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# The Advanced Clinical Practitioner (ACP) in UK Healthcare: Dichotomies in a new 'multi-professional' profession

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**The Advanced Clinical Practitioner (ACP) in English Healthcare: Dichotomies in a new 'multi-professional' profession**


## Abstract

Advanced Clinical Practitioners (ACPs) work in a wide range of settings across the English National Health Service. ACPs come from a wide range of health professional backgrounds. This paper explores the ACP as a multi-professional role, and the implications of these understandings for the sociology of professions. This paper analyses what happens when a new occupational role is created that encompasses several established professions.

This qualitative study gathered views and experiences across a range of stakeholders. Fifty-eight semi-structured interviews were undertaken with participants employing ACPs (n=14) actively working in an ACP role (n=10), training as an ACP (n=13) or engaged in the delivery of the ACP education programme in England (n=21). Findings were analysed into three overarching themes: (i) professional identity, (ii) differing definitions of ACP and (iii) advanced practice, professional regulation and recognition.

ACPs hold a unique and emerging professional identity based on their previous professional health background and are themselves clear that they are not doctors. The role is not yet formally regulated, though many ACPs aspire to this. This research is an early look at a new type of professional which challenges existing understandings of what a profession is.

**The Advanced Clinical Practitioner (ACP) in English Healthcare: Dichotomies in a new 'multi-professional' profession**

Advanced Clinical Practitioners Advanced Clinical Practitioners (ACPs) are a multi-professional role undertaken in a wide range of contexts across the English National Health Service (*redacted* 2021). The development and evolution of advanced practice roles has been a complex journey (Barton and Allan, 2015). The advanced nurse practitioner role evolved in the United States and Canada in the mid-1960s in response to service needs.

The advanced practitioner role is also undertaken globally to varying degrees (*redacted* 2021, Lowe & Plummer 2019, Freund, Everitt, Griffiths et al 2015). While advanced practice began in nursing in the UK, the role has now extended beyond nursing. Other professions, including clinical scientists and pharmacists, as well as midwives and allied health professionals (AHPs) had developed advanced roles. Advanced clinical practice was developed as a term to encompass advanced practice in all of these professions. Globally, health systems are increasingly challenged by the complex needs of ageing populations, health workforce shortages and escalating costs (Evans, Pearce, Blake et al 2020). The UK has a long tradition of using other professions when there is a shortage of doctors (e.g. the recognition of opticians in 1936 (Larkin 1983)). The impetus for ACP in the UK is not straightforward. It did not arise from any specific policy initiative but developed organically as various NHS organisations saw it as a way of addressing workforce issues (including the global shortage of doctors). In England the university sector, where the majority of healthcare professions are trained, responded by offering programmes of advanced study to become a recognised ACP. It was only when already well developed that ACP started to feature in national NHS policy.

Globally, most studies consider advanced practitioner roles in the context of their individual professions including nurses, pharmacists, physiotherapists, and dieticians (Cardwell & Smith 2018, Cohen, Jellinek, Hatch *et al.* 2009, Spacey, Hipperson, Gloster *et al.* 2020, Bigham, Kennedy, Drenna*, et al.* 2013). However, there has been tension between the traditional view of healthcare roles, as some view advanced practice as undermining professional foundations (Barton and East, 2015). Another source of tension is whether ACPs are direct substitutes for doctors (Thompson and McNamara 2022). There is evidence for this including local NHS governance policies which treat them as doing medical work, not least as ACPs often appear on medical rotas. In addition, some medical Royal Colleges (including the Royal College of Emergency Medicine) offer programmes and credentials in advanced practice for non-medical professionals though they have no formal regulatory role. However, as we show later, some ACPs are keen to distance themselves from this.

In the UK, ACPs come from a wide range of professional health backgrounds and ACP is constructed as both potentially a uni and *multi or omniprofessional* role (Lawler, Maclaine & Leary 2020). This refers to the ambiguity in how ACPs are being defined (both by self and others). ACP is a multi-professional role because members from different professions can become an ACP (a nurse or a physiotherapist could become a critical care ACP) and thus ACP encompasses multiple potential cognate professions. There is ambiguity over which professional identity becomes dominant, as we shall see.

What ACPs do is very broad. It can involve assessing patients (for instance in the Emergency Department or primary care), diagnosis (with the support of imaging or laboratory tests), treatment, including prescribing medication, and referring patients to other services. Regulation for most healthcare professionals in the UK allows for this fairly broad scope of practice, and even though ACP is not specifically regulated, relevant regulation and legislation apply to ACPs (for instance in prescribing). ACPs can and do discharge patients on completion of an episode of care.

