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Implementing advanced practice: identifying the factors that facilitate and inhibit the process

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Summary

• This paper reports the preliminary results of research investigating the factors that help or hinder advanced nurse practitioners as they attempt to implement new roles in clinical practice.

• Multiple facilitating and inhibiting factors are identified, the majority of which are shared across various clinical settings.

• Factors fall into three categories: re-negotiating relationships; becoming an advanced practitioner; and the clinical context and deployment.

• Whilst the results of this case study research are not necessarily generalizable, they provide evidence of the lived experience of advanced nurse practitioners attempting to implement new roles in a variety of clinical settings following their graduation from a Master's degree programme.

Keywords: advanced nurse practitioners, case studies, facilitators and inhibitors of practice, role implementation.

Introduction

In recent years, the debate surrounding the issue of nurses developing new and different roles and expanding the care they provide has gained momentum in the UK. As with any change or development, the notion of nurses taking on additional roles and responsibilities has been met with both support and criticism. The UKCC has fuelled the debate by recognizing the concepts of specialist and advanced practice (UKCC, 1990), yet whilst being explicit about the concept and standard of specialist practice, it remains vague (and probably rightly so at this stage) about advanced practice (UKCC, 1994). To some extent this has added to the confusion about what constitutes 'advanced' practice and exactly what roles and activities advanced nurse practitioners should or should not be developing. Events, however, have overtaken the philosophical debate and nurses and other health care professionals are developing and implementing new roles in clinical practice. Furthermore, an increasing number of universities in the UK are offering, often at the Master's degree level, courses designed to formally prepare nurses to 'advance' their practice (Gibbon & Luker, 1995; Paniagua, 1995).

This paper reports preliminary research findings from an ongoing study relating to factors identified by nurses as facilitating or inhibiting their attempt to implement an 'advanced' practitioner role in clinical practice. The participants involved in the study are all graduates of a Master's degree programme at a UK university designed to prepare nurses for 'advanced' practice. It is not the aim of this paper to add to the semantic debate regarding the definition or development of specialist and advanced practice roles, but rather to report on the lived experience of nurses as they are faced with the challenge of implementing and develop-

ing 'advanced' practice in the reality of the day-to-day clinical environment. The terms 'advanced'/'advanced practitioner' are used throughout in acknowledgement that a number of research participants have formally incorporated the term(s) into their job titles, as an indicator of their new roles, responsibilities and status.

Background to the study

This paper refers to an ongoing longitudinal study entitled 'A Prospective Analysis of Factors which Contribute to the Development and Performance of Advanced Nurse Practitioners and the Impact of the Role on Professional Practice'. The study is funded by a full-time Research Fellowship offered by a Regional Health Authority and is being undertaken solely by the author. *One* of the objectives of the study is to 'Identify the factors which facilitate and/or impede role development and performance'. This paper reports the preliminary findings relating to this particular aim of the study.

Literature review

There is an dearth of empirical data from the UK on advanced practice roles. This is in part due to the relatively early stage of development and formal preparation (i.e. at Master's degree level) of advanced nurse practitioners (ANPs) in the UK. Thus one has to draw on the international literature, predominantly emanating from North America, when reviewing this subject, with the usual caveat regarding its transferability.

A number of studies have explored the factors that advanced practitioners, including nurse practitioners and clinical nurse specialists (CNSs), state are a help or hindrance to them as they develop and implement their roles in clinical practice (Sullivan *et al.*, 1978; Zammuto *et al.*, 1979; Hayden *et al.*, 1982; Hupcey, 1993; McFadden & Miller, 1994; Maguire *et al.*, 1995). Most of these studies identify a wide variety of factors that can be classified (for the purpose of this review) into four main themes, namely:

- professional relationships;
- individual practice;
- the clinical environment; and
- legislation.

Additional factors identified concern policy for reimbursement for services, which is not perceived as being directly relevant to the UK.

