Research report May 2023

Independent report on the regulation of advanced practice in nursing and midwifery

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Summary

1. Nurses and midwives are increasingly taking on more complex, autonomous and expert roles, commonly referred to as ‘advanced practice’. These roles have been developed over time for a range of clinical, operational, financial, resourcing and professional reasons and are intended to benefit patients, practitioners and health and social care. The policy across the four countries of the United Kingdom (UK) appears to be to increase the number of advanced nurse roles. All midwives are autonomous at the point of registration and ‘advanced practice’ in midwifery remains at a far smaller scale, although there have been some recent efforts to more clearly establish such roles.

2. The regulation of health and social care professions is intended to protect the public from the risk of harm and maintain public confidence. Nurses and midwives are regulated by the Nursing & Midwifery Council (NMC). Currently, there is no specific additional regulation covering advanced practice. As a result, nurses and midwives working in advanced practice are responsible for ensuring that they work within existing regulatory frameworks. Meanwhile, employers are responsible for assuring, for example, the suitability of an individual’s qualifications along with previous experience of undertaking advanced practice roles. There are also some other processes for providing assurances around advanced practice, including through the commissioning and (non-mandatory) accreditation of educational programmes and via credentialling (formal recognition of professionals’ competencies) by some professional bodies.

3. Most nations with nurses working at a similar advanced practice level as nurses in the UK have specific advanced practice regulation. A cross-country comparison identified 11 countries with significant similar scopes of advanced practice as in the UK and, of these, Finland was the only other (alongside the four countries of the UK) to not specifically regulate advanced practice. However, the NMC has committed to review the possibility of regulation for advanced practice and, in turn, commissioned this report. Where countries have sought to additionally regulate advanced practice, experiences have varied, with some, for instance, enacting changes in a short time span (for example, the Netherlands) while in others it took longer (for example, a decade in New Zealand).

4. In our research, we identified only one example of a country (Ireland) with specific statutory regulation for advanced practice in midwifery. The development of advanced practice in midwifery in the UK is more recent and differs from that of nursing, and the numbers of midwives holding an advanced practice title remain

small. The different contexts around advanced practice in nursing and midwifery are important to bear in mind and the current risks are not identical but, that said, the types of considerations are still largely similar.

What are the risks in the current arrangements?

5. The merits of advanced practice are not in doubt. Indeed, there is a substantial literature that demonstrates that it can support better delivery of services and improve a range of outcomes for people who use services. However, our specific task in this research has been to explore where there are risks attached to advanced practice and whether additional regulation might ameliorate or mitigate them. Previous reviews on the regulation of advanced practice in the UK have pointed to a lack of systematic direct evidence that advanced practice presents a risk of harm to people using services.[1,2] However, these reviews were looking at rare events such as deaths and fitness-to-practise cases. Moreover, advanced practitioners are still a relatively small (but unknown) proportion of the workforce and sometimes difficult to identify in investigations of clinical practice complaints.

6. While the evidence is admittedly limited – including internationally – the literature suggests that there are latent risks in the current arrangements for preparing and employing advanced practitioners, as described below, which should be considered seriously. The greatest risks (across all clinicians) appear to relate to tasks such as diagnosis and interventions, which increasingly sit within the scope of advanced practice.

7. Many participants in our research considered that there was an increased risk of harm to people using services in some settings, particularly where the employer was not a National Health Service (NHS) organisation. Some suggested – albeit typically not about the UK as a whole – that assurances on the suitability of the advanced practitioner and their role could occasionally be weak in, for example, some general practice and out-of-hours services, third sector providers (nursing homes and charities) and agencies. We also found wide variation in understanding of, and support for, advanced practitioners across different NHS employers too.

