Experiences of advanced clinical practitioners in training and their supervisors in primary care using a hub and spoke model

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10.12968/pnur.2020.31.8.334

Title:

An exploration of the experiences of Advanced Clinical Practitioners in training and their supervisors in using a hub and spoke model to develop advanced level practice in primary care.

Short title:

Experiences of ACP training in primary care

Abstract:

Background: Advanced Clinical Practitioners have been fundamental in ensuring the provision of expert care resulting in an increase in demand in primary care. This demand has incentivised innovation in approaches to education to maximise the benefits of training with limited resources and harnessing the expertise within the workforce

Aim: To develop a method of educating and supervising Advanced Clinical Practitioners in Training (ACPiTs) in primary care settings situated in a novel environment, related to a new venture of ACP training involving a hub and spoke environment.

Methods: A qualitative approach with close methodological links to the philosophical work of Heidegger was used to capture the nature of existence and reality in such a world (hub and spoke environment).

Results: Three main themes emerged from the study: support, supervision and vision.

Conclusion: This format of training is a useful alternative to traditional methods in developing practitioners who work in a bespoke yet broad practice environment.

Keywords:

Advanced Practice Nursing, Allied Health Personnel, Primary Health Care, Education,

Keypoints:

Consistent clinical supervision and support enabled growth in confidence and to gain an emerging sense of being in the role, even when initially struggling to make sense of the model being used.

The need for qualified ACPs for support is lacking and would aid ACPiT to overcome some of the challenges faced for the emerging role in general practice.

The level of competency and aptitude to role may be in advance of expectations with ACPs practicing at an advanced level from the end of the programme.

Reflective questions

1. What methods of supervision / mentoring have you experienced and how has that affected your practice?
2. Considering the challenges ACPiT faced from this paper, how can you facilitate the development of advanced practice in your specialty / area of practice for future health professionals?
3. How can ACPs disseminate their practice to advance advanced practice nursing?

Main text

Introduction

Advanced Clinical Practitioners (ACPs) are often misguidedly regarded within the health care arena as nurses with extra knowledge and skills. Such a situation

probably presents a façade of ACP's as nurses as there are predominantly more nursing ACP's than any other profession. However over many years' multiple professions (e.g. Physiotherapy, Social Work, Audiology, Paramedic fields) have trained professionals who are now practicing in a role that demands advanced clinical and theoretic skills. Importantly though, ACP's do not have a separate professional registration and remain solely recorded with their original regulatory professional body. Recognition of ACP status is widely disputed partly due to the lack of title protection and due to a lack of professional regulation of the role and training required despite the recent multi-professional framework and definition of the Advanced Clinical Practitioner (HEE 2017) which defines a level of practice.

The roles ACPs have started to take on board have broadened over time and there has been an emphasis on primary care and utility within General Practitioner (GP) practice. ACPs have been fundamental in ensuring the provision of expert care and maintaining essential services and the role is in greater demand than ever in primary care. This demand has incentivised innovation in approaches to education to maximise the benefits of training with limited resources and harnessing the expertise within the workforce.

Background to study

Following a consultation period and review of primary care services, one local commissioning group requested a fresh approach to ACP training to meet the needs of a primary care service and one which would function within current service structures. The key aim was to develop a method of educating and supervising

Advanced Clinical Practitioners in Training (ACPiTs) in primary care settings, the objectives being agreed to:

- Explore the ACPiT's experience of their development towards working at an advanced level of practice in primary care.
- Examine the stakeholders' perspectives (GPs) who have been directly involved in supporting the trainee ACPs.

Supervision for the 14 ACPiTs would be provided by GPs over a two-year period. The professional background of trainees was to be drawn from all available healthcare professions at the time deemed competent to undergo the training at MSc level. The bold sub directive was to train the ACPs so they could manage primary care and home consultations as an independent practitioner with prescribing and a high level of systems assessment skills.