The group of factors that appears to be most frequently identified relates to the theme of 'professional relationships'. Hupcey (1993) conducted a survey of a random sample of 80 nurse practitioners and reports that the top three factors that they identified as helping their role performance were linked to support from medical and nursing colleagues. In a study of CNSs (Hamric & Taylor, 1989), peer support from fellow CNSs and support from nursing administration were seen to be of significant importance in helping role development. The support of physicians has also been identified as being necessary for the successful implementation of the CNS role (McFadden & Miller, 1994). One suggested reason why professional relationships are considered to be important for advanced practice nurses is that their establishment is seen as the initial step towards empowerment and the creation of a successful environment for practice (Maguire *et al.*, 1995).

Just as the importance of support and acceptance from professional colleagues is identified as a facilitator of practice, its absence is equally noted as an inhibitor of role development. In a study of Emergency Nurse Practitioners (Hayden *et al.*, 1982) the top barrier to practice that influenced role development was resistance from other health care providers. Likewise, a study of 497 nurse practitioners (Sullivan *et al.*, 1978) identified that over one-quarter ($n = 143$) identified resistance from other health care providers. This may be due in part to reimbursement issues in the USA, as opposed to direct resistance to advanced practitioners on grounds of beliefs about the concept of advanced nursing practice. Interestingly, however, resistance to the advanced practice role specifically from nursing colleagues has been identified as an inhibiting factor (Hamric & Taylor, 1989; Hupcey, 1993). The nature of such resistance is exemplified in a respondent's comment in one study where it is stated that 'her greatest barrier was that experienced staff considered themselves specialists and felt threatened by her' (Hamric & Taylor, 1989; p. 70). Hupcey (1993) finds it remarkable that after almost 30 years nurse practitioners are still meeting resistance from their own profession.

The second group of factors identified concerns 'individual practice', in particular autonomy and independence in the work setting. Hupcey (1993, p. 184) states that:

> This sense of autonomy may allow nurses to use the skills that they feel are appropriate for their roles.

Clinical nurse specialists identified that clinical competence and confidence in their ability, interpersonal skills and motivation all played an important part in facilitating their role development (Hamric & Taylor, 1989).

The nature of the clinical environment in which the advanced practice nurse is employed also has a significant influence on the way and rate at which the role is implemented (Zammuto *et al.*, 1979). For example, from a resource perspective, the need for sufficient material resources and human resources for the implementation of the role to be successful is apparent (McFadden & Miller,

1994). Similarly, limitation on physical resources such as space and facilities are identified as barriers (Sullivan *et al.*, 1978). Furthermore, understanding of the advanced practice role by nursing and medical colleagues is another important factor. It has been noted that a *lack* of understanding of the role by managerial and medical personnel (Hupcey, 1993) and nursing colleagues (Hamric & Taylor, 1989) acts as a barrier to practice.

The final group of factors refer to the impact of legislation on the role of the advanced practice nurse. This appears to be manifest in both practical and conceptual terms. The former focuses on issues surrounding licensure for nurses to undertake certain activities that have traditionally been within the prerogative of other health care providers, such as prescribing privileges. Hupcey (1993) identifies the absence of such privileges as a barrier to nurse practitioner practice, whereas the conceptual factors revolve around fear of litigation in the light of an ambiguous legal status (Sullivan *et al.*, 1978) of some roles. Dowling *et al.* (1996) reiterate this argument in the UK by identifying that the changing scope and standards of practice of new nursing roles, coupled with uncertainties about appropriate management, has resulted in 'a confusion of accountability'. They argue that nurses taking on new roles may expose themselves to risk of complaint and disciplinary and/or legal action if there is not clarification over the legal status of their practice.

Which of these factors, if any, are present when nurses attempt to implement advanced practice roles in the UK is the focus of this study.

Research Design

The design involves longitudinal, multiple case studies, and was selected for its methodological appropriateness for the purpose of the study (see Woods, 1997 for full explanation and rationale for the research design).

SAMPLING STRATEGY

The population for the study consisted of a cohort of 25 nurses seconded to a one-year, full-time Master's degree programme designed to prepare them to take on advanced practice roles upon their return to clinical practice.

