and accept the professional identity of an advanced practitioner will hopefully reduce the tensions. Being visible and enabled to fulfil your role is key to confidence and autonomy, and this should be reflected on the positive impact on patients and services that the advanced practice role provides.

This study utilised a unique approach to investigating a complex role in a complex situation. The findings have demonstrated the influences of power and knowledge on the role, and exploring how this relates to the structure and agency of the role provides an exclusive insight into tensions that have not been articulated previously. This study has added to the existing body of knowledge by identifying the tension of professional identity. ANPs hold their nursing identity close to their professional identity, combining this with further training to develop cross-over skills shared with medicine, professional identity becomes a notable tension. The ANPs in this study recognise this role as a 'new way of nursing' but the confusion about what this role truly is, mega-nurse or mini-doctor, is destabilising. ANPs in this study, reported uncertainty about their role. However, it is the voice of their medical colleagues that adds new insight into the understanding of the advanced practice role. The doctors (of all levels) recognised the value of the role within the multidisciplinary team, they recognised the 'extra' skills the advanced practitioner brought. It was the doctor's recognition of the oppression of the role by the lead or senior nurses that was a new and interesting finding. As a powerful professional group, the doctors are an

untapped resource in raising the value and profile of the advanced nurse practitioner role in secondary care.

This study has sought to reveal the tensions in the advanced nurse practitioner role in a defined setting. These tensions have now been mapped, and articulated, revealing the benefits and challenges of being an advanced nurse practitioner in a secondary care hospital. This study has added to the wider body of knowledge regarding advanced nurse practitioner roles and concludes a journey of personal frustration with a role that I love.

References

Acocella I., 2012. The focus groups in social research: advantages and disadvantages *Quality & Quantity* 46 pp1125 – 1136

Adu-Ampong, E. A., & Adams, E. A. 2020 “But You Are Also Ghanaian, You Should Know”: Negotiating the Insider–Outsider Research Positionality in the Fieldwork Encounter. *Qualitative Inquiry* 26 6 pp583-592. https://doi.org/10.1177/1077800419846532

Ahmady, S., and Khani, H., 2022. The situational analysis of teaching-learning in clinical education in Iran: a postmodern grounded theory study *BMC Medical Education 22 520 pp 1-15*

Allen, L.M., 2010. A critique of four grounded theory texts. *The Qualitative Report*, *15*(6), pp.1606-1620.

Anderson, H., Birks, Y., Adamson, J. 2020. Exploring the relationship between nursing identity and advanced nursing practice: an ethnographic study *Journal of Clinical Nursing* 29 pp1195 – 1208

Annells, M. 2010. Grounded theory method: Philosophical perspectives, paradigm of inquiry and post modernism In*:* Atkinson, P. and Delamont, S. (eds) *SAGE Qualitative Research Methods* Great Britain SAGE Publications pp380–393

Barbour, R.S., 2010. Focus groups. *In: Atkinson, P. and Delamont, S. (eds) SAGE Qualitative Research Methods* Great Britain SAGE Publications, pp.327-52.

Barton, D. and Mashlan, W. 2011. An advanced nurse practitioner-led service–consequences of service redesign for managers and organizational infrastructure. *Journal of nursing management 19*(7), pp.943-949.

Batty, J. 2021. An evaluation of the role of the advanced nurse practitioner on an elective orthopaedic ward from the perspective of the multidisciplinary team *International Journal of Orthopaedic and Trauma Nursing* 41 1000821

Benner, P. 1984. From novice to expert. *Menlo Park*, *84*(1480), pp.10-1097.

Benner, P., Tanner, C.A., Chesla, C.A. 2009. *Expertise in Nursing Practice. Caring, Clinical Judgement & Ethics. Second Edition.* United States of America Springer Publishing Company.

Birks, M., Chapman, Y. and Francis, K., 2008. Memoing in qualitative research: Probing data and processes. *Journal of research in nursing*,*13*(1), pp.68-75.

Booth A., Sutton S. and Papaioannou D., 2016. *Systematic Approaches to a Successful Literature Review second edition* Croydon UK SAGE publications LTD pp182-183

Booth, A., 2006. Clear and present questions: formulating questions for evidence based practice. *Library hi tech*, *24*(3), pp.355-368.

Brinkmann, S. and Kvale, S., 2018. *Doing Interviews 2nd ed.* UK SAGE Publications Ltd

British Medical Association 2022. *Doctors titles explained* [online] Available at: https://www.bma.org.uk/advice-and-support/international-doctors/life-and-work-in-

the-uk/toolkit-for-doctors-new-to-the-uk/doctors-titles-explained#:~:text=Junior%20doctors%20are%20qualified%20doctors,three%20years%20in%20general%20practice. (accessed 2nd February 2023)

Brockmann, M., Clarke, L., Winch, C., et al 2011. *Knowledge, skills and competence in the European labour market. What's in a vocational qualification?* Great Britain Routledge

Brooker, P. 1999. *A concise glossary of cultural theory* Great Britain Arnold Publishers

Brush JE., Sherbino, J., Norman, GR. 2017 How expert clinicians intuitively recognise a medical diagnosis *The American Journal of Medicine* 130 6 pp629-634

Campbell, S., et al 2020. Purposive sampling: complex or simple? Research case examples *Journal of research in Nursing* 25 8 pp652-661

Capovin, R., 2020. *Postmodernism* London SAGE Publications Ltd DOI: http://dx.doi.org/10.4135/9781526421036

Carlsen, B. and Glenton, C., 2011. What about N? A methodological study of sample-size reporting in focus group studies. *BMC medical research methodology*, *11*(1), pp.1-10.

Carter, M. 2014. Vocation and altruism in nursing *Nursing Ethics* 21 6 pp695 – 706

Charmaz K. 2008. Reconstructing grounded theory. In Alasuutari P et al (eds) *The SAGE Handbook of Social Research Methods* Great Britain SAGE Publications pp461-478

Choperena A, Fairman J. 2018. Louisa May Alcott and Hospital Sketches: An innovative approach to gender and nursing professionalization. *Journal of Advanced Nursing* 74(5) pp1059-1067. doi: 10.1111/jan.13510.

Chun Tie, Y., Birks, M., Francis, K., 2019. Grounded theory research: a design framework from novice researchers *Sage Open Medicine* 7 1-9 DOI:10.1177/2050312118822927

Clarke, AE. 2005. *Situational Analysis. Grounded theory after the postmodern turn.* United States of America SAGE Publications

Clarke, AE. 2007. Grounded theory: critiques, debates and situational analysis In: Outhwaite W. Turner SP. (eds) *The SAGE Handbook of Social Science Methodology* Great Britain SAGE Publications Ltd pp 423-442

Clarke, AE. 2019. Situating grounded theory and situational analysis in interpretive qualitative inquiry. In: Bryant A., Charmaz K., eds *The SAGE Handbook of Current Developments of Grounded Theory* Croydon (UK) SAGE Publications Ltd pp3-48

Clarke, AE., and Friese, C. 2011. Grounded theorizing using situational analysis In: Bryant A. and Charmaz K. *The SAGE handbook of Grounded Theory* Wiltshire SAGE publications pp362-397

Clarke, A., Friese, C., Washburn, R.S., 2018. *Situational Analysis. Grounded Theory after the Interpretive Turn 2nd ed.* United States of America Sage Publications Inc

Collins, H., Leonard-Clarke, W. and O'Mahoney, H., 2019. 'Um, er': how meaning varies between speech and its typed transcript. *Qualitative Research*, *19*(6), pp.653-668.

Cooke A., Smith D., Booth A., 2012 Beyond PICO: The SPIDER tool for qualitative evidence synthesis *Qualitative Health Research* 22 10 pp1435 – 1443 DOI: 10.1177/1049732312452938

Cooper, J. and Lidster, J., 2021. Perceptions of competency in advanced clinical practice. *British Journal of Nursing*, *30* (14), pp.852-856.

Cooper, MA., McDowell, J., Raedsie, L., ANP-CNS group., 2019. The similarities and differences between advanced nurse practitioners and clinical nurse specialists *British Journal of Nursing* 28 20 pp1308 – 1314

Council Directive, 2000. 2000/34/EC of the European Parliament and Council *Official Journal of the European Community* 195 41 – 45 [online] Available at: https://www.legislation.gov.uk/eudr/2000/34/pdfs/eudr_20000034_adopted_en.pdf [Accessed 28th February 2023]

Cowley, A., Cooper, J., Goldberg, S., 2016. Experiences of the advanced nurse practitioner role in acute care *Nursing Older People* 28 4 pp31 – 36

Crouch R, Brown R. 2018. Advanced clinical practitioners in emergency care: past, present and future. British Journal of Hospital Medicine 79(9) pp511-515. doi: 10.12968/hmed.2018.79.9.511.

Dalton, MA., 2013. Perceptions of the advanced nurse practitioner role in a hospital setting. *British Journal of Nursing 22* 1 pp.48-53.

Darbyshire, P., Thompson, D., 2018. Gosport must be a tipping point for professional hierarchies in healthcare *British Medical Journal* 363 p1 – 3 doi:10.1136/bmj.k4270

Denzin NK., Lincoln YS., 2018. Introduction: the discipline and practice of qualitative research In: Denzin NK., Lincoln YS., eds *The Sage Handbook of Qualitative Research 5th edition* United States of America Sage Publications Inc. pp1-26

Department of Health, 1997. *The new NHS modern. Dependable* [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/266003/newnhs.pdf [Accessed 8th August 2022]

Department of Health, 2000. *The NHS Plan* [online] Available at: https://www.bsuh.nhs.uk/library/wp-content/uploads/sites/8/2020/09/The-NHS-plan-2000.pdf [Accessed 8th August 2022]

Department of Health, 2010. *Advanced Level Nursing – A position statement* [online] Available at: https://www.gov.uk/government/publications/advanced-level-nursing-a-position-statement last accessed 25th July 2020

Department of Health and Social Care, 2021. *Regulating healthcare professionals, protecting the public – Consultation* [online] Available at: https://www.gov.uk/government/consultations/regulating-healthcare-professionals-protecting-the-public [Accessed 7th August 2022]

Diamond-Fox, S., 2021. Undertaking consultations and clinical assessments at advanced level *British Journal of Nursing* 30 4 pp238 – 243

Easton, K. Griffin, A. Woodman, N. and Read, M.D. 2004. Can an advanced nurse practitioner take on the role of senior house officer within a specialised area of practice: an evaluation *Journal of Obstetrics and Gynaecology* 24 6 pp667–674

Eaton, K., Stritzke, W.G. and Ohan, J.L., 2019. Using scribes in qualitative research as an alternative to transcription. *The Qualitative Report*, *24*(3), pp.586-605.

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.

Epstein, R.M., Hundert, E.M. 2002. Defining and assessing professional competence *Journal of the American Medical Association* 287 (2) pp226-234

Erault, M. 1994. *Developing Professional Knowledge and Competence.* Great Britain. The Falmer Press

Fleming, E. and Carberry, M. 2011. Steering a course towards advanced nurse practitioner: a critical care perspective *Nursing in Critical Care* 16 2 pp67 – 76

Forbat, L., Maguire, R., McCann, L., Illingworth, N. and Kearney, N., 2009. The use of technology in cancer care: applying Foucault's ideas to explore the changing dynamics of power in health care. *Journal of advanced nursing*, *65*(2), pp.306-315.

Fothergill, L.J. et al 2022. Nationwide evaluation of the advanced clinical practitioner role in England: a cross-sectional survey *BMJ Open* 12 e055475. Doi:10.1136/bmjopen-2021-055475 pp1 – 7

Foucault, M., 1980. *Power/knowledge: Selected interviews and other writings, 1972-1977*. ED Gordon, C., UK Harvester Wheatsheaf Vintage.

Foucault, M., 2002. *Archaeology of Knowledge* Suffolk Routledge

Garcia, R., Qureshi, I., 2021. Nurse identity: reality and media portrayal *Evidence Based Journal* 0 pp1 – 5

Gardner, A., Hase, S., Gardner, G., Dunn, S.V., Carryer, J. 2008. From competence to capability: a study of nurse practitioners in clinical practice. *Journal of Clinical Nursing.* 17 pp250-258

Garside, J.R., Nhemachena, JZZ. 2013. A concept analysis of competence and its transition in nursing *Nurse Education Today* 33 pp541-545

Giacomini, M., 2010. Theory matters in qualitative health research In: Bourgeault I., Dingwall R., De Vries R., eds *The Sage Handbook of Qualitative Methods in Health Research* pp 125-156 London Sage

Giles, T., King, L., and de Lacey, S., 2013. The timing of the literature review in Grounded Theory research. An open mind versus an empty head. *Advances in Nursing Science* 36 2 ppE29-E40

Gill, P., et al 2008. Methods of data collection in qualitative research: interviews and focus groups *British Dental Journal* 204 6 pp 291 - 295

Glaser, B., Strauss, A.,1967. *The Discovery of Grounded Theory: Strategies for qualitative research* Chicago Aldine

Gloster, A., Leigh, J. 2021. The knowledge and skills required of advanced level practitioners for accreditation and safe practice *British Journal of Nursing* 30 3 pp168 - 171.

Government UK, 2002. *The National Health Service Reform and Health Care Professions Act* [online] Available at: https://www.legislation.gov.uk/ukpga/2002/17/contents/2019-12-02 [accessed 12th February 2023]

Greenwood, M., Kendrick, T., Davies, H. and Gill, F.J., 2017. Hearing voices: Comparing two methods for analysis of focus group data. *Applied Nursing Research*, *35*, pp.90-93.

Griffin, M. and Melby, V., 2006. Developing an advanced nurse practitioner service in emergency care: attitudes of nurses and doctors. *Journal of advanced nursing 56* 3 pp.292-301.

Hallett, C. 2007. A 'gallop' through history: nursing in social context *Journal of Clinical Nursing* 16 3 pp429-430

Halliday, S., Hunter, D.J. and McMillan, L., 2018. Ward staff perceptions of the role of the advanced nurse practitioner in a 'hospital at day' setting. *British Journal of Nursing 27*(2), pp.92-97.

Hanson, CM., Hamric, AB., 2003. Reflections on the continuing evolution of advanced practice nursing. Nursing Outlook. 51 5 pp203-11. doi: 10.1016/s0029-6554(03)00158-1.

Hardin, P.K., 2001. Theory and language: locating agency between free will and discursive marionettes. *Nursing Inquiry*, *8*(1), pp.11-18.

