



CRITICAL REVIEW OF LITERATURE

Advanced practitioner roles: relevance and sustainability in a 'liberated' NHS

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Abstract

Background: The advanced practitioner or extended scope of practice role has been introduced into many countries worldwide. However, reviews of the advanced practitioner role within nursing and the professions allied to health (physiotherapy, radiotherapy, occupational therapy) are usually confined to a single specific discipline, and have not been explored to include nursing and those allied health professions who have adopted this role.

Aim: The purpose of this article is to discuss and explore the development of the advanced practitioner role within nursing and the allied health professions from a United Kingdom and a global perspective. This follows from the United Kingdom government's vision for the National Health Service (NHS) in England, as set out in 'Equity and excellence: Liberating the NHS' (Department of Health., 2010a).

Approach: In the light of regulations and guidance on, for example, shorter working hours for doctors, workforce shortages, retention and recruitment problems and the current financial crisis affecting European countries and the USA, far more severe than first anticipated, we explore the development of advanced practitioner roles in nursing and allied health. We raise critical questions to determine whether such roles remain relevant, beneficial and sustainable within the NHS system of healthcare management and the government's vision for healthcare reform and service delivery.

Implications for practice:

- The trend for new roles and extended scope of practice amongst non-medical professions is increasing
- Nursing particularly provides some evidence that advanced practitioners remain relevant and beneficial
- Advanced practitioners have the potential to enhance the workforce, while maximising patient choice and care management tailored to individual needs, which are central elements within the vision of most healthcare providers
- Longer-term sustainability, however, may depend on addressing issues of education, training and professional regulation

Keywords: advanced practitioner, role, nursing, allied health professionals, doctors, National Health Service

Introduction

Changes aimed at 'liberating' the National Health Service (NHS) in England have been set out by the current coalition government:

'Puts clinicians in the driving seat and sets hospitals and providers free to innovate, with stronger incentives to adopt best practice' (Department of Health, 2010a, p 8)

One of the important stated aims of the proposed changes is *'to make the NHS both self-improving and financially sustainable'* (Department of Health, 2010b, p 5). Patients will be given a greater say in relation to decisions made about their care, with staff and care providers given more autonomy to respond to patient preferences, and improvements facilitated to service lines and care pathways, thus increasing quality while reducing costs. All this will require a change in the regulatory structure of the system in order to ensure that quality and essential services are maintained (Department of Health, 2010b).

In the United Kingdom, medical doctors' roles and responsibilities were challenged in the 1990s when prescribing responsibilities were extended to nurses and pharmacists and it is now Department of Health policy to continue this process by including a wider range of professions (Department of Health, 2011). Do the proposed changes warrant an argument for greater numbers of nurse and allied health practitioners to have extended roles and be trained as advanced practitioners? Nurses and allied health professionals may advance their roles through obtaining additional qualifications. Numerous universities deliver courses with 'advanced practitioner' in their titles, competing for their share of a limited market. With so many higher degree courses available to health professionals, are we therefore creating a workforce of academics? However, if patients are offered greater choice, wish to be treated by a nurse or a therapist, as opposed to a doctor, should these health professionals not have knowledge and skills beyond their present levels? According to the government's white paper:

'The NHS will need to achieve unprecedented efficiency gains, ... to meet the current financial challenge and the future costs of demographic and technological change' (Department of Health, 2010a, p 5).

Would hospitals and providers be making such efficiency gains by employing advanced practitioners rather than doctors?

Compared to other countries, the NHS outcomes record is poor in some areas, as evidenced by higher mortality rates from some respiratory diseases and some cancers (Department of Health, 2010a). Would outcomes be improved through employment of more front-line clinicians, more advanced practitioners, more general practitioners or a combination of all three?

This paper aims to explore the development of advanced practitioner roles in nursing and allied health to determine whether such roles remain relevant, beneficial and sustainable within the NHS system of healthcare management and the government's vision for healthcare reform and service delivery. In doing so, we raise critical questions around the roles of nurses and allied health professionals, including occupational therapists, physiotherapists, and radiographers, in an attempt to highlight critical issues for future research.