8. We also heard that poor public understanding of advanced practice could undermine consent to treatment. Previous reviews have suggested that public understanding is limited[3] and a survey found that two in five (42%) of trainee and advanced clinical practitioners in England thought that patients did not understand their role.[4]

9. Practitioners working in advanced practice roles are responsible for being aware of their own limitations and recognise the parameters of their scope of practice. However, we heard that their scope of practice was not always clear. While not specific to nursing and midwifery, it is noteworthy that in a survey of allied health

professionals, more than half of respondents (55%) perceived ‘assurance to self of knowledge and skills’ as a benefit of the regulation of advanced practice.[5]

10. The most common current route to advanced practice in nursing and midwifery is through higher education, namely a master’s degree. There is substantial variation in master’s courses and in some instances only limited assurance on the standards of those completing them. The variation includes the amount of clinical content (something that also varies between countries where there is regulation) and entry requirements, including the amount of experience needed before enrolling. Previous work even identified an advanced practice course with content considered to be undergraduate as opposed to master’s level.[6] We also heard concerns about – and differences of opinion on – the extent to which courses should be tailored to the clinical settings in which advanced practitioners work. An increasingly diverse set of providers are offering advanced practice courses, and some of these providers have not been involved in nursing or midwifery education before.

11. External examinations and/or an assessment of a portfolio of skills and competencies are commonly required for registration for higher levels of practice internationally across a broad range of professions (for example, medicine, law and finance). Advanced nursing practice in Australia, New Zealand and the United States (US) requires external examination and/or submission of a portfolio. In the UK, assessment for advanced nursing practice is based predominantly on professional qualification. In addition, for those already working at this level in England, the Centre for Advancing Practice can formally recognise previous learning and experience, with a similar portfolio route also offered in Wales.

12. There was broad consensus that while it is appropriate to have flexibility and a degree of difference in the approaches to advanced practice in the four UK countries, there is a risk if they became too divergent. In particular, the risk to the movement of clinicians within the UK was raised. A similar argument was made on the importance of some international consistency, noting that half of recent joiners to the NMC register trained overseas.

What are the views on introducing additional regulation?

13. Overall, stakeholders were in favour of the specific regulation of advanced practice. Separate research that the NMC has commissioned on the views of nurses and midwives will provide further detail, but counterparts from other clinical professions have largely agreed (78% of survey respondents) that advanced-level practice should be regulated.[7] However, many stakeholders were not clear on the implications of statutory regulation as a tool and whether, in practice, it would be useful. Even those with a strong desire for the regulation of advanced practice

acknowledged this was, at least in part, due to keenness to advance the profession and there was a recognition of the trade-offs around the complexity and cost of introducing more regulation.

14. Our review of the international experience, as with stakeholders we spoke to, highlighted that there are various approaches that could be taken to provide greater assurance. While challenges remain across the UK, each of the four countries has tried to – albeit in different ways – address the inconsistency in the employment of advanced practitioners, for example. While some national bodies have sought to provide some clarity on governance structures, few participants in our research were able to articulate a specific blueprint for what such an overall approach to regulation might look like.

15. One of the most consistently raised regulatory issues was around the protection of the title, although the scale of the problem appears to vary between the UK countries. One of the greatest concerns was around the lack of protection in law of the title 'nurse' (unlike 'midwife'), although we heard examples of practitioners using the 'advanced practice' title despite, for example, failing to complete the full master's or attending only a half-day course. However, those we spoke to largely recognised that protecting the 'advanced practice' title through statutory regulation would not entirely safeguard against this (as alternative job title wording could be used) and employers and other oversight bodies could instead provide some additional assurance and consistency. Moreover, we heard that the introduction of yet another official level of practice would not necessarily help public understanding, which is also a lesson from the US.

16. Some considered the revalidation process as a potential opportunity to help strengthen the appraisal and support processes for advanced practitioners. We heard concerns about the lack of ongoing development of some advanced practitioners, with one study of advanced clinical practitioners, for example, finding that only three-quarters had access to clinical supervision.[8] While some areas of the UK might not be alone in having challenges in providing support, countries such as Australia, Canada, New Zealand and the US all have continuing education requirements for advanced practitioners.[9]

17. Cost was considered to be potentially problematic for all involved – practitioners, employers and the NMC. The increased cost of regulation was perceived to be the biggest disadvantage of regulation in a survey of professionals that the Health & Care Professions Council (HCPC) conducted.[10] There is a possibility of additional cost to employers, including increasing burden on services, if there is a significant expansion of clinical supervision and assessment requirements. The experience of other regulators suggests that the introduction of additional regulation would likely be expensive, resource-hungry and time-consuming for the NMC itself.