After obtaining permission to access the cohort, a letter of introduction and explanation about the study was sent to all students on the course, along with a short biographical questionnaire. This yielded a sample of 16 nurses willing to be involved in the study. From this sample, five were selected to be the focus of the longitudinal case studies. The selection of the five cases was discussed with the research supervisors, and was based on a number of factors including the clinical speciality in which they worked, the part of the region in which they were employed, their clinical experience and their educational background. The selection of the cases was based on a purposive sampling strategy, whereby each of the five individuals was selected specifically for their particular interest and relevance (Patton, 1990) to the phenomenon under study. The case study sites cover three different health authorities throughout one health region. One of the nurses is identified as the 'key' informant in each case study. However, in designing the study it was decided that a 'case' would also comprise people who were deemed likely to have a direct or indirect influence on the way the role was conceptualized, developed and implemented. Therefore in addition to the 'key' informant, each case also comprised their clinical nurse manager, directorate manager, consultant preceptor, a lecturer/co-ordinator in the appropriate clinical field at the host university and a member of the key informant's peer group. Currently, a junior member of the medical staff is also being recruited into each case study. Thus each case comprised six or more individuals.

The nurses were followed for the duration of the course and for the first six months after graduation. As the study is ongoing, the cases will be followed for a further six months as they attempt to consolidate their new roles into clinical practice.

In addition to the five case studies, the remaining 11 nurses recruited into the study agreed to complete role development diaries (see below) for the first six months that they were back in practice following graduation from the programme.

This provided an overall sample of 16 nurses, working at 16 different sites. The sample was eventually reduced to 13 when, of the additional 11 nurses who agreed to participate in the role development diary phase of the study, one withdrew from the course, and two failed to complete or return any diaries.

METHODS OF DATA COLLECTION

For the purpose of this study, four methods of data collection were adopted. They were interviews, direct observation, self-completed role development diaries and documentation such as nursing and medical records.

INTERVIEWS

Each member of the five case studies has been interviewed twice, with the exception of the nursing peers, who have been interviewed once, and junior medical staff who are currently being recruited and interviewed. The first series

of interviews were semistructured and concerned establishing participants' perceptions and understandings of advanced nursing practice and how they envisioned the role being implemented. The second interview was more reflective in nature and focused on their perception of how successfully the role was being implemented in actual practice. Part of the second interview (first interview, for nursing peers) involved asking participants to identify the influences and factors that had either helped or impeded the ANPs as they attempted to implement the new role into their clinical areas. A further series of interviews with a number of case study members is scheduled in a further six months' time.

DIRECT OBSERVATION

In addition to data collected via interviews, direct observation of clinical practice at three of the case study sites (Neonatal Unit, Accident and Emergency, and Respiratory medicine) has been undertaken. To date a total of approximately 50 h of observation at each site, spanning a nine-month period, has taken place. A further period of observation will take place in each of the three cases over the next six months. Once again, part of the focus of the observations, including on-site discussion with the 'key' informants, helped identify facilitating and inhibiting factors to implementation of the advanced practitioner role.

ROLE DEVELOPMENT DIARIES

Using data gathered during interviews and observations, a *role development diary* was developed, incorporating the key activities of advanced practice as they were perceived and anticipated. The key informants were asked to use the diary to document their practice for five consecutive working days in each of the first six months of practice, following their graduation. In addition, the diaries were completed by the further eight graduates from the course who had agreed to participate in the study. In addition to documenting daily activities, for each day the diary was completed the informant was asked to enter the factors that had helped or hindered them in their practice that day.

CLINICAL RECORDS

The completion of clinical records was noted and investigated where appropriate in order determine where and how advanced nursing practice was documented. The data yielded by this source is not reported here.

Thus, to date, the data set for the study comprises 42 interviews, 150 h of observation and 52 completed role development diaries (not all participants completed a diary for *each* month), covering a total of 247 days of clinical activity across 13 separate sites. Table 1 illustrates the distribution of the sample and the practice environments in which the advanced practitioners are employed.

Table 1 Distribution and Practice Environments in which ANPs are employed

A & E	$n = 2$	(1 case study)
Community Psychiatry	$n = 1$	
ENT ward/OPD	$n = 1$	
Gynaecology	$n = 1$	(1 case study)
ITU	$n = 3$	(1 case study)
Neonatal units	$n = 4$	(1 case study)
Respiratory Medicine	$n = 1$	(1 case study)

Clustering of the data

Throughout the study it has become evident that the way in which the new roles are being developed, practised and implemented is varying according to the type of clinical environment in which the practitioner is employed. Therefore, for the focus of this paper, it was decided to consider the evidence in relation to the nature of the clinical environment in which the ANP works.

