Abstract

Progression in any career involves the phenomenon of role transition. Transition is defined as 'a process of movement that occurs over time, from a familiar place or role to an unknown setting requiring an adjustment in behaviour and relationship with colleagues'.In England, Advanced Clinical Practitioners (ACPs) and Trainee Advanced Clinical Practitioners (TACPs) come from a variety of professions and in some NHS Trusts, ACPs are now an integral component of surgical and medical units including Gastroenterology and Hepatology departments. Commencing an ACP training programme is a significant career change and a transition of role needs to occur. It is recognised that clinical knowledge does vary between staff from differing professional backgrounds and during role transition, there is a shift from being a confident, competent expert in an area to being inexperienced or novice in the new TACP role. It is also acknowledged within the literature that there are potential issues arising from role transition and a recognition that there is a high failure rate to change. Regarding the ACP route, there are many contributing factors identified, including, but not exclusive to; the individual, environmental, work culture, organisational and national factors.

Introduction and background

This article will examine and reflect on the factors and theories that influence role transition into an ACP in England. It will also examine some of the difficulties that a TACP could encounter with transition, as well as suggest strategies to assist in coming to terms with change. The lead author recently completed their ACP training, but originally, trained as a paramedic. This article reflects some of their experiences of role transition.

Advanced Clinical Practice has been defined by Health Education England (HEE) (2017, page 8) as 'Advanced clinical practice… 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.' ACPs and TACPs come from a variety of professions: paramedic, speech and language therapists, nursing, physiotherapy,

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pharmacists and operating department practitioners (HEE, 2017). Therefore, commencing an ACP training programme is a significant career change for the majority of TACP's (Sharrock, Javen and McDonalds, 2013). To accomplish the attributes identified in the HEE (2017) definition above, a transition of role needs to occur.

Drivers influencing ACP role development

Advanced Clinical Practice is in its infancy in the United Kingdom compared to nursing or other medical professions (Tracy and Hanson, 2014). The consequences of the European Working Time Directive, reducing the 'doctoring' hours available towards delivering patient care was one of the main drivers of Advanced Clinical Practice. In addition, The NHS England Five Year Forward View (2014) and the NHS England Next Steps on the Five-Year Forward View (2017), recognised the current challenges experienced by the NHS such as, poor recruitment rates, low morale and retention issues. These increased demands and constraints led to intensified pressure on its workforce and resources (HEE, 2017). Innovative workforce planning was required to address the continuing growth of demand on the NHS due to the increasing volume of patients with complex needs (Moran and Nairn, 2017). Pioneering, dynamic new ways of delivering patient care resulted in the rise in numbers of ACPs (Barnes 2015; Burke, 2017). ACPs enhance the multidisciplinary delivery of patient-focused care by improving clinical continuity and safety (Barnes 2015; Moran and Nairn, 2017).

In 2013, the gastroenterology and hepatology departments within a local Trust, were part of the original medical specialities to incorporate TACPs into the medical team. The consultant team had clear vision of how the role would be utilised and this clearly influenced development of the role, augmented by one to one working with consultants on the acute medicine round.

Local ACP training in secondary care

Local TACPs were offered further education and training which allowed an expansion of clinical skills by undertaking procedures such as: arterial blood gases, early diagnostic paracentesis, which is invaluable in suspected spontaneous bacterial peritonitis, and therapeutic paracentesis for refractory ascites causing pain or impairing respiratory function. This education and training of ACP's was offered

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alongside junior doctors, to ensure no deskilling was encountered, improve patient safety and support interprofessional working. The effectiveness of TACPs in the original speciality wards was rapidly displayed influencing not only further medical wards but also into other areas such as surgery, trauma and orthopaedics, and mental health where new trainee ACPs have been employed.

Professional and Regulatory bodies

There currently lacks a national overarching regulatory body for ACPs (Moran and Nairn, 2017). Professions are working in isolation within regulations set by the Nursing and Midwifery Council (NMC), the General Pharmaceutical Council (GPhC) and Health and Care Professions Council (HCPC), as well as directed by guidance set by the professional organisation of the Royal College of Nursing (RCN). Certain professions also face challenges on the advanced clinical practice pathway as they are not permitted to undertake non-medical prescribing (NMP) on current legislation (O'Grady, 2019). However, in 2018, legislation was amended, and advanced paramedics were permitted to undertake NMP training (College of Paramedics, 2018). This was a significant moment; with an allied health professional role being added to the prescribing register. It inspires hope for other professions working in an advanced role that they may follow soon (O'Grady, 2019).

Specialist or Generalist ACP roles

Advanced clinical practice is an umbrella term; it overarches both specialist nurses who have an extensive depth of knowledge in a specific area of medicine and ACPs who are more generalist with a greater breadth of knowledge but not the same level of depth (Cooper, McDowell and Raeside 2019). Both are autonomous roles and are involved in patient care (Carter *et al*. 2013), research (Donald *et al*. 2010), leadership, education (Begley *et al.* 2014), and guideline development and audit (Carter *et al.* 2013). However, a lack of awareness of these capabilities and unique differences results in ambiguity and uncertainty towards advanced clinical practice and what the role of an ACP entails (Donald, Bryant-Lukosius, Martin-Misener, 2010; Cooper, McDowell and Raeside, 2019). Furthermore, managers and commissioners who lack this awareness can result in impeding the development of services, which is detrimental to patient care (Carter, Dobbins, Hoxby, *et al.* 2013; Begley, Murphy, Kiggins, *et al.* 2014; Cooper, McDowell and Raeside 2019). Bryant-Lukosius, Dicenso,

Browne *et al.* (2004) emphasise that a lack of a clear role identity is one of the challenges when transitioning into the ACP pathway. Individuals can perceive a loss of identity, purpose and belonging.

Role Transition

Progression in any career involves the phenomenon of role transition. Transition is defined as 'a process of movement that occurs over time, from a familiar place or role to an unknown setting (Barnes, 2015 page 137). There is often adjustment in roles, behaviours, and relationships with others' (MacLellan, Levitt-Jones, & Higgins, 2015 page 389). Many theories have been published to explain the concept and identify potential issues arising from role transition (Barnes, 2015). Schlossberg's Theory explained that transition is a personal event, influenced by the perception of the individual experiencing it (Schumacher and Meleis,1994; Maten-Spetsnijder, Pool, Grypdonck *et al.* 2015). Within the nursing profession, there are many transitioning models described, Kramer (1975) was most notably influential. She explained that during the transitioning process, an individual would advance through a series of phases. Opening with the honeymoon phase and feelings excitement and exhilaration, the individual proceeds to the second phase, where a sense of disorientation, disillusion and feelings of shocking assault on professional values are experienced (Kramer, 1975). The conclusion is achieved in the final recovery and resolution phase, by the realisation of a returned sense of balance. However, this has been criticised for being a very linear, or a one-dimensional model to describe role transition, as many factors influence the degree to which role transition impacts (Cash, 2015).

One of the challenges faced in role transition, as acknowledged by Moran and Nairn, (2017), Barnes (2015) Voet, Groeneveld, Kuipers (2014) is a high failure rate to change. Focussing on the ACP route, there are many contributing factors identified, including, but not exclusive to; the individual, environmental, work culture, organisational and national factors (Barnes, 2015; Moran and Nairn, 2017).

Individual Wellbeing and Role Training

An essential desired attribute of an ACP is to have a wealth of clinical experience, or expertise in their previous area as defined by HEE (2017). The strengths of ACPs are their experiences and skills, for example, advanced communication skills, and positive

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behaviour attributes which are vital and transferable between roles (Moran and Nairn, 2017). It is recognised that there is a variance in both clinical knowledge and skills sets which vary between staff from differing professional backgrounds (Moran and Nairn, 2017; Cooper, McDowell, Raeside, 2019; O'Grady, 2019). During role transition, there is a shift from being a confident, competent expert in an area as described by Benner (1984) 'Novice to Expert' to being inexperienced or novice in the new TACP role. Individuals are highly reflective of their practices during the transition and can be intimidated by the scale of work in required during the process. This is also reflected in Kramer's (1975) seminal works. This can result in a loss of confidence, loss of professional identity and impairment of ACP development (Burke, 2017; Moran and Nairn 2017; Cooper, McDowell, Raeside, 2019). Each will have their own individualised transition journey. The transition of a role as an individual is a personal experience often described as challenging (Barnes, 2015; Burke, 2017).

Insecurity and Imposter Syndrome

Nursing literature shows that anxiety, stress, isolation, self-doubt and uncertainty of clinical knowledge are common feelings experienced when transitioning (Brown *et al.* 2015: Burke, 2017, O'Grady, 2019). Self-doubt and insecurity often grow when initially exposed to areas deemed outside of their comfort zone and where clinical confidence is damaged (MacLellan, Levett-Jones, Higgins, 2015; Burke, 2017, O'Grady, 2019).

Individuals can experience symptoms of imposter syndrome, believing they are fraudulent, and are not worthy of the position they have obtained, but achieved it through luck rather than skill and merit (MacLellan, Levett-Jones, Higgins, 2015). MacLellan, Levitt-Jones and Higgins (2016) explored the psychological elements of Imposter syndrome and found there was often a perception of being powerless and found challenges in adjusting to their new perceived position of being a novice in a new area, compared to an expert in their previous role. ACP roles still have a higher demographic of female to male staff, interestingly, Clance and Imes (1978) recognised imposter syndrome does seem to be a phenomenon more prevalent in high achieving woman (Sullivan-Bentz, Humbert, Cragg, *et al.* 2010).

Masters' level of study

The HEE (2017) definition states that advanced clinical practice should be underpinned with a masters' level qualification to provide a nationally recognised level of clinical and theoretical knowledge in ACPs. Both the Nursing and Midwifery Council (2018) and College of Paramedics (2018) stipulate that to be an ACP successful completion of study at masters needs to be evidenced. Commencing studying at masters' level is an additional requirement which is stressful, many clinicians have not studied at this level before or have not academically studied for a long time, finding it a daunting process (Moran and Nairn, 2017). Gaskell and Beaton (2015) suggest that education preparation is essential to reduce anxieties to returning to study and improved education success rates. When undertaking the first module there is an element of not knowing if the academic standard required is being achieved. Successful completion of the first module is somewhat perceived as an affirmation that the TACP has the ability and right to be in there (Moran and Nairn, 2017). Clinical and academic support are essential to run parallel to education programmes for both pre and post qualified positions (La Fleur and White, 2010; Burke, 2017; Cooper, McDowell, Raeside, 2019). French, Colbert, Pien *et al.* 2015, promote the culture that transition occurs of time with plateaus, progression and set back all being recognised as elements of professional development. Acknowledging learning is not restricted to a period it is a continuum, by accepting this it will help try and unburden the pressure the mentee puts on themselves (Jack, Hamshire, Harris, *et al.* 2018).

Moran and Nairn's (2017) study recognised many ACPs underestimated the difficulties involved when undertaking the transition to a new role. Changing roles can produce challenging political situations, through professional jealousy or preconceived ideas which can present with hostility or opposition which can result in alienation (Tracy and Hanson, 2014; Lipman, 2015; Moran and Nairn, 2017).

Resistance and obstruction

Resistance is a well-documented natural phenomenon, especially in organisations with ingrained culture (Beer and Nohria, 2000; Burke, 2010; Burnes, 2011; Lipman, 2015). Resistance can be a result of a lack of understanding, which then manifests as a sense of threat or competition, culminating in obstruction or inertia at all levels of an organisation (Carter, Dobbins, Ireland, *et al.* 2013; Tracy and Hanson, 2014; Lipman,

2015). To reduce resistance, a point of reference including a clear definition of the role and responsibilities, scope of practice and desired aims in their clinical area are beneficial. As Education and Leadership are pillars that underpin advanced practice, ACPs themselves have responsibility to demonstrate behaviours of providing education and leadership towards changes to improve practice

Hostility

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It could be suggested to not place a TACP in the same area where they previously worked to reduce risk of resistance or challenge from staff. However, the NHS advocates a no bullying culture and this should be addressed and managed accordingly to local policy and procedure.

Identifiable uniform

In the local Trust, the ACP role is easily identified by the red scrubs uniform but, the colour or type of uniform varies between NHS Trusts. The 'red' is associated with the reputation of being a senior clinician with extensive skills. TACPs also wear red scrubs which makes differentiation between trainee and qualified challenging. TACPs often must excuse themselves for being unable to undertake a task for which they are not yet competent, and if frequent, this can be damaging to their self-esteem (Moran and Nairn, 2017). Furthermore, because the role is associated with the reputation of being a senior clinician, TACPs often feel a sense of trepidation, that they are not achieving the standard of the role (Harris, 2014). To alleviate trainee's anxiety, the local Trust has utilised imprinted lanyards to delineate the level of training and thus indicate ACP experience the level of training (picture1).

Picture 1: TACP lanyards

On an organisational level conflict can arise between achieving service delivery and supporting staff development needs. HEE (2017) published a national definition of the ACP role and what advanced clinical practice is, to provide some clarity. The role is

promoted as an experienced practitioner with core capabilities and specific competence in skills in their area of work, this is most successful when working in one area (Burke, 2017; HEE, 2017). In the local trust, ACPs work in many specialties including adults, paediatric, mental health, elderly, surgical and acute medicine and in some cases these areas have many subdivision or specialities within them (Tracy and Hanson, 2014). Gaining generalist clinical experience and knowledge is best achieved through completing rotations through all wards (Rohatinsky and Ferguson, 2013; Moran and Nairn, 2017). However, as explained by Benner (1984), the benefit of knowledge gained, is followed by loss of confidence, as every rotation recommences the novice to expert journey. ACPs allocated for an extended period of time to a specific speciality, have developed extended scope of practice, for example in the local trust gastroenterology ACPs perform therapeutic paracentesis independently, conduct upper GI endoscopy, involved in quality improvement projects and are planned to run their own clinics.

Mentorship

The effects of transitioning are most prominent in the first year (Burke, 2017) and mentorship is proven to be extremely beneficial (Sullivan-Bentz *et al.* 2010). It enables appropriate support for the TACP influencing role transition positively and is not restricted to a specific duration of time as suggested by O'Grady (2019). The RCN (2017) guidance for mentors cover provides guidance on both pre and post registration nursing. Mentorship is been defined in line with the NMC Code, as "support students' and colleagues' learning to help them develop their professional competence and confidence" (NMC, 2015). Hanna (2007) and Sullivan- Bentz *et al.* (2010) have suggested to the government that a formal mentorship process should be available to ACPs when in the initial stages of role transition, to offer psychosocial support and assist in the trainee ACP's personal development (Mellon, Murdoch-Eaton 2015). It is recognised that mentorship is a crucial element in assisting health care professionals to achieve an adequate level of clinical experience (Williamson, Glenn, Spencer *et al.* 1988). This is recognised by Moran and Nairn (2017) promote the investment in mentorship and the supportive skills to help staff undertaking transition of role. Grant and Marsden (1988) noted after observing junior doctors graduating, those who engaged with mentorship improved clinical skills and abilities ~~much quicker~~ more rapidly than those without it.

Communication, passion for exchanging knowledge, displaying mutual respect and demonstrating behaviours of a role model are vital elements to mentorship (Eller, Lev and Feurer, 2014). Jack et al. 2018 acknowledge mentorship at times, has been conducted in a relaxed, unstructured fashion, and this lack of structure can have detrimental effects on the mentorship experience. To assist with this development, La Fleur and White (2010) suggest that mentorship standards should be defined and adhered to, in order to achieve their maximum potential. Furthermore, La Fleur and White (2010) discuss whether mentorship should be undertaken from the same professional background or having a mentor from a different background is beneficial. Rohatinsky and Ferguson (2013) suggest that different clinical backgrounds could be a tremendous positive to explore and develop broader interprofessional knowledge and opportunity to demonstrate role model behaviour of multidisciplinary working. However, there are challenges faced by TACPs with conflict between professional or regulatory bodies' guidelines using different wording. For example, the current HCPC standards continuing professional development (2018) advocate providing mentoring is a recognised vital part of professional development, however, the NMC Standards (2018) no longer refer to mentorship but updated this to practice supervisors and practice assessors in 2018.

HEE (2014) advocate mentorship can also be supported by other members of staff, consultants, senior practitioners who can enhance the learning experience. However, Barton (2006) conducted primary research around the impact of mentorship crossing over professional boundaries between nursing and medical supervisors, and their results identified that the mentee found this more challenging, suggesting this was due to different cultures and beliefs on what is supportive behaviour.

Clinical Supervision

Clinical supervision is a vital component in a supportive environment (Sharrock, Javen, McDonalds, 2013). A supervisor will assess a trainee's performance and encourage an increase in the depth of knowledge, clinical skills and clinical decision making, all of which takes time (Moran and Nairn, 2017; CQC 2013). However, the role of supervisor can result in potential conflict with regards to obligations when providing support to a trainee concerning other personal training demands, and in these

instances, the role between supervisor and mentor can become blurred (O'Grady 2019; Mellon and Murdoch-Eaton 2015; CQC 2013).

Supporting new ACP's

Qualified ACPs help facilitate supervision and support, as competent and caring leaders, they can empathise with the difficulties faced by the TACP and offer advice (Department of Health 2010; Tracy and Hanson 2014). Regular interactions with a mentor have been shown to reduce the sense of isolation, reinforcing a sense of belonging (La Fleur and White, 2010; Cooper, McDowell, Raeside, 2019).

Induction to the role, orientation to the working environment and exploration of expectation of the TACP have a significant favourable influence in the transition process (Sullivan-Bentz, 2010). However, many studies document a low prevalence of this occurring in practice (Sullivan-Bentz 2010; Fleming and Cumming 2011; Moran and Nairn 2017). ACPs who have experienced a successful transition received a structured, organised orientation with the addition of being jointly supported by a more experienced colleague in the same clinical setting (Moran and Nairn, 2017) The transition of role requires open-mindedness to explore a dynamic process to develop further (Maten-Spetksnijder *et al.* 2015).

Summary

When transitioning into an ACP role there are many variables which can influence this journey: professional background, new working environment, different level of work, the requirement of masters' study, experiencing transitioning from an expert to novice can easily be an overwhelming challenge (Moran and Nairn, 2017). Many ACPs severely underestimate and feel underprepared for the experience (Fleming and Cranberry, 2011). Mentorship is perceived as the most valuable resource to help support colleagues transitioning roles. However, this seems too limited and varies nationally (Sullivan-Bentz *et al.* 2010; Fleming and Cranberry, 2011, Moran and Nairn, 2017). Many ACPs feel deskilled initially from their previous experiences due to role ambiguity (Moran and Nairn, 2017).

(TABLE 1)

Recommendations

To help overcome these issues, the Author's recommend investment in the production of an individual induction plan, would provide clear guidance, direction and orientation support, in keeping with the flexible transition process identified by Moran and Nairn (2017). The individualised induction plan provides reassurance and a sense of being a valued member of the ACP team by clearly identifying a timeline of areas requiring competency to be achieved (Burke, 2017; Cooper, McDowell, Raeside, 2019). By exploring the achievements from the TACP's previous role it allows exploration and acknowledgement of skills they have but also what can be utilised in their new role (La Fleur and White, 2010). Not only will this help reduce the sense of de-skilling but also help maximise the abilities of the ACP team for the future (Cooper, McDowell, Raeside, 2019).

Conclusion

Progression in any career involves the phenomenon of role transition. As trainee ACPs derive from a variety of backgrounds, commencing an ACP training programme is a significant career change and a transition of role needs to occur. However, there are many variables that can affect this transition such as professional background, new working environment, different level of work, the requirement of Masters' level study, making the experience of transitioning from an expert to novice an overwhelming challenge. It is also acknowledged within the literature that there are potential issues arising from role transition and a recognition that there is a high failure rate to change. Regarding the ACP route, there are many contributing factors identified, such as the individual, environmental, work culture, organisational and national factors. To circumvent these issues, it is suggested that qualified ACPs should offer supervision and support as they can empathise with the difficulties faced by the TACP. It is recognised that ACPs who have experienced a successful transition received a structured, organised orientation, jointly supported by a more experienced colleague in the same clinical setting.

Successful transitioning of role is imperative for a TACP to engender a sense of efficiency, effectiveness and fulfilment, as this is proven to help achieve high patient care and ensure job satisfaction.

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