Brief Literature Review

Medline and CINHAL were searched (as they are regarded as comprehensive repositories for health and allied health research). The search timeframe was limited to 2015-2020 to only include recent material to pick up on the constantly changing face of primary care. The databases were searched using the following simple terms and derivatives of; Advanced Practitioner, Primary care. The flow diagram below – see Fig.1 is used to show the search and reduction of data to address the key aim above. Added to the data retrieved was one paper which was yielded from a search of the grey literature.

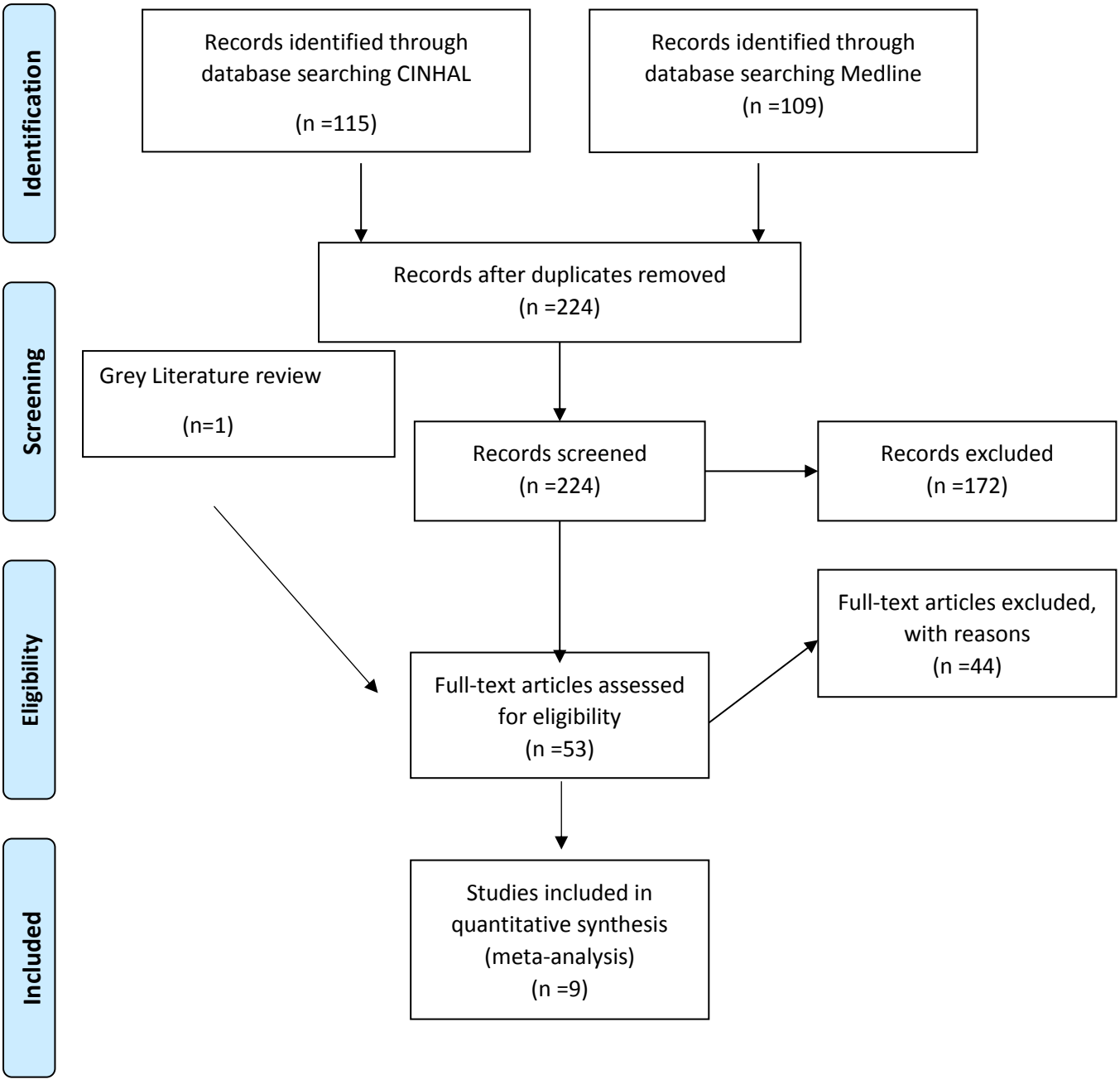

Fig.1. **Flow chart based on PRISMA structure**

The search yielded 9 papers for review.