For the purpose of data analysis, clinical areas were divided according to patient dependency into the following three groupings:

1 High patient dependency on medical, nursing and instrumental intervention, including Neonatal Unit ($n = 4$) and adult Intensive Care Unit ($n = 3$).
2 Acute patient dependency. Varying from high to low dependency on medical, nursing and instrumental intervention, including Accident and Emergency ($n = 2$) and Gynaecology ($n = 1$).
3 Episodic and chronic patient dependency. Varying in dependency on medical and nursing intervention, however generally low dependency on instrumental intervention, including Respiratory Medicine ($n = 1$), ENT Outpatients ($n = 1$) and Community Psychiatry ($n = 1$).

The factors identified during data collection that were perceived to have had a positive influence on the implementation of the role in practice (facilitators) or a negative influence (inhibitors) were then sorted via patient dependency groupings.

Interpreting the data – a note of caution

The purpose of this paper is to *identify* the factors that facilitate and inhibit the process of implementing advanced

nursing practice and provide a preliminary analysis. It will be recalled that the data collection methods used throughout the study are *qualitative* in orientation. As the study is ongoing at the time of writing, the *interpretation* of the data is yet to be verified with the research participants, in terms of which of the *identified* factors are having the greatest or least impact on the implementation of their new role. In other words, the *strength* of the association between a particular factor and its impact on clinical practice remains to be assessed. On completion of the data collection phase, it is intended to check findings and conclusions with research participants.

In the meantime, in order to *display* the results in an accessible way, frequency logic, more associated with the quantitative paradigm, has been adopted. The data have been sorted, ranked and displayed on the basis of the frequency with which each factor was identified. However, it should be noted that in this instance, frequency does *not* necessarily correspond to the degree of importance or significance the research participants place on any particular factor. Frequency logic was selected as a way of presenting the data at this stage because it gives an indication of the factors that are *commonly* encountered by individual practitioners, and which have been identified as having either a facilitative or inhibiting effect on their practice.

Because of the large number of factors that have been identified ($n = 118$), it was decided that for this paper only those factors identified on *three* or more occasions in each dependency grouping would be included. For example, the number one ranking facilitating factor identified overall was 'support of medical staff', identified on 24 separate occasions. The number one ranking inhibiting factor identified overall was 'being expected to develop the ANP role whilst being counted in the nursing numbers and/or being required to undertake "old" job', which was identified on 48 separate occasions. To illustrate that frequency does not necessarily relate to importance, one of the case study participants reported that the *biggest* problem in developing the advanced practitioner role is caused by 'the lines of accountability and red-tape that have to be negotiated before achieving even a minor change'. This factor was only identified on two occasions and therefore does not appear in the ranking lists.

Table 2 Frequency of facilitating and inhibiting factors by dependency grouping

	Number of facilitating factors	Number of inhibiting factors
High dependency	32	48
Acute dependency	29	27
Low dependency	22	29
All groups	50	68

Findings

A total of 50 separate factors were identified as being 'facilitative' of implementation of the advanced practitioner role, compared with a total number of 68 'inhibiting' factors, across all three dependency groupings. Table 2 gives the frequency and distribution of facilitating and inhibiting factors by dependency grouping. It should be noted that the majority of both 'facilitating' and 'inhibiting' factors were common to all three dependency groupings.

As the majority of facilitating and inhibiting factors were experienced in at least two of the patient dependency groupings, the results are presented in Tables 3 and 4 as an overall aggregate. Where the occurrence of a factor was specific to a particular dependency grouping, this is indicated next to the relevant entry.

FACILITATING FACTORS

Table 3 illustrates the most frequently identified facilitating factors over all dependency groupings. Because of the overall volume of the factors identified ($n = 50$), the table includes only those factors cited in the data on three or more occasions in each dependency grouping. The frequencies with which particular factors were identified were then aggregated and ranked in descending order. The

Table 3 Aggregate ranking for facilitating factors – all groups

Facilitating Factors
1) Support of medical staff[1]
2) Support of nursing staff
3) Increased knowledge and confidence in own ability
3) Being supernumerary from the nursing establishment
5) Support of nurse managers
6) Having increased autonomy to organize and undertake practice[2]
6) Recognition and trust in the ability of the ANP by medical staff[3]
8) Being valued and acknowledged as a resource by nursing colleagues
9) Good staffing levels
10) Expanding the range of skills possessed[4]

[1]Achieved the same ranking in each dependency grouping.
[2]High dependency only.
[3]Acute and Low dependency only.
[4]Acute dependency only.