ACP Training

NHS Health Education England (HEE) oversees the training and development of the clinical workforce in England. In 2017, HEE published a framework that defined ACP as follows:

> *Advanced clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision-making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area-specific clinical competence.*

It is important to point out that HEE have no statutory control over, or regulation of, ACP. Different NHS Trusts have thus interpreted and developed ACP in different ways leading to inconsistencies in representing ACP as a profession or a role. For example, HEE has developed a competency framework for advanced nursing practice in primary care specifically related to nursing, and with 'nursing' in the role title. By contrast, the advanced role in critical care in England is explicitly multi-professional and represented as a new role (FICUM 2019). HEE commissions Master's level training for ACPs in England, who can apply from any clinical discipline registered with a professional body. The training, which is two years, includes classroom-based knowledge and skills development embedded into practice through mentoring and clinical assessment in the workplace. Trainees typically work for NHS Trusts either in primary care (community) or secondary care (hospital).

Prescribing

One component of the training is to achieve prescriber status where there is conflict between ACP as envisaged by HEE, and legislation. Certain health care professionals in the UK are allowed to prescribe, if they pass an additional programme of training. However, not all professions, for example occupational therapy and speech therapy, are included in the legislative scope of non-medical prescribing even though they are eligible for ACP training. This creates a tension for those professions which do not typically have prescribing rights. This is further complicated by the framing of the non-medical prescribing legislation which would not allow a prescriber to prescribe when practicing outside of the scope of their profession – a situation which can occur with ACPs. This could have consequences in terms of litigation and indemnity and is a concern for professional regulators.

Situating this research in sociological theory

This paper seeks to explore the unique concept of ACP as a multi-professional role, which appears to have some overlap with the traditional role of a doctor (GMC 2021) and the implications of these understandings for the sociology of professions. This paper explores what happens when a new occupational role is created that encompasses several established professions and professional bodies and may be seen to encroach on the territory of other recognised professions. This will contribute to recent debates in sociology of the professions about 'new' professions and professional boundaries, such as those around the new role of physician associates (Drennan, Gabe, Halter et al 2017; Nancarrow & Borthwick 2021)

The sociology of professions has always used a (perhaps unacknowledged) assumption that professions are, certainly in their relations with the state, unitary entities. Professions may have different specialisms within them or may historically be the result of mergers between different occupations (Smith, Roberts & Balmer 2000), but have never encompassed more than one

profession. Most of the major theorists in the field (e.g. Abbott 1988, Larson & Larson 1979, Freidson, 1999) share this assumption. Interprofessional competition, boundary crossing, and jurisdictional extension have long been considered part of being a profession although professions consider themselves to be a unitary entity. There is a growing literature on new and emerging health professions, and on how they achieve 'full' professional status (e.g. Saks 2021, *redacted* 2004), but again this is predicated on the nascent profession as a unitary group. For instance, Drennan et al (2017) studied physician associates, who have some features in common with ACPs in that they are intended to take work from physicians. However, ACPs are very different from physician associates in that ACPs are already established health care professionals when they commence their training and are drawn from a wide variety of regulated professions. Physician associates are regulated as a group by the General Medical Council.

Indeed, much of the work that an aspirant profession typically undertakes in the professionalisation process is to claim rhetorically that they are unique, unified, and different from other professions or occupations (*redacted* 2011). Again, unlike physician associates or nurse associates, ACPs have not been created by policy (i.e. by the UK state). They have evolved in the NHS more organically, with influences from outside the UK, such as the United States (Lawler, Maclaine & Leary 2020, Lawler, Maxwell, Radford & Leary 2021).

Recent theoretical developments

A key concept in sociology of professions currently is post-professionalism, defined by Nancarrow and Borthwick (2005) as "the loss of exclusivity over knowledge that is experienced by existing professions. Post-professionalism arises because of the growth of technology and access to information and differences in the way that knowledge is applied through increasing specialisation". Their definition is derived from the work of Kritzer (1999). Nancarrow and Borthwick (2021) distinguish post-professionalism from transprofessionalism as defined by Tyhlefors, Persson and Hellstrom (2005). In transprofessionalism the professional retains their primary professional identity whereas in post-professionalism they acquire a new identity. This is an important issue for ACP.