HCPC (Health and Care Professions Council), 2021. *Scope of practice* [online] Available at: https://www.hcpc-uk.org/standards/meeting-our-standards/scope-of-practice/ [accessed 26th March 2023]

Health Education and Improvement Wales, 2023. *Professional framework for enhanced, advanced and consultant clinical practice in Wales* [online] Available at: https://heiw.nhs.wales/workforce/workforce-development/professional-framework-for-enhanced-advanced-and-consultant-clinical-practice/ [Accessed 8th July 2023]

Health Education and Improvement Wales, 2020. *A Healthier Wales: Our workforce Strategy for Health and Social Care* [online] Available at: https://heiw.nhs.wales/programmes/health-and-social-care-workforce-strategy/ Last accessed 7th August 2022

HEE (Health Education England), 2017. *Multi-professional framework for advanced* [online] Available at: https://advanced-practice.hee.nhs.uk/multi-professional-framework-for-advanced-clinical-practice-in-england/ [Accessed 5th February 2023]

HEE (Health Education England), 2022a.*Advanced Practice. Credentials* [online] Available at: https://advanced-practice.hee.nhs.uk/credentials/ [Accessed 7th August 2022]

HEE (Health Education England), 2022b. *Centre for Advanced Practice* [online] Available at: https://advanced-practice.hee.nhs.uk/ [Accessed 11th August 2022]

Hill, B., 2017. Exploring the development and identity of advanced practice nursing in the UK. *Nursing Management* 24 5 pp36 – 40

Hogan, J., 2019. The Critical Juncture Concept's Evolving Capacity to Explain Policy Change. European Policy Analysis 5: pp170-189.https://doi.org/10.1002/epa2.1057

Hooks, C. and Walker, S., 2020. An exploration of the role of advanced clinical practitioners in the East of England. *British Journal of Nursing*, *29*(15), pp.864-869.

Hoskins, R., 2012. Interprofessional working or role substitution? A discussion of the emerging roles in emergency care. *Journal of advanced nursing*, *68*(8), pp.1894-1903.

Hughes, H., Logan, C., Webster, A., and Hiles, P., 2022. BIR POSITION STATEMENT: Governance requirements for non-medical referrers to radiology. *British Journal of Radiology* **95**:20220749

Imison C. Castle-Clarke S. Watson R., 2016. *Reshaping the workforce to deliver the care patients need* Nuffield Trust [online] Available at: https://www.nuffieldtrust.org.uk/files/2017-01/reshaping-the-workforce-web-final.pdf [accessed 17th February 2021]

International Council of Nurses (ICN), 2008. *The scope of practice, standards and competencies of the Advanced Practice Nurse*. Monograph, ICN Regulation Series. Geneva.

Ionising Radiation (Medical Exposure) Regulations, 2017. [online] Available at: https://www.cqc.org.uk/guidance-providers/ionising-radiation/ionising-radiation-medical-exposure-regulations-irmer (accessed 7th January 2023)

Iphofen, R. and Tolich, M., 2018. Foundational issues in qualitative research ethics.In: Iphofen, R. and Tolich, M. (eds) *The Sage handbook of qualitative research ethics*, UK SAGE pp.1-18.

Jaworski, A., Coupland, N., 2014. Introduction: Perspectives on Discourse Analysis In Jaworski, A., Coupland, N., eds *The Discourse Reader third edition* Oxon Routledge pp1 – 35

Jones, A., Powell, T., Watkins, D. and Kelly, D., 2015. Realising their potential? Exploring interprofessional perceptions and potential of the advanced practitioner role: a qualitative analysis. *BMJ open*, *5*(12), p.e009740.

Kamberelis G., et al 2018. Focus group research and/in figured worlds In: Denzin, N.K., Lincoln, Y.S., ed *The Sage handbook of Qualitative Research 5th edition* United States of America Sage pp692 – 716

Kearney, MH., 2011. From the sublime to the meticulous: the continuing evolution of grounded formal theory In: Bryant, A. and Charmaz, K. eds *The SAGE handbook of Grounded Theory* Wiltshire SAGE publications pp127-150

Kelly SE., 2010. Qualitative interviewing techniques and styles In: Bourgeault et al (eds) *The Sage Handbook of Qualitative Methods in Health Research* London Sage pp.307-326

Kendall G., Wickham, G. 1999. *Using Foucault's methods* Great Britain Sage

Kennedy, C., Brooks Young, P., Nicol, J., Campbell, K., Gray Brunton, C., 2015. Fluid role boundaries: exploring the contribution of the advanced nurse practitioner to multi-professional palliative care *Journal of Clinical Nursing* 24 pp3296 - 3305

Kernick, D., 2004. Chaos theory and its relationship to complexity In Kernick, D. (ed) *Complexity and Healthcare Organization, a view from the street* Cornwall Radcliffe Medical Press Ltd pp13 – 21

Kerr, L., Macaskill, A., 2020. Advanced nurse practitioners' (emergency) perceptions of their role, positionality and professional identity: a narrative inquiry *Journal of Advanced Nursing* 76 pp1202 – 1210

Kidner, M., 2022. *Successful Advanced Practice Nurse Role Transition A Structured Process to Developing Professional Identity through Role Transition* Switzerland Springer

King, R., Sanders, T. and Tod, A., 2021. Shortcuts in knowledge mobilization: An ethnographic study of advanced nurse practitioner discharge decision-making in the emergency department. *Journal of Advanced Nursing*, *77*(7), pp.3156-3167.

Kluijtmans, M., de Haan, E., Akkerman, S., van Tartwijk, J., 2017. Professional identity in clinician-scientists: brokers between care and science *Medical Education* 51 pp645 – 655

Koro-Ljungberg M. et al, 2018. D…a…t…a…,Data++, Data, and some problematics In: Denzin, N.K., Lincoln, Y.S., ed *The Sage handbook of Qualitative Research 5th edition* United States of America Sage pp462 – 483

Laird, E.A., McCauley, C., Ryan, A. and Beattie, A., 2020. 'The Lynchpin of the Acute Stroke Service'—An envisioning of the scope and role of the advanced nurse practitioner in stroke care in a qualitative study. *Journal of Clinical Nursing*, *29*(23-24), pp.4795-4805.

Laurant M, Reeves D, Hermens R, Braspenning J, Grol R, Sibbald B. 2005. Substitution of doctors by nurses in primary care. *Cochrane Database Systematic Review* doi: 10.1002/14651858.CD001271.pub2.

Laurant, M., fin van der Biezen, M. Wijers, N. Watananirun, K. Kontopantelis, E. van Vught, A.J. 2018. Nurses as substitutes for doctors in primary care. *Cochrane Database Systematic Review* Jul 16 7 7 doi: 10.1002/14651858.CD001271.pub3.

Leary, A., Maclaine, K., Trevatt, P., Radford, M. and Punshon, G., 2017. Variation in job titles within the nursing workforce. *Journal of Clinical Nursing*, *26*(23-24), pp.4945-4950.

Levy-Malmberg, R., Hilli, Y., 2014. The enhancement of clinical competence through caring science *Scandinavian Journal of Caring Sciences* 28 pp861-866

Lewis, R., 2022. The evolution of advanced nursing practice: Gender, identity, power and patriarchy. *Nursing Inquiry*, *29*(4), p.e12489.

Liamputtong P., 2015. *Focus Group Methodology: Principles and Practice* London SAGE Publications Ltd

Lincoln, Y.S. et al, 2018. Paradigmatic controversies, contradictions, and emerging confluences, revisited. In: Denzin, N.K., Lincoln, Y.S., ed *The Sage handbook of Qualitative Research 5th edition* United States of America Sage pp108-15

Lloyd Jones, M. 2012. A brief history of the registration of nurses. *British Journal of Healthcare Assistants*, *6*(1) pp41-44.

Lockwood, C., Munn, Z. and Porritt, K., 2015. Qualitative research synthesis: methodological guidance for systematic reviewers utilizing meta-aggregation. *JBI Evidence Implementation*, *13*(3), pp.179-187.

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), p.e12978.

Long K.M., McDermott F., Meadows G.N., 2018. Being pragmatic about healthcare complexity: our experiences applying complexity theory and pragmatism to health services research. *BMC Med*. Jun 20;16(1):94. doi: 10.1186/s12916-018-1087-6.

Mannix, K. and Jones, C., 2020. Nurses' experiences of transitioning into advanced practice roles. *Nursing Times*, *116*(3), pp.35-38.

Martin, W., Pauly, B., MacDonald, M.,2016. Situational analysis for complex systems: Methodological development in public health research *AIMS Public Health* 3 1 pp94-109 DOI:10.3934/publichealth.2016.1.94

McDonnell, A., Goodwin, E., Kennedy, F., Hawley, K.. Gerrish, K., Smith, C., 2015. An evaluation of the implantation of advanced nurse practitioner (ANP) roles in an acute hospital setting

McMurray, R., 2011. The struggle to professionalize: An ethnographic account of the occupational position of Advanced Nurse Practitioners. *Human relations 64*(6), pp.801-822.

Medina Ruiz, L., 2018. Multidisciplinary team attitudes to an advanced nurse practitioner service in an emergency department *Emergency Nurse* pp1 – 10 doi:10.7748/en.2018.e1793

Methley, A.M., et al, 2014. PICO, PICOS and SPIDER: a comparison study of specificity and sensitivity in three search tools for qualitative systematic reviews. *BMC Health Services Research* 14 579 pp1-10 DOI 10.1186/s12913-014-0579-0

Morse JM. Clark L. 2019. The nuances of grounded theory sampling and the pivotal role of theoretical sampling In: Bryant A., Charmaz K., eds *The SAGE Handbook of Current Developments of Grounded Theory* Croydon (UK) SAGE Publications Ltd pp145-166

Murphy, K., Mortimore, G., 2020. Overcoming the challenges of role transition for trainee advanced clinical practitioners *Gastrointestinal Nursing* 18(5) pp35-41 https://doi-org.abc.cardiff.ac.uk/10.12968/gasn.2020.18.5.35

National Leadership and Innovation Agency for Healthcare (NLIAH), 2010. *Framework for Advanced Nursing, Midwifery and Allied Health Professional Practice in Wales* NHS Wales Available at: https://heiw.nhs.wales/transformation/workforce-development/introducing-advanced-practice/ [last accessed 31st July 2022]

NHS England 2023 *Governance Maturity Matrix for advanced clinical practice* [online] Available at: https://advanced-practice.hee.nhs.uk/news-and-events/governance-of-advanced-practice-in-health-and-care-provider-organisations/ [Accessed 10th August 2024]

NHS Supply chain, 2021. *National uniform consultation: the results report.* [online]. Available at: https://azuksappnpdsa01.blob.core.windows.net/datashare/National-Uniform-Consultation-The-Results-Report-20-September-2021-T11.pdf [Accessed 1st July 2023]

Nursing and Midwifery Council, 2020. *NMC Regulate Support Influence Strategy 2020 – 2025* [online] Available at: https://www.nmc.org.uk/globalassets/sitedocuments/strategy/nmc-strategy-2020-2025.pdf Last accessed 7th August 2022

Norris, T. and Melby, V., 2006. The acute care nurse practitioner: challenging existing boundaries of emergency nurses in the United Kingdom. *Journal of clinical nursing*, *15*(3), pp.253-263.

Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC), 2016. *Advanced Nursing Practice Framework. Supporting Advanced Nursing Practice in Health and Social Care Trusts.* [online] Available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/advanced-nursing-practice-framework.pdf [last accessed 8th April 2023]

Nursing and Midwifery Council, 2017. *Response to Department of Health consultation 'the regulation of medical associate professions in the UK'* [online] Available at: https://www.nmc.org.uk/globalassets/sitedocuments/consultations/nmc-responses/2017/nmc-response-map-consultation.pdf [accessed 2nd August 2022]

Nursing and Midwifery Council, 2018. Standards for Nursing online available at: https://www.nmc.org.uk/standards/code/read-the-code-online/

Nursing and Midwifery Council, 2018. *The code. Professional standards of practice and behaviour for nurses, midwives and nursing associates.* [online] Available at: https://www.nmc.org.uk/standards/code/ [accessed 1st August 2022]

Nursing and Midwifery Council, 2019. *strategy 2020-2025* [online] Available at: https://www.nmc.org.uk/globalassets/sitedocuments/shaping-the-future/nmc-consultation-final-english.pdf [Accessed 31st July 2022]

Nursing and Midwifery Council, 2022. *What we do* [online] Available at: https://www.nmc.org.uk/about-us/our-role/ last accessed 4th August 2022

Nursing and Midwifery Council, 2023. *Prescribing standards* [online] Available at: https://www.nmc.org.uk/standards/standards-for-post-registration/standards-for-prescribers/ [accessed 1st May 2023]

O'Connor D, Green S, Higgins JPT (ed). 2011. Chapter 5: Defining the review question and developing criteria for including studies. In: Higgins JPT, Green S (ed), *Cochrane Handbook of Systematic Reviews of Intervention.* Version 5.1.0. The Cochrane Collaboration. Available from www.handbook.cochrane.org [Accessed 12th June 2018]

O'Connor, T., 2015 Men Choosing Nursing Negotiating a Masculine Identity in a Feminine World. *The Journal of Men's Studies*. 1060826515582519.

O'Keeffe, A.P., Corry, M. and Moser, D.K., 2015. Measuring job satisfaction of advanced nurse practitioners and advanced midwife practitioners in the Republic of Ireland: a survey. *Journal of nursing management*, *23*(1), pp.107-117.

Oxford English Dictionary, 2023. [online] Available at: https://www.oed.com/view/Entry/37567?redirectedFrom=competence#eid accessed 22nd May 2023

Page, M.J., McKenzie, J.E., Bossuyt, P.M., Boutron, I., Hoffmann, T.C., Mulrow, C.D., Shamseer, L., Tetzlaff, J.M., Akl, E.A., Brennan, S.E. and Chou, R., 2021. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *International journal of surgery*, *88*, p.105906.

Palazzo S., and Hocken DB., 2010 Patients' perspectives on how doctors dress. *Journal of Hospital Infection.* 74(1):30-4. doi: 10.1016/j.jhin.2009.08.021. Epub 2009 Nov 14. PMID: 19914743.