Table 4 Aggregate ranking for inhibiting factors – all groups

Inhibiting factors
1) Being expected to develop the ANP role whilst being counted in the nursing numbers[1]
2) Poor levels of nursing staff
2) Lack of resources (including time)
4) Nursing colleagues feeling threatened, resentful and non-accepting of the role[2]
5) Lack of understanding/clear definition of the ANP role by colleagues and unrealistic expectations of the ANP role from colleagues
6) Not be graded/financially rewarded appropriately for the job[3]
7) Control over the development and scope of practice of the ANP by managers and consultants[4]
7) Conflict with nurse managers
9) Opposition to the ANP role by medical staff[4]
9) Competing with SHOs for opportunities to practise skills[2]
11) Being used as junior doctor replacements[2]
11) Absence/incomplete protocols for some activities[5]

[1]Achieved the same ranking in each dependency grouping.
[2]High and acute dependency only.
[3]Acute and low dependency only.
[4]High dependency only.
[5]Acute dependency only.

factor identified most frequently was given a ranking of one, the second most frequently identified given a ranking of two, and so on. Where factors are tied in terms of their frequency, they are given the same ranking.

The wording used to describe a factor has, wherever possible, used the informant's own words. Inevitably, some judgments have been made especially during the analysis, whereby different terms have been used by the research participants to describe the same concept. In this instance, wording has been paraphrased in order to be succinct in conveying the identified factor, and the item located into the closest established category conveying the same/similar concept.

INHIBITING FACTORS

Table 4 illustrates the most frequently identified inhibiting factors over all dependency groupings. Once again, because of the overall volume of the number of factors identified ($n = 68$), the table includes only those factors cited in the data on three or more occasions. Likewise, the list of factors is ranked in descending order, with the factor identified most frequently being ranked number one, the second most frequently identified ranked number two, and so on. Where factors are tied in terms of their frequency, they are given the same ranking.

Discussion of findings

FACILITATING FACTORS IN ALL GROUPS

When considering the facilitating factors that are identified overall, the data can be viewed in terms of three distinct categories:

- re-negotiating relationships;
- becoming an advanced practitioner;
- deployment and environmental context.

Re-negotiating relationships

The first category is entitled re-negotiating relationships, as the ANPs were seconded to the Master's degree course and then returned to their original place of work upon graduation. The new role they are currently attempting to implement means that they are viewed 'differently' by many of their nursing and medical colleagues. This new role, along with their one-year absence whilst undertaking the Master's course, has meant that they have had to re-negotiate their relationships with colleagues.

An important concept that arises is support. Both instrumental and emotional support are mentioned as being of benefit to the ANP in implementing the role. However, of particular interest is that in all dependency groupings support not only features prominently, but it is support from medical staff that is most frequently cited. Why might this be so? It is possible to hypothesize a number of reasons, some more probable than others. For example, medical staff may perceive the development of the ANP role to be in the interests of medicine by helping the reduction of junior doctor hours, ensuring protected teaching time for medical staff, or partly as a solution for staffing and rotational problems. However, some medical staff interviewed have acknowledged that having an ANP in post has already brought benefits to the service they provide and hence they are supportive. Arguably, a more convincing rationale for why the support of medical staff is cited so frequently is that it is an indication of the changing nature of nursing practice, in which the ANP is crossing traditional boundaries. This is not only in terms of skills and procedures, but also in terms of patient assessment, diagnosis and management, and the associated clinical judgement skills. As these skills have traditionally been the remit of medicine, it is hardly surprising that ANPs rely on the support and help of doctors as they attempt to develop their own skill base. Interestingly, in a study of Nurse Practitioners in the USA (Hupcey, 1993) the number one ranking factor that was identified as helping nurse practitioner role performance was acceptance and support by doctors. Not only the support of doctors but also that of

nursing staff and managers is seen as important in facilitating the process of development of the advanced practice role.