King et al (2019) develop this concept in a study of diabetes educators. The diabetes educators studied were drawn from a range of professional backgrounds but having acquired a diabetes education qualification from a professional association (not a professional regulator) they were considered to be part of a new profession. King et al see the diabetes educators as post-professionals, saying "In this illustration, a range of professions from different disciplinary backgrounds adopt a new and common title and recognised role based on the adoption of agreed, shared competencies that are developed and endorsed by an external accrediting body". King et al (2019) say "post-professions are a new species of profession emerging from existing professional groups". Nancarrow & Borthwick (2021) also point to an Australian group of 'rural allied health generalists' as post-professionals. Though ACP is not post-professional in the sense originally defined by Kritzer it is possible that they could be a new example of this phenomenon, certainly in the terms of Nancarrow and Borthwick (2005). Other commentators (such as Nicholls 2022) see post-professionalism as the reduction of the dominance of professions in the organisation of society and a slow degradation of prestige applied to these groups.

New forms of professionalism

Much of the debate in the field has been focussed on conflict between managerialism, especially New Public Management (Hood 1989) and a traditional notion of professionals as autonomous, with some authors arguing for a decline in the importance of profession and professionals (Malin 2020). Other critics saw a process of new forms of professionalism responding to this environment, suggesting instead reprofessionalisation (Petrakaki, Barbour & Waring 2012). Noordegraaf (2015) transcended this distinction analytically by positing hybrid professionals who combined both managerial and more 'traditionally' professional aspects to their work. Noordegraaf (2016) further argues that sociologists have paid too much attention to managerialism and insufficient to "the surroundings and processes that make up their work [that] are producing professional powers—or the lack thereof".

In his most recent work, Noordegraaf (2020) argues for an analytically new distinction between traditional 'protective' professionalism, and what he terms a newer form of 'connective' professionalism. Noordegraaf explains "Instead of establishing and maintaining as much "(self)controlled content" as possible, professionals and others will have to enact new forms of control that enable them to cope with constrained autonomies, contingent case treatment, and ephemeral identities. Whereas classic professionalism rested upon isolation … and exclusion … new professionalism is unavoidably much more *connective*". Noordegraaf has been criticised by Adams et al (2020) who take issue with his use of ideal types. Nonetheless, this debate remains central to the field.

Defining professional and professional boundaries

A third key issue within the sociology of professions is boundaries. From Abbott (1988) onwards the establishment and defence of professional boundaries, in the light of threats from higher, lower or equivalent status professions has been an important part of the professional project. The arrival of a new occupation with aspirations to be a profession is often a cause of conflict with other professions (e.g. *redacted* 2011, *redacted* 2004)

Healthcare professions in the UK, as elsewhere, follow a standardised path to professional registration and regulation. ACP presents an intriguing challenge to this process whereby some members argue for regulation without professional 'incorporation' while others aspire to be a new and distinctive profession in their own right. We will present an analysis of an occupation/profession at an early stage of its formation with an opportunity to show how these debates play out in a contemporary rather than a historical context, where, often, a 'foundation myth' has become the dominant narrative. We acknowledge that formal regulation is not a pre-requisite for professional status (Macdonald 1995). However, it is a common expectation among aspirant professions in the NHS (*redacted* 2010). Analysis of ACP also has potential to shed some new light on an issue that has not been extensively considered in the sociology of the professions since the 1960s, that is, how a profession might define itself and how it is differentiates itself from an occupation. For all that trait theories have been discredited in the sociology of the professions, many professions appear to describe themselves in taxonomic terms (Nancarrow and Borthwick, 2021). It is possible that ACPs may acquire some of the features that they perceive to be indicators of professional status without ever becoming incorporated.

Finally, ACP can contribute to understanding another contemporary phenomenon found within health care professions, that of the generic health care worker. Contemporary employers have sought to reduce the importance of professional boundaries and create a more flexible workforce by various strategies to diminish professional differences. Sometimes this has been through the

creation of a new cadre of generic health care workers, unaligned with any of the professions (Rolfe, Jackson, Gardner et al 1999), though doing work that has been the purview of professionals. Another strategy is to symbolically erase professional boundaries, such as the instance reported by *redacted* (2011) where professionals from different professions were required to wear essentially the same uniforms. It is possible that ACP, spanning as it does several clinical professions could be part of this wider strategy on the part of employers to create a more 'flexible' health care workforce, such as the increased use of 'unqualified' health care assistants (Boyce, Borthwick, Moran, et al 2011).

Methods

Our methodological approach is Interpretative Description (Thorne, Kirkham and MacDonald-Emes 1997, Burgess et al 2021). This approach seeks to go beyond the qualitative traditions of grounded theory, phenomenology and ethnography. Interpretative Description (ID) is "a qualitative methodology used for applied health research that builds upon, rather than bracketing out, existing experiential knowledge of the topic of interest" (Burgess et al 2021 p2). This suited our project as we were aiming to richly describe an emerging phenomenon (Sandelowski 2000)

This qualitative study was commissioned by HEE to evaluate the ACP role and the education for current England-based healthcare professionals to gain ACP status. The work commenced in 2020 and was reported in 2021 (HEE 2021, *redacted* 2021). Ethical approval was given by *redacted*. It was stressed to participants that participation in the project was completely voluntary, that interview content would be completely confidential, and all data would be anonymized prior to reporting. All those who agreed to be interviewed returned confirmed consent either in writing or verbally prior to the online interview. The reporting of this qualitative study has conformed to the COREQ 32-point checklist (Tong, Sainsbury & Craig 2007).