Paul, F., Cooper, M., Sabin, M. and Smith, M., 2015. Advanced nursing practice: the strategic, cultural and organizational challenges. In Barton, TD and Allan, D. (eds) *Advanced Nursing Practice: Changing Healthcare in a Changing World*, p.87.

Pawluch, D., and Neiterman, E., 2010. What is grounded theory and where does it come from? In: Bourgeault I., Dingwall R., De Vries R., eds *The Sage Handbook of Qualitative Methods in Health Research* pp 174 – 192 London Sage

Pawlowski, P., Mazurek, P., Zych, M., Zun, K., Dobrowolska, B., 2019 Nursing dress code and perception of a nurse by patients. *Nursing in the 21st Century* 18 10.2478/pielxxiw-2019-0008.

Pennbrant, S., 2016. Determination of the concepts “profession” and “role” in relation to “nurse educator”. *Journal of Professional Nursing*, *32*(6), pp.430-438.

Perez, MS., Cannella, GS., 2013. Situational analysis as an avenue for critical qualitative research: Mapping post-Katrina New Orleans *Qualitative Inquiry* 19 7 pp507-517 DOI:10.1177/1077800413489514

Phillipson, L., Goodenough, B., Reis, S. and Fleming, R., 2016. Applying knowledge translation concepts and strategies in dementia care education for health professionals: recommendations from a narrative literature review. *Journal of Continuing Education in the Health Professions*, *36*(1), pp.74-81.

Piedra, L. M. 2023. Positionality—An analytical building block. *Qualitative Social Work* 22 4 pp611-618. https://doi.org/10.1177/14733250231183294

Popay, J. Mallinson, S, 2010. Qualitative research review and synthesis. In: Bourgeault, I., Dingwall, R., de Vries, R., eds *The SAGE Handbook of Qualitative Methods in Health Research* Cornwall (UK) SAGE Publications Ltd pp289 – 306

Pritchard, M.J., 2017. Is it time to re-examine the doctor-nurse relationship since the introduction of the independent nurse prescriber?. *Australian Journal of Advanced Nursing, 35*(2), pp.31-37.

Puravady, S. and McCarthy, R., 2021. Evaluating a competency assessment framework for ANPs. *Nursing Times*, pp.51-54.

Rabinow, P., 1984 *The Foucault Reader.* England Penguin Books

Ralph N., Birks M., Chapman Y., 2015. The methodological dynamism of grounded theory *International Journal of Qualitative Methods* pp1-6 DOI: 10.1177/1609406915611576

Rethlefsen ML, Kirtley S, Waffenschmidt S, Ayala AP, Moher D, Page MJ, Koffel JB; PRISMA-S Group., 2021.PRISMA-S: an extension to the PRISMA statement for reporting literature searches in systematic reviews. *Journal Medical Library Association*. 109(2) pp174-200. doi: 10.5195/jmla.2021.962.

Reyes, V., 2020 Ethnographic toolkit: Strategic positionality and researchers' visible and invisible tools in field research. *Ethnography*. 21. 146613811880512. 10.1177/1466138118805121.

Richardson W.S., et al, 1995. The well-built clinical question: a key to evidence-based decisions *American Clinical Physicians Journal Club*. 123: 12. doi:10.7326/ACPJC-1995-123-3-A12

Rieger, K.L., 2019. Discriminating among grounded theory approaches. *Nursing inquiry*, *26*(1), p.e12261.

RCEM (Royal College of Emergency Medicine), 2021. *Emergency Care ACP Sustainable Careers* [online] Available at: https://rcem.ac.uk/wp-content/uploads/2021/11/RCEM_EC_ACP_Sustainable_Careers_January_2021.pdf [Accessed 2nd March 2023]

Royal College of Emergency Medicine (RCEM), 2022. Advanced Clinical Practitioner curriculum [online]. Available at: https://rcem.ac.uk/acp-curriculum/ [Accessed 10th January 2023]

Royal College of Nursing, 2018. *Advanced Level Nursing Practice* [online] Available at: https://www.rcn.org.uk/Professional-Development/Advanced-Practice-Standards Last accessed 7th August 2022

RCN (Royal College of Nursing), 2021. *Clinical Imaging Requests from Non-Medically Qualified Professionals 3rd edition* [online] Available at: Clinical Imaging Requests | Publications | Royal College of Nursing (rcn.org.uk) [Accessed 8th April 2023]

Royal Pharmaceutical Society, 2021. *A Competency Framework for All Prescribers* [online] Available at: https://www.rpharms.com/resources/frameworks/prescribing-competency-framework/competency-framework accessed 30th January 2023

Scottish Government, 2008. *Supporting the development of advanced nursing practice. A toolkit approach* [online] Available at: https://www.advancedpractice.scot.nhs.uk/media/1371/supporting%20the%20development%20of%20advanced%20nursing%20practice.pdf Last accessed 31st July 2022

Sheehan, D., Wilkinson, T.J., 2022. Widening how we see the impact of culture on learning, practice and identity development in clinical environments *Medical Education* 56 1 pp110-116 doi:10.1111/medu.14630

Soedirgo, J. and Glas, A. 2020 Toward Active Reflexivity: Positionality and Practice in the Production of Knowledge *PS: Political Science & Politics* 53 3 pp527–531. doi:10.1017/S1049096519002233.

Stanford, P.E., 2016. How can a competency framework for advanced practice support care?. *British Journal of Nursing*, *25*(20), pp.1117-1122.

Stein, LI. 1969. The doctor-nurse game. *ETC: A Review of General Semantics*, *26*(2), pp205–216. http://www.jstor.org/stable/42574557

Strauss, AL., 1993 C*ontinual Permutations of Action* New York Aldine de Gruyter

Strauss, AL., et al, 1997. *Social Organization of Medical Work* United States of America Transaction Publishers

Tausch, A.P. and Menold, N., 2016. Methodological aspects of focus groups in health research: results of qualitative interviews with focus group moderators. *Global qualitative nursing research*, *3*, p.2333393616630466.

Tavory, I. and Timmermans, S., 2019. Abductive analysis and grounded theory In: Bryant A., Charmaz K., eds *The SAGE Handbook of Current Developments of Grounded Theory* Croydon (UK) SAGE Publications Ltd pp532 – 546

Ten Hoeve, Y., Jansen, G., Roodbol, P., 2014. The nursing profession: public image, self-concept and professional identity. A discussion paper. *Journal of Advanced Nursing* 70 2 pp296 – 309 doi:10.1111/jan.12177

Thirtle, S., 2021. Identity and the learning experience of non-traditional students undertaking the specialist practitioner qualification *British journal of Community Nursing* 26 8 pp378 – 383

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 Organization and Management*, *33*(4), pp.443-459.

Thompson, W. and McNamara, M., 2022a. Constructing the advanced nurse practitioner identity in the healthcare system: A discourse analysis. *Journal of Advanced Nursing*, *78*(3), pp.834-846

Thompson, W. and McNamara, M. 2022b. Revealing how language builds the identity of the advanced nurse practitioner *Journal of Clinical Nursing* 31 pp2344 – 2353

Thorlby, R. and Maybin, J., 2007. Health and ten years of Labour government. *Health*.

Trivedi, C., 2020. Postmodern paradigm explained. *ConceptsHacked* [online] Available at https://conceptshacked.com/postmodern-paradigm/ [Accessed 20th August 2022]

Wang, H. English, M. Chakma, S. Namedre, M. Hill E. Nagraj, S. 2022. The roles of physician associates and advanced nurse practitioners in the National Health Service in the UK: a scoping review and narrative synthesis *Human Resources for Health* 20 69 pp1 – 10 doi.org/10.1186/s12960-022-00766-5

Weigel, T., M. Mulder & K. Collins, 2007. The concept of competence in the development of vocational education and training in selected EU member states. *Journal of Vocational Education and Training*. 59 (1) pp51-64.

Welsh Assembly Government, 2010 *All-Wales NHS Dress Code. Free to lead, free to care* [online] Available at: https://www.gov.wales/sites/default/files/publications/2019-03/all-wales-nhs-dress-code-free-to-lead-free-to-care.pdf [Accessed 19th February 2023]

Welsh Government (Chief Nursing Officers Office), 2016. *Nursing and midwifery in Wales – Key priorities 2016 – 2021* [online] Available at: https://gov.wales/sites/default/files/publications/2019-03/nursing-and-midwifery-in-wales-key-priorities-2016-2021.pdf [Accessed 31st July 2022]

Welsh Government (Chief Nursing Officers Office), 2022. *Priorities 2022 – 2024* [online] Available at: https://gov.wales/chief-nursing-officer-wales-priorities-2022-2024 [Accessed 31st July 2022]

Willetts, G. and Clarke, D., 2014. Constructing nurses' professional identity through social identity theory. *International journal of nursing practice*, *20*(2), pp.164-169.

Williamson, S., Twelvetree, T., Thompson, J. and Beaver, K., 2012. An ethnographic study exploring the role of ward-based Advanced Nurse Practitioners in an acute medical setting. *Journal of advanced nursing*, *68*(7), pp.1579-1588.

Wilson, C., Janes, G., Williams, J., 2022 Identity, positionality and reflexivity: relevance and application to research paramedics. *British Paramedic Journal*. 7 2 pp43-49. doi: 10.29045/14784726.2022.09.7.2.43.

Wood, E., King, R., Robertson, S., Senek, M., Tod, A. and Ryan, T., 2021. Sources of satisfaction, dissatisfaction and well-being for UK advanced practice nurses: A qualitative study. *Journal of Nursing Management*, *29*(5), pp.1073-1080.

Woodyatt CR, Finneran CA., Stephenson R., 2016. In-person versus online focus group discussions: a comparative analysis of data quality *Qualitative Health Research* 26 6 pp741 – 749

Workforce Education and Development Service, 2013. *Advanced Practice review* [online] http://www.weds.wales.nhs.uk/sitesplus/documents/1076/Final%20Review%20Advanced%20Practitioner%20Report.pdf [accessed 1st May 2017] this is no longer available.

World Health Organisation, 2022. Data and Statistics https://www.who.int/europe/publications/i/item/WHO-EURO-2022-5975-45740-65795 [online] Available at: Technical brief on strengthening the nursing and midwifery workforce to improve health outcomes: Government Chief Nursing and Midwifery Officers (GCNMOs) in the WHO European Region

Yanhua, C., Watson, R. 2011. A review of clinical competence assessment in nursing *Nurse Education Today* 31 pp832-836

Young, ME., et al 2020 Mapping clinical reasoning literature across the health professions: a scoping review *BMC Medical Education* 20 107 pp1-11 doi.org/10.1186/s12909-020-02012-9

York, R., 2021. Perceptions and beliefs about the regulation of advanced nurse practitioners *Nursing Management* June pp1 – 6 doi:10.7748/nm.2021.e1999

Zaidi, Z., Partman, I.M., Whitehead, C.R., Kuper, A. and Wyatt, T.R., 2021. Contending with our racial past in medical education: a Foucauldian perspective. *Teaching and learning in medicine*, *33*(4), pp.453-462.

Appendix A

My portfolio includes more than a decade of evidence and acts a record of the development of my professional practice as an ANP. During this period, I worked in the same organisation but in three speciality areas: General Surgery (Adult); Emergency Medicine; and General Paediatrics. As these roles were all in the same organisation, there was an expectation that the 'permissions' to practice from departments outside of the speciality such as radiology and pharmacy, would be similar. However, this was not the case, and each change of role required writing an entirely new scope of practice relating to radiology requesting and prescribing. Emergency medicine had an approved curriculum and training programme that mapped to the doctors' training programme, but paediatrics and surgery did not. To mitigate against this, I developed my own framework to demonstrate my skills, knowledge and experience in those specialities based on recognised frameworks such as the NLIAH (2010) Advanced Practice Framework.

Reviewing my portfolio demonstrates my journey as an advanced nurse practitioner (ANP) with increasing complexity in the clinical cases I autonomously manage, the levels of influence and networking that I have developed and the contribution to education I have provided. Each year has a master folder which holds 4 folders to represent the four pillars of advanced practice. In each folder are records of assessments of clinical skills and cases, teaching sessions, feedback, reflections and certificates of training. The evidence in these folders is discussed annually as part of the appraisal process and are used as part of the revalidation requirements every three years with the NMC.

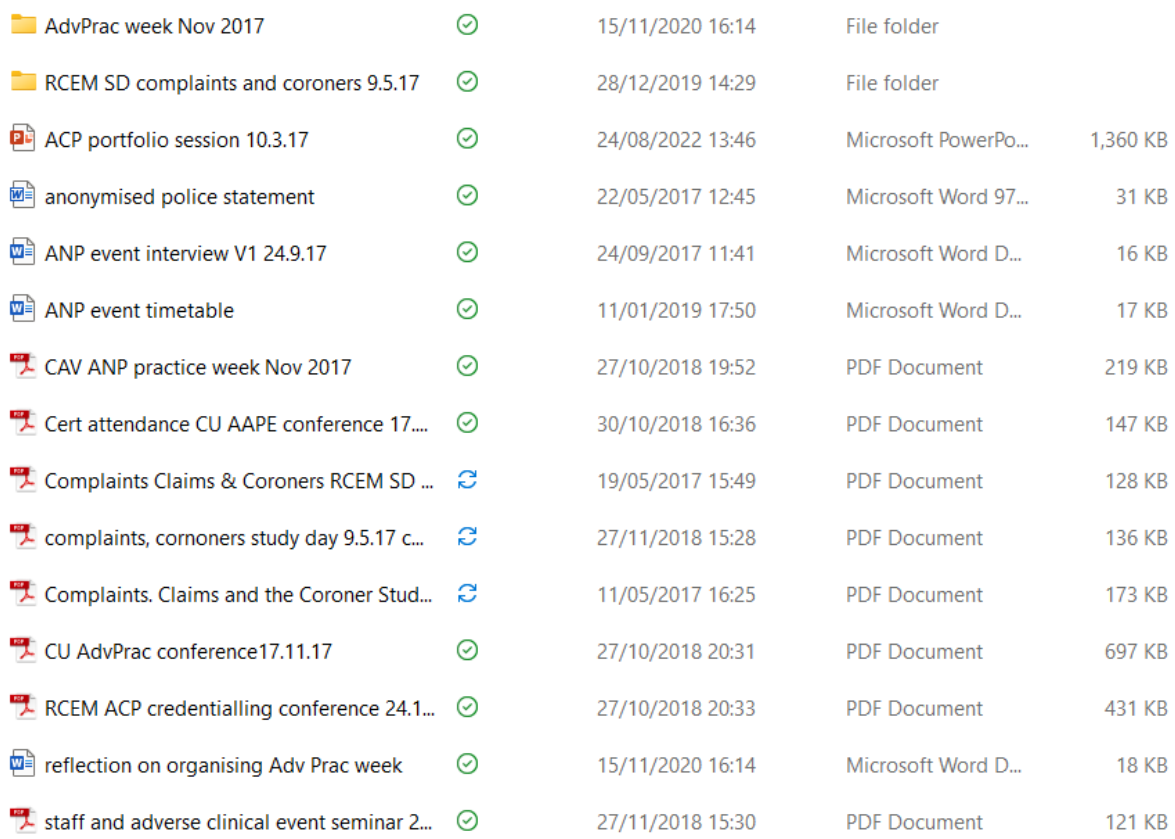
Example of clinical pillar:

