



Whole systems approach: Advanced Clinical Practitioner development and identity in primary care

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3 **Whole systems approach: Advanced Clinical Practitioner development and identity in**
4 **primary care.**
5

6 **Abstract**
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8 Purpose
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10 The purpose of this paper is to ascertain primary care Advanced Clinical Practitioners' (ACP)
11 perceptions and experiences of what factors influence the development and identity of ACP
12 roles, and how development of ACP roles that align with Health Education England's
13 capability framework for advanced clinical practice can be facilitated in primary care.
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15 Design/methodology/approach
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17 The study was located in the North of England. A qualitative approach was used in which 22
18 staff working in primary care who perceived themselves to be working as ACPs were
19 interviewed. Data analysis was guided by Braun and Clarke's (2006) six phase method.
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21 Findings
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23 Five themes emerged from the data – the need for: a standardised role definition and
24 inclusive localised registration; access to/availability of quality accredited educational
25 programmes relevant to primary care and professional development opportunities at the
26 appropriate level; access to/availability of support and supervision for ACPs and trainee
27 ACPs; a supportive organisational infrastructure and culture; and a clear career pathway.
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29 Originality/value
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31 Findings have led to the generation of the Whole System Workforce Framework of
32 INfluencing FACTors (IN FACT), which lays out the issues that need to be addressed if ACP
33 capability is to be maximised in primary care. This paper offers suggestions about how IN
34 FACT can be addressed.
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36 Keywords: Workforce, workforce planning, primary care, advanced clinical practice, nursing,
37 allied health professional
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39 Paper type: Research paper
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Introduction

The challenges that primary care is facing have been well documented. Issues include increasing demand on primary care services to support an ageing population with growing numbers of older people living with complex multi-morbidities and frailty (Barnett *et al.*, 2012a; NHS England, 2014; NHS England, 2019). In addition, the primary care sector is faced with increasing budgetary and organisational pressures (Fawdon and Adams, 2013), rising demand and increased patient expectations (Williams, 2017), and continuing problems with staff shortages, particularly general practitioner (GP) shortages (NHS England, 2019). The Centre for Workforce Intelligence (CFWI, 2014) identified that the existing GP workforce did not have sufficient capacity to meet current and expected patient needs. The *Five Year Forward View* (NHS England, 2014) suggested radical changes to current care models, which would support out of hospital care and the integration of health and social care. In response, the *General Practice Forward View: GPFV* (NHS England, 2016) aimed to support general practice with a strategy that included creating 5,000 additional doctors and at least 5,000 non-medical staff working in general practice by 2020/21, and investing in development programmes for practice nurses and administration staff. The focus on primary care continues in the recently published *NHS Long Term Plan* (NHS England, 2019). This report proposes extending the skills of registered professionals and developing advanced clinical practitioner (ACP) roles. These changes aim to mitigate some of the challenges of an overloaded GP workforce, offering opportunities for improved patient centred care, organisational efficiencies, and rewarding careers for health professionals.

Currently, ACP roles are utilised in a number of ways within primary care. NHS Digital (2018a) data for general and personal medical services suggest GP practices employ ACPs with nursing, pharmacy, physiotherapy, and paramedic backgrounds. These staff primarily provide care for presenting patients from initial clinical assessment to diagnosis, treatment and evaluation of care (Swan *et al.*, 2015). Clinical Commissioning Groups (CCGs) and NHS Trusts employ ACPs as nurse consultants, extended practice physiotherapists, and advanced practitioner speech and language therapists (SALTs). Occupational therapists, dieticians and opticians working as advanced practitioners are increasingly being employed (NHS Digital, 2018b). These CCG/NHS Trust employees are expert clinicians, lead the development of non-medical led services, and lead service improvement and service transformation initiatives (Chartered Society of Physiotherapy, 2016; Pottle, 2018).

Literature review

A number of studies suggest the development of non-medical advanced practice roles in primary care is a response to medical staff shortages resulting from difficulties in recruitment

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3 and retention (Delamaire and Lafortune, 2010; Barton *et al.*, 2012a; Williams, 2017). These
4 authors suggest that to a large extent, the introduction of these roles involves a substitution
5 of tasks away from doctors, with the main aim being to reduce demands on doctors' time,
6 improve access to care, and reduce costs. Participants in Clay and Stern's (2015) study
7 *Making Time in General Practice* commissioned by NHS England, estimated that 27% of GP
8 appointments were potentially avoidable if the bureaucratic system operated differently. The
9 most common potentially avoidable GP consultations were where the patient would have
10 been better served by consulting someone else in the wider primary care team, for example,
11 an ACP. A number of studies identify the benefits of the ACP role. For example, systematic
12 reviews into the effectiveness of the ACPs in primary and community care services
13 undertaken by Begley *et al.* (2013), Donald *et al.* (2013) and Laurant *et al.* (2018) suggest
14 ACP care improves patients' functional, health and psychological status; improves rates of
15 patients' goal achievements, and increases levels of family-expressed satisfaction. Swan *et al.*'s
16 (2015) systematic review of the quality of ACP care delivery suggests that ACPs in
17 primary care settings perform as well as medical staff in terms of clinical outcomes and
18 patient satisfaction, but at a lower cost.