Our concluding remarks

18. This is not the first time that the regulation of advanced practice has been considered, but given the fast-changing landscape it is reasonable that the topic is revisited. Indeed, in terms of the fluid context, at the time of writing, the UK government was consulting on proposals for reforming the regulation of health care professionals, including proposals to introduce more consistency between regulators and provide them with greater autonomy.

19. The risk of harm to the public that advanced practice in nursing and midwifery poses needs to be at the forefront of any considerations. And while there is limited evidence on the scale of such risks internationally, and previous UK reports on advanced practice have not presented any systematic evidence of harm, our view is that the scale of advanced practice currently and the systems in place to identify harm mean that this should not be interpreted as conclusive evidence of a lack of harm.

20. What is fairly clear is that advanced practice – particularly in the UK – commonly involves complex activities and tasks that inherently carry a risk to people using services. Given the lack of assurances around education and employment in some instances, coupled with a likely growth in the numbers of advanced practitioners, we prescribe a precautionary approach to the protection of people using services and maintaining public confidence against the risks arising from a lack of consistency and standardisation (while still being mindful of the need to be proportionate). Key issues, as things stand, include the clinical content of courses and programmes, the experience required for advanced practice roles, and some employers' understanding of the role and ability to take assurances on the appropriateness of individual practitioners.

21. This research was not intended to define what the single best solution would be. In any case, the limited nature of the published international research on the effectiveness of the regulation of advanced practice, coupled with the different contexts overseas meaning it is not clear how translatable existing arrangements are to the UK, render making such a specific conclusion impossible. However, we believe our research does support us in outlining the primary options available and key considerations around these, as well as the principles that should be followed in agreeing what course of action to take and how to implement it.

22. Those key options available around statutory regulation (discussed in more detail in section 'Options' in Chapter 5) are as follows:

    i. **Keep the existing statutory regulatory framework as it is.** Current assurances do not appear to be sufficient in all services and all settings and could increasingly represent a risk if advanced practice continues to expand in

scale. However, the ongoing legislative changes to the regulation of health care professionals in the UK mean that, at least in the short term, there is a case for delaying any changes to the NMC's current stance on advanced practice. During such a delay, other means to provide assurances can be sought (including continued development of accreditation and credentialling by various professional bodies and employment and commissioning practice), and inconsistencies in approaches to advanced practice between the four countries of the UK that could otherwise prove a barrier to future additional regulation could be addressed.

ii. **Develop annotation of the existing NMC register for advanced practice qualifications or evidence of equivalence.** This could provide some additional assurance around many of the issues highlighted but would require the NMC to further develop its register (to permit such annotations) and still require sufficient oversight of educational organisations.

iii. **Develop a second tier of regulation for advanced nursing and midwifery practice.** This option would provide some greater assurance but there are significant challenges in the complexity, cost and time required, as well as risks around appropriately regulating those already working at advanced practice level and ensuring assurances taken on the qualification are appropriate.

23. In terms of the process to agree a regulatory approach, any solution will have to involve a range of actors beyond the NMC, although with an appropriate and clear balance of responsibilities. The respective national departments of health of the UK, arm's-length bodies and Royal Colleges are already doing a considerable amount – often successfully – to provide assurances and good governance around advanced practice. Our findings – coupled with the recognised principles of good regulation (being proportionate, consistent, targeted, transparent, accountable and agile[11]) – can help define some parameters for considering what changes are needed. To this end, we believe our findings suggest the following:

    - The regulation of advanced practice needs to be **future proofed** – particularly given ambitions to expand advanced practice – and provide sufficient assurance for a larger and perhaps more heterogenous set of staff seeking to work in such roles. Given the earlier stage of development of advanced practice in midwifery, specific consideration is needed for this profession to ensure regulation is appropriately flexible.