ACAT-EM (paeds) 17.2.17	30/10/2018 15:41	PDF Document	297 KB
ANP study day 12.01.17 copy	27/11/2018 15:24	PDF Document	148 KB
burns study day 17.5.17 cert of attendanc...	22/05/2017 16:04	Microsoft Word 97...	174 KB
cardiovascular assessment wih Jo Mower	27/11/2018 15:26	PDF Document	110 KB
CBD formative adolescent trauma S.Mull...	30/10/2018 16:25	PDF Document	565 KB
CBD formative allergic reaction R.Evans 1...	30/10/2018 16:14	PDF Document	826 KB
CBD formative Hypoglycaemic collapse ...	27/10/2018 20:44	PDF Document	800 KB
CBD formative hyponatreamia Nic Wen 6...	30/10/2018 16:00	PDF Document	632 KB
CBD summative Abdo pain Lyndsey McD ...	30/10/2018 16:22	PDF Document	693 KB
CBD summative Chest Pain Atif 14.2.17	27/10/2018 20:39	PDF Document	620 KB
CBD summative Chest Pain Lyndsey McD ...	30/10/2018 16:18	PDF Document	649 KB
CBD summative Fall. AKI.Rhabdomyolysis...	30/10/2018 16:10	PDF Document	944 KB
CBD summative Headaches Prof Rainer 1...	27/10/2018 20:37	PDF Document	639 KB
CBD summative hyperkalemia Nic Wen 6...	30/10/2018 16:02	PDF Document	697 KB
CBD summative ingestion of Ecstasy R. E...	30/10/2018 16:04	PDF Document	664 KB
CBD summative suicidal ideation R.Evans...	30/10/2018 16:08	PDF Document	672 KB
DOPS shoulder reduction K Empson 7.4.17	27/10/2018 20:40	PDF Document	605 KB
MiniCEX - breathlessness (asthma) R Eva...	30/10/2018 16:27	PDF Document	901 KB

Example of Education pillar:

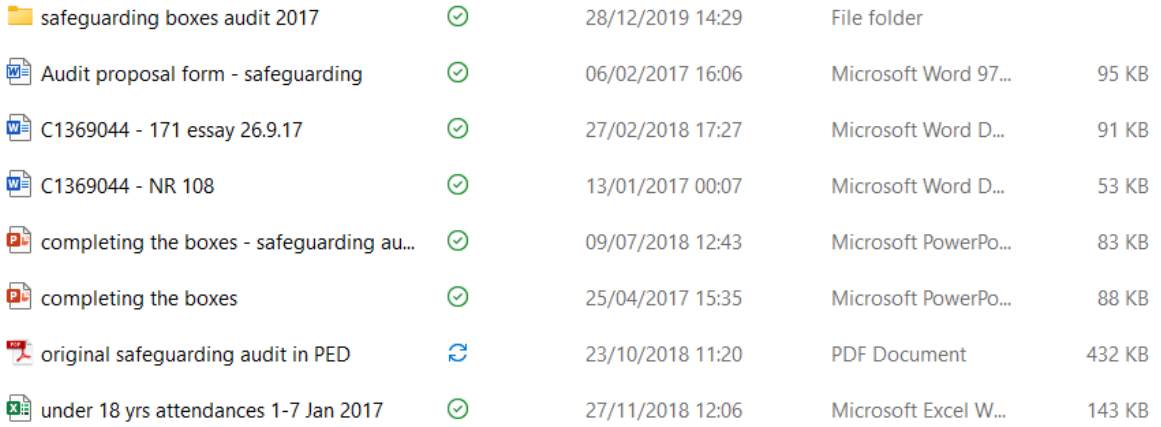
limping child teaching session Feb 2017	28/12/2019 14:29	File folder	
Advanced Nurse Practitioner Study Day 1...	28/02/2017 15:02	Microsoft Word D...	52 KB
ANP e-portfolio teaching feedback 10.3.17	30/10/2018 15:58	PDF Document	805 KB
APLS course instructed 3rd & 4th Oct 17	30/10/2018 16:12	PDF Document	211 KB
back pain in children	12/03/2019 10:41	PDF Document	1,414 KB
epidemiology of transient synovitis Harri...	12/03/2019 10:34	PDF Document	2,585 KB
feedback from limping child feedback17....	04/03/2017 15:13	PDF Document	836 KB
limping child BMJ 2016	12/03/2019 10:41	PDF Document	1,770 KB
limping child teaching session reflection ...	12/03/2019 10:50	Microsoft Word D...	18 KB
limping child vs spinal disorder 2012	12/03/2019 10:38	PDF Document	3,741 KB
LIMPSS 2015	12/03/2019 10:39	PDF Document	1,907 KB
Perthes case report 2016	12/03/2019 10:36	PDF Document	1,365 KB
RCN CYP conference reflection 9.11.17	15/11/2020 16:13	Microsoft Word D...	18 KB
Teaching feedback ACP e-portfolio 22.3.17	30/10/2018 16:30	PDF Document	930 KB
Teaching feedback ALS 30.3.17	30/10/2018 16:32	PDF Document	906 KB
the limping child copy	16/02/2017 22:12	Microsoft PowerPo...	2,624 KB
tibial torus & toddlers # Sevahi et al 2011	12/03/2019 10:30	PDF Document	1,543 KB

Example of leadership pillar:



AdvPrac week Nov 2017	15/11/2020 16:14	File folder	
RCEM SD complaints and coroners 9.5.17	28/12/2019 14:29	File folder	
ACP portfolio session 10.3.17	24/08/2022 13:46	Microsoft PowerPo...	1,360 KB
anonymised police statement	22/05/2017 12:45	Microsoft Word 97...	31 KB
ANP event interview V1 24.9.17	24/09/2017 11:41	Microsoft Word D...	16 KB
ANP event timetable	11/01/2019 17:50	Microsoft Word D...	17 KB
CAV ANP practice week Nov 2017	27/10/2018 19:52	PDF Document	219 KB
Cert attendance CU AAPE conference 17....	30/10/2018 16:36	PDF Document	147 KB
Complaints Claims & Coroners RCEM SD ...	19/05/2017 15:49	PDF Document	128 KB
complaints, cornoners study day 9.5.17 c...	27/11/2018 15:28	PDF Document	136 KB
Complaints. Claims and the Coroner Stud...	11/05/2017 16:25	PDF Document	173 KB
CU AdvPrac conference17.11.17	27/10/2018 20:31	PDF Document	697 KB
RCEM ACP credentialling conference 24.1...	27/10/2018 20:33	PDF Document	431 KB
reflection on organising Adv Prac week	15/11/2020 16:14	Microsoft Word D...	18 KB
staff and adverse clinical event seminar 2...	27/11/2018 15:30	PDF Document	121 KB

Example of research and audit pillar:



safeguarding boxes audit 2017	28/12/2019 14:29	File folder	
Audit proposal form - safeguarding	06/02/2017 16:06	Microsoft Word 97...	95 KB
C1369044 - 171 essay 26.9.17	27/02/2018 17:27	Microsoft Word D...	91 KB
C1369044 - NR 108	13/01/2017 00:07	Microsoft Word D...	53 KB
completing the boxes - safeguarding au...	09/07/2018 12:43	Microsoft PowerPo...	83 KB
completing the boxes	25/04/2017 15:35	Microsoft PowerPo...	88 KB
original safeguarding audit in PED	23/10/2018 11:20	PDF Document	432 KB
under 18 yrs attendances 1-7 Jan 2017	27/11/2018 12:06	Microsoft Excel W...	143 KB

NMC revalidation:

Fall, sternal fracture & supervision of tAN...	02/03/2017 14:41	Microsoft Word D...	18 KB
Medical unexplained symptoms in CH - r...	06/02/2017 10:28	Microsoft Word D...	17 KB
NMC 87Y0141W cpd-log	24/08/2017 11:41	Microsoft Word 97...	223 KB
NMC 87Y0141W Nov 2017 confirmation-...	29/08/2017 13:17	Microsoft Word 97...	243 KB
NMC 87Y0141W practice-hours-log	11/10/2017 22:57	Microsoft Word 97...	245 KB
NMC 87Y0141W practice-related-feedba...	29/08/2017 10:14	Microsoft Word 97...	123 KB
NMC 87Y0141W reflective-accounts-1	29/08/2017 08:48	Microsoft Word 97...	257 KB
NMC 87Y0141W reflective-accounts-2	11/10/2017 22:59	Microsoft Word 97...	253 KB
NMC 87Y0141W reflective-accounts-3	11/10/2017 23:00	Microsoft Word 97...	253 KB
NMC 87Y0141W reflective-accounts-4	29/08/2017 08:57	Microsoft Word 97...	255 KB
NMC 87Y0141W reflective-accounts-5	11/10/2017 23:01	Microsoft Word 97...	253 KB
Paediatric minor illness teaching session ...	06/02/2017 10:16	Microsoft Word D...	17 KB
pii-final-guidance	24/08/2017 10:41	PDF Document	311 KB
Prescribing for GI conditions - teaching s...	06/02/2017 09:22	Microsoft Word D...	17 KB
RCEM Mental health study day reflection...	06/02/2017 09:22	Microsoft Word D...	21 KB
reflective-discussion-form	24/08/2017 10:40	Microsoft Word 97...	186 KB
shoulder examination BMJ learning mod...	30/12/2016 14:09	Microsoft Word D...	22 KB
teaching thanks 06.11.16	29/08/2017 09:22	PDF Document	157 KB

Appendix B

For management of the word count the following sections lay out the background of grounded theory and its development into situational analysis with an explanation of why this is the methodology of choice for this study

Qualitative research methodologies (and methods) have evolved and developed in response to the changing social world that they investigate. Denzin and Lincoln (2018 p ix-xvi) note the increasing sophistication of [interpretivist] researchers and the hybrid paradigms at play to facilitate inquiry. This thesis seeks to address the tensions in the ANP role within a secondary care hospital. Therefore, a methodology that incorporates the situation is key to revealing the tensions, silences and the unknown.

Grounded theory was a response to the dominant paradigm of the time which facilitated theory substantiation by logical deduction via a priori notions rather than generating 'new' theory (Pawluch and Neiterman, 2010). However, the nomenclature 'grounded theory' is somewhat misleading as it is not a theory as one would traditionally understand. In essence, it is a means of data collection and analysis that creates a theory or as Clarke (2007) describes it 'data-grounded theorizing' (p424). Glaser and Strauss (1967) argued against the descriptive studies that abounded in the 1960s and challenged researchers to carry out their qualitative studies in a systematic manner, maintaining that elements such as rigor and theorising were not limited to quantitative studies or elite thinkers.

Further influence of the interpretative turn has allowed researchers to reflexively incorporate postmodernist social theories as situated in their epistemological world, accepting that knowledge is not representative but is productive and, as such, the research has a responsibility to the social worlds where this knowledge will be used (Clarke et al, 2018). Approaching the world of the ANP, situational analysis allows for the multi-faceted complexity of enacting the role in a whole hospital system to be captured.

The various iterations of GT and Charmaz (2008) notes that the original aim of GT was to create fundamental theories to illuminate and explain vital social or social psychological processes within a social setting, for example dying in hospital. The aim of this study is not to theorise the social process of ANPs working in a secondary

care hospital but explore the tensions within the complexities of the role. In the context of this thesis surfacing these tensions is a key objective. The policy, portfolio, and literature review have identified current broad tensions, this thesis seeks to further understand what these tensions mean for ANPs, their colleagues, supervisors, workforce planners and Higher Education Institutes.

Work by Strauss et al (1997) explored and revealed the social order of medical work, identifying the complexities of healthcare, and the concept of negotiated order. Clarke et al (2018) expanded on Strauss's influence with the development of situational analysis, from his recognition of complexity within social arenas/worlds, the additional work regarding the negotiations that took place within them, including the discourses associated with them. Clarke and Friese (2011) suggest that society can be conceptualised as interwoven layers of social worlds and arenas that are in a state of constant fluctuation. This increasing drive to recognise and capture the complexity of the 'world' under examination was key to the development of situational analysis. Clarke (2019) acknowledges the various influences that led to this advancement. In the context of this thesis the policy, portfolio and literature review identified that much of the ANP role is enacted through negotiations in a complex system and it is this aspect where situational analysis as a methodology fits. It allows for the questioning of both human and non-human social constructs with the inclusion of situation rather than context. Doing so allows the silent discourses and actors within the situation, in this case a secondary care hospital, to be recognised and included as meaningful data. These concepts begin to explain the world of the ANP when applied to current knowledge/research, therefore using situational analysis as methodology and method was identified as a unique approach to capture and explore what has not been fully revealed thus far.

Using an analogy of bees and a beehive provides a visual description of the methodological approach applied, with the beehive as a complex adaptive system, and the bees a self -organising responsive workforce with the shared goal of maintaining the collective and producing honey. The ANP is a multi-talented bee in a secondary care hospital (beehive). This study seeks to understand how all the other bees relate to the ANP bee and how the beehive facilitates this ANP bee to fulfil their job. Situational analysis is designed to capture this complexity

The following is a description of the principal methods of using situational analysis.