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Despite the benefits that can arise from ACP care, a number of challenges to the
development and effectiveness of the role have been identified. As highlighted above, the
development of advanced roles in primary care has been reactionary in nature. In addition,
in England, primary care is provided by a variety of health and social care providers
including GP practices (which are independent employers), NHS Trusts, private social care
providers and voluntary services. A number of studies suggest that these two factors have
led to difficulties in defining, further developing and valuing the role. Bryant-Lukosious *et al.*'s
(2004) evaluation of the implementation of ACPs identifies a range of problems relating to
these difficulties: inconsistency and confusion about job title terminology; lack of clear
definition in relation to role and objectives; and limited use of evidence-based approaches to
guide role development, implementation and evaluation. A decade later these issues remain
pertinent. Surveys and studies exploring ACP job titles and descriptions have identified
considerable variation (East *et al.*, 2015; Elliot *et al.*, 2016). Barton *et al.* (2012b) and
Fawdon and Adams's (2013) studies identified that recruitment to, and development of,
advanced roles is ad hoc. These authors argue that such role inconsistency and confusion
leads to inefficiencies in care, inconsistencies in levels of competency, duplication in care
activities, ineffective professional relationships, and undeveloped career structures and
pathways.

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3 A number of suggestions have been made about how to address inconsistency in ACP roles
4 and competence. For example, some organisations have attempted to define the role. The
5 International College of Nursing (2008) focusing specifically on nurses, rather vaguely
6 defines the role as:
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11 *A registered nurse who has acquired the expert knowledge base, complex*
12 *decision-making skills and clinical competencies for expanded practice, the*
13 *characteristics of which are shaped by the context and/or country in which s/he is*
14 *credentialed to practice.*
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16 In England, more recent definitions have been extended to include descriptions of expected
17 practice levels, and minimum education standards. For example, DH policy statements
18 expect that ACPs will have successfully achieved Master's level education (DH, 2010).
19 Pearce and Breen (2018) provide a definition of ACP identifying that:
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23 *Advanced practice is a level of practice, rather than a type of speciality of*
24 *practice...advanced clinical practitioners (ACPs) are educated to Master's level*
25 *and are assessed as competent in practice, using expert knowledge and skills.*
26 *They have the freedom and authority to act, making autonomous decisions.*
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28 By setting out clear frameworks for Master's level education, and emphasising autonomous
29 practice, these definitions suggest ACP roles are not substitutes for medical care, but roles
30 that enhance services.
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33 Other organisations provide further clarity about the nature of 'expert knowledge and skills'.
34 The DH's (2010) benchmark for advanced level nursing comprises of 28 elements grouped
35 under four themes – clinical/direct care practice; leadership and collaborative practice;
36 improving quality and developing practice, and developing self and others. Health Education
37 England's (HEE) (2017) definition is similar in many respects to these definitions, but
38 highlights the multi-professional potential of the role:
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44 *Advanced clinical practice is delivered by experienced, registered health and*
45 *care practitioners. It is a level of practice characterised by a high degree of*
46 *autonomy and complex decision making. This is underpinned by a master's level*
47 *award or equivalent that encompasses the four pillars of clinical practice,*
48 *leadership and management, education and research, with demonstration of core*
49 *capabilities and area specific clinical competence.*
50

51 These statements and definitions advocate for agreed standards for ACP as a way forward.
52 In England, the question of registration of the role, however, has been the subject of long-
53 standing debate. From a nursing perspective, Barton *et al.* (2012a) identify that UK
54 regulatory debates have continued over decades, Ward and Barratt (2005) highlighted
55 continued interest in this area, and the Nursing and Midwifery Council (NMC) has called for
56 consultation (Royal College of Nursing (RCN) 2010). However, ACPs as part of the NMC
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3 and Health and Care Professions Council (HCPC) registers has remained unrealised. Barton
4 *et al.* (2012a) suggest that registration is unlikely and potentially unworkable, and propose
5 advanced practitioners represent no greater public risk than new registrants, therefore, a
6 separate part of the register would hold little benefit. Nevertheless, concerns about lack of
7 registration remain. This has resulted in a number of suggestions about how to regulate the
8 role in the absence of national registration. Barton *et al.* (2012b) and East *et al.* (2015)
9 highlight the use of governance via local NHS regulation, and the use of integrated health
10 education boards. In England, the RCN (2018) has developed the notion of 'credentialing',
11 where practitioners can apply to be recognised as ACPs via an on-line application, but this is
12 not universally recognised as a means of regulation.
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20 Achieving a standardised role definition is not the only challenge in the development and
21 implementation of the ACP role in primary care. Kennedy *et al.* (2015) note wide variation in
22 ACP education programmes offered by universities. These authors propose that such
23 variation exacerbates inconsistencies in ACP competency levels, and preparedness for the
24 role. Some studies have proposed that the role is only effective where service design as a
25 whole is supportive. Imison *et al.* (2016) caution that careful attention to service design,
26 executive level commitment to incorporating ACP roles within business/workforce planning,
27 and effective education, training and commissioning processes are essential. The authors
28 propose that without these, new and extended roles will simply supplement the existing
29 workforce, rather than leading and managing care; cost rather than save; threaten the quality
30 of care; and fragment care. Miller *et al.*'s (2009) evaluation of ACP roles, and the West
31 Midlands' ACP framework (HEE, 2015) also emphasise the importance of executive support
32 and a team approach when introducing new advanced roles, particularly if roles are to be
33 standardised, sustainable and impact positively on service outcomes.
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43 Previous literature suggests that the inclusion of ACPs in primary care can enhance care
44 provision and alleviate some of the workload pressures on GPs. However, inconsistency and
45 confusion about the scope and competency of ACP activity has led to calls for
46 standardisation of the ACP role definition, and ACP education programmes and qualification
47 requirements; ACP registration, and executive level commitment to ACP development
48 processes. As few studies consider ACPs' perceptions and experiences of the factors that
49 influence the development and utilisation of the role in primary care settings, the aim of this
50 study was to explore these factors.
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56 This paper reports on an aspect of a wider study commissioned by Health Education
57 England to scope the profile and application of ACP in primary care in the North of England,
58 and identify any specific developments required to support ACP is to be effectively
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maximised 'at scale' within primary care. This article does not represent the study's findings in entirety, but presents the phase 2 aspect: ACPs' perceptions and experiences of what factors influence the development and identity of ACP roles, and how development of ACP roles that align with the 4 pillars of HEE's ACP capability framework can be facilitated.