The range of papers were of variable quality (each where possible assessed using a CASP [https://casp-uk.net/] quality appraisal tool). The higher quality papers adopting a clear research methodology and outcome, the weaker ones being individual reflections on the role and journey to advanced practice qualification. All were included due to their recent and focused attention to the role of the ACP and the emphasis on primary care and the ongoing development within the narrative.

Much of the literature reviewed focused on ACP's involvement within primary care however, related aspects to the primary care practice were developed; highlighting personal journeys encountered in ACP training (Brown 2017) and creating change in MDT working (Jenkins et al 2018; Leask and Tennant 2019; Ljunbeck & Sjogren 2017) and addressing complaints (Oliver 2017). The poster presentation (Jenkins et al 2018) was included due to the development debate and the novel focus on advanced practice in primary care. Evidence was also identified in the training of GPs (O'Connor et al 2018) and exploration of role development of ACP's Nelson et al 2018; King et al 2017; Preston & Irvine 2019).

A local commissioned report (Nelson et al 2018) identified scepticism re role, potential challenges to professional identity, and discrepancies in expectations. The research team, acknowledging the past research and the local commissioned report, designed a project to not only meet the original aim but to also explore ACPs experiences from the insider perspective. The research team decided to explore the 'being' an ACP using a novel approach to training and support; using a hub and spoke model (see Fig.2 for further information and brief comparison). The research team had identified a gap in previous research and wanted to truly unearth the sense of 'being' and explore personal factors that enabled or resisted development. It was felt that a good point

from previous studies and reports was the use of other opinions in the research[8] and planned to establish others (GP supervisors) opinion about the model and development of the role in primary care.

Traditionally, trainees were recruited from commissioned numbers, and employed in the areas where they were commissioned from. If a trainee worked in a GP practice, they would have one GP assessor and undertake all learning in that practice. Outside of practice, training was conducted in the university. To support the ACP's and their supervisors and the quality assurance of learning opportunities a University learning facilitator would visit.

The hub and spoke – The Primary Care Organisation employed all trainees; they took overall responsibility for the trainee's workplace learning and allocated GP practices and GP's to the trainees – they met as the hub once a week to do more training and offer support (in addition to the university training). In addition to the university learning facilitator visiting, if there was an issue in the practice the hub would go and visit and if needed offer additional learning opportunities / support at another practice

Fig. 2. Hub and Spoke/ Traditional programme

Methodology

The methodology needed to be a conduit to address the key objectives;

- Explore the ACPiT's experience of their development towards working at an advanced level of practice in primary care.
- Examine the stakeholders' perspectives who have been directly involved in supporting the trainee ACPs.

And in doing so add value-based commentary in addressing the aim to develop a method of educating and supervising ACPiTs in primary care settings.

These objectives were situated in a novel environment, related to a new venture of ACP training; hub and spoke environment. As outlined in Fig. 2, the traditional training was slightly different to the hub and spoke.

In order to come to some understanding of the perspectives from the hub and spoke, the researchers were aware of the need to frame their standpoint. The researchers operated within a philosophy that permitted any participants the chance to explain and reflect, whilst also allowing them to interpret and reinterpret the nature of what it was to be in the everyday existence that they had adopted. The underpinning philosophy was an important adjunct to developing a way that the study would be conducted and an understanding of the materials to be both collected, but also to how they were to be interpreted. A key driver to this was the researchers unerring question of what it is like to be an ACPiT and a GP supervisor in the world of a hub and spoke environment. The methodology links to the philosophical work of Heidegger (1967) and closely to his 'Being' (experiences of an ACPiT or GP) and importantly, unearthing ontological perspectives to the nature of existence and reality in such a world (hub and spoke environment).