Becoming an advanced practitioner

The second category of factors relate to what could be termed the process of 'becoming an advanced practitioner'. These factors are linked to how the *changed* knowledge and skill base of the practitioner are of help and are integrated into the new role. Hence, increased knowledge and confidence were often cited, more so than expanding the range of skills, which was only mentioned in the acute care dependency grouping. In addition, a number of the cases noted an increase in their degree of autonomy and discretion in the organization and delivery of care. For a number this was a new experience, and one deemed to be facilitative in the development of the ANP role.

Next in this category are the factors concerned with developing a new professional identity (which also encompasses the previous category) and gaining recognition. The fact that the ANP was recognized as a resource by nursing colleagues and that their ability was recognized and trusted by medical staff was identified as a facilitating factor.

Environmental context and deployment

The final category refers to the environmental context in which advanced practice takes place and the deployment of the practitioner within the service.

Deployment Four participants are deployed in their new role on a full-time basis, i.e. they are not included in the nursing establishment. The majority of the others are deployed on a variable part-time basis in their new role, and part-time within the normal nursing establishment, where upon they are required to undertake their 'old' job. At least one case study participant has no officially allocated time in her new role, and has been required to attempt to undertake the role while managing her work area on a full-time basis. Being supernumerary from the nursing establishment was cited on 14 separate occasions as being an important factor in helping implementation of the ANP role. The benefits of this are apparent in allowing time and scope to develop desired aspects of clinical practice.

Environmental context As will be shown in the following section, the nature of and factors within the working environment play an important part in determining not only how the advanced practice role develops but also how workplace characteristics affect the implementation process. The only factor cited as being of help in implementing the role in terms of the environment was good staffing levels. This factor was only mentioned in the high-dependency area, and on five occasions. Having sufficient staffing resources appears to be bound with deployment of the ANP on a supernumerary basis, in that the latter often depends on the former.

INHIBITING FACTORS IN ALL GROUPS

As with the facilitating factors, the overall inhibiting factors identified can be viewed in terms of the same three distinct categories, and therefore may be seen as opposing poles on the same continuum:

- re-negotiating relationships;
- becoming an advanced practitioner;
- environmental context and deployment.

Re-negotiating relationships

Whilst support featured prominently in the list of factors identified as helping ANPs implement their role, at the opposite end of the continuum resistance to the role did not feature as highly. It is interesting to note, however, that resistance and resentment towards the ANP did not occur as often with medical colleagues (identified on eight occasions – predominantly in high-dependency areas), which might have been anticipated given the nature of the ANP role in some areas, but was more commonly cited from nursing colleagues – identified on 20 separate occasions. Why might this be so? Resentment from junior medical staff was cited infrequently, and appears to revolve around the issue of competing with ANPs to practise and develop new skills during their rotation. The fact that this factor was predominantly cited as occurring in the high-dependency grouping may be indicative of the nature of some of the new skills nurses are developing in this area.

There were few occasions of resentment from senior medical staff, but where this was cited it appeared to evolve from a fundamental opposition to the ANP role, as opposed to any pragmatic problems. Resentment and non-cooperation from nursing colleagues appeared to be borne out of fear and distrust, at least in some quarters. Senior clinical nurse managers were most frequently cited as feeling most threatened by the existence of an ANP. The reason given for this appears to link to components of their role coming under threat from the ANP. The reasons given for resistance to the role from other nursing colleagues seem to revolve around jealousy, or disagreement with the concept of advanced nurse practitioners.

Becoming an advanced practitioner

The challenges of developing a new professional identity as an ANP are not without their problems. As well as dealing with the re-negotiation of professional relationships, a problem that was highlighted on a number of occasions concerned the clarification of the ANP role and its goals. This created conflict and led to a lack of understanding on the part of some colleagues as to what exactly constituted advanced practice. This in turn led in some cases to claims that unrealistic expectations were being made of some ANPs.