    - A **UK-wide solution** should be sought given the scale of migration of nurses and midwives between the four countries of the UK. This neither means that responsibility has to lie with a single, UK-wide organisation (noting that the regulation of social work, for instance, has separate national regulators with an agreed approach) nor that this would unduly

fetter the flexibility for each country to ensure the regulatory system is fit for purpose for their needs.

- A **wider strategy** will be required to address all the risks that advanced practice raises (as well as deliver on the opportunities). Whatever statutory regulation is – or is not – in place, employers and individual practitioners will retain many responsibilities. Employers and commissioners of services as well as, for example, Royal Colleges that undertake credentialling will have to be part of the solution and any statutory regulatory changes should not be seen as providing all the necessary information and assurance.

- There needs to be sufficient **consistency in approach between professions**. While regulation alone will not fully address currently limited public understanding of the advanced practice role, there is a risk that inconsistent approaches to regulation between the NMC, HCPC and other regulators could erode it further.

- Any regulatory decisions need to be conscious of, and likely mitigate against the risks of, **unintended consequences**. Specific regulation on advanced practice would, for instance, have implications for other levels and forms of practice (such as clinical specialists, consultant practitioners and extended scope practitioners) and fields that could already be considered as advanced, such as health visiting.

- Any regulatory changes will have to be consistent with the **highly complex and evolving regulatory landscape**.

24. Our research also points towards lessons for implementing any regulatory changes. A realistic implementation plan is certainly required, as paths to regulation are typically longer, more convoluted and more expensive than regulators initially anticipate. Usually there is a run-in period whereby the new arrangements are voluntary or prospective (just covering the newly qualified). The NMC and UK government could simplify some of the issues by providing clarity on the protection of the ‘nurse’ title. And the NMC could also develop proposals around annotating its register for qualifications such as appropriate advanced practice master’s courses.

About this report

This is not the first time the regulation of advanced practice has been considered. However, the expectations, understanding and scale of use of the role of advanced practice in nursing and midwifery in the UK are evolving at pace. In response, the Nursing & Midwifery Council (NMC) committed to undertake 'a comprehensive review of advanced nurse practice including consideration of whether regulation is needed' and commissioned this work to feed into the review.[12]

Our work is intended to provide a baseline review of the key regulatory implications of advanced practice in nursing and midwifery in the UK. To do so, we have taken stock of the existing policy and published international literature on the nature and effects of the regulation of these roles, reviewed job adverts for advanced practice roles, analysed available administrative data and engaged with an array of stakeholders. More detail on our methodology is given in Appendix A.

Our intention is to highlight the range of regulatory approaches and key risks and benefits of these. However, we did not set out to provide a comprehensive review. We explored the issues across the UK and present findings relating to all four UK countries although, given the larger scale, we do draw heavily on examples from England. To fully understand the regulatory implications, further work will be needed, including to talk to clinicians (noting that the NMC has already commissioned an accompanying piece of research exploring implications with nurses and midwives already working in advanced practice roles) and the public, which was outside the scope of this specific piece of work.

We have not sought to comment on the merits of advanced practice but rather the regulatory implications. For example, we do not cover some aspects of the effectiveness and planning of the workforce, including considerations around: where such roles are best placed; their purpose and objectives; and their impact on outcomes.

Structure of the report

Chapter 1 provides an overview of the nature and development of advanced practice and of professional regulation in health care both domestically and internationally. This has informed the remaining chapters, which discuss:

- the definition, scope of practice, recognition and understanding of the advanced practice role (Chapter 2)
- the pathways into advanced practice (Chapter 3)

- the evidence on patient and service user safety in relation to advanced practice (Chapter 4).

The final chapter summarises the benefits and risks of regulation, gives a brief appraisal of the available options for regulation and highlights other key considerations that should be taken into account when the NMC comes to making a final decision on regulation (Chapter 5).

A note on terminology

Various terms are used in the UK and internationally for advanced practice – often interchangeably by stakeholders and in the literature – including:

- **nurse practitioner –** used internationally, this role falls within advanced practice nursing and is a protected title in a number of countries, including Canada and New Zealand

- **advanced clinical practitioner** – this term is used in England, includes non-nursing professionals and is generally used as a job title alongside advanced nursing practice.

