CHAPTER 1

The Conceptualization of Advanced Practice

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Key Issues

- Concepts of "competence" and "capability"
- Critical practice
- Collaborative practice
- Factors in pioneering innovations
- Master's level preparation of advanced practitioners

LEARNING OBJECTIVES

By the end of this chapter you will be able to:

- Explain the global context in which advanced practice has developed.
- Critically examine the concepts of "competence" and "capability" in relation to advanced practice.
- Critically discuss the concept of "critical practice" in relation to advanced practice.

1.1 Introduction

Healthcare has never been as good as it is now, in the early twenty-first century. New knowledge, technology, and the expertise of doctors, nurses, and allied health professionals (AHPs) now make it possible to prevent many diseases, cure others, and alleviate the suffering caused by factors that we cannot yet overcome. The world is now a much better place for human beings than it was, for example, in 1800 (Rosling et al. 2018). As a result, human beings can now lead healthier, more productive, and longer lives than their forebears, providing that they are able to access good-quality services, which meet their needs and which they experience as acceptable. Unfortunately, this is not always the case,

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because these advances and advantages are not evenly distributed within or between countries. Escalating costs, poverty, geography, conflict, violence, malnutrition, and lack of basic infrastructure such as electricity and roads are among the many factors that delay, prevent, or even reverse the equitable distribution of healthcare. As a result "many of the 7 billion people who inhabit our planet are trapped in health conditions of a century earlier" (Frenk et al. 2010, p. 7).

Alongside this situation is an increase in communicable diseases. These include viral infections for which there is, as yet, no cure or vaccine: Ebola, Zika, Marburg, and the Lassa virus. The incidence of preventable communicable diseases, such as measles, is rising among unvaccinated populations, including those previously protected by immunization programs; in Europe, 31 deaths from measles were reported in July 2018 (European Centre for Disease Prevention and Control 2018). The influence of the anti vaccination movement is one of the many factors that have affected the uptake of vaccination. Gonorrhea, syphilis, and other sexually transmitted infections are also increasing, particularly among young people (Public Health England 2018a). Even diseases for which cures are available remain highly prevalent. Each year, viral, parasitic, and bacterial diarrheal diseases due to poor sanitation and lack of clean drinking water account for over half a million deaths among children aged under 5 (WHO 2017). The incidence of tuberculosis is declining, but not fast enough to meet Sustainable Development Goal 3; the multi-drug-resistant strain of tuberculosis is a major threat to health (United Nations 2015).

Noncommunicable diseases, often associated with increasing affluence and lifestyle, are also increasing in prevalence. Obesity, smoking, alcohol and other substance abuse, lack of exercise, and eating insufficient fruit and vegetables all contribute to the development of disease. An estimated 451 million adults have diabetes, usually Type 2, and many more may be undiagnosed (International Diabetes Federation 2018). Cancer, heart disease, stroke, and respiratory diseases are among the leading causes of death worldwide. Approximately one in four adults and an increasing number of children will suffer from some form of mental illness at least once during the course of their lives. Lack of education and understanding about mental illness can prevent individuals from seeking help and lead some to suicide.

Populations are also changing as large numbers of people seek better economic or social opportunities elsewhere. Some 68.5 million people have become refugees, seeking to escape violence and persecution outside their own countries, and many are displaced within their own nations (United Nations High Commission for Refugees 2018). Their health needs are often complex and multifaceted: untreated long-term conditions such as diabetes and asthma, injuries sustained as a result of conflict or torture, sexual abuse, pregnancy, and mental health problems arising from these and other health issues.

It is in this context that advanced nursing practice has gradually developed from the work of individual practitioners in rural areas of the USA into a movement that now spans many different countries, societies, and cultures across five continents. Advanced nurse practitioners have shown that, given suitable preparation, they are competent to meet everyday healthcare needs, reduce pressures on hospital services, and develop local solutions to specific health challenges. In doing so, they have also revealed the previously untapped creative potential of nurses to innovate and improve the accessibility and acceptability of health service delivery and care, particularly to members of underserved groups. Local and country-specific needs have been at the forefront of these developments and, consequently, there is considerable variation in advanced nursing practice roles, work activities, preparation, and regulation (Schober and Affara 2006). In comparison to nursing, the development and impact of advanced practice in allied health professions is less well documented and there is no evidence of a global movement. The UK

appears to be one of the few countries that has invested in advanced allied health practitioners; preparation is at the same level as that of advanced nurses. Given the inequitable distribution of health services and care, we argue that advanced allied health professionals have untapped potential to provide accessible, affordable and appropriate care to patients in many parts of the world (WHO 2014).