Since this was a qualitative study, we aimed to gather views and experiences across a range of professional groups and Higher Education Institutions (HEIs) that deliver the ACP training. A purposive snowball sampling technique was used to identify key participants meeting the inclusion criteria. The main inclusion criteria were that participants were actively working in either an ACP role, training as an ACP or engaged in the delivery of the education programme in England. All interested parties were provided with an information sheet, details about the study and a study consent form. This followed the sampling strategy recommended by our Interpretative Description design though we are mindful that our sample was no doubt constrained by the COVID19 pandemic.

Semi-structured individual interviews were undertaken with 58 key stakeholders in 2020. The interview schedule was designed by two PIs (*redacted*) and the interviews were conducted by two researchers (*redacted*). Since the research was focused on different stakeholder groups, employers, professionals and educators, the research team developed two separate interview schedules, the second with a more educational focus. Due to the pandemic all interviews were conducted remotely, digitally recorded and transcribed verbatim. They were then anonymised and thematically analysed separately by two researchers (*redacted*) using NVivo 12.

Interviews were with participants employing ACPs (n=14) actively working in an ACP role (n=10), training as an ACP (n=13) or engaged in the delivery of the ACP education programme in England (n=21). Employers were principally from NHS Trusts delivering acute hospital or community services, with the interviewees being senior clinicians/managers. No GP employers of ACPs were interviewed due to the pandemic ACP participants had a range of backgrounds from 2 years – 20 years post-

qualifying experience in their 'home' profession. The majority had 5+ years' experience and there were several with 20+ years' experience. The 23 ACP participants (qualified or trainees) were:

| | |
|---|---|
| Nurse | 9 |
| Radiographer | 2 |
| Speech and Language Therapist | 1 |
| Pharmacist | 2 |
| Physiotherapist | 2 |
| Dietician | 1 |
| Paramedic | 2 |
| Operating Department Practitioner | 1 |
| Occupational Therapist | 2 |
| Nursing & Paramedic (dual qualified) | 1 |

Iterative development was undertaken during coding through presentation and discussion of emergent findings and themes with the broader team (*redacted*) on a monthly basis. This was an approach aiming to enhance the trustworthiness of the research (Lincoln & Guba 1986). A thematic framework for analysis followed the planned research questions and also allowed for other themes to be identified, in tune with Interpretative Description (Thorne, Kirkham and MacDonald-Emes 1997) A broad overview of findings in relation to global workforce development is presented in the 1st study output for this work (*redacted* 2021). The data presented in this paper relates to the independent analysis of emergent categories and their relationship to current debates around the sociology of professions to explore the sociological dichotomies of the ACP role as a new multi or uni professional role. We are only presenting a portion of our data in this paper, which is relevant to these theoretical debates.

## Findings

Our findings were interpreted into three overarching themes in relation to the sociology of the ACP role: professional identity, differing definitions of ACP and advanced practice and professional regulation and recognition.

## Professional Identity

There was evidence that ACPs develop a new professional identity, but this could either be in addition to their existing professional identity or could supersede that identity.

> *I started off professionally as a pharmacist and I am still a pharmacist. I use my pharmacy skills every day. But I am employed as an advanced clinical practitioner,*
>
> *ACP (Pharmacist) P31*

The primary struggle described by ACPs associated with their professional identity can be summarised as the battle between their previous profession and their ACP role and the extent to which they existed as one, or another profession - or in transition between the two.

> *For me you're … to create a new professional group with a single title. Yet people have come into it from …, different professional bases. And do they actually want a unique professional identity or actually do they want their original?*
>
> *HEI (Nursing) P35*

Trainee ACPs showed some confusion with the transitional nature of their professional identity.

> *My ID badge says 'MSK [Musculo-skeletal] practitioner', My System One (the IT system used in General Practice) calls me a 'Physiotherapist Specialist Practitioner'. It depends who I am talking to and what I'm doing. I will usually say I am a 'Trainee ACP with a physiotherapy background'. I must say I have struggled a bit with my professional and personal identity since the course,*
>
> *Trainee ACP (Physio) P41*

Broadly speaking, trainee ACPs were differentiated in job title from accredited ACPs but this was not always the case and depended on a number of factors. For example, some NHS Trusts supported the developing identity of ACPs in a range of ways – either by differing uniforms for levels of ACP and some with use of different staff lanyard colours.