Methods

For the study as a whole, a mixed methods approach was used. As phase 2 focused on exploring factors that influence the development of ACPs, a qualitative approach was taken for this aspect of the study.

Sample

The study location was the 3 HEE regions in the North of England (North West, Central North, and North East). During phase 1 of the study, an online survey was opened to staff working in primary care in these regions who perceived themselves to be working as ACPs. Due to the potential for variability in definitions and perceptions about what constitutes advanced clinical practice, purposive and snowball sampling was used. In total, 116 surveys were returned. All staff who completed the survey were invited to take part in an interview. Those agreeing to participate were requested to sign a consent form.

A total of 22 individuals agreed to participate in interviews. 91% were female; mean age was 49.1 years (SD=8.4 years); mean years qualified as a healthcare professional was 27 years (SD=9.8 years), and mean years working as an ACP since qualification was 13.5 years (SD=10.9 years). Table 1 provides details of participants' job groups, professional backgrounds, and employing sectors:

Table 1: Interview participants

INSERT TABLE 1 HERE

Data collection

Individual semi-structured interviews were carried out to explore participants' views and experiences of their ACP role. Topics covered during interviews were: professional and educational pathway to becoming an ACP, support required to achieve this, role activities in relation to the 4 pillars of the ACP framework, and barriers and enablers for future development. Participants were interviewed at locations chosen by themselves, and 15 chose to be interviewed at their work location, 3 were interviewed at the university, and 4 were telephone interviews. As all members of the research team were involved in

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3 interviewing, an interview schedule was used to maximise consistency in interview
4 approach.
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6 *Data analysis*

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9 Audio recordings were made of the interviews. Audio recorded data was transcribed
10 verbatim, then open coded by individual members of the research team. This allowed
11 elucidation and description of participants' experiences, while creating meaningful themes.
12 Thematic analysis was chosen as it is 'a method for organising, analysing and reporting
13 patterns (themes) within data. It minimally organises and describes data set in (rich) detail'
14 (Braun and Clarke, 2006, p.79). The approach taken was inductive, in other words the
15 analysis was data-driven, rather than theory-driven. The 6 phase guide to conducting
16 thematic analysis, as outlined by Braun and Clarke (2006) was used. During this process, all
17 transcripts were independently coded by another team member, and the outcomes were
18 compared with the original coding to validate themes.
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26 Research ethics approval to undertake the study was secured from the Faculty of Health and
27 Life Sciences, Northumbria University on 16 April 2018.
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31 **Findings**

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33 Findings from the study suggested that five factors had a significant influence. These were:
34 role definition; access to/availability of quality educational and professional development
35 opportunities; support and supervision, organizational culture and infrastructure; career
36 pathway. These factors are discussed below.
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41 ***Role definition***

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43 Participants' responses suggested that there is a lack of standardisation and consistency
44 with regard to the ACP role. They proposed that an ACP role definition is required that is
45 standardised across all sectors and organisations working in primary care, and that this
46 standard definition should be based upon a number of factors. For example, practitioners
47 need to be able to demonstrate a set of standardised advanced capabilities, if they are to be
48 assigned the ACP title:
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53 C2: There is such variation of skills in ACP, many working at different levels. If
54 we're trying to make it a consistent standard that people meet and adhere to,
55 then there's a consistency in practice and expectations.
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3 Some participants said that implementing this requirement would be difficult because ACPs
4 are employed in different sectors, professions and organisations. A number of participants
5 proposed that a solution to this problem would be regulation via registration of the role with
6 the NMC and HCPC:
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9 W1: I would want it to be the NMC that would do that...our regulatory body. It's
10 protection for people who are employing these people. People who are misusing
11 the title.
12

13 Participants also suggested that a standardised capability framework and regulation
14 would inform a standardised practice remit, job titles, and job descriptions for ACPs.
15 They identified that currently there is a distinct lack of standardisation in these areas,
16 resulting in problems such as varying remits, and confusion about remits and
17 capabilities. Some participants argued that this leads to inefficiencies in care because
18 the ACP role is not utilised to its full potential:
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23 W2: I don't think people really understand it...that the term clinical specialist
24 or nurse practitioner or practice nurse or non-medical prescriber, and
25 advanced practitioner...And the impact is that I work in one place and I do
26 all my referrals to consultants and two-week waits and things. And, in
27 another place that I work, they don't think that that's really my role to do
28 that, so it's less efficient.
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31 Findings indicated that practice remits, and job titles and descriptions are often driven by the
32 needs of individual employing organisations, rather than the ACP capability framework.
33 Many interview participants, particularly those employed in GP practices proposed that they
34 are primarily employed to ease the pressure on GPs affected by GP recruitment problems,
35 which leads to the perception that they are 'inferior GPs' (C3). Some participants said
36 because they are employed to 'fill clinical gaps' they are not required, or given opportunities
37 to practice advanced level skills in leadership, education or research:
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42 W2: It's frustrating. Certainly, all I do is clinical practice. Because I don't do any
43 leadership. I don't do much teaching. And I don't do any research. And we all
44 know that that is predominantly how nurses are used.
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47 The majority of interviewees were nurse ACPs employed in GP practices. Recruiting
48 participants from other professions and other sectors proved problematic. Participants who
49 were recruited from these areas suggested low response rates were perhaps due to: AHPs
50 not being regarded as ACPs, despite working to an advanced level, and can struggle to
51 acknowledge ACP status themselves; the perception that ACPs do not work in the private
52 sector.
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57 E6: It's not my title, and my husband, who is a nurse consultant, he said, "You're
58 not advanced clinical practice. That's a nurse consultant role". But actually, when
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3 I think about the four pillars...this is bread and butter for me. I am an advanced
4 clinical practitioner, but in some ways, I don't perceive it as that in my head [OT].
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6 E4: So, advanced practitioners to me are NHS and GP-based, not private sector [care
7 home manager].
8
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10 **Education**