Making maps:

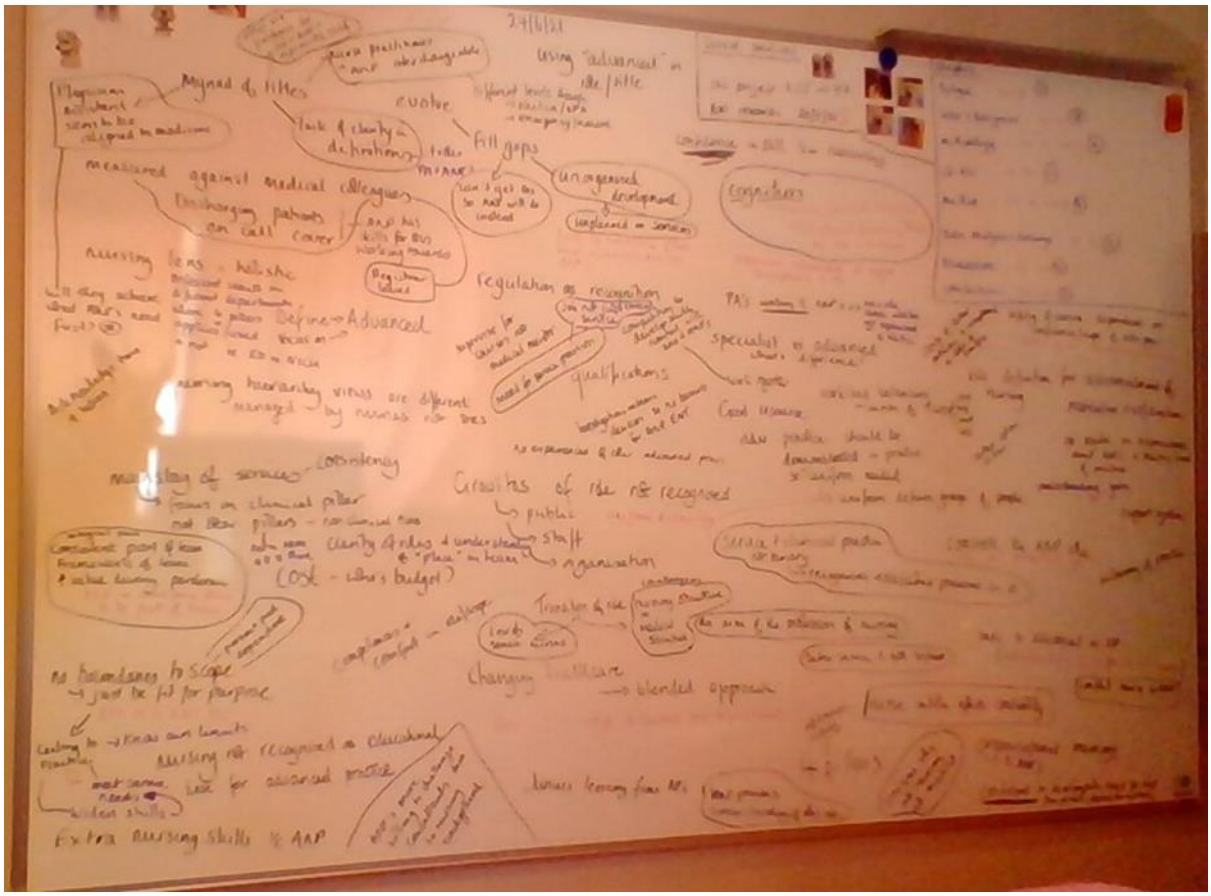
Not all the maps created will be shared in the final work, but they are key to the investigation and analytical process. The following section discusses the purpose of each map. I have sought to be openly reflective with the prologue as well as reflexively identifying my positionality throughout the thesis, situational analysis accepts this as being an analytical resource not a contamination (Clarke et al, 2018)

Situational map:

In keeping with Clarke et al (2018) approach to situational maps, any work undertaken on these, or subsequent maps is supported with concurrent memoing, examples of which are also in appendix C. Relational mapping was undertaken to inform the ongoing study by identifying individuals and areas for further exploration. Strauss's interactionalist roots are threaded throughout the social world and arena maps used by Clarke et al (2018), particularly the concepts of negotiation. Strauss (1993) identifies negotiation as a major social process and added scepticism to the understanding by describing it as cooperation without consensus. These maps can manage specific organisations and their negotiations without the customary closed system or reductionist approach of previous methods (Clarke et al, 2018). In this study, it is expected that these maps will identify the actors in the social worlds to be recruited to the study, this has been addressed in chapter 4. Further social world maps will be developed from the analysis of the data gathered

Appendix C

To support the abductive analytical approach, Clarke et al (2018) advocate initial messy maps as at the early stages the unknown and the important issues are still hidden. The following is an example of the messy map I wrote on my study white board. This process allowed for easy addition of actants and issues as well as facilitating the colour coding that became helpful during the full analytical phase.



These are examples of messy maps from the first focus group. I tried various options to analysis the data in multiple ways.

Innovative free rein
Carry others along with you
Supervision
Position in hierarchy
Evolving role
Up the ranks
looked upto ANPs in awe
Extra skills
Patient contact
Responsibility
Supervising medics
Acknowledged as safe practitioners
Prove yourself to everybody
Consultant mentor
Support of ANP team
Invest time, effort and money
Recognition in role
Autonomy
Expectations of others
Extra
Professional governance
Work/life balance
No plan
lynchpin
whole patient care
More respect from doctors than nurse managers
Figure out this new way of nursing
Being of values to whole team
Patient needs vs service needs
Challenge for acceptance
Establishing the role across both teams
Extra layer on rota
Taking opportunities

The following are written transcripts from a sample of voice notes regarding the interviews to demonstrate the cognitive processes.

11/6/21

From voice notes – concept of trust as from C5 interview where the comment was around colleagues needing to learn who you were to trust you and he experienced that but didn't relate it to a race issues just a lack of know what skills someone has.

24/06/21

There feels like something going on with the perception of role by the ANP being limited and without an end to 'training' with an opposite view by the doctors of being broad scope without a limit other than personal choice and that there is an end point to training with ongoing natural development in the role much like when a consultant becomes a consultant.

Think these might be points of contention for the positional map…

Its interesting to hear the differences between the NICU experience and the ED experience where one wouldn't have a service without ANNPs and the other is really only playing lip service to the concept.

I think there's something in the success of the ANP is individual not a given because of the role.

The falling between nursing and medicine for management and regulation is an issue and the job contract A4C etc is different to the medical contracts which limits rota etc.. though you could argue that they could be job planned like a consultant/AS/CF not as a doctor in training.

25/06/21

Been thinking about is my interpretation of data influenced by knowing the staff and department and does that influence what is said, eg C1 has different view of ANPs than C4 and C5 but I've assumed it because of the ANPs in the department. They have also had 18 months of not having ANP's working in the department and their focus is on service not the other aspects anyway. Need to think on this so that I can be sure that analysis is not biased.

3/7/21

From voice note – concept of 'disconnect' the feeling from the ANP's towards the wider hospital and its not reciprocated as a concept in the interviews from the those who work with them.

7.7.21

Thought more about the C1 interview and reflecting on her understanding of adv practice it is easier to see that it's a lack of understanding about the role not necessarily the team she's worked with who have influenced her experience and opinion. Reflecting back on both the focus groups and interviews I'm starting to see 'disconnect' as a point of contention, the ANPs feel they are disconnected from each other and the wider teams but the teams see them as integral so how did that happen???

5/8/21

Just reading the interview From C3 and it struck me that there is a disconnect between the medical approach and the nursing approach with managers and supervisors not working together and their expectations being different so I think there is a need for to me to try and push getting a senior or lead nurse to be interviewed trying to sort out what's going on why this difference

26/08/2021

I read and reflected other than this but have now done final interview, sent further email requesting lead or senior nurse manager and had one suitable respondent from 3 responses. There really does feel like silence in the nurse manager voice. Starting to get deeper into the analysis today

Appendix D

The following is a copy of one of the transcripts (coded NM1) from the interviews with any identifiable information being redacted:

Interviewer: So my opening question has generally been what is your understanding of advanced practice, what do you know about it and where does it come from?

Respondent: That's a big wide question, my understanding of, I suppose what have I done 30 odd years in nursing, there was and during that time I've heard about advanced practice evolving, there was nurse practitioners that kind of stuff and advanced came into the role and then I suppose what we've probably got I think in [redacted] but across nursing in general is a myriad of roles where there's advanced in the role and you've got to question sometimes whether that's advanced surely should be in there or fits in there but I suppose my experience of advanced nurse practitioners I've sort of over the last 15 years really they've been in my sort of opinion they've really come into force. Whether I agree with it or not but they seem to grow and evolve where there's a gap so there's a gap in a service that they can't fill whatever reason and you know in the past I've had conversations myself oh we'll get a nurse practitioner to do that and I don't know whether on reflection you know it's easy to look back on reflection but on reflection I think even I've entered conversations in the wrong way about oh well we'll stick, we'll a train a nurse up and stick a nurse practitioner you know into that or advanced nurse practitioner. So I suppose that's been my experience, my experience, my wider experience often, now that's my experience of how they've evolved I suppose although I know it's probably realistically been more structured than that. My experiences of nurse practitioners are really positive, you know i know there's lots of evidence out there to suggest that you know a nurse practitioner does as good or even better sometimes than a medical colleague because you not only train a nurse practitioner to work at a certain advanced level in, you know comparative to a medical colleague but they never leave their nursing go either so they're always still looking at it with a nursing lens and sometimes that can be more holistic than a medical lens for instance. So I think my personal experience has been really, really positive of nurse practitioners, of advanced nurse practitioners. But I think there's a lot of work that can be done moving forward and I think that NMC potentially is missing a trick when they're now agreeing the new post-reg practice, you know they're talking about, I've obviously touched a nerve because you're smiling, they touched, you know there's a big focus on advanced or specialist practice, what's the difference, what's the difference between specialist and advanced but there's a lot of focus on specialist practice in community and yet what about specialist practice in hospital so I think we're missing a trick.

Interviewer: yes, yeah so you've mentioned there areas where your solution has been oh we'll put a nurse practitioner in or we'll train someone up. What are some of the areas where that's happened?

Respondent: Oh god over my time I've been aware that we've you know put them into certain and I'm just talking about not just [redacted] but other organisations but you know I'm aware that we've put nurse practitioners, advanced nurse practitioners into specialities such as general surgery, I notice that we've, I'm aware that we've put advanced nurse practitioners into orthopaedics, I've noticed you know I know I recall we put advanced nurse practitioners and I'm just going to term as the out of hours area and again I suppose we could talk and debate for a long time about you know, we're talking about advanced nurse practitioners but another issue for me is where nursing is missing a trick is that have we really, really, have we really defined what an advanced nurse practitioner role is because we've got, I've touched upon it earlier, we've got lots of roles spanning from nurse practitioner to specialist practitioner to advanced nurse practitioner where you know, where for me the boundaries of definition between advanced, specialist, you know is blurred. We call practitioners out of hours particularly at night, we call a band 7 a nurse practitioner, are they a nurse practitioner or is that just an old title that has been kept in the organisation or are they you know evidence goes to suggest they work in an advanced role so but there's not advanced in their title and then there's other titles with advanced in where they're not working in their role. So going back to the question I'm aware that we've got advanced nurse practitioners in paediatrics and I'm aware that my biggest experience has probably been the out of hours type role and where we put them in there.

Interviewer: So…

Respondent And community I know we've got them in advanced practice in community and in fact I had a conversation with oh he's a band 5 community nurse practitioner in [redacted], I was talking to him externally the other day and he's, he wants to develop in community practice and primary care district nursing and he's being pushed to do, he's wanting to do his advanced practice but he's being pushed down the SPQ, Specialist Practitioner because that's community whereas he stood his ground and he said no I'm doing an advanced nurse practitioner course because I think we need advanced and that's nurse practitioners in community and I thought well that's really, really good, that's a real turn do you know what I mean. Because he hasn't gone down the normal specialist practitioner, he's gone down a well I think advanced nursing practice qualification will enable me to do things slightly different in the community and I'm aware that they're all over really.

Interviewer: Yes, yes so titles is a key problem that keeps coming up, what people are called and what role they've got and I've experienced that with trying to recruit to this. It's like we haven't got anyone advanced, it's like anyone you think might be doing something outside of what's normal nursing.

Respondent: Yes that advanced type

Interviewer: So that was quite complicated trying to get people to recognise

Respondent: I think we have about, I think when we did the last count in [redacted] alone I think we had something like 36 different titles other than registered nurse and

nurse and ward nurse. It was all about advanced nurse practitioner, nurse practitioner, oh god, we had about 36 different titles.

Interviewer: Yes whereas actually you know there is now definitions of what is advanced practice, it is easy to sort of say that's what that is so anything

Respondent: And when we looked and that's exactly why we did the piece of work, when we looked everybody with you know a lot of people that are advanced, all of a sudden put advanced on their badge and on their title even though their job description didn't say advanced. Some of them or a lot of them weren't working at an advanced level when you look at the definition of advanced.

Interviewer: So we've talked about titles being a big issue there, any other sort of barriers or things that you're aware of with the role or problems that's come up with trying to develop it or?

Respondent: I think, I think nursing needs to, I suppose because, for me because the role has evolved or the title is evolved over time and like i said I know there's a definition, there's a clear definition of four pillars, MSc level that type of stuff, it doesn't, for me it doesn't hold the gravitas that I think it should do you know what I mean? You wouldn't have, you know you wouldn't have a registrar or a consultant in medicine without the gravitas and yet nursing it's, I just and you know they do a superb job and I want to sort of lift that level of practice and that title up in an organisation or you know in nursing because it's you know, they are, they, yeah I just don't think it gives and it's not all about title and status but they're not given the status and the gravitas in a structure that they should really considering the work they do and they are working at an advanced level so for me it's like because we use them to plug gaps it's like oh we'll stick another one there, we'll stick another one there, we'll put another one there without really defining you know, I hear people saying oh yeah I'm an advanced nurse practitioner, oh right. Now I don't know whether people don't know enough about it so therefore don't ask the question, just glance, oh oh right okay, but you're still a nurse are you? Yes, oh yeah right okay. Whereas I don't know, you know we did it with consultant nurse didn't we, we lifted that profile up so the consultant nurse had that profile you know, same four pillars, advanced practice and yet these people are beavering away often holding services together and services up, you know because we know that when that one advanced nurse practitioner ends up going off sick or whatever because we've overworked them, that the bloody service falls down. So you know these people are beavering away and yet haven't got that status in an organisation to say that they're an advanced nurse practitioner. Because I don't think enough people, general public know about what an advanced nurse practitioner is, they just see a person in uniform, I get patients and relatives saying well this doctor come and examined my mother's chest and when I look at the notes it was like well actually it wasn't a doctor it was a nurse within an advanced role. So for me it's about I think gravitas, I don't know whether that's the right word but status in an organisation needs to be looked at and without, and that's why I think the NMC are missing a trick because you know they're raising the status of this specialist practitioner community role and yet nothing is being done about advanced practice in hospital and I think another thing we work

in the NHS it's money, again some coming out of a nursing budget whereas often it's like oh we're short of SHO's, we can't recruit SHO's you know, nobody wants to work in this service because it's not, I hate the saying when you know I hear medics all the time saying oh we can't get consultants and registrars to work in the service because it's not a sexy service but actually can you do me a favour can you put two nurses in that role. So it's about, so then the money never comes from medicine because I say well actually if you can't get doctors and you never will get a doctor there let's convert the money and let's put a proper advanced nurse practitioner infrastructure in there to support the service. So I suppose money is a barrier, for me I suppose the two big barriers, money and we often have to find money and re-design nursing money and of course when you re-design nursing money you take nursing away from the coalface and status but along with status comes with people's perceptions of a nurse, an advanced nurse practitioner role. You look on the internet for an advanced nurse practitioner role and there's nothing on there that really describes to the public what they do, there's what qualifications they've got to have to do it, what universities teach them, you know often it'll be a, any advert for an advanced nurse practitioner role tends to focus on a maternity role of whatever do you know what I mean, there's nothing on there that would alert the public to what that role does and the importance of it.