Throughout this report, we typically use the term ‘advanced practice’.

Acknowledgements

The authors would like to thank everyone who took part in this study, in particular those who contributed to the interviews and workshops.

We are grateful to the NMC for commissioning and supporting the work.

We would also like to thank Professor Kenda Crozier and Dr Gerry Lee for their expert input and comments on an earlier draft, as well as Professor Alison Leary who provided additional data around patient safety.

We are also very grateful, as always, to our colleagues at the Nuffield Trust, particularly Nigel Edwards and Olivia Wallace for their support throughout the research and those in the communications team for their help in delivering and launching the report.

Chapter 1: The landscape

About advanced practice

Advanced practice in nursing emerged internationally in the 1960s. Initially pioneered to meet the unmet needs of rural populations, it has developed and expanded into almost all areas of nursing practice. The International Council of Nurses has defined an advanced nursing practitioner as:

> *a generalist or specialized nurse who has acquired the expert knowledge base, complex decision skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialled to practice*.[13]

While the precise definitions of advanced practice vary from jurisdiction to jurisdiction, including across the four devolved countries of the UK, advanced practitioners have the ability to make decisions on the assessment, diagnosis and treatment of people who use services. They are variously described as having the ability to deal with complexity, uncertainty and varying levels of risk and are professionally accountable for their clinical decision-making. Notions of the 'autonomy' and/or 'independence' of the practitioner are also considered important, although how these terms are defined is often nebulous.

In many, but not all, countries, forms of advanced practice are recognised across the allied health professions, not just nursing and midwifery. In the UK, there are a range of registrants who work in other areas of advanced practice, with job titles such as advanced clinical practitioner, advanced paramedic practitioner, advanced physiotherapist practitioner or advanced pharmacist. In this report, however, we focus on nursing and midwifery except where the multi-professional aspects of advanced practice are directly relevant to the regulation of these two professions.

In the UK, advanced practice for nursing and midwifery is framed around 'four pillars' broadly covering: clinical practice; leadership and management; education; and research. While similar in many respects, there are subtle differences in the ways that these are described and defined across the four devolved countries of the UK, in part because advanced practice has developed at different times with different policy drivers, including the following:

- In England and Wales, the four pillars are defined identically. Scotland and Northern Ireland differ in their definition of the research pillar, using ‘evidence, research and development’ and ‘research and evidence-based practice’ respectively. Similarly, Scotland adapts its education pillar to the ‘facilitation of learning’ and Northern Ireland adapts its leadership and management pillar to ‘leadership and collaborative practice’.

- Advanced practice frameworks covering nurses in England and Wales are multi-professional whereas they are nurse-specific in Scotland and Northern Ireland.

Advanced practice in midwifery

The development of advanced practice in midwifery is more recent and differs from that of nursing, in part because of the level of autonomy that all midwives have at the point of registration. The number of midwives holding an advanced practice title remains small. In fact, historically the Royal College of Midwives has been reluctant to support the development of advanced practice in lieu of the established consultant midwife role, stating that ‘what most maternity services need is not another new Advanced Practitioner role but more Consultant Midwives’.[14] As a result of this scale, the international literature on advanced practice in midwifery remains sparse.[15]

The different contexts around advanced practice in nursing and midwifery are important to bear in mind when reading this report. In particular, much of the evidence is specific to nursing or from previous work that has looked broadly across professions. However, the considerations are still relevant – even if not necessarily identical – for advanced practice in midwifery now and in the future.

Again, there are differences in how this level of practice is framed in midwifery across the UK. For example, England is the only UK country to have a specific framework for advanced practice in midwifery.