One such issue is the lack of a clear definition of advanced practice common to nursing and allied health. To be considered 'advanced', practitioners must have expanded their responsibilities and/or be substituting for those of others. This is not always clear from job titles alone. Within nursing, for example, there are practitioners who undertake such extended roles, but who do not necessarily

have the term 'advanced' in their title, such as the emergency nurse practitioner. In addition, there has also been confusion surrounding specialist and extended roles. Clinical nurse specialists can be described as having the necessary clinical skills and in depth knowledge to recognise the patient's overall care needs, whereas those who had an extended role had adopted certain duties, usually restricted to the medical profession, such as physical examination (Herrmann and Zabramski, 2005). For the purposes of this paper, 'advanced' hereafter refers to all such extended-scope practitioners who have not been medically trained and 'doctor' to individuals who have been medically trained.

Advanced nurse practitioner role

Nurses have long been called upon to demonstrate elements of advanced practice. These are especially prevalent in certain areas, for example, outpatient and emergency departments, general practice surgeries, community clinics, walk-in centres and the service known in the UK as NHS Direct. In addition, nurses working as the only health professional, in some countries or in exceptional circumstances and conditions, may undertake roles of other professionals, generally doctors, if the need arises (Schober, 2009).

There are many advanced nurse practitioners in post in the UK. In 2008, Coombs estimated that between 3000 and 5000 advanced nurse practitioners were practising in the UK, including those working at junior doctor level or above. In the 1960s physicians in the USA began mentoring expert nurses, which led to the role of the nurse practitioner. In New Zealand advanced nurse practitioners are regarded as the highest level of clinical nurse expert (Unac et al., 2010). They are well established in Canada, Australia and in European countries such as Ireland, The Netherlands and Sweden. Singapore has implemented advanced practice based on the nurse specialist and practitioner role in the USA. In some countries in the World Health Organisation Western Pacific Region, there are nurse practitioners who have completed training in advanced curative and preventative care knowledge and skills (Schober, 2009).

The International Council of Nurses (2002) defines advanced nurse practitioners as:

'A registered nurse who has acquired the expert knowledge base, complex skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice'

Following national US guidelines, the UK's Royal College of Nursing (RCN) (2010) set out a generic practice standard and set of competencies in seven core domains: management of client health status; nurse-client relationship; teaching-coaching function; professional role; managing and negotiating the healthcare delivery system; monitoring and ensuring quality of healthcare practice; and cultural competencies.

In February 2006, the UK Nursing and Midwifery Council (NMC) revised its definition of advanced nurse practice (in the proposed framework for the standard for post-registration nursing, 2005) to make it more accessible to patients and the general public:

'Advanced nurse practitioners are highly experienced and educated members of the care team who are able to diagnose and treat your healthcare needs or refer you to an appropriate specialist if needed'

The NMC's proposed framework also states:

'Only nurses who have achieved the competencies set by the Nursing and Midwifery Council for registered advanced nurse practitioner are permitted to use the title Advanced Nurse'

Practitioner. The title will be protected through a registered qualification in the council's register'

According to Yaseen and Vickers (2005), there was an assumption that nurses and midwives would adjust their roles to meet the needs of workforce modernisation. These authors stated that, since 'nurse practitioner' was a job title, it should be left to employers to decide whether they wanted to use it. An example of modernisation relating to the advanced practitioners comes from NHS organisations in the North West of England. In recognition of the potential and the advantage of advanced practitioners a 'concordat agreement' was produced, which detailed role definitions and specifics, approaches to and levels of education and training, and links to career frameworks and other jobs (Swift, 2009). This collaborative partnership agreement would maintain equity and consistency throughout the region.

Having gained a university qualification, usually a masters degree, advanced nurse practitioners are assigned a mentor, undergo supervised practice and various forms of specific competency based training. In the UK this may also occur whilst undertaking the masters degree and intensified once the advanced nurse practitioners has obtained their degree.