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12 Participants discussed a number of challenges in education and development provision, for
13 example, ensuring education courses are available that support and underpin advanced skill
14 development. The majority of participants said that undertaking a formal programme of
15 education specifically constructed to develop students to become ACPs in primary care is
16 essential. The introduction of ACP Master's degree programmes that align with the HEE
17 ACP framework was welcomed by the vast majority of interviewees. Those who had
18 undertaken an ACP Master's degree programme felt that this had improved their critical
19 thinking and decision-making skills, and 'changed' their professional identity:
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26 W1: Master's level study is to critique evidence that is out there...And it's made
27 a difference to my practice. And it has changed the practitioner I am to when I
28 started the Masters - has changed.
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32 When asked about their views on the quality of educational and professional development
33 programmes they had accessed, participants expressed a number of concerns. Firstly, they
34 said that ACP study programmes offered by universities vary in quality, which they felt
35 impacts on the levels of care quality provided by ACPs undertaking these courses. To
36 address this, participants proposed that a standard ACP course should be offered by all
37 universities:
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40 E3: It needs to be absolutely standard....We talk about managing unwarranted
41 variation in all aspects of our care. I think this is no different.
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44 Participants reported that quality depends upon courses' relevance to practice. Some felt
45 that current provision does not always address the advanced level needs for ACP practice.
46 They also proposed that clinical skills development is most effective when relevant, practice-
47 based approaches are embedded in education. Some participants suggested that current
48 provision lacks this, leaving ACPs unprepared for the demands of their role:
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52 E8: The biggest issue is effective clinical development. Most courses fail to give
53 this because practice-based learning is often limited, time critical and therefore
54 not always sufficient to give the required depth of knowledge.
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57 Participants also commented upon education provision regarding the leadership and
58 research pillars. Again, they suggested this needs to be relevant to their everyday work, and
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3 to innovations and projects they would like to take forward. Participants felt that these
4 aspects are often omitted from courses that tend to be more theoretically-based:
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7 E2: It's helpful to know where to go to look for project management skills and
8 service development, would make much more sense than a purely academic
9 piece of research.
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12 A significant concern for participants was the limited relevance of current ACP education
13 provision to primary care. A number of participants reported that current provision includes
14 courses that are adapted versions of ACP secondary care courses that are already in
15 existence. These participants proposed that if primary care ACP education is to be
16 relevant, valuable and engaging, it has to be developed specifically with primary care in
17 mind:
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23 C1: You need whoever is running the course to be able to understand primary
24 care and be able to see how you give exemplars of what works in primary care
25 versus what works in secondary care. And I think that's been part of the
26 problem is that primary care has been left behind in training courses.
27

28 A major issue discussed was funding of education programmes. Participants said that while
29 funding for courses is available (for example, from HEE), backfill needs to be funded to allow
30 trainees to be released from their existing practice roles to enable them to take advantage of
31 learning opportunities. Many participants stated that backfill costs prohibited the expansion
32 of the ACP role in primary care:
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36 E3: The biggest challenge of developing ACPs is that people can't afford to
37 allow that person to become supernumerary, to be learning. You can't get
38 funding for a workforce thing. It's purely about the academic qualification that
39 they fund.
40

41 There were some instances where employers had negotiated with CCGs to provide backfill
42 funding. While this support was very much welcomed, participants explained that even
43 where funding for backfill is secured, it can be difficult to obtain because there is a dearth of
44 skilled staff to provide cover:
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47 E2: It's pointless saying to people "We'll give you backfill. We can pay for backfill."
48 Because people aren't sitting about waiting to pop in and fill in a gap.
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51 The inconsistency in the provision of CPD updates, in particular non-medical prescribing
52 (NMP) updates, was referred to during interviews. Participants felt that a more standardised,
53 formalised approach to updates is required, and that updates should occur regularly to
54 ensure ACP practice is safe and up-to-date:
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3 E9: Once you've got your qualification, there doesn't seem to be much
4 afterwards...I feel like we could do with more formal updates for non-medical
5 prescribers. Just to make sure that we're still practicing as we should be.
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8 **Support/supervision**