A further interesting aspect of the advanced practice role is the degree of discretion afforded to the incumbent to develop the role in the way they feel would be of most benefit to the service. This was inhibited by a number of factors including the absence of practice protocols for certain activities. Moreover, whilst it would be naive to expect the ANP to have *carte blanche* in developing their role, problems of consensus and control over the scope of practice have been experienced by some ANPs, particularly in the high-dependency grouping. This has led to feelings that medical and managerial staff are determining the scope, organization and deployment of advanced practitioners. This reason is cited as a further cause of conflict with managerial and medical staff, and has resulted in some ANPs stating that they feel they are primarily being used as junior doctor replacements, which is not how they envisaged the role. It is possible that the issue of 'junior doctor replacement' in the high-dependency grouping is linked to the reduction of junior medical staff in certain specialities (Medical Workforce Standing Advisory Committee, 1995). In these cases, there are pressures from senior medical staff and trust managers for ANPs to specifically take on the tasks and roles of junior doctors to compensate for reductions in numbers. This means that the focus of role development is initially on 'medicalized' tasks and activities. This was identified as an *inhibiting* factor to the development of advanced nursing roles. However, there are important implications for future role development in as much as nurses are likely to face increasing pressure from some trusts and senior medical staff to act wholly in a 'replacement' capacity for junior doctors. Whilst such conflicting professional agendas may serve to frustrate nurses in advanced roles, as the notion of doctor replacement is not in keeping with their personal philosophy (as in this study), a substantial focus on 'medicalized' tasks and activities may serve to validate claims in the eyes of some in the nursing profession that nurses are in danger of becoming nothing more than 'mini-doctors'.

The final problem highlighted concerns financial recognition. Of those ANPs involved in the study, only one is known to have negotiated a local contract and pay based on the post of ANP. The vast majority of ANPs have returned to their workplaces on the same grades as they were seconded, i.e. 'F' and 'G' grades. There are even ANPs within the same trust on different grades. This has led to the issue of financial reward being highlighted as an issue of concern – cited on 11 occasions. The consequences of being expected to implement the ANP role, along with its additional responsibilities, whilst on the same grade as other nursing colleagues with fewer responsibilities has created dissatisfaction and has already caused one ANP to seek alternative employment.

Deployment and environmental context

Of the three categories, it is issues related to the environmental context and deployment that are the top three most frequently cited inhibiting factors to the implementation of the advanced practice role.

Deployment The most frequently cited inhibiting factor in each dependency grouping is being expected to develop the ANP role whilst being counted in the nursing numbers. This was the most frequently cited single factor – cited on 48 separate occasions. This appeared to create conflict for ANPs as they attempted to develop and implement the advanced role. In a number of cases, despite reassurances that upon their return the ANP would be supernumerary to the nursing establishment, they were required to take charge of the workplace or to be counted in the nursing numbers. Whilst the necessity for this to happen can be appreciated in order to meet the service commitment, its impact on role development and implementation should not be underestimated.

Environmental context In terms of the environmental context, two factors are equally identified as inhibiting the development of the advanced practice role. These are poor staffing levels, often due to sickness, and a lack of resources – each cited on 25 occasions. It is precisely the poor levels of staffing and lack of resources that contribute to the necessity for the ANP to be included in the nursing establishment, requiring advanced role development to be delayed and planned activities abandoned. Resources refer to time and also to physical resources. The chief complaint with regard to time, cited on 15 occasions, was that there were too many other commitments taking up the ANP's time and delaying development of the role. An example of a lack of physical resources was cited by one ANP, who stated that part of her advanced role involved running a clinic in the outpatient department for her client group. On one

occasion, a room was not available for her use. This resulted in her taking an administrative role and her patients being seen either in conjunction with or solely by medical staff.

Conclusion

There are many factors that influence the implementation of any change process. This paper has demonstrated that the implementation of a new nursing role is no exception. The dearth of empirical literature in the UK, probably due to the ANP role being relatively new, prevents comparison of this study's findings with those of other UK studies. There are, however, interesting similarities with the experiences of advanced practitioners in the USA.

When considering these results, one has to bear in mind that this is a single study, in one health region, with a relatively small sample of nurses. Furthermore, these results cannot be generalized any wider population of advanced practitioners. However, they do provide an insight into the lived experience of advanced practitioners as they attempt to implement the new role in their clinical areas in the UK.

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