The shortage of doctors, the European working time directive, and the GPs' contracts introduced in 2004, amongst other factors, have meant that more flexibility has been required of NHS staff. Substituting doctors with nurses with relevant knowledge and skills, however, has been a challenging and controversial option. Following the expansion of the nurse practitioner role in the 1990s, several research studies set out to directly compare the performance of nurse practitioners and doctors (Kinnersley et al., 2000; Horrocks et al., 2002; Jones et al., 2005; Coombs, 2008). Findings suggest that advanced nurse practitioners can provide more efficient outpatient care, whilst cutting waiting times (Lane and Minns, 2010). With appropriate training, advanced nurse practitioners can achieve high-quality care and patient health outcomes comparable with primary care doctors (Laurant et al., 2005). Patients report satisfaction with advanced nurse practitioners' communication and advanced assessment skills, care partnerships and their overall consultation (Haider, 2008). Nurse practitioners may also be a useful adjunct to the multidisciplinary team, with innovative forms of advanced nursing practice to enhance care effectiveness (Van der Sluis et al., 2008). The UK is not alone. The use of nurses to compensate for shortages of doctors has led to the development of extended roles and education programmes in both developing and developed countries: for example, the Cayman Islands, Botswana, Pakistan, Philippines, Singapore, Switzerland, France and The Netherlands (Schober, 2009). By contrast, less has been published with regard to the allied health professional advanced practitioner roles. There appears to have been minimal opposition and/or debate from other disciplines in relation to these advanced practitioners compared to their nursing counterparts. This may be because, in some instances, allied health advanced practitioners have extended their practice into the realms of other non medical roles, as opposed to doctors' roles.

Extended scope physiotherapist practitioner role

The extended scope physiotherapist practitioner role first appeared in 1989, although the first definitive statement about specialist practitioners was not issued by the UK's Chartered Society of Physiotherapists until 2001, when, in the absence of a national strategy or agreed pay scales, the Chartered Society of Physiotherapists introduced three advanced practice roles, linked to clinical specialism or extended practice and intended to lead to consultant physiotherapy roles. Since then, the numbers of physiotherapists in extended practice roles have been growing steadily and a masters degree is considered important (Green et al., 2008). According to Stewart (1998), the terms 'advanced practice in physiotherapy' and 'advanced physiotherapy practice' are both in use; however, each may be interpreted differently. More recently the Chartered Society of

Physiotherapists within its scope of practice guidance (2008) has formally acknowledged the blurring of professional role boundaries within healthcare, responding to this shift in professional recognition by piloting a practice framework based on levels of complexity, unpredictability and sphere of influence.

Yardley et al. (2008) found considerable enthusiasm for clinical specialist and/or advanced practitioner physical therapy roles from employers and physical therapists and suggested both were ready for advanced practitioner roles to be implemented in Canadian healthcare. Although at the time there was no formal recognition of these titles under Canadian legislation, some therapists regarded themselves as clinical specialists or advanced practitioners. These authors state that there had been a successful pilot of an advanced practitioner role, based on the nurse practitioner model, in paediatric rheumatology at a Toronto hospital, which had subsequently been extended to adults and orthopaedics, achieving client and parental satisfaction.

Hoskins (2011) reports the application of extended roles in orthopaedics, rheumatology and spinal out-patient clinics since the 1990s, but reveals a lack of evidence relating to emergency departments, which she suggests may be because the role there is still fairly new. Hoskins (2011) also states that the scope of practice within emergency departments is more limited than that of the nurse practitioner, except in relation to soft tissue injuries of the ankle, where the functional outcome is far greater if the initial patient assessment is performed by an extended scope physiotherapist practitioner, rather than a nurse or a doctor.

Advanced radiotherapy practitioner role

One important reason for introducing the advanced radiotherapy practitioner role, similar to those in other services, is the possible enhancement of the efficiency and quality of the radiological service, for example through the advanced radiotherapy practitioner taking on extended duties, thus freeing up radiologists' time for more complex interventions and the speeding up of reporting (Nightingale and Hogg, 2003).

Advancement of the radiographer clinical role appears to have begun mainly with reporting of ultrasound images and as a result of government policy and national guidance enhanced roles were subsequently supported by the Society and College of Radiographers and the Royal College of Radiologists (Nightingale and Hogg, 2003). These authors state that advanced radiotherapy practitioners work at three levels; One: Referrer (health professional requesting medical exposure); Two: Operator (health professional performing medical exposure) and; Three: Practitioner (health professional justifying medical exposure, hence allowing for examining to occur).

There have been further extensions of the advanced radiotherapy practitioner role resulting in endorsement as well as challenges, the main challenge being that advanced radiotherapy practitioners continually need to prove their worth to stakeholders, especially those who can influence managerial or strategic post holders (Kelly et al., 2008).