This chapter examines two issues in advanced practice: *competence* and *variation*. It begins with a discussion about competence. There are numerous ideas about this and lists of what advanced practitioners should be competent in, and usually these are examined separately. This discussion differs by emphasizing their interrelatedness under three broad topics: *professional maturity, challenging professional boundaries*, and *pioneering innovations*. It also builds on ideas about advanced practice developed through the last two editions of this book, our own research, one author's (PM) experience as a consultant nurse in National Health Service (NHS) Trusts, and, as educationalists, our many years' experience in preparing nurses and AHPs to become advanced practitioners.

The second discussion is based around a case study about the four countries in the UK. This highlights variation in the development of advanced practice. It introduces the concept of *capability* in advanced practice; this is discussed here with reference to the difference between "capability" and "competence." The discussion brings the chapter to a close by highlighting how lack of clarity about *Master's-level* preparation for advanced practice and local issues, for example, changes in initial nurse education may have implications for this level of practice.

1.2 Competence

Competence, as a personal, educational, and professional attribute, is a central feature of the discourse about advanced practice. There appears to be a general agreement that competence in the provision of treatment and care directly to patients is the essential criterion for all advanced practice roles (Department of Health 2010; Hamric 2014; Manley 1998; McGee 2009; International Council of Nurses [ICN] 2008; Royal College of Nursing [RCN] 2018a). Health professionals who do not engage in practice cannot be advanced practitioners. As clinical experts, advanced practitioners are professionally mature. They work collaboratively, across professional boundaries, as clinical and professional leaders; provide education for patients, families, carers, and fellow professionals; and pioneer new, evidence-based approaches to care. Thus, competence in direct patient care is complemented and enhanced by competence in other domains and the integration of additional skills through which advanced practitioners can broaden their sphere of influence (Hamric 2014). Leadership, educating others, research skills, collaborative working, and ethical reasoning are regarded as generic competences for all advanced practice roles (Department of Health 2010; Hamric 2014; Manley 1998; McGee 2009; International Council of Nurses 2008; RCN 2018a). These are complemented by specialty-specific competences, which receive rather less attention in the advanced practice literature. In addition, individual theorists have added other competences, for example acting as a consultant for others is a domain for Hamric (2014) but not the RCN (2018a). Some of this may be due to the ways in which competences are described: the RCN's (2018a) standards for advanced nursing practice leave room for broad interpretation, whereas Hamric's (2014) descriptions are more detailed. However, as advanced practice has evolved, we question if it is necessary to consider whether new generic competences are needed (Table 1.1).

TABLE 1.1

Additional areas of competence for advanced practice.

Competence	Examples of attributes of competence to include
Interpersonal skills	Ability to communicate effectively with: • A wide range of people at different levels in the organization and outside. • Patients, families and carers, and different age groups. Ability to adapt different communication styles, broker communication between parties, manage and resolve conflict. Effectively manage situations in which patients and professionals do not share a common language.
Computer and information technology	Familiarity with and ability to use a variety of packages, conduct internet searches, contribute to the development of online research for patients and families. Ability to advise and guide patients in using the internet to learn about/manage their health problems.
Promoting equality and diversity	Identifying and acting on organizational, professional, and individual factors that help/hinder appropriate, accessible, and acceptable care and treatment. Developing and sharing accurate and up-to-date knowledge about diverse individuals and communities with other health professionals. Developing own and others' practice to provide care and treatment for diverse individuals and communities. Recognizing and tackling discrimination.
Legal issues	Familiarity with relevant legal issues in treatment and care as they relate to specific fields of advanced practice.
Policy issues	Understanding of current national health policy and how this is made, as well as the implications of this for the organization and for the treatment and care of patients. Ability to apply understanding of policy to advocate for and bring about change.