Interviewer: You've mentioned in some of that about that sort of status and understanding and things so currently the uniforms of advanced nurse practitioners, they're the same, it's that bluebell blue as I think [redacted] called it in a meeting, and you know it's but there are a lot of people in that colour so do you.

Respondent: I mean uniforms are a state of bloody discussion wherever you are in nursing isn't it, or in health now because everybody has developed you know I think we've almost done the whole rainbow of colours now in an organisation. We'll be starting to go to metallic now just to double up the colours, to get through the colours again. But no I agree, you know it's, there's an argument saying actually do you really, does the uniform matter because you're working at that advanced level and through your pillars of leadership and you know, management of academia and clinical practice you shouldn't have to but it's important to general public isn't it and you're right you've got to, it doesn't help when I say general public can't delineate who they are, the uniforms don't help because yes you know, you look at a myriad of people in a room, you think I assume you know that the majority of them are tending to be a clinical nurse specialist or a band 6 type role rather than an advanced nurse practitioner. So you know I absolutely agree that we need to have a defined, have a defined uniform but until we stand up there with the NMC, the RCN and define concrete, not define because we can define it, until we concrete the advanced nurse practitioner role and say this is an arm and a profession of nursing, this isn't some, you know somebody will drift into it and then come back out, the majority of people go into it because they want to work at that advanced level and advanced practice. So until we, I'm trying to sort of, I had a conversation a couple of weeks ago regarding the All Wales Research Nurse and how that's grown as a body and lo and behold they've managed to get themselves to a position in Wales where they've got their own uniform. So now we've got, you know we've got albeit a small in the

fraternity of nursing across Wales, we've got a small, a relatively small body of people who are some of the newest titles to the table really, research nursing, but they developed a forum, they've developed a society, they've developed a research nurse body and they've now gone to CNO and RCN and NMC and everybody else that they need to go to and they have agreed a uniform for a research nurse. So I'd be able to pick out the research nurse but I wouldn't be able to pick out an advanced nurse practitioner.

Interviewer: So some of the other stuff that's come up and talking to other departments as well is around the scope, it's around what advanced nurse practitioners are allowed to do. So do you have any thoughts about should there be limits to scope, should it be fit for purpose, what?

Respondent Personally I suppose, oh there's two things here isn't there, personally I, my personal opinion is that you know scope shouldn't have boundaries as long as everybody, as long as the individual is educated to a level where they can function at that within that scope, are trained and you know are designated as that advanced I'd say slash because it depends how far the scope/expert practitioner, I mean out of advanced nurse practitioner roles you know I'm constantly pushing for advanced healthcare support workers, band three/four you know and nursing is quite old fashioned though isn't it so I suppose I come up constantly against barriers that say we can't have a healthcare support worker doing that because you know that's a registered nurses job. I mean come on those days are gone, do you know what I mean? It's when I'm an 80 year old patient in a bed, as long as, that's all I want, I don't care you know, what I will care about is that the person in front of me is trained and to a level to provide the care that I, whatever care that they are delivering to me at that time because you know I've dealt enough in my career with people who sit in a title, who are incompetent, who get things wrong. So you're talking to the wrong person here when you're saying about scope because you know I remember 15 years ago probably 10/12/15 years ago in [redacted] having discussions with, you've got to be careful now, older more traditional nursing colleagues when you know an individual gastro nurse we were putting on a course to train to do endoscopies, do you know what I mean and were mortified, my god what if she misses a cancer and I'm saying actually what about the consultant, because the consultant treatment being, the consultant has got a pair of eyes exact, the consultant's eyes aren't any better than the nurses you know and the signal that goes from the eye to the brain is no bloody different either so you know a nurse will be as competent to identify cancer and when we train the nurse practitioner or advanced nurse practitioner to do breast examinations, oh my god what if a nurse misses a lump well doctors miss lumps but the nurse will find a hell of a lot of lumps do you know what I mean and so I suppose for me it's in any part of my professional career it's I'm not governed by traditional boundaries, I think, in fact my personal opinion is I'm not governed by traditional boundaries it's whether the individual has been trained, assessed and competent to do that role and whether but I know that moving forward healthcare is going to change because it has to because there's not enough doctors, there's not enough registered nurses so whatever role is out there is going to change and we're going to see a blended, a more of a blended approach so we'll probably see more

change in scope of practice but making sure, but my role as I suppose in charge of the governance of that will be to make sure there's a governance framework to make sure people are safe, secure and competent and then the more advanced I suppose they become it's about that ongoing, that ongoing validation to me, for their practice.

And for me there's, I can imagine and god forbid, can you imagine 18 years ago us saying oh there's going to be a woman called [redacted] and she's going to be in that assessment lounge and she's going to be making decisions about kids. There would have been an outcry even 18 years ago that oh my god, kids, you can't treat kids, it has to be a registrar because so many things can go wrong with a kid. For god's sake. But I suppose for me why I'm sort of far more, why I'm probably more comfortable about scope of practice is that the health service and clinical practice isn't binary, it's not dependent on one person, there's usually a system that the decisions fall into so for instance you, you know if a consultant requests a CT scan of a child, that request goes to a department where there's a consultant there who validates that request, do you know what I mean. So it's not as if [redacted], you've got the responsibility to say right little child I'm going to CT your brain because you've got a headache and then you walk them off to the CT scanner, you lay them down you go, you fiddle about with a few controls and you do it yourself. There's a validation process along the way which is there to keep patients safe so and it's a well known, well trodden path of validation so therefore that's what keeps practitioners safe and you will be as safe as an advanced nurse practitioner as the consultant who's requested the brain scan.

Interviewer: Yes

Respondent Do you see what I mean. So for me that's why I'm less controlled, I'm less worried I suppose about advancing scope of practice, the only thing I know is we've got to start advancing practice.

Interviewer: And some of the other conversations have come out are around the whole supervision and training and development of the post and I think you've touched on some of that with how they're developed and it's often ad hoc so if you had a blank piece of paper and you were going to start from scratch we've got a service that needs to be developed who are you going to put where and how are you going to approach developing an advanced nurse practitioner part of the team?

Respondent: I suppose at this moment in time, at this moment in time it's about what's best, you know the reality at this moment in time finger in air oh a new service, you know, we get business cases all the time about new services in [redacted] and you know there's usually a consultant or two or three consultants, some middle grade, and then they come down and they say right we need a pharmacist and we need a band 7 to take charge of the department and this type of thing and oh let's link two or three nurse practitioners in we might get 2, they might turn the third down but we might get two so it tends to be a bit finger in the air at this moment in time based on this and I suppose people's experience of managing and running services and what services really need. And I suppose it's going to be like that for a long time really because it's about what best fits because there's no standard framework that I'm aware of where we can say right this is a new service, this service needs this

person and it's and still I suppose it's built on tradition there has to be a consultant overseeing the service to take responsibility, there has to be some type of manager to manage the service so I suppose if there was a new service going to be built up it's built on tradition, experience, on what the NHS has been built up on I suppose. Whether that's the right thing moving forward I don't know, I can't see it changing from that, I can't see the bit of the, there's a new service put people in there, I can't see that changing much at this moment in time or not for a long time really because that's what happens.

Appendix E

Non-medical referral for diagnostic imaging

The organisational documents for non-medical referral for plain film and non-plain film diagnostic imaging are to be completed and signed by the advanced nurse practitioner with supporting signatures from supervising consultant, clinical director for radiology, and professional head of imaging. Approval is given if the scope of practice, list of imaging referrals/requests and audit process meet the requirements set out in the documents. There is a requirement to complete a recognised training course that meets the standards as set out in the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) (2017). These documents are available on the organisations website and need to be completed to be registered as a non-medical referrer for diagnostic imaging. The governance process for the non-medical referrer for diagnostic imaging lies with radiology. They are the area that give permission for referring, they also request and review the audit information to provide assurances that the referral and reporting processes are being followed.

Non-medical prescribing

There is a similar approach with pharmacy as they hold the register for non-medical prescribers in the organisation. There is a governance document that details who can apply to be a prescriber, how they should be supervised and then how they consolidate their practice after completing the non-medical prescribing course. There are approved processes for new employees who are prescribers as well as how to manage a change in scope of practice. Each registered non-medical prescriber is required to provide evidence that their prescribing practice is discussed annually and there are six reflections to support this. The scope of practice must be reviewed and updated every three years and should reflect the case mix of patients that the individual will be prescribing for and in what setting (inpatient, outpatients, community). The purpose of these documents and processes are to provide an accurate record of who is a non-medical prescriber in the organisation. It is also to provide assurances that the individual has and maintains the clinical assessment and diagnostic skills to safely prescribe. The governance to manage the non-medical prescribing role lies with the line manager of the prescriber.

The following is the non medical prescribing governance framework for the organisation. Organisational details have been removed.

Non-Medical and Dental Prescribing Governance Framework

1. Introduction:

This Governance Framework has been developed to ensure that all non-medical/dental prescribing (NMP) practice within [redacted] is governed by the robust procedures and processes necessary to preserve patient safety and support and safeguard non-medical prescribers (NMPs). The framework enables NMPs to function in line with: professional standards; National Guidance; and legislation. The framework clarifies the [redacted]'s approach to the governance of NMP and is supported by the following documents:

1.1 Nursing and Midwifery Council. The Code

1.2 HCPC: Standards of Conduct, Performance and Ethics

1.3 Nursing and Midwifery Council. Realising Professionalism: Standards for Education and Training. Part 3: Standards for Prescribing Programmes

1.4 Non-Medical Prescribing in Wales: Guidance. Welsh Government (May 2017) http://www.awmsg.org/docs/awmsg/medman/Non%20Medical%20Prescribing%20in%20Wales%20Guidance.pdf

1.5 Competency Framework for all Prescribers' Royal Pharmaceutical Society (2016) https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/Prescribing%20competency%20framework/prescribing-competency-framework.pdf

[redacted]

1.7 All Wales Prescribing Standards

1.8 All Wales Policy for Medicines Administration Recording Review and Storage

[redacted]

2. Scope:

The framework applies to all non-medical/dental prescribers working in all care settings within the [redacted] their line managers and service leads. It covers primary care staff who are employed by the [redacted] and/or GP practices including practice nurses, cluster pharmacists and AHPs; it also includes

independent contractors who are commissioned to provide services for the [redacted]. The framework does not encompass non-NHS prescribing by independent contractors e.g. private prescription in community pharmacy practice. It also does not cover other methods of providing medicines to patients such as Patient Group Directives (PGDs); Patient Specific Directives (PSD); or the prescribing of borderline substances in secondary care by dieticians and speech and language therapists.

The framework applies to three categories of prescribers. The scope of these three categories are defined in the Welsh Assembly Government (WAG) Guidance 'Non-medical prescribing in Wales' (WAG, May 2017) as follows:

2.1 Independent prescribers:

"Prescribing by a practitioner….. responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing".

Independent prescribers must work within their own level of professional competence and expertise and are accountable for their own actions.

Currently the following registered practitioners may train to be registered as independent prescribers:

- Nurses
- Midwives
- Pharmacists
- Physiotherapists
- Podiatrists
- Optometrists
- Therapeutic radiographers
- Paramedics

2.2 Supplementary Prescribers:

"A voluntary prescribing partnership between an independent prescriber (doctor or dentist) and a supplementary prescriber, to implement an agreed patient-specific clinical management plan with the patient's agreement".

Supplementary prescribers can only prescribe in partnership with a doctor or dentist. Going forwards, the only disciplines that will train as supplementary prescribers are dieticians and diagnostic radiographers. The following registered practitioners who have previously trained as supplementary prescribers may continue in this role if they have an up-to-date Scope of Practice statement and are on the UHB Register of Non-Medical Prescribers:

Nurses

Midwives

Pharmacists

Physiotherapists

Podiatrists

Therapeutic or Diagnostic Radiographer

Optometrists

Please note: that the only way that a supplementary prescriber can qualify as an Independent Prescriber is to complete the full IP course.

2.3 Community Formulary Nurse Prescribers:

The Nursing and Midwifery Council rules to allow any registered nurse to prescribe from the limited formulary. Registered nurses must complete the V100 programme to become Community Nurse Prescribers.

Legislation in Wales has clarified that the term 'independent nurse prescriber' should be used for this category of prescriber – this is because whilst the community nurse prescriber will only prescribe from an identified community formulary, they will do this independently.

3. The Process for the selection, training and management of Non-Medical Prescribing (NMP)

3.1 HEIW commissioning process:

This process enables the UHB to access Health Education and Improvement Wales (HEIW) NMP funding. The number of NMP programme places needed for each academic year must be commissioned via the HEIW Workforce Commissioning Process which is coordinated by the Workforce Information Team in November and December each year.

The need for new prescribing roles must be driven by service development, IMTP priorities and HEIW national priorities. The commissioning process can be summarised as follows.

a.	Patient and service need for non-medical prescribing identified (as per IMTP)
b.	Training places commissioned by the Head of Service/Director of Nursing via the HEIW workforce commissioning process (linked with IMTP)
c.	HEIW confirm number of funded training places for the UHB – usually by the end of March each year.