Advanced occupational therapy practitioner role

In the UK, the College of Occupational Therapists does not define advanced practice (College of Occupational Therapy, 2006). In recent years, however, extended scope roles of clinical specialist and consultant occupational therapy have started to emerge, but the number of practitioners at this level has scarcely made it into double figures (McGee, 2009). All occupational therapists in the UK must be registered with the Health Professions Council in order to practice, but there are no separate arrangements for the registration of advanced practitioners and the British Association of Occupational Therapists does not indemnify these practitioners. In the USA, the American

Occupational Therapy Association has only recently implemented certification based on generic competencies within four clinical practice areas (Hinojosa and Moyers Cleveland, 2009).

Changes in UK government policy, however, have enabled higher level practitioners to take on case management roles, more traditionally considered a preserve of nursing (Department of Health, 2006); patient assessment, development of therapeutic relationships and action plans for managing patients' care needs in conjunction with other professionals. To adopt an advanced occupational therapy role, therefore, involves crossing the professional boundaries of nursing. As far as can be ascertained, to date there appears to have been no opposition and/or debate with regard to this from the nursing profession.

Discussion

The blurring of roles which gave birth to the advanced practitioner probably started and is more developed within the nursing profession. The experience, progression of and support for this role in nursing is greatly acknowledged in medical publications, where it has been extensively reported and debated, and the allied health professional literature (Jones et al., 2005; Laurent, 2004; Nightingale and Hogg, 2003; Richmond, 2005). Extension of the nursing role in certain areas is also generally supported by professional bodies other than nursing (White, 2007). The title 'advanced practitioner' could be open to various interpretations. Attention should be given to the clarity of the definition, as the term does not necessarily convey the context in which it is being used (Stewart, 1998). NHS organisations in the North West of England have through collaboration produced the North West advanced practitioner concordat agreement, which covers all aspects of the advanced practitioner role (Swift, 2009). In the absence of registration if such an agreement could be implemented nationwide it would not only be advantageous in facilitating the advanced practitioner role, but also eliminate many barriers and myths.

There are a number of nurse practitioners who, as a result of specific education and specialist training to extend their scope of practice, qualify to be called an advanced practitioner, but do not have 'advanced' in their title. For consistency and to avoid confusion, there should be one title for all these practitioners, preferably including that word reflecting the additional knowledge and skills they have acquired. The title should also be protected and subject to registration and monitoring. To this extent nursing again has taken the lead with definitions from the International Council of Nurses (2005), NMC UK (2005) and generic practice standards from the RCN UK (2010), in line with other countries, such as the USA, Canada, Australia and New Zealand, where protection, standards and guidelines are in place (Hoskins, 2011; Inman and McGee, 2009; Schober, 2009; Coombs, 2008). To ensure that patients and the public are fully informed, the NMC revised the definition and expanded it through the addition of points stipulating the parameters of advanced nurse practitioner work (NMC, 2005). This transparency should allow patients to make more informed choices and give them a greater say in how they are managed, a move envisaged and supported by UK government policy (Department of Health 2010a,b).

Hands-on direct clinical practice should be an essential part of the advanced or extended scope practitioner role and one in which they engage most of the time. However, in addition to the relevant clinical practice elements required of an advanced practitioner, inherent in the role should be elements of research, clinical audit, teaching, delivering an evidence-based service and experience of patient and public involvement, if the required changes suggested in liberating the NHS are to be met. Hence, any professional following an advanced career path should have a minimum of a masters degree in order to demonstrate acquisition of the relevant knowledge underpinning many of the above skills.

Challenges to these roles are to be expected, including competition from other advanced roles, notably that of the clinical specialist. As the NHS continues to evolve, so advanced nurse practitioner roles must develop, demonstrating utility, effectiveness and value in order to remain credible and maintain their status. However, one could argue that the financial crisis experienced by many countries could lead to a further enhancement of the advanced/extended scope practitioner role to meet healthcare requirements of, for example, the ageing population in first world countries and in enabling patients to have greater choice of care provision.

Masters degree

There is general agreement amongst nursing and allied health professionals that advanced practitioners should have acquired at least a masters degree, with some advocates stating it should be an essential requirement (Green et al., 2008; Frith and Walsh, 2009; Inman and McGee, 2009; Brown et al., 2011; Swift, 2009; Coombs 2008; Yardley et al., 2008). This raises the concern that a postgraduate qualification may force clinicians away from the clinical area and forcing a move towards greater academic roles and responsibilities. Green et al. (2008) however, found that physiotherapists in the UK who attained a masters degree did not change career from clinician to academic, but instead benefited from emerging career structures that encouraged them to specialise without requiring a shift away from practice to academia. In addition, Green et al. (2008) found that having a masters degree enhanced teaching, research, clinical reasoning and advanced clinical skills. Green et al. (2008) is only one study and it is not possible to generalise the findings. However, this may be similar to other health disciplines. For example, at the authors' own institution, a masters forms the entry level for the professional doctorate degree for both nurses and allied health professionals. This programme is specifically designed for practitioners who have or intend to pursue professional careers, such as nurses/allied health consultants, advanced practitioners, senior managers, clinical specialists or lecturer-practitioners. In-house evaluation suggests that the majority of advanced nurse practitioners possessing a masters degree are not deterred from staying within the clinical area, but recognise the value of pursuing another qualification to prepare them for further advancement within that environment.