1.2.1 Professional Maturity

Direct patient care is a performance art requiring the integration of knowledge and skill that go well beyond those needed for usual professional practice. Advanced practitioners, particularly those who provide complete episodes of care and treatment, need to be able to listen attentively and respectfully to patients' explanations of their health problems and respond in ways that are meaningful. Listening is an active skill that is difficult to learn, mainly because it is taken for granted. People assume that they know how to listen, that they are listening to what is being said to them, but, if questioned afterward, they may remember very little. True listening means being open to the experiences of another person and being attuned to their preferred communication style, language, and emotional expression. It requires empathy and compassion in order to recognize and respond to

another's difficulties and suffering (Papadopoulos 2018). Listening means paying full attention to what another person is saying, rather than thinking about what one is going to say in return or the information that one has to record (Covey 2006). Listening properly is hard work, because concentrating on what another person is saying can be very tiring. However, it is through paying full attention and synthesizing the information gained with clinical knowledge that the advanced practitioner is able to identify an individual patient's particular needs. Inherent in this process is *critical practice*, which facilitates ethical decision making about the best course of action to be taken (Brechin 2000). Personalized interventions can then be selected from a wide range of clinical and technical skills and developed through broad experience with members of diverse populations (Tracy 2014). Their outcome can be evaluated in the light of the individual's response.

Critical practice (see Exercise 1.1) is an "open minded, reflective appraisal that takes account of different perspectives, experiences and assumptions" that is essential in dealing with the unpredictable and changing nature of individual patients' health problems (Brechin 2000, p. 26). It is also essential to advanced practice. Critical practice begins with analysis of a patient's needs and progresses to *critical reflection*, which synthesizes different forms of knowledge to create practical knowledge, "knowledge that accrues over time in the practice of an applied discipline" and is not acquired through formal teaching or reading (Benner 1984, p. 1). Critical reflection provides the reasoning which, in turn, informs *critical action*, the decisions and actions taken. This is mastery of practice, "an active synthesis of skill, an art of practice which goes beyond established boundaries" (Schön 1983, p. 19).

EXERCISE 1.1

Select an episode of care from your own practice. To what extent did/might critical practice inform your actions?

Developing and sustaining mastery in practice depend first on the preparation of the advanced practitioner. There is no international agreement about the educational level of courses preparing nurses to become advanced practitioners. The ICN (2008, p. 20) originally stated that "there is a growing global acceptance that this education should be set at Master's level," but this has now softened to "educational preparation at advanced level" (ICN 2018). The terminology used invites a broad interpretation of educational level, and consequently courses and preparation can vary in length and standard. For example, in the UK the framework for advanced clinical practice requires successful completion of a Master's-level course which addresses the key theoretical and practical elements; this could be a full Master's degree or a graduate diploma. Alternatively, aspiring advanced practitioners may undertake "a formal accredited work-based programme" or "submit a portfolio of evidence or work-based learning," which will be assessed through "a process of accrediting or recognising prior formal or informal learning and experience" (NHS Health Education England 2017, pp. 16–17). Unfortunately, the shelf life of "informal learning and experience" is not stated.

In contrast, in the USA, the American Association of Colleges of Nursing (AACN) has reported on the development of doctoral-level programs. These are justified if there is a need for higher-level study that goes well

beyond that required for Master's level, and the "challenge will be to identify, using an evidence-based approach, the curricular standards associated with both master's and doctoral APN education and provide for a seamless interface between educational programs" (AACN 2004, p. 12). Variations in the level of preparation of advanced practitioners must, therefore, be a matter of concern. If the level, content, and quality of preparation differ, then there may be inequalities in the knowledge and competence of advanced practitioners produced via diverse routes. This may also undermine acceptance of advanced practice by medical and other colleagues, and may even prevent career progression. These issues are not addressed in current advanced practice research. However, it is also important to acknowledge that broad statements about "Master's level" may be advantageous in countries that do not have the resources to fund higher-level study. Sending their health professionals abroad for Master's degrees creates a temporary loss of experienced, capable practitioners who may not return. In addition, individual practitioners, even in wealthy countries, may not be able to meet the cost or find the opportunity to become advanced practitioners.

1.2.2 Challenging Professional Boundaries

Health professions have tended to develop in response to either the needs of underserved populations, such as those requiring physical rehabilitation, or technological advances, for example the use of radiation. Each grew to occupy a specific niche within health services, providing treatment and care at the discretion of the patient's doctor, who was regarded as having overall control and responsibility. Thus, the doctor could decide to refer a patient for physiotherapy, but if that therapist thought that the patient would benefit from help with speech problems, the physiotherapist could only recommend this to the doctor, who could then choose whether to act on the suggestion.

The complexity of modern healthcare means that this system, in which all decisions can only be made and initiated by the doctor, is no longer viable. What is needed is "interprofessional and transprofessional education that breaks down professional silos while enhancing collaborative and non-hierarchical relationships in effective teams" (Frenk et al. 2010, p. 6). This will not be easy to achieve. Medicine is a very diverse field with multiple specialities in which traditional responsibility for all aspects of patient treatment have lain with doctors. In this context, there are challenges to be faced in gaining full acceptance of advanced practitioners' expertise. However, it must also be recognized that no profession can encompass all the expertise needed to treat and care for patients. In all health professions, technological and clinical advances have not only brought changes to professional practice, but also contributed to an increase in the amount and level of post-qualifying education required to specialize. There is also no doubt that the cost of healthcare continues to rise. In the UK, spending on the NHS is expected to be around £126.269 billion in the 2018/19 financial year, but this may not be enough to meet demand (NHS Confederation 2017). NHS England (2014, p. 5) has predicted a shortfall of "nearly £30 million a year by 2020/21." Consequently, funders and providers are challenged to use resources, including staff, more economically and to find the best value for money, which includes allowing professionals to practice in more efficient and effective ways. Referring every decision to a single professional who has the absolute power of

veto is potentially wasteful in terms of certain types of decision. It creates a cumbersome system that can work to patients' disadvantage, and can undermine other professionals, especially if their expertise is ignored or overridden.

Patients' needs and expectations are changing as their lifespans increase (see Chapter 12). Global life expectancy increased by five and a half years during the first 16 years of the twenty-first century, which means that the number of adults aged over 65 is rising (Office for National Statistics 2017; WHO 2018). Members of this age group are likely to have more than one long-term condition as well as the problems that arise with the process of aging. Younger people with long-term conditions from which earlier generations died can now lead longer lives. These changes call for new approaches to patient care. Patients with multiple and complex needs are currently treated by a similar number of professionals who have specialized in one area. This system can place considerable demands on patients as they attend multiple appointments to receive advice and treatment from different people; they struggle to make sense of everything they have been told and balance what may seem like conflicting ideas. In this context, being a patient is like having a full-time job.

Modern healthcare and professional education have not kept pace with these changes. What is needed is a different approach, and it is here that advanced practitioners can effect change by applying their expertise, and interpersonal competence in particular, in working across professional boundaries and acting as a care coordinator for patients. Care coordination is a vital role. Advanced practitioners can act as lynchpins for patients with complex needs, streamlining their care, advocating on their behalf, and improving their quality of life. People are more than the various illnesses or conditions that affect them. What they need is not always more specialized services, but the equivalent of a "one-stop shop" where the majority of their needs can receive attention from generalists who are skilled in tackling an individual's multiple health problems and who can call on specialists when necessary.

Advanced practitioners could lead the way in developing such an approach by collaborating with fellow professionals. *Collaboration* is "a dynamic, interpersonal process in which two or more individuals make a commitment to each other to interact authentically and constructively to solve problems and learn from each other to accomplish identified goals, purposes or outcomes" (Hanson and Spross 2005, p. 34; see Exercise 1.2). It is a process based on the sharing of power between individuals and/or groups, who respect each other as equals and who value and trust one another's professional expertise. It also requires a willingness to consider different points of view and new ideas without being obstructive or insisting that one's own opinion must prevail. Reasons for collaboration in patient care include more timely, better-coordinated treatment, improvements in patient safety (Hsueh and Dorcy 2016), and better management of long-term conditions (Kutzleb et al. 2015).

EXERCISE 1.2

As an advanced practitioner, who do you collaborate with and why?

To what extent does your collaboration match the definition provided by Hanson and Spross?

However, collaboration, especially across professional boundaries, may involve conflict. Advanced practitioners need to be able to manage this effectively and ensure transparency in decision making based on sound knowledge of patients, the best evidence available, and the ethical issues inherent in the situation. Ethical issues may arise if there is tension between what is possible, what a patient wants, and the costs in terms of resources, finance, time, and likely outcomes. The various parties involved in collaboration may struggle to understand each other and communicate effectively. Nursing in particular has a long history of clarifying and rephrasing what has been said to facilitate understanding between professionals and patients. Advanced practitioners may find that they have to do the same in brokering conflict between colleagues.

Collaborative skills enable the advanced practitioner to develop networks that extend across the healthcare organization and externally into local, national, or international settings. These networks provide a wide range of personal contacts, at differing levels and "know-how" about how systems in the organization really work, and how to make things happen. It is often through networks that opportunities arise for collaborative working on specific issues and a deeper understanding of diverse professional perspectives. Here, collaboration overlaps with leadership to create and maintain the advanced practitioner's sphere of influence. However, networks have to be nurtured and sustained. Connections with others depend on good interpersonal skills and commitment to genuine working relationships, in which people feel valued rather than used as means to an end.

1.2.3 Pioneering Innovation

As a leader, the advanced practitioner uses research skills to evaluate current practice to determine what is going well, what needs to be improved or changed, and how this may be achieved. Ethical reasoning informs consideration of both what is happening and what should happen, together with a willingness to challenge the way things are done. Good interpersonal skills enable the advanced practitioner to communicate effectively about the need for change and actively involve others in developing and enhancing patient care. The advanced practitioner's collaborative networks connect people and resources to involve them in a new venture. These include people both inside and outside the immediate working environment, because innovation may require support from managers in charge of resources, senior personnel responsible for the organization as a whole, and ancillary staff who provide services. Thus, the first point about pioneering innovation is that it brings together several competences: research, leadership, collaboration, ethics, and expertise in clinical practice; the second is the importance of involving the right people.

Patients and their families or carers should be involved at every stage in the development of innovation. In the UK this is a requirement set out in the Health and Social Care Act 2012, which states that patients have the right to be involved in all decisions about their care. There are several ways in which patients, families, and carers are currently involved in making their voices heard in the NHS: the Friends and Family Test, surveys, and patient-reported outcome measures. These methods usually involve the use of questionnaires given to patients. Methods aimed at the more active involvement of patients, families, and carers,

for example patient groups, require careful planning to make clear the nature of the project and ensure a broad spectrum of opinion. In some instances, training may be necessary to ensure that people feel able to voice their opinions and understand the processes through which innovation develops. Funding may also be needed to cover travel expenses.

Innovation may have implications beyond the immediate working environment. Consequently, managers and senior personnel in the organization must be involved, because they are responsible for ensuring that the innovation is clearly thought out in terms of the anticipated benefits, costs, and any potential difficulties. They must also ensure that those involved achieve the competences required for the performance of their new activities. Policies and procedures must be formulated to address practice standards and monitor performance.

Thus, innovation requires a wide range of people with different perspectives and priorities. The leader's task is to focus their energies on the achievement of the new venture by devoting an equal amount of time to each of six activities: gathering information about what is proposed, identifying the ways in which the proposal might work in the setting concerned, examining the value and benefits of what is proposed, expressing feelings, looking honestly at what may go wrong, and identifying the management issues involved (De Bono 1991). In this way the proposed development can be examined from multiple perspectives; everyone has a chance to contribute, but no single point of view is allowed to dominate until all the angles have been considered.

Research skills inform the leader's activities through rigorous evaluation of the current situation in order to justify to everyone why a particular innovation is needed, what it will involve, and whether it is successful. Evaluation is therefore a continuous process of inquiry that informs each stage of development. *Critical practice* facilitates evaluation through *critical analysis* of current treatment and care and *critical appraisal* of evidence drawn from a variety of sources. Good-quality research, particularly meta-analyses and systematic reviews, is among the best sources of evidence, but it may still be necessary to conduct a wider search, particularly if the subject is not widely addressed. *Critical reflection* assists in clarifying the aims of an evaluation and the nature and analysis of the evidence required. *Critical action* relates to the outcomes of evaluation in terms of both the impact on practice and patient care and the presentation of the outcomes to the different groups involved: patients, managers, colleagues, and senior personnel (Brechin 2000).

Research skills also enable the advanced practitioner to identify and pursue aspects of practice that require deeper investigation, either through leading a project or working collaboratively as a team member alongside other researchers. Alternatively, the advanced practitioner may act as a resource by coaching and guiding less experienced colleagues, enabling them to develop research skills and complete their own projects.

Professional maturity, challenging professional boundaries, and pioneering innovation all require the integration of direct care with a range of other competences. Some of these are generic and generally accepted: leadership, ethics, research skills, working collaboratively, and educating others. Interpersonal competence is crucial to success in relation to each one. Without it, treatment and care are exercises in technical skill and clinical expertise, but the real nature of helping patients lies in the way in which that help is given, and interpersonal skills are the channel through which that nature is made explicit.

Interpersonal competence is addressed as part of generic competences. For example, in discussing guiding and coaching, Spross and Babine (2014, p. 195) state that interpersonal competence enables advanced practitioners to "establish therapeutic caring relationships." The problem with subsuming such an important area under another competence is that its central role throughout all aspects of advanced practice may receive less attention. For this reason, we argue here that interpersonal competence should be a competence in its own right (Table 1.1).

1.3 Variations in Advanced Practice

The UK consists of four separate countries, which vary in terms of population size, geography, and economy. Scotland, Wales, and Northern Ireland have their own national assemblies devolved from a central government based in England. Devolved powers include responsibility for the NHS. The preparation and practice of health professionals are required to meet standards set by UK national bodies such as the Nursing and Midwifery Council. The title of "advanced practitioner" is not protected and there is no additional regulation for advanced practice roles. Consequently, "advanced practitioner" may be included in some job titles, but this does not guarantee that the postholder has successfully completed the expected Master's-level preparation.

Initial work on advanced practice began in the 1990s and was undertaken by nurses. It is documented in earlier editions of this book. An account of contemporary developments and sources of influence is available in chapter 5. The discussion presented here focuses on developments in each country since 2007. Recent developments in England are presented last, because these raise a number of contentious issues.

1.3.1 Scotland

The definition of advanced nursing practice issued by the ICN (2008) was broadly accepted. In 2007, NHS Education for Scotland identified four main themes for advanced nursing practice: advanced clinical/professional practice, facilitating learning, leadership/management, and research. These were launched as part of the Advanced Practice Toolkit, an online repository of resources which continues to support the development of advanced practice (www.advancedpractice.scot.nhs.uk). This repository is wide ranging and includes examples of good practice as well as resources for the assessment of competence and activity analysis. Whilst many items in the repository reflect advanced nursing practice, they are not exclusive and can be used to apply to advanced AHP roles. The four themes are now accepted across the UK as the *four pillars* of this level of practice (RCN 2018a).

1.3.2 Wales

Wales has pursued a slightly different path in developing advanced practice based around the four pillars developed in Scotland. From the outset, the Welsh strategy incorporated both advanced nurses and AHPs to create a framework

for advanced practice that was "applicable across all areas of practice and include staff working in clinical, education, management and leadership roles," which required Master's-level preparation and an integrated approach to workforce planning (National Leadership and Innovation Agency for Healthcare [NLIAH] 2010, p. 4). Here, the four pillars have been adapted to meet the demands of two roles. Clinical practice forms the core of both, but the leadership and management pillars are less pronounced in roles that carry an emphasis on research and education; this situation is reversed in roles that require greater leadership and management responsibility. This demonstrates that the four pillars can be combined in different ways depending on the individual's particular post, (see Exercise 1.3) and the flexibility this affords is now reflected in the RCN's credentialing criteria (RCN 2018b).

EXERCISE 1.3

What combination of the four pillars best reflects your role as an advanced practitioner?

1.3.3 Northern Ireland

Northern Ireland was the last of the four countries to introduce advanced practice. Its new framework is based around the four pillars and the work undertaken in Scotland, Wales, and England. Direct clinical practice is still the core pillar, and it is the level and scope that differentiate the advanced nurse practitioner from other nurses. The other three pillars are combined in a slightly different way: leadership and collaborative practice, education and learning, research and evidence-based practice. Advanced practitioners are expected to demonstrate "highly developed assessment, diagnostic, analytical and clinical judgement skills" that enable them to practice autonomously (Department of Health, Social Services and Public Safety [DHSSPS] 2016, p. 4). This framework is for nursing only and, as yet, there do not appear to be any plans to extend it to include AHPs. However, the current strategy is committed to developing AHP roles (DHSSPS 2012).

1.3.4 England

Advanced nursing practice was previously defined as a level of practice "beyond that of first level registration," the main features of which are "clinical/direct care practice; leadership and collaborative practice; improving quality and developing practice; and developing self and others" (Department of Health 2010, p. 5). Nurses working at this level were described as autonomous practitioners and were "able to apply knowledge and skills to a broad range of clinically and professionally challenging and complex situations" (Department of Health 2010, p. 7). The new framework for advanced clinical practice extends these ideas in line with Scotland and Wales, to include AHPs. Thus, in three UK countries, advanced practice has now expanded beyond nursing to incorporate AHPs and provided opportunities for them to use their expertise in new ways.

Like their advanced nurse practitioner counterparts, appropriately prepared AHPs are able to use their skills to provide complete episodes of treatment and care, promote health, and pioneer new approaches to practice.

The advanced clinical practice framework introduces capability alongside the four pillars and the concept of competence (NHS Health Education England 2017; see Exercise 1.4). The idea of capability originates in economic theory and is concerned principally with people's freedom and opportunities to achieve quality of life (Sen 1999). It is concerned with what someone can do in the context or situation in which they find themselves. Capability has attracted quite a lot of attention in other fields such as human resources, but there is very little reference to its application in advanced practice or healthcare generally (O'Connell et al. 2014).

EXERCISE 1.4

How would you define:

- Competence?
- Capability?

Capability is "a combination of skills, knowledge, values and self-esteem which enables individuals to handle change" and "the ability to formulate and devise solutions in unfamiliar situations" (O'Connell et al. 2014, p. 2731). It is a step beyond competence, which is focused on knowledge and skill acquisition measured against standards. Competence is essential in ensuring the performance of practice at the required level, but it does not take account of the unique situation of each patient or the context in which treatment and care are delivered. The real world is a volatile and, at times, chaotic place. The capable practitioner is able to cope with this complexity, work within it, and still find solutions that bring some form of partial or complete resolution. Thus, the introduction of capability in relation to the four pillars "is intended to convey the extent to which health and care professionals working at the level of advanced clinical practice can adapt to change, generate new knowledge and apply it in different ways to formulate and problem solve within a context of complexity and uncertainty" (NHS Health Education England 2017, p. 6). The four pillars constitute the "core capabilities" which are then to be applied to the "knowledge, skills and behaviours relevant to the health and care professional's setting and job role" and "may be manifested/demonstrated in different ways depending on the profession, role, population group, setting and sector in which an individual is practising" (NHS Health Education England 2017, p. 6).

Alongside this framework is the introduction of two other factors which have the potential to have an impact on advanced practice. First, there are new standards for initial nurse education issued by the Nursing and Midwifery Council (2018). These are presented as seven platforms and include some procedures that, until recently, have been considered part of advanced nursing practice. The level of practice expected may not be the same as for advanced practice, but this development does raise some awkward questions about work activities. Advanced practitioners have taken on some of the activities previously performed only by doctors; now professional nursing practice is undertaking work that was part of advanced practice. This suggests that assistant

practitioners may have to adopt more aspects of professional practice, with possible consequences for patient care.

The second factor is the introduction of NHS apprenticeships, which provide employer-based training for individuals seeking health-related careers. Apprentices are employees who undergo training whilst at work that is complemented by day or block release at a college or university; those successfully completing the end-point assessment receive qualifications or certificates of competence. Initially apprenticeships focused mainly on assistant practitioner roles, but they have now been extended to undergraduate nursing and to advanced clinical practice for both nurses and AHPs. The new Master's-level apprenticeships will "allow employers to train new and existing staff in advanced clinical practice," and training will take 36 months (NHS Employers 2018). The scheme forms a major part of NHS workforce transformation, which is aimed at developing staff to meet the anticipated needs of patients over the next 10 years by improving and expanding knowledge and skills and increasing staff retention (Public Health England 2018b). It may well prove attractive, particularly to those who wish to avoid the high costs of student loans or whose personal circumstances favor part-time learning. It can also be seen as an attempt to address the decline in recruitment which has occurred following the replacement of bursaries for students. The ensuing 2016–2018 shortfall in nursing alone is estimated to be in the region of 16 580, which, when combined with the number of nurses eligible for retirement and current vacancies, represents a near catastrophic loss of nursing expertise (RCN 2018c). However, the apprenticeship scheme also raises a number of concerns about the preparation of advanced practitioners, particularly with regard to the meaning of "Master's level" and whether there are likely to be advanced practitioners with differing levels of qualification.

1.4 Conclusion

Advanced practice continues to develop in the context of multiple changes as countries seek to find the best ways of applying their resources to meet the needs of patients, combat escalating diseases, and contain costs. In doing so, they have opened up new possibilities for nurses and AHPs to expand their contributions to treatment and care through advanced practice. This development has necessitated a strong focus on competence but, in the UK at least, it seems that this is no longer enough: the practitioner's capability to perform in diverse contexts and under pressure is also becoming important. It is certainly something that other countries may wish to consider because, in the context of healthcare, change has never been as fast as it is now, but it will never again be as slow.

Key Questions

1. What aspects of your work as an advanced practitioner do you think could or should be part of usual professional practice in your field? Give reasons.
2. Is a full Master's degree essential for all advanced practitioners? Give reasons.
3. As an advanced practitioner in your field:
   a. What competences are required and why?
   b. What capabilities are required and why?

Glossary

Collaboration: a term with two meanings in the advanced practice literature:

- The interpersonal processes described in this chapter.
- The requirement in many US states for advanced practitioners to have a signed contract regarding collaboration with a doctor.

Department of Health and Social Care (**DHSC**; https://www.gov.uk/government/organisations/department-of-health-and-social-care): a government department responsible for "strategic leadership and funding" of health and social care in England. **NHS Scotland, NHS Wales**, and the **Department of Health, Social Services and Public Safety (DHSSPS) in** Northern Ireland are responsible for the health service in their respective countries

DHSC oversees several bodies, including:

- **NHS England** (www.england.nhs.uk), which is responsible for the health service in England.
- **NHS Healthcare Education England** (**HEE**; www.hee.nhs.uk), which is a government-funded body that works across England to deliver education to the healthcare workforce.
- **Public Health England** (https://www.gov.uk/government/organisations/public-health-england), which is responsible for all issues relating to public health including health promotion, tackling health inequalities, and health security.

Friends and Family Test (www.england.nhs.uk/fft): a measurement of patient satisfaction. Patients are asked if they would recommend the service, treatment, and care they have received to members of their family and their friends. Data are published monthly. NHS staff are also surveyed on an annual basis.

Nursing and Midwifery Council (www.nmc.org.uk): the professional regulator for nurses and midwives in the UK.

Patient-reported outcome measure: a measurement of patients' health-related quality of life, experiences of treatment, symptom management, or some other health-related issue. Data are gathered directly from patients, usually through a questionnaire, and are unmediated by the views of professionals.

Royal College of Nursing (www.rcn.org.uk): a trade union and professional body for nurses and healthcare assistants in the UK.

UK: the United Kingdom of Great Britain and Northern Ireland, consisting of four countries. The overall population is just over 66 million. England has the largest population (55.6 million) and is the location of central government. The DHSC provides policy and leadership for health and social care in England through NHS England. Scotland (5.4 million), Wales (3.1 million), and Northern Ireland (1.8 million) have devolved responsibility for healthcare (Office for National Statistics 2018).

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