Prior to the use of the hub and spoke, training the ACPs adopted a predominantly 'medical' competency bound approach, used to mechanistically shape and manufacture learning as artefacts of emergent clinical events. Building a contemporary supervisory relationship within the hub and spoke environment used the strengths of both the ACP and the GP(s) with fluid governance of ringfenced opportunity for personal development and challenge. Exploration of practice in a new relationship and environment was eminent in the thoughts of the participants.

An important factor the researchers wanted to gain, was the interpretation of the being in the midst of the environment, rather than just identifying what can become known about being in the world of the hub and spoke environment. It is argued by Mackey (2005) that Heidegger considered being-in-the-world (environment) to be a priori. Importantly the researchers focused their attention to the participants reflections on their 'everyday' activities using the environment, and their values related to the such.

To generate information for the researchers to interpret, interviews with a series of questions were adopted. The questions posed the participants with the opportunity to explore their understanding and experiences in their everyday work, but also to reflect and reinterpret what their 'everydayness' was for them.

As the researchers were ACP educators and one was a current ACP in Practice, some advanced interpretation was already understood, and the baggage of personal experiences acknowledged. The descriptions of the participants in this 'everydayness' would be needed to be interpreted and valued for their content. Interpretation would need to explore in a cyclical approach, reinterpreting 'being in the word' of the shared experiences of the participants and then establishing a clearer definition of meaning. Such a process needs the researchers to reflect on interpretations to generate deeper meanings, questioning the text being used to highlight the experiences and engagement in the hub and spoke.

Sample

The sample size for the project was to be in line with a convenience sampling strategy, aiming to recruit all trainees (n=14) and their GP assessors (see Fig.3 for

demographics). Although this may seem ambitious, it wanted to establish as much information as was available in order to meet the aims.

Practitioner participants; Professional background- paramedic x 1, nurses x 4 and physiotherapist x 1. Experience- more than 5 years post qualifying experience with a mix of primary care / secondary care experience. Age band 36-54 years old GP x 5; all previously supervised trainee GPs. All working in the same Local Commissioning Group

Fig. 3**. Demographics of sample**

Ethics

Ethics approval was sought from the University and the local commissioning group ethics panel, with approval to conduct the research granted.

The project adhered to established ethical issues used in interviewing, parallel to those about human research in general (Morse 1991), and care was taken to ensure the rights of the participants involved were protected. The key ethical principles in this study were, autonomy (Beauchamp and Childress 1994). Importantly, it was the researcher's responsibility to protect the participant, through anonymity and confidentiality, informed consent, and the right to withdraw from the study (British Psychological Society 2014; Royal College of Nursing 2011).

Any issues identified in relation to practice that breached the health professionals' code of conduct (Nursing and Midwifery Council 2015; Health and Care Professions Council

2016; General Medical Council 2013) would be reported to the gatekeeper as discussed with the participant.

Method

The use of interviews enabled the generation of narratives that captured the experiences of both the ACPiTs and the GPs. Key prompting questioning for the ACPiTs were used to engage the participant in reflecting on the 'style' of support they worked within whilst avoiding inculcating past thinking into practice. Encouragement was used in the questions to delve deeper into the personal view by the use of phrases such as; can you share your experiences, how valuable do you feel, how could you improve.

With the GPs there was a focus on the experiences of working and supporting ACPiTs within a hub and spoke model. Exploration moved the interviews to look at the educational development and the view of the experience. Similar encouraging questions were used to engender personal views. The outcome generated a great deal of conversational text that was formatted to word documents for data analysis.