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10 Participants proposed that ACP development requires the support and supervision in
11 practice of allocated mentors/supervisors. They suggested that in order for
12 mentors/supervisors to provide adequate support, they need to be fully committed, and
13 need to understand what this role entails in terms of demonstrating, observing and
14 assessing practice, and the long-term commitment involved:
15
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17 C1: They need to understand what that might mean. That they might need to sit
18 in with the trainee ACP while they're practicing, as an observer. They may need
19 to be there, being the person who's being observed. They need some ability as
20 a mentor. And some understanding of the fact that this is a two-year thing.
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23 Some participants felt that supervision is not only about supporting clinical development,
24 but a means of providing support for staff coming to terms with a change in role, and the
25 uncertainty about professional identity that may bring:
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28 W2: An aspect of clinical supervision, that is seen to be most important is the
29 massive change that goes on when you're transitioning from nurse to ACP. We
30 do nothing to support people at an emotional and personal level, in how they go
31 through the evolution of coping with the change from being an ordinary nurse to
32 an ACP.
33
34

35 Many participants stated that it is essential to obtain the support of practice education
36 facilitators who have knowledge and understanding about ACP development programmes,
37 are skilled at facilitating teaching/learning within practice, understand and can address the
38 logistical and organisational challenges involved in practice learning, and can support both
39 students and mentors:
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43 E3: There's something about practice education facilitation, so you've got that
44 cover. And thinking about the relationship and support that management and
45 mentors need as well.
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48 **Organisation and culture**

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50 All participants reported that organisational and cultural factors have a significant impact on
51 ACP development and practice. The pressure on services in primary care, together with the
52 GP recruitment crisis, is a driver for ACP recruitment. Some participants suggested
53 recruitment of ACPs to 'fill GP gaps' can restrict ACPs' scope of practice to clinical activities.
54 These participants proposed that a hierarchical culture operates in primary care, whereby
55 GPs are perceived as business/practice/clinical leaders, and the only option to manage
56 complex clinical cases. Some participants said this leads some GPs to feel 'threatened' by
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3 ACPs, which can result in GPs' reluctance to allowing ACPs scope to work at their full
4 potential. They also said that this situation is unlikely to change unless GPs are willing to
5 change how care is organised and delivered:
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8 C4: And there was loads of them that had seen a GP that actually could've seen
9 an ACP nurse or physio, or pharmacist. But I think the doctors don't want to give
10 up their role. So, there's a reluctance from GPs to change.
11

12 Other participants suggested the problem lies less with hierarchical culture, and more with
13 employers' lack of understanding or recognition of the scope or benefits of the ACP role in
14 care delivery. These participants felt that until employers are properly conversant with the
15 scope of the role, opportunities to utilise its full scope would be limited:
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19 E8: There needs to be some focus on increasing the understanding and
20 appreciation of ACP roles across the wider system to ensure that the scope of
21 the job is recognized.
22
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24 Many of the factors influencing the development and practice of ACPs that were discussed
25 by participants concerned system-wide, organisational infrastructure challenges. For
26 example, cross-organisational ACP referral procedures are inconsistent leading to
27 inefficiencies in practice. While some NHS Trusts and departments accept ACP referrals,
28 others do not:
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32 E9: Some of the barriers come from secondary care in some don't like referrals
33 from us. They like referrals from GPs.
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36 Participants working in the private social care sector and voluntary sector proposed that a
37 major difficulty in initiating development of ACPs outside of the NHS is the need for NHS/GP
38 medical support. They explained that the challenges of obtaining agreement for cross-sector
39 support in the current climate prohibits this development:
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42 E9: I just don't know it would be achieved. Who would be able to provide them
43 with the relevant support...that's where we, from a care home perspective, would
44 really struggle.
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47 A few participants proposed that wholesale organisational system change is required if
48 ACPs are to be developed to meet standardised capabilities, have standardised role
49 definitions, receive comprehensive support, and practice to their full potential. This would
50 involve a move away from individual GP practice businesses to large primary care
51 employing organisations. The following interviewees proposed that the current GP led
52 system is too diverse, reactive and inconsistent to offer a standard quality service that is
53 both effective and efficient:
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59 E3: We haven't moved from general practice to primary care, and we have to
60 move to primary care. I go into every forum now to say if you don't think of primary

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3 care as an organisation in a system, that needs the same kind of logistical set up
4 as big Trusts have - we're finished.
5

6 **Career pathway**

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8 During interviews, participants were asked how they became ACPs in primary care.
9 Although many suggested that there was an appetite for development opportunities, the
10 majority of participants said that there is no clear career pathway for ACPs in the primary
11 care sector. For many participants, career development was a reactive process to address
12 local need. For example, many were directed towards the role specifically to address gaps in
13 service. For many participants, career development was a reactive process to address
14 local need. For example, many were directed towards the role specifically to address gaps in
15 service:
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18 W3: I'd worked in the practice for nearly 30 years, then at the time there was a
19 shortage of GPs and there was funding, so I was nudged in that direction.
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21 Others had moved into primary care after long careers in secondary care. These
22 participants often commented that this move was a kind of 'winding down'. One interviewee
23 'fell into the role' when looking for post-retirement opportunities:
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26 E8: I fell into the role by accident, retired from an NHS role and actually
27 through visiting my own GP surgery and seeing the nurse there thought it
28 would be interesting.
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31 Phase 1 of the study indicated that in primary care, many ACPs are reaching or considering
32 retirement. In addition, the responses cited above show that the ACP primary care role may
33 not be perceived as a dynamic role, or a career goal in its own right. Many participants were
34 concerned that this would result in: gaps in the ACP workforce in the near future because
35 there is no structured succession plan; a depletion of other parts of the workforce as staff are
36 moved into ACP roles to fill that gap; staff who have 'fallen into' ACP roles not having the
37 advanced level skills required to manage an ageing population with complex needs. Most
38 participants expressed the opinion that in order to address these problems, more needs to
39 be done to develop a clear career pathway. Many said that having the ACP framework was a
40 good start, but that other factors need to be considered too, for example, developing a
41 pathway requires an infrastructure, funding and organizational processes to facilitate skilled
42 backfill, and learning support in practice in order to provide a sustainable professional
43 development 'flow'. Many participants stated establishing a career pathway and an ongoing
44 professional development 'flow' would be best facilitated by a nationally recognised career
45 framework. They also suggested that currently, ACP level practice is the most nurses and
46 AHPs can expect to achieve in clinical primary care, but a formalised, standard national
47 career framework, which prescribes a career pathway, would enable development beyond
48 ACP:
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4 C5: At present once you are an ACP, you are perceived to be at the top of your
5 clinical career path. Surely we should be seeing this is the initial stepping point to
6 progression as a “General Clinical Practitioner” for those that want to progress. I
7 would hope that one day these individuals are given a career pathway to support
8 this.
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10 11 12 **Discussion**