For some professions there was tension and confusion between their primary role, for example that of a nurse, and their new role as an ACP as a direct result of misunderstanding of their role within their workplace. This is because the title of ACP was not (and is not) protected and therefore was often used inaccurately or used for functions or roles which did not relate to the HEE ACP accredited Master's programme:

> *And currently … anyone can call themselves an advanced practitioner. And we've done research at this university into the misuse of the Advanced Practitioner title, which is widely misused by people who've had no education or any training at all.*
>
> *HEI (Nursing) P35*

One participant reported that an internal audit at their Trust revealed 50 posts with ACP in the job title but found that none of the roles demonstrated a requirement to undertake higher level study. This was a source of frustration to those working in the field who suggested that the ACP title needed to be protected in order to protect staff reputation, validate their role and their clinical contribution and their recognised higher-level skills and knowledge.

Several participants acknowledged that the ACP role might appear to be used to solve a general shortage of key professionals, particularly doctors and there was an appetite to review and 'task-shift' some roles and functions within and across professional groups (Feiring & Lie, 2018). This was not just related to ACP roles, as the WHO (2007) described task shifting as the 'vanguard' for improving health-care service provision and overall strengthening of healthcare systems (World Health Organisation 2008). Typically task shifting is conceptualised as the sharing of tasks between professions but not the alteration of language or enhancement of professional roles.

However, our data indicates that from the perspectives of ACPs, they recognised that they were filling gaps left by doctors but many ACPs had different professional identities and therefore thought they '*speak a different language to the medics'*. Another ACP suggested they hoped the role was a more '*meaningful way of helping people than just replicating a doctor's role'* and, as a paramedic ACP states:

> *Doctors are completely different roles; we do actually have very similar roles but I'm quite proud that I'm in an ACP and proud that I'm a paramedic and I think actually what I do now really represents what doctors do anyway.*
>
> *TACP (Paramedic) P42*

In some cases, ACPs felt they had been successful in supporting clinical pressures across different settings, for example in ED. There was, however, a misconception in some clinical settings that ACPs were just filling a task gap and were not recognised for their higher-level clinical judgements for patient care and the holistic care a wider group of advanced practitioners were able to offer.

> *It's not being a mini doctor; it's working in partnership with them and picking up where you can.*
>
> *Practitioner (Nursing) P33*

There was evidence from participants in all sectors that whilst the ACP role 'fills a gap' it did so in a way that also added value, by utilising the specific expertise of professionals, providing holistic care and freeing up doctors to focus on the specific tasks which required their attention.

> *We know that there are like globally a shortage of doctors, shortage of nurses … but I do think that the ACPs do bring something else to the table. They do bring that holistic approach to patient care. … they get to think about the impact of the condition and the disease on a patient rather than just this is your …*
>
> *HEI (Nursing) P21*

Those ACPs interviewed were very clear that they perceived their own professional identity as different to that of doctors, not just in clinical knowledge but their constructs of care:

> *I am a nurse and that comes with certain abilities. And way you act, that comes from nursing. I will quite happily f get somebody a cup of tea after I've finished doing a review, well there's not many of the doctors that even know where the kitchen is.*
>
> Employer (Nursing) P38

## Definitions of ACP and advanced practice

Our data from the interviews highlights that there was confusion over the very title, role and place of ACPs within the NHS in England.

There was confusion not only on the ground between practitioners, but also at the level of regulators and professional representation:

> *When I started all this work it was about working in an ACP role, but then being told that this is about a level of practice, but we still tend to use advanced practice and ACP interchangeably. I think that leads to quite a bit of confusion.*
>
> *Regulator (Pharmacy) P17*

> *the difference between a role and a level of practice. And the framework talks about a level of practice but it also alludes to a role…And they are two very different things because the level of practice, it doesn't matter if I can prescribe, if this profession can prescribe drugs A, B and C*

> *and the other one can prescribe D, E and F, the level means I am a prescriber and I can do that. Role demands a level playing field.*
>
> *Employer (Nursing) P23*

This then led to a lack of clarity as to the role for the trainee or accredited ACP but also for those delivering and teaching the ACP programmes:

> *You know, they've got ACPs doing different roles in their organisation but they don't know where to put me because they don't assume that … because they see it as different roles rather than a level of practice.*
>
> *HEI (Nursing) P22*

One employer thought that whilst there was a role for ACPs, they had to be able to offer a level of practice to fulfil that role:

> *There are lots of people who will be able to show that they fulfil the HEE four pillars. As an employer I'm primarily interested in the people in the roles. I like the other people, they're the people that I will have lined up for future roles but I need those people to do the jobs that we need. Because we are developing new services with these roles just now.*
>
> *Employer (Nursing) P23*

Several trainee ACP participants suggested that the ACP role was their only choice as an allied health professional (AHP) to progress in their career and develop their role with a clinical (rather than management) focus. Typically clinical roles in the NHS are limited to band 7 (of the NHS pay structure) and roles above this at band 8 and beyond included management functions.

> *I'm surprised when an occupational therapist joined and when a speech and language therapist joined, pharmacists and paramedics. I discuss in my team about the course and quite a lot of my colleagues wanted to enrol for next year, one of them is an OT (occupational therapist) who wants to join next year. And the main reason is because that there is no career progression once you achieve a band 7, The only route available at the moment is the ACP route for people who want to stay clinical*
>
> *Trainee ACP (Physio) P20*

The ACP role was specifically patient-facing, which some participants argued was a descriptor of a role rather than a level of practice, but others argued it was not unique as a defining feature of a level of advanced practice:

> *I think we still have the problem of ACP versus advanced practice. So, we've had pharmacist Master's courses focused on advanced practice for years, which might look different to ACP ones because we have Pharmacists is working in all sorts of different roles.*
>
> Regulator (Pharmacist) P17

By contrast with consideration of ACP as a role, several participants said they perceived ACP as a level of practice or progression, within their current context and utilising their expertise:

> *In radiography you don't have advanced practice, … newly-qualified radiographers will come through a level of a Band 5, then they will specialise in CT or MRI and you may gain extra qualifications and become a 6 and then keep moving.*
>
> *ACP Practitioner (Radiography P17*

Some ACPs drew attention to the fact that the clinical skills undertaken by ACPs were often skills previously performed by doctors, leading to an uplift in the level of practice and skills undertaken by the clinician:

> *It's a skill that has rested in medical sphere forever. And now it's not but that very advanced skill may not be recognised depending how the rules are written. And that's … so I think that is a challenge and then … is it an advanced practice or is it an extended skill?*
>
> ACP Practitioner (Radiography) P13

Several participants identified that the ACP 'role' carried responsibilities that were equal to a 'advanced level of practice'. Conflicting evidence was presented about whether the role was a specialist or high-level generalist. This specialist/generalist debate was closely linked to the role or level of practice debate with many participants saying that specialisms were associated with roles whereas a level of practice across professions was generalist. One employer said that the ACP related to a generalist role but in doing so excluded the advanced nature of specialist healthcare workers:

> *Where does that join up? Because I mean advanced practitioner is a job title but there are people out there who again work at a level of practice which, you know, I look at and think crikey, you're amazing*
>
> *Employer (Nursing) P38*

Professionals such as physiotherapists, speech therapists and occupational therapists thought that they brought specialist skills to the ACP role and developed their generalist skills in an already specialist role. Employers suggested that the role was generalist and usually defined by service needs. Therefore, this ambiguity and lack of transparency continued to proliferate in the continuing debate amongst those with an interest in ACP. However, we did not find that there was any disconnect between ACPs' work and their expectations of the role, possibly because the role is so varied and ambiguous that much health care work could be subsumed within it.

Regulation and recognition

One fundamental and agreed difference between a profession and a level of practice is regulation. Each health profession has a regulating body with whom a practitioner must register in order to practice. It is this organisation which determines the scope of practice for the profession. ACPs did not (and do not) have a regulatory body. This impeded ACPs from being recognised as a stand-alone profession within the healthcare system, particularly within the UK regulatory structures.

HEE accredited the courses undertaken by ACPs in England, which provided a benchmarking process. Multiple participants suggested the accreditation process was vital to reduce variation in courses. Some HEIs said that without standards there is the potential for broad variation in ability within the

ACP role. The majority of participants indicated that the standards were a valuable and necessary tool for measuring quality across the sector. At the same time, there were multiple regulatory or professional bodies developing agendas related to advanced practice. Many NHS Trusts, as employers, described the involvement of such a wide range of bodies in regulating or accrediting advanced practice as obscuring and problematic:

> *You can have every programme in the country accredited but if the majority of people with the title haven't done such a programme then you haven't really achieved much in the way of safeguarding things.*
>
> *HEI (Nursing) P01*

This suggests there were perceived advantages in holding a national register of ACPs. There is significant evidence in our data from employer stakeholders that they would have valued a directory for registration of ACPs.

> *As an employer I would view that we need to have a level of standardisation on regulation of some form because otherwise how do we know what we're getting when we have more and more, ACPs in the country, and then how do we standardise that across organisations?*
>
> *Employer (Nursing) P55*

Some suggested a register would be beneficial for ACP candidates for an overview of their achievements. Other practitioners and employers were not convinced about the benefits of registration for themselves or for patients. Multiple HEI and practitioners raised concerns about conflict with existing registers and having to make choices between alternatives, in particular due to cost. Practitioners thought they would wish to remain registered with their primary profession (e.g. nursing, pharmacy) and have ACP as an additional rather than replacement registration. Many HEIs and employers refer to the generalist/specialist debate about the role and some suggested that registration of ACPs could also have a mechanism to record sub-specialisms. Some said that the voluntary nature of the proposed register could be problematic; participants thought that registration would need to be mandatory for the role, in the same way registration is necessary for (full) professional status, in order for it to gain momentum.

Some participants, especially AHPs without prescribing rights, and some employers, said registration and regulation was impossible until the link between prescribing and ACP was clarified and equitable. Participants drew attention to the fact that the ACP role (as defined by HEE) embeds prescribing as a key function of the role but highlighted frustrations that some professions who can act as ACPs are unable to prescribe, for example Operating Department Practitioners (ODPs), Dieticians and Speech and Language therapists. Several trainee ACPs and practitioners called for HEE to take a role in developing prescribing for all AHPs in order to support moving the ACP agenda forward and being transformative (RCOT 2021).

Some NHS employers and HEI participants felt regulation was required for ACPs but were unclear where it should come from. Some employers and practitioners raised the need for regulation in relation to safety and safeguarding:

> *I've always been quite firm about the fact that we aren't regulated and that we are from different professions. We've got now our 4 or 5 professions in ACP and we haven't got one core regulatory body for advanced clinical practice or a protected title. So, what that means is anyone can call themselves ACP and get away with it and, if they do mess up and they called*

> *themselves in ACP, then it looks bad on all of us. So, I think we need a regulatory body desperately in order to protect that title.*
>
> *Practitioner (Pharmacy) P31*

The landscape of regulation was complicated by the numbers of bodies involved in the broader regulation of all of the associated health professions now acting as ACPs. The question was raised about the interesting dilemma of what would happen if an error were made – for example, if there was an issue which might affect ACP registration and regulation, would it have a similar impact on professional (Nursing/Pharmacy) registration?

Some participants suggested that other models of regulation from other countries could be considered as examples of best practice. These included the Australian Health Practitioner Regulation Agency (Ahpra) who regulate all AHP ACPs, the European Federation of Nurses (EFN) who are doing a meta-analysis of standards in European countries with a view to writing advanced standards for Europe, and the International Council of Nurses (ICN) who regulate ANPs in generalist roles. Likewise, in the United States of America and Canada all Advanced Nurse Practitioners (ANPs) are regulated through a single body. However, regulation and prescribing rights remained a contentious issue, with little prospect of a definitive resolution in the short term.

## Discussion

This study has identified some key, and interesting, dichotomies in the development of a new, 'multi-occupational' profession including clashes in professional identity, debates over whether ACP relates to a role or level of practice, and in general or specialist areas. Finally, the data identified significant issues in regulation.

Our data suggests that some ACPs want to create a new, 'multi- professional' profession and leave their old professions behind, while others want to retain their primary professional identity. There is significant literature debating notions of professional identity. Noordegraaf (2000) outlines debates in professional identity (groups and behaviour research) including professional dynamics in and between professional groups and new groups as well as changing roles, resistance and coping mechanisms. In Pickard's (2009) research on the GP with special interests role, there were similar findings to our study where some participants did not want to lose their previous professional identity, where others were willing to embrace a new clinical identity. Noordegraaf (2000) suggests that protecting current professional structures and values is 'returning to professionalism' whereas the modernisation of professions 'goes beyond professional'.

Noordegraaf (2000) suggests that organisations have become important anchors for producing professional standards and identities. This has significant parallels with our study where participants expressed their varied professional identity in terms of their integration in their NHS role and in their Trust, and furthermore to differing degrees in primary and secondary care.

In our study, employer participants often took a different position to trainees and educators, focusing on ACP specifically as a potential substitute for medical roles. This fits with Cooper and Robson's (2006) research that showed professional organizations make claims to specific activities and expertise and the nature of the claims they make are influenced by their histories, allegiances and struggles with other occupations and economic institutions.

Clearly there is much confusion about the professional identity of an ACP position, both by those undertaking the role and questioning their own identity, as well as the perspectives of other professions, employers and the organisations. The findings from this study raises questions about whether ACP is a role or level of practice and a generalist or specialist. Considering ACP as a role or level of practice is closely linked to the earlier debates around professional identity. Our data suggests that ACPs see themselves as treading between a role and new profession for which the only advantage in some professions is to gain prestige and recognition for their role. However, there is a juxtaposition for ACPs between their identity as an ACP and their previously gained professional identity. There are few professions where this occurs and there appears, for our study, that this has not been squared away to a satisfactory conclusion. Regulation, and particularly of prescribing, remains a contentious issue for all the stakeholders we interviewed.

The boundaries of ACP were certainly an issue but in our data there were no signs of serious conflict unlike Nancarrow & Borthwick's (2021) nurses and podiatrists. Why not? This could be because ACPs were perceived by professions who might have seen them as a threat as still being members of their home professions (as they undoubtedly were). The interviews were conducted at the height of the COVID19 pandemic, and it could be that workforce pressures were so acute at that time that any threat from an aspirant profession was thought to be unimportant. Given that the workforce crisis in the UK NHS persists, it may be that boundary disputes will not become significant any time soon.

This issue with a lack of career structure for nurses and AHPs is long-standing one in the NHS, acknowledged as long ago as the 1966 Salmon Report (HMSO 1966). These professions usually have to leave direct patient care in order to progress their careers (unlike doctors), typically moving into management or education roles. ACP represents an opportunity for a better-paid, higher-status role that is primarily focussed on patient care – hence its popularity with some of our ACP respondents. However, an emergent issue within ACP is a lack of a career structure within ACP itself. Many ACPs find that there are few opportunities for further promotion, without a change of role into management.

ACP is post professional in the sense used by King et al in their paper on diabetes educators. They are also similar to Nancarrow & Borthwick's (2021) disability educators and rural allied health generalists. Nancarrow & Borthwick argue that the regulatory regime in Australia is one factor that makes it easier for new professions to emerge. By contrast this is harder to do in the centralised UK NHS. There is nothing like Allied Health Professions Australia in the UK, so there is no formal 'candidate' status. Achieving specialist status is generally hard for the AHPs (Nancarrow & Borthwick 2021) but ACP is a route to it in England. ACP is also higher-status work in so far as it is more akin to medicine; there is also less 'dirty' work (Hughes 1962).

However, the post professional category is not a perfect fit for ACP. Unlike King et al's diabetes educators a state agency (NHS HEE) is involved rather than an association. Though ACP started in nursing, it is not a formal qualification in nursing *per se*, and though the nursing regulator has regularly considered regulating an advanced level of practice, no action has been taken to date. Though ACP has similar roots in nursing like the diabetes educators, ACP now is much wider in scope, and in the professions it encompasses. ACP is perhaps more like Nancarrow & Borthwick's (2021) rural allied health generalists but again, ACPs have a much broader remit and scope of practice. We thus conclude that the English variant of ACP is a post profession, though it extends and complicates this category. We disagree with Nicholls (2022) in so far as post professionalism does not necessarily signal the end of professionalism, as we will argue below.

We concur with Noordegraaf that "professionalism has become an unstable category and has to be *manufactured* and legitimized in active ways". The status of ACP confirms this. ACPs do not signal the end of professional status (Kurtz, 2021) (at least not in the UK) – but they may point the way to new forms of professional, especially given that the policy direction from the state has moved away from the creation of new professions. The 2021 White Paper (DHSC 2021) included proposals that in England the Secretary of State could remove a profession from professional regulation. It could be that Noordegraaf's protective professionalism really is over, and no new group in the UK will attain that kind of status in the foreseeable future. New professions may be more like ACP in the future. The UK Healthcare Professions Council (the regulator for AHPs) has looked at regulating ACP but has decided not to bring forward any proposals at the time of writing. Indeed, one could question whether there is there much for ACPs to gain by formal state regulation. It was a disappointment to the ODPs studied by *redacted*. ACP are arguably still gaining some of the privileges of professionalism, and higher status in comparison to their 'home' profession. Our data shows that regulation or recognition, if it happens at all, will be driven by employers who, at the current time, are more interested in filling posts than in regulatory issues.

## Conclusion

This paper has extended the theoretical category of post professionalism to include a much larger and more diverse profession than has been demonstrated empirically hitherto, and in the English NHS. It is possible that ACP is an early sign of a different future for professions, where the classical 'protective' model of professionalism is increasingly not supported by the state, but this does not mean that professions will disappear. ACP's contested, liminal status as a profession may become more common. In a wider context, we agree with Noordegraaf that ACP is a contemporary response to wider societal changes. ACP is only possible because the power of (notably) medicine and the other professions has been diminished. Similarly, it is a response to an ageing population and financial crises in late capitalism.

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