Data Analysis

The interviews were recorded and transcribed verbatim. The interviews had a general theme that focused the participants to explore their experiences of the process and use of the hub and spoke, but to also interpret their position and interpretations as related to them. The interviews lasted for up to one hour and were conducted in a place of choice of the participant. Although using a series of questions with an aim,

the questions were open ended and guided rather than directed the conversation to generate value to the contribution and allow acknowledgement of them in the environment and their interpretation. The analysis involved each researcher reading and re reading the transcripts. Utilising a framework analysis method for generating understanding engaged the researchers in familiarising themselves with the narrative text and making notes and indexing themes important to them. This generation of themes allowed them to interpret and reinterpret the emergent themes that appeared. Care was taken not to fit the themes into a priori understanding and to allow the themes to emerge and develop supported by their own data from the interviews. The combination of themes was then agreed following a series of discussions focused on each interpretation, but importantly was arrived at by making personal judgements and not in allowing the process to become a formulaic process of data reduction. Rather than coding and mechanistically thematising, the transcripts were read in a way to allow emergent points to shine through and highlight the contextual link with the aims of the study which aided the development of an index for the data. This process presented the opportunity for the researchers (for the first time) to extract sections of data and collate in tables for further analysis. A key concern that the researchers wanted to protect was the context of the lifted sections to easily identify its source. The final interpretation involved the researchers ensuring that the true voice of the participants was displayed and highlighting the values related to their experiences.

Findings

The findings are presented in three simple themes. Although wanting the themes to be overarching and detailed, some distinct clarity was made using simple broad terms. Extracts from the transcripts are used to highlight detail and these are related to specific participants; I = Trainee, S= GP supervisor.

Theme 1: Support-

Participants overwhelmingly valued the nature of consistent clinical support from their designated GP mentor in practice and peers as afforded by the hub and spoke model. Commonly participants would work across practice boundaries with the support of different GPs

sat in for a couple of weeks with the different GPs to see how they work differently then, seeing patients for a 20-minute period and then the GP coming in and going through the assessment or them sitting in and watching the assessments. (I1)

participants had experienced a range of support before, however, attuning to the model's mode of support, enabled them to grow in confidence and gain an emerging sense of being in the role, even when initially struggling to make sense of the model being used

I've always felt supported, I think it's been explored that was so, patients have booked in with me without any barriers, and it's been a little bit a case of, right, let's see what you do with and if she's thought, maybe we need to steer you in that direction, it's always been a little bit more of a case of that. (I6)

The support provided and model of such applied was felt to aide a progression in skills and confidence of participants. However, the sense of being confident in this role was not uniform and those coming from a secondary care background felt particularly disadvantaged, more challenged and in need of hub support structures/guidance. With time and support, confidence and skills grew and as a result, the sense of being developed as support began to be understood from the view of being different to other support experienced and unique to this role

More support in the first year, and as I got experienced and have gained trust amongst the GPs, amongst my clinical mentors, then there's less strict supervision. Because they know that I'm able to do the job. (I3)

Theme 2: Supervision-

The models of supervision utilised generally similar platforms, yet in some instances, organising the four arms of the supervision (see below) had its challenges.

So I think there is four elements to this. There is myself, the academic/university side, there is my GP side, and then 'employer'. And trying to get all four people in the room is sometimes the potential, I felt was an issue from there, because everyone has their different views and approaches on doing things differently, and different demands at different times as well. (I5)

To address the organisational challenges of supervision, many students grew to favour opportunistic supervision and elements of the hub and spoke approach which some GPs appeared familiar with. One comments and reflected others in asking about the way supervision was used, "*opportunistic, and flexible, I would say" (S2)*

Engaging in the role (ACPiT in primary care) and experiencing supervision was linked by all to the development of knowledge and training opportunities, but also the impact that more of each has on the ACPiT. This impact extends beyond the work environment yet is anxiously seen as the role in primary care of an ACP. The quality of such were perceived by ACPiTs by GP availability....