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14 Findings from the study suggest that a number of factors influence the development and
15 practice of ACPs in primary care settings, and ACP professional identity. These are not
16 limited to access to, and quality of, education but reflect the need for a ‘systems thinking
17 approach’ as findings demonstrate a need to address role definition, supervision/support
18 requirements, organizational infrastructure and culture factors, and career progression, as
19 well as education. Table 2 summarizes the findings of the study and highlights the
20 influencing factors (IN FACT framework) that should be considered if ACPs in primary care
21 to be effectively maximized at scale:
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28 **Table 2: IN FACT framework**

29 INSERT TABLE 2 HERE
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33 **Role Definition**

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35 Fundamentally, findings from this study have identified that a major challenge for ACPs in
36 primary care is negotiating and navigating their professional identity, and their professional
37 boundaries and development, where there is a system-wide lack of understanding or
38 recognition of the scope or benefits of the ACP role in care delivery. This lack of
39 understanding may result from a perception of ACPs as ‘gap fillers’, and confusion, in the
40 absence of a standard definition, about what the remit of ACP actually is. Findings also
41 identified that AHPs and staff from the private and voluntary sector are less likely to be
42 recognised as ACPs, even if they have extended practice roles. This can impact in various
43 ways. ACPs working in GP practices suggested their practice is restricted and professional
44 boundaries are reduced. Their expectations of what ACP working is are therefore not
45 realised, nor are they working at their full potential – something which they found frustrating.
46 Their response reflects Hackman and Oldman’s role characteristic model (Hackman and
47 Oldham, 1980, Devaro et al., 2007), which proposes that such circumstances impact on
48 occupational identity and job satisfaction. The model supposes that job satisfaction results
49 from individuals’ abilities to perform the work characteristics which they perceive to be
50 intrinsic to their role. The performance of expected characteristics associated with any role
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3 increases job satisfaction because there is a link between expectations regarding role and
4 feelings of personal meaningfulness. When the actuality of the role does not equate with
5 expectations, then job satisfaction is diminished, and role identity becomes uncertain. On the
6 other hand, ACPs employed by the private and voluntary sector, and those with AHP
7 backgrounds, 'internalised' the lack of understanding about their ACP status to the extent
8 that they did not always recognise themselves as ACPs. This may be a consequence of
9 interpellation, defined for example, by Althusser (1971), as the process by which a social
10 situation precedes or produces an individual's sense of their own identity. Only by changing
11 the social situation, in this case by clearly promoting ACP as inclusive and broad, can this be
12 rectified.
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20 Findings indicate other possible contributing factors to restrictions in ACP practice are at
21 play. For example, negotiating differing agendas generates a tension for ACPs, particularly
22 those working in GP practices. This group of participants acknowledged their role in 'freeing
23 up GPs', as intended by the *GP Forward View*. However, they also proposed GPs can be
24 reluctant to relinquish aspects of their role other than 'routine' clinical practices. It may be
25 that some GPs resist any role overlap, as an incursion on their own professional identity and
26 boundaries. This can lead to the creation of a hierarchy of practice whereby leadership,
27 education, research and complex clinical practice become the remits of medics, and the
28 scope and career progression of ACP practice is restricted, and potentially undervalued.
29 Judge *et al.* (2000) suggest restricting complexity within occupational roles can impact on
30 individuals' self-concept. Complex activities are more likely to require and encourage skill
31 improvement, interest and innovation, aspects which promote feelings of fulfilment and
32 positive self-concept. Furthermore, ACPs undertaking restricted practice fails to
33 acknowledge the strategic plan (NHS England 2015; 2019) to develop primary care and out
34 of hospital services to meet the changing demographics.
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46 **Organisational system change**

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48 Some participants argued for wholesale organisational system change if ACPs are to be
49 developed to meet standardised capabilities, have standardised role definitions, receive
50 comprehensive support, practice to their full potential, and have opportunities for career
51 progression. These participants proposed radical system change, involving a move away
52 from individual GP practice and private businesses to large primary care employing
53 organisations, in which ACPs would work alongside a range of professionals. Robertson *et*
54 *al.*'s (2016) report on clinical commissioning for the King's Fund, to some extent supports
55 this finding. The report proposes that effective, efficient primary care that is consistently of a
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3 high quality, requires an integrated organisation of care delivery including 'scaled up' forms
4 of care. In GP practice in England, scaling up is generally achieved via federation working. In
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6 2008, the Royal College of GPs (RCGP) published its plan for primary care federations. In
7
8 this plan, federations were viewed as a method of offering extended services, strengthen
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10 links with other primary care services, and redesign services to be closer to patients. There
11
12 was no mention of plans for ACP utilisation at scale. The NHS *Five year Forward View*,
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14 proposed future care models including multi-speciality community providers (MCP). MCPs
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16 offer federations the potential to integrate with community services to create a broader,
17
18 resilient type of general practice with a single whole population budget. Plans and
19
20 recommendations for the development of MCPs and federations recognise that they could
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22 facilitate flexible and adaptable workforce models, and centralisation and standardisation of
23
24 workforce development (Connor, 2016; NHS England, 2016). However, these
25
26 recommendations do not make clear whether these new models should include plans for
27
28 ACP practice. In this study, participants who suggested the GP model was restrictive were
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30 employed in federation and non-federation practices. This suggests that the utilisation of the
31
32 full ACP potential at scale is less about the size of the employing organisation, and more
33
34 about employment and workforce development strategies.

31 **Access to professional development programmes**

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33 Findings suggest education level and professional registration can influence role identity and
34
35 development of ACPs. Professional registration and having a Master's qualification were
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37 viewed as integral to being an ACP. This reflects Beddoe's (2010) work, which suggests
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39 professional registration and qualifications support standardisation of practice and facilitate
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41 safe, effective care, but also generate professional capital, recognition, understanding and
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43 value for the role from the perspectives of both the individual practitioner, and the society in
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45 which they work. The question of registration has been the subject of debate for several
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47 years. Critics of registration with professional bodies propose it is unnecessary and
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49 unworkable, because ACPs are already registrants therefore do not represent any greater
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51 risk to the public than non-ACPs (Barton *et al.*, 2012a). In the absence of national
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53 professional registration, East *et al.* (2015) propose local NHS regulation. However, NHS-
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55 held registers would not account for ACPs working in the private and voluntary sectors.

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57 While participants welcomed the advent of a requirement for a Master's degree, some
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59 proposed having a Master's qualification in itself is not enough. This is because a tension
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exists between being 'educated to Masters level', and 'how staff are educated to Masters
level'. Lack of standardisation of programmes leads to differentials in ACP capability, but
also findings indicate that current Master's education is not practice-based enough, in that

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3 education (particularly research and leadership) focus on theory and philosophies that do not
4 sit well with practical project management/service improvement that are expected of the ACP
5 role. In addition, participants were concerned that ACP programmes do not adequately
6 address the requirements of primary care. While this can be detrimental to the quality of
7 primary care specific competency development, it also suggests that primary care is not
8 acknowledged as an area requiring advanced practice skills in its own right. According to
9 Beddoe (2013), areas of practice are devalued where there is such absence of professional
10 recognition.
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17 For participants, supervision and support within the working environment are integral to ACP
18 competency development, but also to supporting a sense of role identity. Illeris (2014),
19 extended Mezirow's (2000) work on transformational learning and argued that learning and
20 competency development are psychosocial processes, not simply cognitive processes. As
21 such, identity both influences, and is influenced by, interaction between the individual and
22 the social environment in which learning and development takes place. For Illeris (2014),
23 lack of this interaction can lead to a poorly developed sense of identity resulting in
24 practitioners learning 'tasks', rather than fulfilling 'role' – in this case, clinical skills rather than
25 fulfilling the role remit as perceived in the ACP literature.
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33 Some previous approaches include methods that may be useful in addressing these factors.
34 For example, the West Midlands ACP framework (HEE, 2015) has standardised the ACP
35 role across England's West Midlands region via engaging all healthcare and university
36 stakeholders in the development and incorporation of the ACP role into organisations. The
37 West Midlands' model also acknowledges the benefits of practice-based education, and
38 supervision and support networks by integrating formal clinical supervision and team support
39 into its workforce development approach. A difficulty with the West Midlands model,
40 however, is that in aiming for standardisation, paradoxically it is perhaps too generic, and in
41 need of consideration and adaptation for the primary care context. In this study, a major
42 concern of participants was that current ACP development approaches are grounded in
43 secondary care approaches, and are not relevant enough for primary care requirements.
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51 Standardisation of programmes can be achieved through commissioning and greater
52 awareness, and use of, apprenticeships, although this would require aligning ACP study
53 programmes with national apprenticeship standards. The apprenticeship model could be
54 useful as a means to support provision of effective learning environments, as learning would
55 be practice-based, which participants proposed was the most effective method of ensuring
56 learning is relevant to their development needs. Also, contractually, apprenticeships would
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3 commit the required resources to provide practice-based support and supervision that is of a
4 standardised, high quality. Apprenticeships do not on their own address some of the other
5 problems highlighted in the study, for example, lack of understanding about the role and
6 remit of ACPs, and difficulties in cross-organisational working.
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10 11 **Career Progression**

12 Findings show that career progression opportunities for ACPs are limited and inconsistent,
13 and there is no clear ACP career pathway, or opportunities to develop beyond the ACP role.
14 Barton *et al.* (2012b) proposes that this is to be expected in circumstances where there is no
15 standard role definition, job title or job description. Findings indicate the lack of career
16 pathway can adversely influence professional identity and as well as professional
17 development, as the situation means staff often drift into the role reactively to 'fill gaps', or
18 take on the role as a means of 'winding down' their careers. Bern-Klug *et al.* (2003) suggest
19 that a number of worker 'types' exist, including 'inheritors' – workers, such as some
20 participants in this study, who enter an occupation because they have inherited a position, or
21 because they have settled for any position. The authors argue that if an occupation's
22 workers are primarily 'inheritors', then occupational status is lowered, and the occupation
23 becomes an unattractive employment prospect
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33 **Recommendations**

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35 During the discussion, proposals have been suggested to address the requirements of the IN
36 FACT framework, but these may be insufficient, as none address the system in its entirety. A
37 potential whole-system strategy could be the development of primary care workforce
38 development hubs, which are employing organisations funded by health education
39 commissioners (in England, this would be HEE), as a means to facilitate standardisation of
40 workforce development. In this model, the hub would take on responsibility for developing
41 capacity for practice-based learning and assessment, and ongoing supervision of ACPs,
42 both during formal learning programmes and upon qualification. The team would comprise of
43 ACPs working as workforce development leads/practice educators, GP vocational training
44 leads and practice placement facilitators. This ensures that appropriate skills resources are
45 readily available, enabling members of the team undertaking ACP study to have time to
46 engage fully with the course. This team would provide the infrastructure to develop practice
47 placements in primary care; and support, supervise and assess students in practice on a
48 wide range of programmes including ACP with backgrounds in nursing and AHP. It may be
49 beneficial to allocate student ACPs to hubs, rather than individual practices or organisations.
50 This would enable students to experience a range of primary care placements, maximising
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opportunities to develop confidence and competence in working across an integrated care system, and could maximise ACP development in primary care at scale. This would also alleviate some of the pressures and challenges faced by employing organisations regarding ongoing provision of a learning environment and backfill for employees who are both studying and working as clinical practitioners within that environment.

In terms of professional registration, if ACP capabilities are clearly defined and able to be evidenced, voluntary local registration is possible and could be managed at regional level by the hubs. This would inform future workforce planning and development, and could encompass all ACPs working in primary care, including independent sector workers.

Findings suggest it is imperative that a universally accepted definition of ACP is implemented, and a National Career Framework for primary care ACPs is introduced. Using the primary care hub approach discussed above would support a professional development 'flow' through the primary care workforce system, which could facilitate future workforce succession planning, and the development of a workforce skilled in managing care specifically in the primary care setting.

Conclusion

The debate about how best to address the challenges of an overloaded GP workforce, improve patient care, and facilitate organisational efficiencies, remains a prominent political, health and social care, and economic theme. Previous literature suggests inclusion of ACPs in the primary care workforce can contribute to the mitigation of these challenges, but standardisation of role and competency are required if the initiative is to be effective. To-date, proposals to address these challenges have been insufficient on their own. Utilising a workforce development approach to explore ACPs' perceptions and experiences of ACP identity and role development has led to the generation of the Whole System Workforce Framework of Influencing Factors (IN FACT), which lays out the issues that need to be addressed if ACP potential is to be maximised in primary care. This paper offers suggestions about how IN FACT can be addressed. However, as the study findings are based on the responses of a small number of participants located in the North of England, recommendations offered need to be piloted, and evaluations undertaken to measure impact on a range of outcomes including practitioner, patient and practice outcomes, and cost benefit analysis.

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Table 1: Interview participants

Number of participants (n=22)	Job group	Professional background	Employing sector
1	Care home manager	Nurse	Private
1	Home care provider	Nurse	Private
1	Care home provider regional manager	Nurse	Private
1	ACP GP services	Nurse	Self-employed
1	ACP primary care/lecturer	Nurse	NHS
2	Clinical commissioning group (CCG) nurse leads	Nurse	NHS
1	Admiral nurse (dementia nurse)	Nurse	Voluntary
7	ANP GP	Nurse	GP practices (3 from GP federations)
2	CCG strategic workforce leads	AHP	NHS
1	CCG strategic workforce leads	Nurse	NHS
1	Clinical lead for intermediate care	OT	Private
1	Practice educator	OT	NHS
1	Extended scope practitioner/lecturer	Physio	NHS
1	Specialist dietician for older people	Dietician	NHS

Table 2: IN FACT framework

A Whole System Workforce Framework of INfluencing FACTors (IN FACT)	
Standardised role definition and inclusive localised registration	<ul style="list-style-type: none"> • Standardised capabilities and capability framework • Registration/regulation • Clearly defined practice remit, job title, job description • AHPs, private sector, social care sector, voluntary sector inclusion and recognition
Access to/availability of quality accredited educational and professional development opportunities at the appropriate level	<ul style="list-style-type: none"> • Masters/APEL aligned to standardised capabilities and capability framework • Standardised, relevant courses that include a practice-based approach • Focus on PRIMARY CARE • Includes regular, formalised CPD updates
Support and supervision	<ul style="list-style-type: none"> • Support within practice for trainee ACPs <ul style="list-style-type: none"> ○ Culture and belief ○ Understanding support needs ○ Induction into the role ○ PEFs • Supervision and support networks for ACPs <ul style="list-style-type: none"> ○ Induction into the primary care sector ○ Supervision ○ Support networks
Supportive organisational infrastructure and culture	<ul style="list-style-type: none"> • Support with accessing and understanding costs of ACP development • Provision of backfill for practice and mentorship • Shift in organisational culture • System-wide recognition of the scope and benefits of the ACP role • Cross-organisational agreement to support ACP development and practice (eg between NHS, private sector, voluntary sector, social care sector)

	<ul style="list-style-type: none">• Move to a system-wide primary care organisational model
Career pathway	<ul style="list-style-type: none">• National career framework for ACPs in primary care:<ul style="list-style-type: none">○ Dynamic, attractive role○ Structured succession planning○ Avoid depletion of other parts of the workforce○ Advanced skills for primary care○ Professional development 'flow' through the system○ Develop beyond ACP level• Regular, formalised appraisals

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