3.2 The [redacted] process:

This process, runs in conjunction with & informs the HEIW commissioning process). Please note that this process ***must*** be followed even if individuals have secured alternative sources of funding e.g. self-funding, educational grants, endowment or directorate funding.

a.	Nominees identified via the IMTP in order to meet service need and then their suitability is confirmed by their line manager using the UHB eligibility criteria check list (appendix 1). Nominations and a copy of the completed eligibility checklist are sent to LED.
b.	Nominees who meet the eligibility criteria are required to complete a nomination form (appendix 2) and are invited to attend a meeting with an NMP Panel (profession-specific) in order to review their nomination form and establish their suitability to undertake the Programme. These meetings may include HEI representation (NMP programme lead).
c.	List of suitable applicants is sent to Director of Nursing/Head of Service and Deputy Executive Nurse Director/Executive Director of Therapies for approval. Individuals who have secured alternative sources of funding can progress to application at this stage.
d.	Nominees are progressed to the [redacted] NMP Approval Panel for agreement and prioritisation according to the number of HEIW funded places. Membership of the [redacted] NMP Approval Panel to be agreed by the Deputy Executive Director of Nursing, Director of Pharmacy and Executive Director of Therapies. HEIW are informed of UHB nominations by LED following agreement by the NMP Approval Panel.

e.	[redacted] will inform the Head of Service/Director of Nursing and Lead Nurse of the HEIW funding outcome and provide funding letters and pre-course information to all successful nominees including course application details. NMP education programmes must be undertaken in a HEI where the [redacted] has an established relationship which supports adherence to this governance process.
f.	Head of Service/Lead Nurse ensures that NMP trainees are supported and robustly supervised by a Designated Prescribing Practitioner (DPP) throughout the training programme. Trainee NMP takes personal responsibility for ensuring that the necessary study and development is completed.
g.	Whilst waiting for confirmation of qualification and registering with professional body trainee NMPs must maintain their competence via continued supervised practice with DPP whilst the necessary registration and induction processes are being completed.
h.	Once confirmation of qualification is received from the University the NMP must commence the UHB pathway for Newly Registered NMPs (appendix 3) to ensure that the correct registration and induction processes are followed, including registration of Scope of Practice (appendix 4) with UHB Register of NMPs (maintained by Pharmacy on behalf of the UHB).
i.	NMPs must ensure that they meet the annual CPD requirements and Heads of Service/Lead Nurses must ensure that they are supported to enable this.
j.	All NMPs must undertake an annual review of their prescribing practice as part of the [redacted] annual appraisal process using the NMP Annual Appraisal Form (appendix 5)
k.	All NMPs must submit an annual prescriber declaration (see appendix 5) to pharmacy in order to update their entry on the UHB Register of NMPs.
l.	On an ongoing basis an updated Scope of Practice (appendix 4) must be submitted to Pharmacy immediately if any elements change. An updated version must also be submitted every 3 years. Established prescribers joining the [redacted] must submit a completed Scope of Practice to pharmacy to register with the UHB before undertaking prescribing practice. The prescriber should also discuss if a supervision or induction period is necessary with their line manager on appointment to the UHB.

3.3 Ongoing governance and annual appraisal (see appendix 5)

Welsh Government requires the UHB to maintain a register of all non-medical prescribers and stipulate that the register must contain the following information:

a. Name
b. Payroll number (staff number is equivalent)
c. Profession
d. Area of practice
e. Independent Prescriber or Supplementary Prescriber
f. Whether the individual is practicing (annual update)
g. How their competence is maintained
h. Signed declaration

The UHB register is held and maintained by pharmacy. Registration is enabled through the submission of a Scope of Practice (SoP) form (appendix 4). An updated Scope of Practice form must be submitted every three years as a minimum and if there is a change to any of the elements.

There may be circumstances whereby an NMP would benefit from an additional period of supervised practice with a DPP e.g.

e. A change in role which requires a significant change in SoP
f. A lapse in prescribing activity which lasts 12 months or more
g. Concerns regarding prescribing competence
h. An established prescriber joining the [redacted] – to enable effective induction to the [redacted]s policies, procedures, prescribing practices etc.

The length and form of supervision should be decided through discussions with the DPP, line manager and the individual and approved by the Lead Nurse/Department Head.

The NMP Annual Review Form (appendix 5) provides clear appraisal guidance for both prescribers and line managers. In order to maintain registration on the [redacted] Register of NMPs the prescriber must submit the annual prescriber declaration (at end of appendix 5) to pharmacy via [redacted]

APPENDICES:

Appendix 1: Eligibility Criteria Checklist for the Selection of New Non-Medical Prescribers

Appendix 2: NMP nomination form

Appendix 3 Induction Pathway

Appendix 4: NMP Scope of Practice form

Appendix 5: NMP Annual Appraisal form

Eligibility Criteria Checklist for the Selection of New Non-Medical Prescribers

Prospective new non-medical prescribers must meet the following eligibility criteria:

	Please review each statement and tick as appropriate	
a.	The practitioner is working in a role in which it is appropriate for them to undertake prescribing practice.	
b.	Prescribing is an essential part of the practitioner's role. There is clear service need and patient benefit.	
c.	The practitioner will have the opportunity to act as a prescriber upon qualifying.	
d.	A Designated Prescribing Practitioner (experienced medic/nurse/AHP prescriber) has been identified who will provide the necessary training, support and practice assessment during the Programme and the post qualification supervision including induction period.	
e.	The practitioner will be released to attend the required training programme and DPP supervision.	
f.	The practitioner will be supported to access continuing professional development opportunities on completion of the course.	
g.	The practitioner has evidenced their ability to undertake advanced patient assessment and decision-making – any identified learning needs can be addressed prior to undertaking (or during) the prescribing programme. A formal programme of patient assessment may be required. If applicable, identified learning needs should be recorded in the practitioner's annual appraisal with their line manager.	
h.	The practitioner has completed a first degree or equivalent. (If no please seek advice from LED regarding the individual's academic qualifications as they may need to undertake further academic study prior to commencing a prescribing programme)	
i.	Financial arrangements are in place to meet the cost of prescriptions (as appropriate).	
j.	The practitioner is registered with the appropriate Professional body: - The General Pharmaceutical Council (GPhC) – must also be a practicing pharmacist. - The Health and Care Professions Council (HCPC). - The Nursing & Midwifery Council (NMC) – registered as a first level nurse, midwife and/or specialist community public health nurse.	
k.	The practitioner has completed one year of practice as a registered practitioner (immediately preceding application to the programme) in their clinical field. (eg mental health / adult / child health) in which there is the intention to prescribe.	
l.	The practitioner is able to demonstrate how they will reflect upon their own performance, take responsibility for their CPD and develop their own inter-professional networks for support, reflection and learning.	

Non-Medical (Independent) Prescribing Programme Nomination Form

Name	
Role	
Department	
Directorate	
Clinical Board	
Do you meet the eligibility criteria set in [redacted] Non-Medical Prescribing Governance Framework? Please provide details	
Have you been registered as a nurse/AHP/ pharmacist for over 3 years?	
Briefly outline your experience in the area of practice for your proposed prescribing role.	
Name of Lead Nurse or Head of Service supporting nomination	
Have you completed a BSc or equivalent? If yes: please provide title of programme and date completed	
Have you completed any MSc level education? If yes: please provide course titles and dates completed	
Have you completed a clinical patient assessment module If yes: please provide course titles and dates completed	
Is independent prescribing a new development for your role?	
Is independent prescribing a new development for your department?	
Proposed prescribing role Please provide detail re: type of service; patient group; patient need; range of medications you wish to prescribe)	
Please outline the service need that supports you undertaking a prescribing role	

What are the anticipated benefits for your patients if you become a prescriber?			
What are the potential consequences for your patients or your service if you are not in a prescribing role?			
Have you applied to undertake the independent prescribing programme before? If yes: what was the reason you did not go ahead with the course?			
Have you started an independent prescribing course before? If yes: please provide details re: 1. Where you studied 2. How you were funded 3. The reason for non-completion of programme			
Are you aware of the extensive time commitment that this course requires?			
Name of Designated Supervisory Medical Practitioner (DSMP) or Designated Supervising Practitioner (DSP)			
Current role of DSMP/DSP			
Has DSMP/DSP supervised a student through the independent prescribing programme before?			
Is DSMP/DSP aware that they will need to attend a session with University course lead to discuss their training and supervisory responsibilities?			
Who will be responsible for clinical supervision for you once you have qualified as an independent prescriber?			
Name of Lead/Senior Nurse or AHP Head of Service supporting application			
Lead Nurse/ Line Manager Signature		Date	
Practitioner signature		Date	

DSP signature		Date	

Non-Medical Prescribing (NMP)

Induction Pathway for Newly Qualified Non-medical Prescribers

Please commence this pathway as soon as you finish the prescribing programme. When completed, a copy of this pathway needs to be uploaded to your personal file.

Name of Non-Medical Prescriber (NMP):	Job title:
Profession:	Department:
Directorate:	[redacted]
Date completed NMP programme:	Date received pass result from University:

Step 1: Maintain your competence:

In order to maintain your competence please ensure that you continue to undertake supervised prescribing practice with your Designated Prescribing Practitioner (DPP) following completion of the programme. Please continue this until you have fully completed this pathway and are able to prescribe independently. Please continue to maintain your prescribing log in your portfolio during this period.

Step 2: On receipt of pass result - register as a prescriber with your Regulatory Body:

Complete registration process with regulatory body as per guidance provided by the University.	Date completed:
	Date confirmation of registration received:

Non-Medical Prescribing (NMP)

Induction Pathway for Newly Qualified Non-medical Prescribers

Step 3: Register as a prescriber with the [redacted]

[redacted] Non Medical Prescriber Register is held and maintained by Pharmacy on behalf of the UHB. You must be registered with the UHB in order to be able to prescribe; a **Non-medical Prescriber will only be covered (in terms of liability) to prescribe if they are on [redacted] Non-medical Prescriber Register and if they have submitted an up-to-date Scope of Practice Statement which accurately reflects their current prescribing role.**

In order to register as a prescriber with [redacted] please complete the following actions:

1.	Book meeting with line manager to complete Scope of Practice (SoP) Statement with line manager (Senior/Lead Nurse or AHP)	Date of meeting:
2.	Complete SoP Statement with line manager (Senior/Lead Nurse or AHP): ▪ Copy to be retained in your prescribing portfolio ▪ Copy to be retained in your personal file ▪ Copy must be scanned and emailed to Pharmacy at [redacted]	Date copy sent to pharmacy:

Step 4: Register for access to Welsh Clinical Portal:

You will need a NADEX account to register – contact your Line Manager if you do not have a NADEX account. Once you have got a NADEX account, follow the link [redacted]	Date registered with Welsh Clinical Portal:

Step 5: Register for prescribing via COPPS (ONLY for prescribers who will prescribe in the out-patient setting)

If you are prescribing in the out-patient setting, you will need to register with COPPS via the following [redacted] link: **please make it clear that you are a Non-medical Prescriber when registering with COPPS.**	Date registered with COPPS (*if applicable*):

Non-Medical Prescribing (NMP)

Induction Pathway for Newly Qualified Non-medical Prescribers

Step 6: Register **with NHS Wales Shared Services Partnership – Primary Care Services** (ONLY for prescribers who will prescribe in primary or community care)

Any non-medical prescriber requiring NHS WP10 prescriptions (for use in primary care) must register with NHS Wales Shared Services Partnership – Primary Care Services.	Date registered with NHS Wales Shared Services Partnership (*if applicable*):

Step 7: Induction period: months 1-3 of independent prescribing practice

During this period the Non-Medical Prescriber should:

Attend a monthly supervision meeting with DPP	Dates of meetings:
Complete a prescribing activity log for a minimum of either one month or fifty prescriptions. Prescribing activity is a term used to describe the process from Patient Assessment, Diagnostic Reasoning, Shared Decision Making and the use of Therapeutics. The log should be reviewed and signed off by the DPP	Date log reviewed with DPP:
Record any critical incidents and discuss with DPP/Lead Nurse/Line Manager/Head of Dept	Dates of any critical incident discussions:
Attend a UHB NMP Peer Forum meeting (or equivalent relevant CPD event / meeting/ peer review)	Date attended:

Non-Medical Prescribing (NMP)

Induction Pathway for Newly Qualified Non-medical Prescribers

Step 8: Pathway sign off – at end of month 3 post prescriber registration:

Please meet with your Lead Nurse/ Line Manager 3 months post registration to confirm that the induction pathway has been completed and to ensure that any further development or support needs have been identified.

Date of review meeting	
Have all relevant components of the pathway been achieved?	
Progress summary	
Future learning or development needs identified and actions required	
Prescriber signature	
Lead Nurse/ Line Manager signature	

Non-Medical Prescribing

Scope of Practice Statement

Completion notes:

1. In order to register on the [redacted] prescribers must submit a signed 'Scope of Practice Statement' to Pharmacy. Therefore a 'Scope of Practice Statement' must be completed by:
   - Newly qualified non-medical prescribers (NMPs)
   - Non-medical prescribers (NMPs) who are newly employed [redacted] or who are providing a commissioned service for [redacted]

2. In order to remain on [redacted] NMP register prescribers must then:
   - Submit a reviewed Scope of Practice Statement **once every 3 years** as a minimum. The prescriber must complete a new Scope of Practice Statement, even if it is unchanged, every 3 years.

   and

   - Submit an updated Scope of Practice Statement immediately whenever **any** aspect of the Scope of Practice Statement changes e.g. changes to clinical area, range of medications, role etc.

3. In order to ensure that you are using the most up-to-date version, the Scope of Practice statement must always be accessed via [redacted] or Internet site each time it needs to be completed:

4. The Scope of Practice Statement **must** be completed by the non-medical prescriber in conjunction with their line manager. Please [redacted] f you require an editable version to complete electronically.

5. The prescriber must immediately return the signed statement to:
   Pharmacy Department
   The line manager must retain a copy for the prescriber's personal file and the prescriber must retain a copy for their portfolio.

6. It is the responsibility of the line manager to ensure that Pharmacy are notified immediately, via the email address provided above, if the post-holder no longer works (or provides commissioned services) for the department or organisation.