There's a lot of earthquakes of change happening everywhere and kind of jumping over these cracks and trying to make things work, while seeing patients, while feeling safe doing them, it's literally like spinning plates and as well, trying to fit in some kind of family life and things like that. It's intense. It's felt like a hurricane. (I6)

Although supervision and support were seen as positive and instrumental in personal development in the role by the ACPiTs, many advocated the need for qualified ACP support whilst training as well.. a sense of something missing.

I think one thing that, I wish I had more access to, was ACP's that have qualified recently from the course, direction and guiding from them. People that have just gone through it, giving tips and tricks really. (I6)

Theme 3: Vision-

Several of the ACPiTs felt that there was an initial lack of understanding of the emerging ACP role in primary care. This general view was argued to be due to

a misunderstanding of who and what we were at the GP level. I think possibly yes, they didn't quite know what we were and how then to train us effectively. (I5)

In coming to understand their position of being in the role of the ACPiT in the primary care hub and spoke model, some came to the conclusion that the GPs may have defaulted to an understanding of role to the previous base profession of the ACPiT and/or alternative experiences of mentoring

She found it very, very different from the medical model and the expectation and things like that. [……..] because she'd come from a such a medical model, we were both left a bit bare I think. (I6)

Reflecting on being in the role of a GP, many were able to not only see their own training as a marker but also to envisage the challenge that the ACPiTs were going through.

It is really intensive. […] Because I look back at my GP training and I don't remember it being as arduous as that. You know, the workplace-based assessment, I don't remember it being quite as arduous as it seemed to be. (S1)

Scepticism and preconceptions were challenged throughout the progression of the training largely due to a misunderstanding of the role and in some instances professional conflict in protecting their own profession. This generated a sense of being in a role that was different to other colleagues where the hub and spoke was not used.

I was very against doing it because I felt that the answer to shortage in GPs should be to train more GPs, not to train other people to do the jobs that GPs do and I was very sceptical of people coming in and doing our job and being able to do it properly, particularly when they don't have a medical degree. But very quickly I learnt from Xxxx's approach … that his … *background of an ex A+E and Paramedic… the way he dealt with emergencies was fantastic. (S3)*

This sense of GPs being in a different position (role as a GP) that potentially challenged professional allegiances, was noticed by the ACPiTs in the model

….a*nd she actually said they were very wary about Advanced Practitioners coming in. Who are these people? They've only been training for two years and they're going to be classed as GPs. But...surprisingly, that she felt quite comfortable straight away. I think I came with quite a lot of experience. ...I think she relaxed and knew that I was capable of something, but I was not capable of the complex stuff that the GPs see on a daily basis. And that's been the nurturing process really. (I2)*

Over time the hub and spoke model drew GPs and the ACPiTs to work together more closely and share more personal experiences of being 'there'. It is noted that the GPs expressed an appreciation of the value of the role, and recognition of previous professional background and experience including alternative consultation styles and a more holistic approach to care

X has a great background in emergency care, he's very direct, and because he's got more of a holistic view he's very, very good at health promotion. ...So I think from patient point of view he's extremely holistic, ... but I actually think it's good for people to have access to different types of clinicians. (S3)

because everybody wants APs and it's been pretty difficult to get somebody to do that. ... And so, there's this big … everybody wants an AP. And should I say, well fair play to them. They are pretty much like … you know, like, when there's a coveted bride (S2)

And they probably felt they got a slightly different consultation. Some of that was good, I think, because she was applying some of that nursing history that she's got (S5)

The ease of embedding of the role and being in the role of the future ACP in primary care was reportedly related to acceptance from the wider team, where often the GP would act as advocate or the practice staff had prior exposure to ACPs.

there was an AP in role at my practice and at the other two practices in the group, so, everyone was familiar with the AP role and what people could see and what they couldn't. (I4)

From a level of service provision now, ... we're better off using the advanced practitioners because they provide a better service for the emergency patients... which is why we've employed other advanced practitioners as well. (S3)

Discussion

This paper highlights some of the emergent reflections of ACPiTs and GPs involved in the hub and spoke model of training. Given the bespoke nature of GP's work, which often contrasts to that of the hospital specialist, exploring the introduction of ACPiTs with a varied clinical background (some of whom had no primary care experience only that of specialist training) to a primary care team, required careful evaluation and sensitive handling of information. Over the two years the ACPiTs have gradually gained experience and knowledge, facilitated by GPs.

The findings were predominantly positive with the ACPiTs feeling as though they were allowed to grow into the role and the GPs, although potentially sceptical, being able to identify skills and approaches that complemented the delivery of a service to a diverse population. Although there was some initial need to modify perceived practice by the ACPiTs, the sense of confidence and trust emerged. Such trust from the GPs

was gained by the emergence of competence and accommodation of new skills akin to the role.

The development of a role was seen in previous research (Leask and Tennant 2019) and the role presented a useful addition to the knowledge and skills currently in the practice. Such roles may have had their genesis in past incarnations of the practice of the ACPiT but was identified and modified for use with the support of the GP. As Ljungbeck and Sjogren (2017) identified, the introduction of such a role allowed more time for the doctors to see people, but as time moved on, the ACPiTs, who initially may have thought they would only see minor presentations, gained the trust to see a random sample of presentations not metered by severity. The trust from being in the training and supervision, enabled the GPs to abdicate work more freely over time.

Although supervision and support were clearly needed and provided, the consistency of approach and embedding in practice led to more trust and more self-reflection by the GPs on the training the ACPiTs were engaged in. Further the level of competency and aptitude to role may be in advance of expectations (Fairhurst 2017) practicing at an advanced level from the end of the programme. In many ways the development of a self-identity as an ACP in primary care may question the findings of King et al (2017), and from the support of the hub and spoke, bring in to question the need for a recognised alternative qualification, as the ACP in primary care from this sample are moving into practicing as active functioning members of a team of primary care practitioners seeing clients as they arrive, rather than by role of the practitioner or by severity.

The GPs have probably had their role questioned by non-medical colleagues moving into roles currently adopted by them. However, closer working and opportunity to

supervise led to more confidence in the relationships and the being at potential odds, moved to being in harmony by the end of the research for some. The potential of having colleagues from different backgrounds enabled the GPs to see alternative practice and although shaping experiences, probably found some of their thoughts and practice being realigned to accommodate other approaches to practice.

As highlighted earlier, the hub and spoke model differed slightly to the traditional training in that it gave bespoke supervision and ringfenced time above what was previously offered and added the support of other GPs and opportunity to work in other practices. From the findings, the broadening of opportunity and increased support enabled ACPiTs to grow more quickly than they expected and gained the trust to treat patients by GPs, who from the cohort in question, left a positive sense regarding utility and training.

A final area for discussion is whether the hub and spoke had advantages or disadvantages for those involved. No attempt was made to compare or contrast the quality of each route. The aim was solely to explore the experience of the hub and spoke. To this end, positive factors emerged, and it could be accepted that this format of training is a useful alternative to the traditional as it succeeded in training and developing practitioners who worked in a bespoke yet broad practice environment. It also succeeded in preparing trainees to be competent from the time of completion and need no further induction to practice. Following publication of the Core Capabilities Framework for Advanced Clinical Practice (Nurses) Working in General Practice / Primary Care in England (Skills for Health 2020) it would be useful to explore and evaluate how this may enable training to be structured for a trainee and supervisor

and whether this may decrease the uncertainty of expectations and provide a more robust understanding of this role and be extended beyond the nurse in GP practice.

Conclusion

The paper has addressed the aims and identified clear experiences gained from the hub and spoke model. The positive aspects in some ways challenge previous research regarding trainees being ready and competent at the end of training (Fairhurst 2019). Fairhurst (2019) outlined clear layers of support provided by a non-traditional support professional (GP), who had previously only supervised other GPs. To an end, the supervision was deemed positive and the support associated valued. The key outcome was that there was a vision of utility of the model and this could be used in the future.

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