Support/benefits for advanced practitioner role

It may come as a surprise to some that doctors, whose tasks have been a prime target for reallocation and renegotiation, in many instances support advanced nurse practitioner and extended scope nurse practitioner roles (Schober, 2009; Benger and Hoskins, 2005; Richmond, 2005). Nightingale and Hogg (2003) reported that radiographers' advanced practice was becoming increasingly commonplace, with support from many levels. In general, there does appear to be support across all disciplines, for example, for any clinician wishing to undertake advanced practitioner courses to receive financial support, protected study time or both. There may be mutual benefits for both the practitioner and the NHS of such support. Benefits for the individual advancing their role include continuous professional development, which should assist registry requirements from professional bodies; increased and specialised knowledge; promotion and financial reward. Other advantages include an increase in practitioner autonomy, greater recognition and respect from other disciplines and more effective interdisciplinary working relationships.

Santry (2011) reports that patients in outpatients departments seen by specialist nurses have risen by more than 100,000 per annum and that there has been a 465% increase in attendances since 2005-6. Referrals are not only from general practitioners, but also from consultant doctors. It is predicted that in 2011, 14% of patients seen by these nurses will be referred elsewhere, which prompted the president of the Royal College of Physicians to state that service delivery by consultants is the best and that nurses are poorly equipped for patient consultations. This led to one reader commenting on the fact that non-referrals (86%) was very high with the president failing to provide percentages for referrals by consultants (Santry, 2011). Allied health professionals and

midwifery manned outpatient attendances have also risen during the same period, but are predicted to fall this year (Santry, 2011). The provision of more advanced practitioners may therefore result in a longer-term solution capable of reducing waiting lists and making savings in the NHS, while also addressing staff shortages.

Financial impact

Evidence around cost effectiveness and cost savings of advanced nurse practitioners in relation to that of medical staff is mixed. Advanced nursing practice that is innovative, part of a consistent work structure and suited to the task environment and skill mix should enhance the effectiveness of overall care (Van der Sluis et al., 2008). However, these authors also found that undertaking new responsibilities and tasks intended to improve care quality and patient well-being resulted in no direct cost savings, although the expectation was that this would positively impact on other aspects of care.

There is some evidence that patients managed by advanced practitioners in emergency settings tended to utilise follow-up services in primary care, thus increasing the financial strain on this sector (Hoskins, 2011), which would place emergency nurse practitioners in a less favourable light with care commissioners. Findings from the North West of England evaluations of the advanced practitioner roles are that advanced practitioners reduce admissions; waiting times are shorter; patients have better access to services; and care can be provided in the community (Brown et al., 2011). The full extent of costs and savings are yet to be determined. More research is needed to assess the actual impact of advanced practice on services and patient outcomes, especially in relation to allied health professionals.

Facilitators/barriers

In spite of numerous facilitators, advanced practitioners have encountered barriers to and criticisms of their roles. According to Coombs (2008), 'Dr Nurse' and 'Noctor' are two amongst many derogatory names for advanced nurse practitioners, because of their taking on medical roles; 'worse still' is the resentment directed against those employed in a post which had been a doctor's. She states that barriers include the absence of professional regulation, low pay and opposition by doctors. Hoskins (2011) identifies a range of perceived facilitators of as well as barriers to advanced practice roles in emergency care. Barriers included: junior doctors not receiving the necessary experience; tensions that could arise from advanced practitioners asking other nurses to perform duties normally requested by doctors; unclear role definition with no protected recognition in the UK. Facilitators included: the potential for improved career structure; the addition of a useful resource in lessening overcrowding and managing greater numbers of emergency care users.