NOTE: A Non-medical Prescriber will only be covered (in terms of liability) to prescribe if they are on the [redacted] Non-Prescribing Register and if they have submitted an up-to-date Scope of Practice Statement which accurately reflects their current prescribing role. The Non-medical Prescriber also needs to be able to provide evidence that they have discussed their prescribing practice in an annual appraisal.

Non-Medical Prescribing

Scope of Practice Statement

Prescriber details:

Name of Non-Medical Prescriber:	
Email address of Non-Medical Prescriber: (*please use a work email address*)	
Employee number (if employed by the organisation):	
Regulatory body:	
Registration / membership number:	
Registered as a prescriber with regulatory body? (please provide line manager with proof of registration)	Yes / No
Independent or Supplementary prescriber?	
Job Title:	
Department/clinical area:	
Directorate:	
Clinical Board:	

Non-medical prescribing qualification:

Higher Education Institute:	
Date of qualification:	

Scope of Practice:

Overarching area of practice: (Please tick)	**Adult**		**Child**	
Area of practice summary statement: (max 5 words eg. adult mental health, paediatric surgery, adult rheumatology, adult emergency medicine etc)				
Area of practice: Describe the patients that you care for and will be prescribing for; please provide as much detail as possible including details of clinical conditions, acute v chronic management, etc. *(continue on a separate attached document if necessary)*				
Independent or **Supplementary** prescribing or both?				
Will you be prescribing for inpatients? *(this includes writing discharge prescriptions)*				
Will you prescribe for outpatients? If yes, you will need to register with COPPS via link below* (*please make it clear that you are a Non-medical Prescriber when registering with COPPS*)				
Will you prescribe in primary or community care? If yes, you will need to register with NHS Wales Shared Services Partnership – Primary Care Services				
Have you arranged access to Welsh Clinical Portal (WCP)? If not, please speak to your Line Manager.				
Post-qualification supervision: Name and signature of person who will provide post qualification supervision for you	Name: Signature:			

*** link for registering with COPPS:**

Authorisation:

The above details have been discussed and agreed. **NB:** It is understood that it is the responsibility of the **prescriber**, in discussion with the line manager, to ensure that prescribing competencies are maintained.	
Name of prescriber:	
Signature of prescriber:	
Date:	
I have checked that the post-holder has the necessary qualification, is registered with their professional body as a prescriber, and that there is a service need for their role as a non-medical prescriber in the given clinical area.	
Name of Line Manager:	
Designation of Line Manager: (*NB for nursing staff this will need to be countersigned by Lead Nurse if Line Manager is not in an equivalent or Lead Nurse role*)	
Signature of Line Manager:	
Signature of Lead Nurse (*if necessary – see above*):	
Date:	

Scope of Practice Statement reviewed by the appropriate signatory (according to professional group) and approved for entry onto [redacted] Register of Non Medical Prescribers. (*Signatories:* [redacted] *Director of Nursing /* [redacted] *Pharmacist / Executive Director of Therapies and Health Sciences*)	
Reviewed and approved by - name:	
Designation:	
Signature:	
Date:	

Pharmacy Admin Use Only	
Date Scope of Practice received:	

Date entered / updated on [redacted] NMP Register:	
Date post-holder contacted to confirm entry / update [redacted] NMP Register:	

In order to remain on the [redacted] NMP register all non-medical prescribers must complete this review annually with their line managers as part of their [redacted]. A signed copy of the final page (declaration) must be submitted to Pharmacy immediately following the review.

An updated signed copy of your Scope of Practice (SOP) statement must also be submitted to Pharmacy every 3 years as a minimum **and** also if any aspect has changed during the 3 year period. Please ensure that you use the most up-to-date SOP paperwork by accessing the document [redacted] using the link below (or contact Pharmacy):

Prescriber details:

Name of Non-Medical Prescriber (NMP):	Job title:
Profession:	Department:
Directorate:	[redacted]
Professional Registration number:	Registration as a Prescriber with Regulatory Body confirmed by Line Manager (LM) (*Check registration website*): LM signature:…… date:……..
Registration as NMP with [redacted] confirmed by email from Phamacy Line Manager signature:……. date:……..	Date Scope of Practice last submitted to Pharmacy? (*if more than 3 years, you will need to urgently submit an updated/revised signed copy of your Scope of Practice statement – see above*)
Does your current Scope of Practice accurately reflect your prescribing role? Yes / No (*if no – you will need to submit a revised Scope of Practice statement – see above*)	

NB It is the responsibility of the Non-Medical Prescriber to complete a new Scope of Practice statement immediately if any changes occur at any time e.g. change of role or clinical area

Review of prescribing practice:

Are you currently using your NMP qualification?	**Yes / No**
If yes: please review your current Scope of Practice Statement and confirm that this accurately and completely describes how you are using your prescribing qualification (see declaration below). If your Scope of Practice Statement is not an accurate description of your current prescribing practice please update your scope of practice immediately – this needs to be done before signing the declaration below.	**If no:** please notify pharmacy that you are no longer an active prescriber. This status needs to be confirmed annually (as a minimum). **NB:** Please refer to UHB NMP Governance Framework for guidance if you have been inactive for 12 months or more and wish to become an active prescriber again.

Required evidence of competence:	**Line manager signature**
6 prescribing logs which have all been discussed with own Designated Prescribing Practitioner (DPP) or another suitable DPP	
Minimum of 1 written prescribing related reflection which has been reviewed and signed by a DPP or line manager if they are a NMP	
Discussion of current prescribing practice during annual appraisal with line manager	

Details of clinical supervision which has been provided to you in the previous 12 months:

Details of continued professional development (CPD) related to prescribing which you have undertaken in previous 12 months (this should include some peer review and may also include copies of completed CPD/revalidation records):

Non-Medical Prescribers who have qualified in previous 12 months are required to maintain an action log of their practice and this should be reviewed during an annual appraisal:

Line Manager signature:……. date:……..

NB Please send a copy of this page only to

Prescriber declaration:

I confirm that:

1. My current Scope of Practice Statement accurately and completely describes how I am using my prescribing qualification
2. I regularly keep up to date with best practice within my scope of practice and have undertaken prescribing related CPD to maintain my competence
3. I have completed 6 prescribing logs and discussed each log with my DPP or another suitable DPP
4. I have completed one written reflection which has been discussed with a DPP
5. I will send a signed copy of this 'prescriber declaration' to pharmacy (immediately following this review meeting and hold one copy of this annual review in my professional portfolio.

Signature of Non-Medical Prescriber:	Date:

Line manager confirmation: (Lead Nurse, Head of Service, Directorate Pharmacist – according to profession of NMP)

I confirm that:

1. I have reviewed the evidence provided by the named prescriber as part of an annual appraisal process and that I support this individual continuing to prescribe in their current role
2. I will place a signed copy of this form on the individual's personal file

Line Manager Name:	Line Manager Signature:	Date:

Appendix F

The following are the participant information leaflets and consent form for the participants in this study.

Advanced nurse practitioner participants

Participant Information Sheet

Study Title: Surfacing the practice tensions of the Advanced Nurse Practitioner; A situational analysis of how ANPs manage and reconcile role ambiguity.

Dear Colleague,

As an Advanced Nurse Practitioner, you are being invited to take part in a study. Your participation in this study is entirely voluntary. Before you decide to participate it is important that you understand why the work is being undertaken and what it will involve. Thank you for reading this information.

What is the purpose of the study?

The Advanced Nurse Practitioner (ANP) role has evolved over recent times and although there are recognised definitions and frameworks for education and practice, the reality is that the role is not widely understood. ANP's have generally been employed to fill gaps within medical rotas, this has led to role confusion and several challenges to the way in which the ANP practices. Previous studies have identified concerns associated with role substitution, clinical decision making, education and supervision. There are also several studies identifying increased patient satisfaction with their care and the safety of ANP's in their clinical practice. The purpose of this study is to understand how ANP's fulfil their role in a large organisation.

Aim of the study

The aim of this study to explore and understand the way in which ANP's manage to fulfil their role and reconcile role ambiguity within a large organisation.

Why have I been chosen?

You are invited to participate in this study as you are or training to be an ANP. As such you can provide a unique insight into how the role works within a large organisation.

Do I have to take part?

It is up to you to whether or not to take part in this study. You will be given more than 24 hours to consider whether you wish to participate or not. You are free to withdraw

at anytime and without giving a reason. Should you chose to withdraw from the study then any data generated may be excluded.

What will happen to me if I take part?

If you decide to take part, you will be invited to participate in a focus group to discuss your experience of being an ANP. The focus group will be digitally audio recorded, and notes will be taken. These meetings will last no more than an hour. When data has been analysed you may be contacted to clarify any information shared if required.

Will my taking part in this study be confidential?
The data will be anonymised. All information collected during the course of the study will be kept strictly confidential and secured against unauthorised access. Data will be held and processed in the strictest confidence, and in accordance with the Data Protection Act (2018). General Data Protection Regulation (2016) principles will also be adhered to.

What will happen to the results of the research study?
At the end of the study the findings will form the thesis for my Professional Doctorate in Advanced Healthcare Practice. The findings will also be published in academic journals and presented at relevant conferences. No identifying information about you or your practice will be included in any reports or papers. In line with university policy, data collected for the purposes of this study will be kept securely at Cardiff University for 10 years before being destroyed.

What if there is a problem or something goes wrong?
If you have a concern or complaint about the way you have been dealt with during the study or any possible harm you might suffer, you should speak to me as the principle investigator in the first instance and I will do my best to answer your questions.

If as part of the focus group there are any concerns identified or raised regarding professional practice the Principal Investigator will discuss the action required at the time of disclosure

If you remain unhappy and wish to complain formally, you can do so by contacting the School of Healthcare Sciences Director of Research Governance [redacted]

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against Cardiff University but you may have to pay your legal costs.

Ethical Review
This project has been subject to ethical review by the School of Healthcare Sciences Ethics Committee, Cardiff University, and has been allowed to proceed.

Contact for further information

If you have any questions regarding this study please contact [redacted] (Principle Investigator), using the telephone number or email provided at the bottom of this sheet.

Thank you for taking the time to read this information.

[redacted]

Other participants information leaflet.

Participant Information Sheet

Study Title: Surfacing the practice tensions of the Advanced Nurse Practitioner; A situational analysis of how ANPs manage and reconcile role ambiguity.

Dear Colleague,

You are being invited to take part in this study as you have experience of working or supervising an Advanced Nurse Practitioner. Your participation in this study is entirely voluntary. Before you decide to participate it is important that you understand why the work is being undertaken and what it will involve. Thank you for reading this information.

What is the purpose of the study?

The Advanced Nurse Practitioner (ANP) role has evolved over recent times and although there are recognised definitions and frameworks for education and practice, the reality is that the role is not widely understood. ANP's have generally been employed to fill gaps within medical rotas, this has led to role confusion and several challenges to the way in which the ANP practices. Previous studies have identified concerns associated with role substitution, clinical decision making, education and supervision. There are also several studies identifying increased patient satisfaction

with their care and the safety of ANP's in their clinical practice. The purpose of this study is to understand how ANP's fulfil their role in a large organisation.

Aim of the study

The aim of this study to explore and understand the way in which ANP's manage to fulfil their role and reconcile role ambiguity within a large organisation.

Why have I been chosen?

You are invited to participate in this study as you have experience of working or supervising an Advanced Nurse Practitioner. As such you can provide a unique insight into how the role works within a large organisation.

Do I have to take part?

It is up to you to whether or not to take part in this study. You will be given more than 24 hours to consider whether you wish to participate or not. You are free to withdraw at anytime and without giving a reason. Should you chose to withdraw from the study then any data generated may be excluded.

What will happen to me if I take part?

If you decide to take part, you will be interviewed to discuss your experiences of working with or supervising an ANP. The interview will be digitally audio recorded and notes will be taken. These meetings will last no more than an hour. When data has been analysed you may be contacted to clarify any information shared if required.

Will my taking part in this study be confidential?

The data will be anonymised. All information collected during the course of the study will be kept strictly confidential and secured against unauthorised access. Data will be held and processed in the strictest confidence, and in accordance with the Data Protection Act (2018). General Data Protection Regulation (2016) principles will also be adhered to. Should there be any disclosures during the interview that raise concerns about patients care or professional conduct then this may need to be addressed outside of the interview and then confidentiality will be waived.

What will happen to the results of the research study?

At the end of the study the findings will form the thesis for my Professional Doctorate in Advanced Healthcare Practice. The findings will also be published in academic journals and presented at relevant conferences. No identifying information about you or your practice will be included in any reports or papers. In line with university policy, data collected for the purposes of this study will be kept securely at Cardiff University for 10 years before being destroyed.

What if there is a problem or something goes wrong?

If you have a concern or complaint about the way you have been dealt with during the study or any possible harm you might suffer, you should speak to me as the principle investigator in the first instance and I will do my best to answer your questions.

If as part of the focus group there are any concerns identified or raised regarding professional practice the Principal Investigator will discuss the action required at the time of disclosure

If you remain unhappy and wish to complain formally, you can do so by contacting the School of Healthcare Sciences Director of Research Governance [redacted]

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against Cardiff University but you may have to pay your legal costs.

Ethical Review
This project has been subject to ethical review by the School of Healthcare Sciences Ethics Committee, Cardiff University, and has been allowed to proceed.

Contact for further information
If you have any questions regarding this study please contact [redacted] (Principle Investigator), using the telephone number or email provided at the bottom of this sheet.

Thank you for taking the time to read this information.

[redacted]

Consent form

IRAS ID: 270009

Centre Number:

Study Number:

Participant Identification Number for this study:

CONSENT FORM

Title of Project: Surfacing the tensions inherent in the Advanced Nurse Practitioner role. A situational analysis.

Name of Researcher: [redacted]

Please initial box

1. I confirm that I have read the information sheet dated.26.10.19 (version 4) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. ☐

3. I understand that the focus group/interview (delete as required) will be recorded using an audio digital recorder. The recording will be deleted once the interview has been transcribed ☐

4. I understand that direct quotes may be used but every effort to protect my identity will be taken ☐

5. I understand that the data collected will be anonymised and may be shared and discussed with the supervisors of the research project and with group of qualitative researchers (DataBee Hive at Exeter University) as part of the analysis. ☐

6. I understand that any issues discussed that are not in keeping with professional conduct may need to be addressed through professional management routes. ☐

7. I agree to take part in the above study.

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature