Chapter 1
The Development of Advanced Nursing Practice in the United Kingdom

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Introduction

The United Kingdom Central Council (UKCC) defined advanced practice as ‘adjusting the boundaries for the development of future practice, pioneering and developing new roles responsive to changing needs and with advancing clinical practice, research and education enrich professional practice as a whole’ (UKCC 1994:20). To a certain extent, this definition can be taken to represent the culmination of years of work and debate in which individual nurses explored and experimented with new ideas and roles that might enable them to provide both better patient care and meaningful professional activity. In this context, the Council can be seen as trying to bring some sort of order to the patchwork of established and emerging roles beyond registration by issuing a statement about the form these roles should take. Alternatively, the definition can be regarded as the beginning of a thorough examination of the nature of post-qualifying nursing practice, about what patients, the profession and society as a whole want from nursing and the impact this might have on other health professions, especially medicine.
One of the difficulties in both analyses is that the Council never quite made clear how the definition of advanced practice would apply to the realities of daily life in practice. Consequently, there was a great deal of confusion among nurses, managers, employers and other health professionals as to what the Council intended. This confusion created a fertile ground for debate, both useful and acrimonious, as nurses and other health professionals tried to determine the most appropriate way forward; there was quite a lot of research, some of which helped illuminate the path. In practice, there was a proliferation of posts and roles that were labelled as advanced but that were never formally scrutinised to ascertain whether they conformed to the Council’s ideas (RCN 2008).

In spite of, or maybe because of, the fluidity of this situation, some consensus has emerged in which there appears to be an agreement that advanced practice should contain a clinical component, set the pace for changing practice and be underpinned by formal preparation that is beyond the level of initial registration. There is also an acceptance that practice is not static and that nursing must continue to move forward. However, there is far less agreement about the nature of this clinical practice, how that move forward should be made or even the direction it should take.

This chapter presents an examination of the main issues and influences that have contributed to the current state of advanced practice in the United Kingdom and the further developments anticipated. The chapter closes with some key questions to prompt further discussion.

Health policies and reforms

The health policies and reforms instigated by the Labour government during the late 1990s and early 2000s have had a marked effect on the development of advanced practice by creating opportunities for innovation both in the development of nursing roles and in clinical practice. The reforms were intended to improve the quality of health services by ensuring that they were tailored to meet local needs and reduce health inequalities (Box 1.1). The reforms were also aimed at valuing staff and developing a more transparent approach to both the management of information and the decision-making process (DH 1997, 2000, 2001a). The strategy for nursing that accompanied the introduction of these policies and reforms made clear that the profession had an essential role to play because nurses were seen as ideally placed to promote health, particularly in community settings such as schools and places of work (Box 1.2). Their skills and expertise could be directed towards early identification and treatment of health problems and the provision of support for those with long-term conditions, especially during periods of crisis. Such nurse-led activity could offset the need for more expensive services including admission to hospital. Where such admission was necessary, nurses could use their skills to develop care pathways, promote continuity of care and address specific problems such as infection control (DH 1999).
Box 1.1  Core principles of health policy reforms

Provision of a health service that covers all clinical needs is available to everyone and is free at the point of delivery
Development of individual packages of care and services that are accessible by, and which meet the needs of, local populations instead of a one-size-fits-all approach
Improvements in the quality of care and greater transparency about what is happening in health-care organisations, both locally and nationally
Creation of a better working environment for staff
Patient and public involvement in service design and delivery
New ways of working, better interprofessional and multi-agency working
Promotion of health and the reduction of health inequalities


Box 1.2  The role of nursing in health policy reforms

Promoting health in ways that meet local needs
Reducing health inequalities, especially among members of marginalised groups
Instigating nurse-led initiatives to provide faster access to services and treatment
Expanding roles in primary care settings to reduce hospital admissions and enable people with long-term conditions to remain at home
Independently prescribing medicines
Expanding roles in secondary care and collaborating with other professionals to provide specialist care, develop care pathways and promote evidence-based practice
Providing intermediate care and promoting independence for those with complex needs
Tackling specific problems such as infection control
Promoting seamless care and inter-agency working

Sources: Summarised from Department of Health (2005) Supporting People with Long Term Conditions: Liberating the Talents of Nurses Who Care for People with Long Term Conditions. London, DH.
The UKCC and higher-level practice

The Council recognised the growing concern about the lack of understanding and agreement regarding forms of practice beyond registration, both within the profession and among employers. There was a lack of clarity about the terms advanced, specialist, specialism and speciality as used within the Council’s statements about practice after registration, and practitioners had difficulty in distinguishing between them, especially with regard to the differences between working in a speciality and being a specialist. Similarly, distinctions between the roles, responsibilities and preparation of both advanced and specialist nurses were unclear. This lack of clarity had the potential to erode public confidence in nursing (Waller 1998).

In response to these concerns, the Council entered into consultation with the nursing, midwifery and health visiting professions, including practitioners, stakeholders and professional organisations, about forms of practice beyond registration; after much deliberation, the Council accepted that these forms were actually levels of practice but carefully avoided associating these with the term advanced (UKCC 1999). From this consultation emerged the concept of higher-level practice, which the Council explained as applying to those nurses who were clinical experts and were able to apply their extensive knowledge, skills and expertise to develop practice and improve patient care (UKCC 1999). Following this consultation, the Council pressed forward with plans to develop higher-level practice, further assisted by 700 volunteer nurses, midwives and health visitors, from across all four countries of the United Kingdom.

The result was a standard for higher-level practice, incorporating seven domains that were later taken up by employers to facilitate the development of nurse consultant posts. The final report from the Council’s working group made 15 recommendations that were then referred to the then newly constituted Nursing and Midwifery Council (NMC) in 2002 (UKCC 2002, Castledine 2003).

One of the many problems with the concept of higher-level practice was the inexact use of terminology; words such as expert require some clarification. There are varying opinions on what it takes to be an expert, none of which seems to provide a completely satisfactory explanation (Table 1.1). The Council itself did not venture to explain what it regarded as an expert, and gradually higher-level practice, expert and advanced practice were used interchangeably. The Council’s decision to award all the volunteers who met the higher-level standard the status of advanced practitioners compounded the situation and subsequently there has been no serious consideration of what these terms mean for advanced nursing.

The interface with medicine

The introduction of the New Deal and the Working Time (Statutory Instrument 2002) Regulations 2002 created opportunities for advanced nursing by altering the working lives of doctors through reducing their contracted hours and improving their training (NHSE 1991). In August 2007 the junior doctors’ contracts stipulated a maximum working week of 56 hours. This will be reduced to 48 hours by August 2009.
### Table 1.1 Perspectives on expert practice.

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<thead>
<tr>
<th>Author</th>
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<tr>
<td>Benner (1984)</td>
<td>An expert is one who is able to intuit the essence of a situation and to focus accurately on a clinical problem; is not distracted by irrelevancies</td>
<td>Benner’s work focuses on clinical practice. The higher-level practice standard incorporates domains that are not necessarily associated with direct practice. It is not clear whether her views of an expert performance would apply</td>
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<td>Hamric (2005)</td>
<td>Clinical practice is the focus of advanced practice but there are other competencies which are also essential. These include acting as a consultant for others. The advanced practitioner is described as an expert</td>
<td>The term expert is not examined in depth but expert clinical practice is only a part of advanced practice. Thus a nurse may be highly proficient in one sphere but not advanced</td>
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<td>Jasper (1994)</td>
<td>The expert must possess a specialised body of knowledge, extensive experience, be able to generate new knowledge and be recognised as an expert</td>
<td>Jasper does not elaborate on how nurses acquire such knowledge the nature of that knowledge, and whether or how expert knowledge differs from that of others. The deeper knowledge of the higher-level practitioner must be recognised by others</td>
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<td>Zukav (1979, pp. 34–5)</td>
<td>The expert is someone who ‘started before you did’ and ‘always begins at the centre, at the heart of the matter’ with the enthusiasm of acting for the first time</td>
<td>Zukav’s expert has a store of knowledge on which to draw and thus may be said to be dealing with what is known. In pioneering new roles the advanced practitioner is entering into the unknown</td>
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(DH 2007). Alongside these contractual changes is a move away from the traditional apprenticeship system for training junior doctors towards a new, competency-based scheme. All junior doctors now enter a 2-year foundation programme that equips them with ‘basic practical skills and competencies in medicine and will include: clinical skills; effective relationships with patients; high standards in clinical governance and safety; the use of evidence and data; communication, team working, multiprofessional practice, time management and decision-making and an effective understanding of the different settings.
in which medicine is practised’ (DH 2004a, p. 8). Those who successfully complete the foundation programme may enter a further programme to become either a general practitioner (GP) or a hospital specialist. Inevitably, implementing these programmes has affected the amount of day-to-day work that junior doctors are able to do, a situation that has been complicated by the number of senior practitioners who are approaching retirement. A flexible retirement scheme was introduced to encourage hospital consultants to continue in post beyond the age of 65 and financial incentives were offered to GPs for each additional year that they deferred retirement (The Lords Hansard 2002).

The implications of the reduction in the availability of doctors were not lost on the British Medical Association (BMA), which proposed that, in primary care, nurse practitioners (NPs) could act as the first point of contact for most patients and refer them on to doctors or other health professionals if necessary. Similarly, in hospitals, specialist nurses could act as care coordinators (BMA 2002a, b). Even prescribing by nurses and pharmacists was accepted provided that it was ‘limited and in line with the individual’s training and experience’ (BMA 2006). The BMA was thus supportive of new roles in nursing to the extent that its members expressed frustration at, as they saw it, the failure of both employers and the NMC to bring about a change, which resulted in ‘the undermining and de-valuing of nurses with extended roles’ (BMA 2004).

This justifiable criticism is not new. The history of advanced practice shows that some doctors have been very influential in spearheading new developments, often providing a vision of what could be achieved. For example, in 1957, in North Carolina, Dr Eugene Stead envisaged an NP’s role that was between nursing and medicine and found a nurse to share this vision but was opposed by both the senior nurses in the local university and the National League for Nursing, which refused to accredit the necessary postgraduate training course because doctors would have had to teach much of the content. As a result of this failure, the university instituted a physicians’ assistant (PA) course. In another example, Loretta Ford, one of the most well-known NPs, worked with Dr Silver setting up a postgraduate course in paediatric care for poor rural children in Colorado but the American Nurses Association would not support this, preferring to concentrate on preparing nurses for teaching or management. In both examples, the doctor provided or helped to provide a significant vision through which particular health needs might be met; it was nursing’s professional bodies that appeared to have difficulties. Unsurprisingly, the doctors concerned lost interest and moved on (Dunphy et al. 2004).

Nursing theorists are keen to point out that advanced practice is about developing nursing and not about taking over medical work, but the interface between the two professions is not clear cut. Advanced NPs diagnose and treat illness – activities that are perceived by patients to be part of the doctor’s repertoire of skills. There is certainly an area of overlap between the two roles. For example, the advanced NP and the doctor may diagnose repeated and severe tonsillitis but it is the doctor who will have the skills required to perform a tonsillectomy and the nurse who will be best equipped to manage the post-operative period. Both will draw on the same research and use the same decision-making and problem management skills but in different ways (Hunsberger et al. 1992) (Figure 1.1). Thus the two roles are complementary.
rather than competitive, allowing both to concentrate their efforts where they are most needed. Moreover, the holistic orientation of the advanced NP allows for greater consideration of factors that may impinge on the patient’s recovery, for example, social circumstances or psychological problems. Patients often do not like to, as they see it, bother the doctor with such details but are likely to reveal them to an advanced nurse.

This notion of complementarity leads naturally to the idea that the two roles of advanced nurse and doctor meet as equals in the practice setting. While individual practitioners in both camps may agree with this, as a body, doctors clearly disagree. The BMA’s support for advanced nursing roles was qualified by their capacity ‘to improve the working lives of doctors’ (BMA 2004). Nurses might extend their roles but only within ‘a defined field answerable to a medically qualified doctor’ (BMA 2005). The subordination of nursing to medical expertise was, therefore, to continue and there was strident protest when nurses attained positions in which this balance of power was overturned. Thus the BMA found it ‘outrageous and totally unacceptable that a nurse consultant has been appointed as the lead clinician in occupational health and that she, with the assistant director of human resources, will perform the annual appraisal of the occupational health consultant’ (BMA 2005).

It would seem, therefore, that the interface between advanced nursing and medicine is highly ambivalent. Individual practitioners may develop pioneering partnerships based on mutual regard for each other’s expertise but formal relations between the two professions still require considerable effort on both sides. In practice, it is usually the advanced nurse who must make the first move, involving medical staff from the start of any initiative so that they understand what is happening and the reasons for it and can begin to see the potential that advanced nursing practice can bring to their own sphere of work.
The introduction of new roles

Modern matrons

The managerial roles of matrons were introduced in hospitals as part of a range of initiatives to improve the quality of service. Other initiatives included tackling standards of cleanliness, improving the quality of hospital food, the introduction of the Patient Advisory Liaison Service and benchmarking. The title of matron emerged following public consultation that revealed a preference for the presence of a clearly identified and authoritative presence, in each setting, to whom patients and relatives could turn for help, advice and to complain. Matrons were to take charge of a group of wards and resources to ensure that patients received the best possible care and that support services fulfilled their responsibilities to the highest standard and to provide leadership (NHSE 1999, DH 2001b).

More recently, matrons’ roles have been exported to primary care settings as part of the strategy for supporting patients with long-term conditions (DH 2005). The intention is to enable patients to receive the help they need from primary care services and, therefore, reduce the number of admissions to hospital. Community matrons were intended to use case management strategies to identify patients’ needs and formulate care plans based on multi-professional working to enable patients to become as independent as possible (DH 2005).

The managerial orientation of matrons’ roles tends to place them outside the advanced nursing sphere. Advanced nurses are primarily practitioners engaged in direct patient care; their roles do not include responsibility for managerial issues such as staffing, budgeting or resources. Matrons, on the other hand, are concerned with precisely these factors as a means of creating environments in which patients can be given the best possible care. It is possible that there may be some areas of overlap between the two roles and research is needed to examine this unexplored territory. What is certain is that, to be effective, the advanced nurse, like the matron, must have the status, power and authority to act and to direct others when necessary. Consequently, the advanced practitioner must ensure that these issues are clearly addressed in the development of any new post.

Nurse consultants

The idea of nurse consultants is not new. In the 1970s, it was envisaged that the development of a consultant’s role would provide clinical leadership but would be free from the demands of managerial responsibilities (Ashworth 1975). The health service reforms introduced in the late 1990s facilitated the introduction of nurse consultant posts (DH 1999, 2000, 2001c, NHSE 1999). Consultants were expected to be clinical experts who spent at least half their working time in practice, working directly with patients and acting as focal points for professional advice, education and research, activities similar to those required by advanced practitioners. Many of the attributes of advanced nursing practice can be found within the consultant’s role and a number of advanced practitioners have gravitated towards nurse consultant posts.
The introduction of nurse consultant posts was of considerable significance because, for the first time, nurses seeking to develop their careers did not have to leave the practice setting. Previous generations of nurses had been faced with two options, management or education, both of which meant leaving practice. The opportunity to remain in the practice setting not only offered satisfaction to those nurses who took it up but also ensured that the much-needed expertise remained in patient care.

**Physicians’ assistants**

This is a separate, non-nursing role that developed in the United States. A PA trains at undergraduate level for at least 2 years and is able to assess patients, diagnose and treat common ailments, undertake routine laboratory work, minor surgical procedures and administrative matters such as billing insurance companies. PAs work within a medical framework and for a doctor (Castledine 1998). However, their roles may at times overlap with those of other health-care professionals.

In Britain, a small number of nurses began working as PAs in the 1990s. The first to do so was Suzanne Holmes who was employed to conduct vein harvesting and other procedures at the Oxford Heart Centre. The development of these posts was quite haphazard and many were initially not paid as nurses but as medical technicians. The PA’s role was eventually formalised as that of ‘a new health-care professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision’ (DH 2006, p. 3). Those wishing to become PAs must now gain a recognised qualification based on a degree-level course, located in a medical school, of at least 90 weeks, followed by a year of supervised practice. It is anticipated that a professional register will be opened.

The PA’s role is open to anyone with the appropriate entry qualifications, which include a first degree in a relevant science. The work involves activities, which, in some ways, appear broadly similar to those of the advanced practitioner: assessing patients and formulating diagnoses, requesting appropriate investigations, formulating treatment plans and prescribing medication (DH 2006). The main difference is that the PA is not a professional in his or her own right; a PA works for and is supervised by a doctor even though, on a day-to-day basis, a fair degree of apparent autonomy may be allowed. In contrast, an advanced nurse practitioner is a member of a recognised profession and is responsible and accountable for all aspects of the care she or he delivers to patients. Nevertheless, it is probable that, as PAs become more widely available in the National Health Service (NHS), patients will have some difficulty in distinguishing them from advanced nurse practitioners and, possibly, other roles. Advanced nurse practitioners will, therefore, need to explore ways of conveying the nature of their role to patients.

**Nurse practitioners and the Royal College of Nursing**

Nurse practitioners were introduced, by the Department of Health (DH), in the early 1990s as part of the strategies to reduce junior doctors’ working hours. There was
no overall plan regarding their role and consequently several parallel developments took place. A survey of the North Thames Region identified four categories of NPs in hospitals: those who performed specified procedures, those in charge of pre-admission clinics, designated posts in accident and emergency departments or minor injuries units and nurses who had extended their skills in order to perform certain tasks for their caseload of patients (Kendall et al. 1997). In contrast, a study of NPs in primary care showed them acting as the first point of contact with the health service and thus having assessment and diagnostic responsibilities similar to prototype NPs’ roles in the 1980s (Burke-Masters 1986, Stillwell et al. 1987, Ashburner et al. 1997). The huge variety of posts was reflected in employment conditions. There was no national agreement about grading and in primary care NPs were initially employed by GPs rather than by the NHS.

A recent postal survey by the Royal College of Nursing (RCN) for the Nurse Practitioner Association (NPA) showed that NPs (n = 1021) are typically women in their mid-forties; two-thirds work in primary care; are highly qualified – 35% at Masters level – and view the core elements of their role as making autonomous decisions, assessing the health needs of patients, undertaking physical examinations, making new/initial diagnoses and formulating a diagnosis. The grading of posts varied from F to H, bands 6–8. Of the NPs, 44% reported that referrals to other clinicians and for X-rays were refused. The numbers were higher among those working in general practices. They reported feeling that their jobs were under threat, especially those who worked in hospitals. This feeling was fuelled by the introduction of the PA’s role (Ball 2006).

In response to widespread concern about the employment of NPs and the roles that they were expected to fulfil, the RCN began to investigate what was happening from both a trade union and a professional perspective. The College drew on the expertise of members and a wide range of other sources, which included the National Organisation of Nurse Practitioner Faculties (NONPF), to develop a definition of an NP as ‘a registered nurse who has undertaken a specific course of study of at least first degree (honours) level’ and who practised in seven core domains each of which was accompanied by a set of competencies (NONPF 1995, RCN 2002). In 2008, the College revised and updated its position. The definition issued in 2002 was applied to advanced practice. Thus, according to the College, an advanced NP is ‘a registered nurse who has undertaken a specific course of study of at least first degree (honours) level’ (Box 1.3) (RCN 2008, p. 3). The College went on to identify seven domains for advanced nurse practitioner practice, each of which was accompanied by a set of competencies to be achieved. For example, the first domain, assessment and management of patient health/illness status, has 32 competencies that include critical thinking, assessing and intervening to assist patients in complex, urgent or emergency situations, performing and interpreting common screening and diagnostic tests (RCN 2008). Finally, the College set out 15 standards and criteria for courses that prepare nurses for advanced practice. These standards and criteria form the basis of a system of accreditation that enables educational institutions to ensure that their courses are ‘up-to-date, of the highest quality, effective in educating nurses and the wider health care family, and to promote best practice’ (RCN 2008, p. 21).
Box 1.3  Characteristics of the advanced NP

Professional autonomy and accountability over one’s caseload
Diagnostic skills that include the ability and authority to initiate investigations and referrals to other agencies
Collaborative working with patients, other professionals and disciplines
Extended knowledge and skill base for providing treatment and care
Counselling and health education
Clinical and professional leadership


The Nursing and Midwifery Council

The NMC received the work of the UKCC’s higher-level practice project but made little progress on the issue of advanced practice for some years. Finally, the Council undertook its own consultation about a post-registration nursing framework and was able to state that ‘advanced nurse practitioners are highly experienced, knowledgeable and educated members of the care team who are able to diagnose and treat your health care needs or refer you to an appropriate specialist’ and who carried out a specific range of activities (NMC 2005, p. 3) (Box 1.4). Furthermore, the Council agreed that advanced practitioners should be registered and that the role should be defined in a way that was meaningful for patients and the public. Advanced competencies were to be mapped against the Knowledge and Skills Framework (DH 2004b). The Council also agreed that a policy was needed to accommodate nurses thought to be already working as advanced practitioners (NMC 2005, p. 3).

Box 1.4  The NMC’s first view of advanced nursing practice

Advanced NPs are highly skilled nurses, with extended skills and knowledge, who can do the following:
Examine patients physically, initiate investigations and diagnose health problems.
Initiate and make decisions about treatment and care, prescribe medication or refer patients to other sources of help.
Evaluate and alter treatment and care as appropriate.
Provide leadership and ensure that patients receive high standards of treatment and care.

In 2006, the NMC tried to obtain approval from the Privy Council to open a further sub-part of the nurses’ part of the register in order to register advanced NPs. A letter was sent to the Privy Council in December 2005 with additional information being sent in January 2006. The Privy Council has been seeking the views of the Department of Health (England), which takes the lead on regulatory matters relating to health-care professions across the NMC (2006). In 2007, some slight progress was evident in the White Paper Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century, which stated that ‘the Department with ask the Council for Healthcare Regulatory Excellence to work with regulators, the professions and those working on European and international standards to . . . the development of standards for higher levels of practice in nursing, AHPs and healthcare scientists’ (NMC 2007). However, at the time of writing, no further progress has been made and the situation remains unresolved.

Conclusion

This chapter has presented a discussion of the main influences on the development of advanced practice in the United Kingdom. This development has been rather haphazard, with new roles introduced to expedite the achievement of particular policies, such as the reduction in junior doctors’ working hours or as a response to public opinion about how the NHS should function. The lack of an overarching plan can be seen as providing an opportunity for experimentation but it has also served to hinder the coherent development of advanced practice and to differentiate it from other new roles. There is an urgent need for progress to allow the title of advanced practitioner to be protected and to ensure that only those who have the appropriate qualifications and experience are allowed to use it. The following key questions are intended to promote discussion about potential ways forward.

**Key questions for Chapter 1**

In your field of practice:

1. What strategies might be useful in educating the public about the advanced nursing role?
2. How might you explain the advanced nursing role, as opposed to that of doctor, matron or PA, to patients?
3. Assuming that the NMC will be able to register advanced practitioners, what further action, if any, should the Council take and why?

References

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