Conversely, there are those from both the medical and non-medical professions who might argue that individuals with no formal medical training, should not offer a medical opinion (Carter, 2008; Rawlins, 2008) and that advanced practitioners will always be limited in their scope of practice (Allen, 2009; Kelly et al., 2008; Coombs, 2008). Laurant et al. (2004) found that increasing numbers of nurses in a general practice did not decrease the doctor's workload, because nurses were used to supplement and not substitute for care. These authors advocate further research into task delegation. Until such time as doctors accept that aspects of care for which they do not have a monopoly of skills, training or education could be carried out by advanced practitioners, there will be little or no improvement in efficiency and quality of patient care and minimal reduction in workload and stress.

Nurses could be seen as having had an unfair advantage over allied health professionals, having been targeted as a practitioner group much earlier and supported by government funding to extend their practice and become advanced nurse practitioners (Stewart, 1998). Some managers were also

seen as failing to recognise allied health professionals' capability to meet advanced practitioner requirements. Rather than regarding the extension of the traditional role of the nurse as beneficial, especially to the patient, as well as to their profession, this was perceived as a threat (Stewart, 1998). For Stewart, the development of advanced practice in allied health professions, including physiotherapy, has progressed with little clarity of meaning and understanding of the measurable standards.

Patient outcomes

Service users generally reported satisfaction with care delivered by advanced practitioners (Horrocks et al., 2002; Hoskins, 2011; Yardley et al., 2008). Published studies to date have largely reported on care delivered by advanced nurse practitioners with little research into advanced practice of other health professionals. Patient satisfaction was reflected in the positive outcomes of the quality and quantity of information they received from advanced practitioners and the decrease in waiting times. Dissatisfaction came from a perceived lack of professional confidence, competence and social skills, which led some patients to prefer to consult a doctor who they believed could better address their needs (Hoskins, 2011). The positive satisfaction with advanced practitioners should and could be maintained and further built upon to deliver a higher quality service to patients. The negative aspects could and are likely to be overcome as these practitioners become more comfortable, knowledgeable and skilled in their role. Additionally more should and could be done by professional bodies in relation to the provision of guidance, regulation and acknowledgement in order to enhance this role. In both respects more research is called for and, as advocated earlier these practitioners should be armed and sufficiently qualified to conduct research themselves and apply the evidence derived from it. Greater patient say and choice is achievable if there are sufficient advanced practitioners in post; hence patients should be able to exercise their right to see whomsoever they wish.

Conclusion

Advanced practice roles are a growing trend amongst non-medical professions in the UK and world-wide. In this respect nursing has taken the lead and provided the initial evidence for others to follow. The evidence is both positive and negative and includes support for, barriers to and critics of the role. Hence, more research is needed to provide evidence for scope of practice and to justify and sustain the role. The role requires education beyond the initial registered/licensed training and requires the advanced practitioner to be accountable and responsible in decision-making and care-giving, which should be based on in-depth knowledge. Longer term sustainability may depend on addressing education and training and issues surrounding professional regulation. Where regulation, registration or licensing and protection are not in place, professional bodies as well as advanced practitioners should lobby for this to be implemented. Where there is more than one title for the role, a single title reflecting the extended role should be developed and utilised. All the above will ensure that patients and critics cannot use regulation, lack of knowledge, skills and training as an excuse for denigrating the role. It will also give advanced practitioners recognition, acknowledgement and the much needed respect they deserve from the general public and health professionals alike. There is great potential for advanced practitioners to enhance the quality of healthcare – and perhaps even help the UK government to achieve its vision of a 'Liberated NHS'.

IMPLICATIONS FOR PRACTICE

If high quality care is to be delivered, a requirement is having a competent workforce that engages in continuing professional development. It is therefore vital for an advanced practitioner to participate in continuing professional development. A master's degree prepares the practitioner not only to be competent in their specific practice area, but also in additional essential elements such as: the importance of networks and communication; information retrieval and analysis; critical appraisal

and interpretation; knowledge and understanding of ethical and governance dimensions; and presentation skills.

Through education and training, advanced practitioners acquire expanded and transferable skills and are therefore in a position to enhance any workforce. It is essential for all those concerned to address the barriers and maximise the facilitators to the role, if the increasingly strong focus on evidence-based care, elimination of unsafe, substandard and inequalities in care are to be achieved and maintained. Together with appropriate support, these practitioners have the potential to be more innovative in their care, adopting best practice more readily, to the ultimate benefit of patients.

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