Development and implementation of advanced practice in the UK

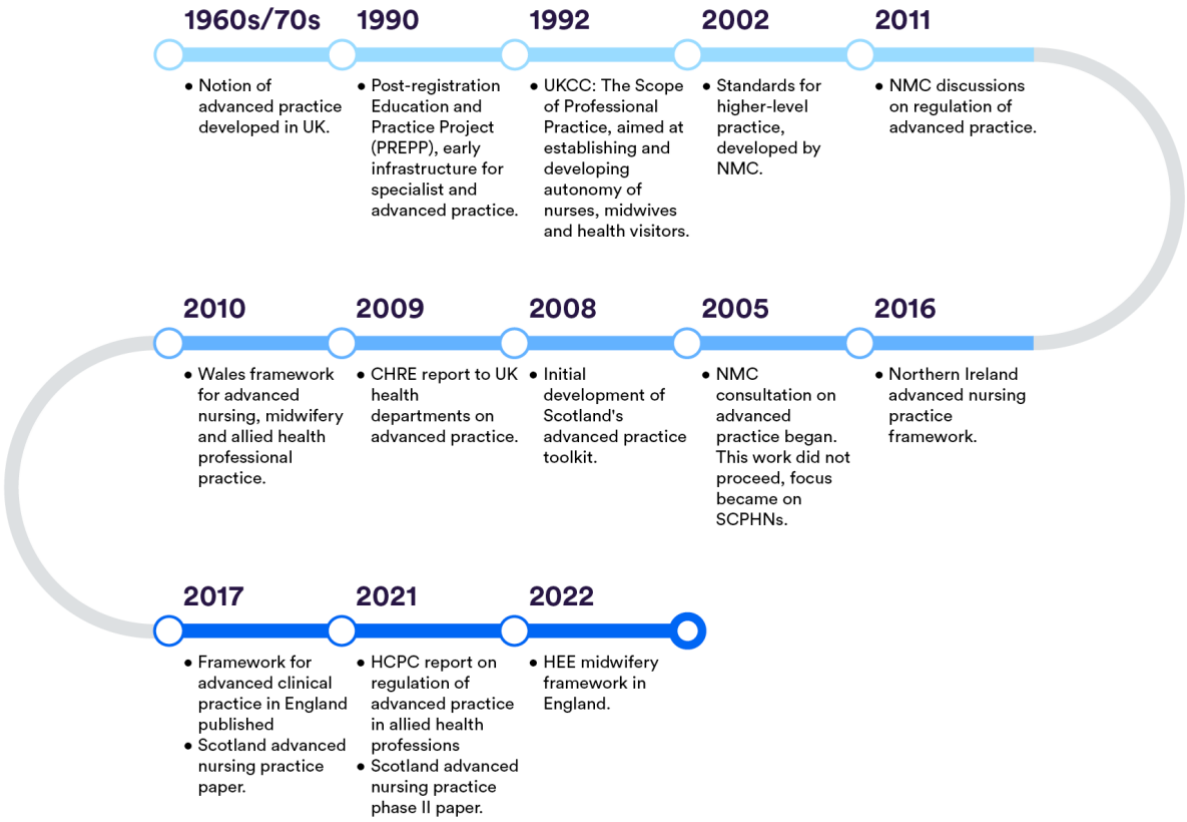
Advanced practitioner roles have been developed over time for a range of clinical, operational, financial and professional reasons. The ambition is that such roles will benefit service users, practitioners and the NHS. Some of the key challenges that they are intended to address are providing care more economically, addressing workforce shortages and providing career development.[16,17]

The advanced practice role in nursing was first established in the US in 1965. The role was originally introduced in the primary care setting in response to increased demand in access to care in rural areas, before evolving into additional clinical settings.[18] Shortly after the implementation of advanced practice across the US, Canada began developing and expanding the role, followed by the UK and then, during the 1990s, Australia, Ireland and New Zealand.[19] A

rapid expansion of advanced practice followed, with countries across all continents having introduced the role.[20]

In the UK, advanced practice was first formally recognised in the early 1990s with the publication of the *Post-Registration Education and Practice Project* report.[21] That report included the notion of autonomy and the following decade saw advanced practice further defined and the concept of the four pillars established, including efforts to distinguish between 'advanced' and 'specialist' practice (see Figure 1).

Figure 1: Overview of the timeline of advanced practice in the UK

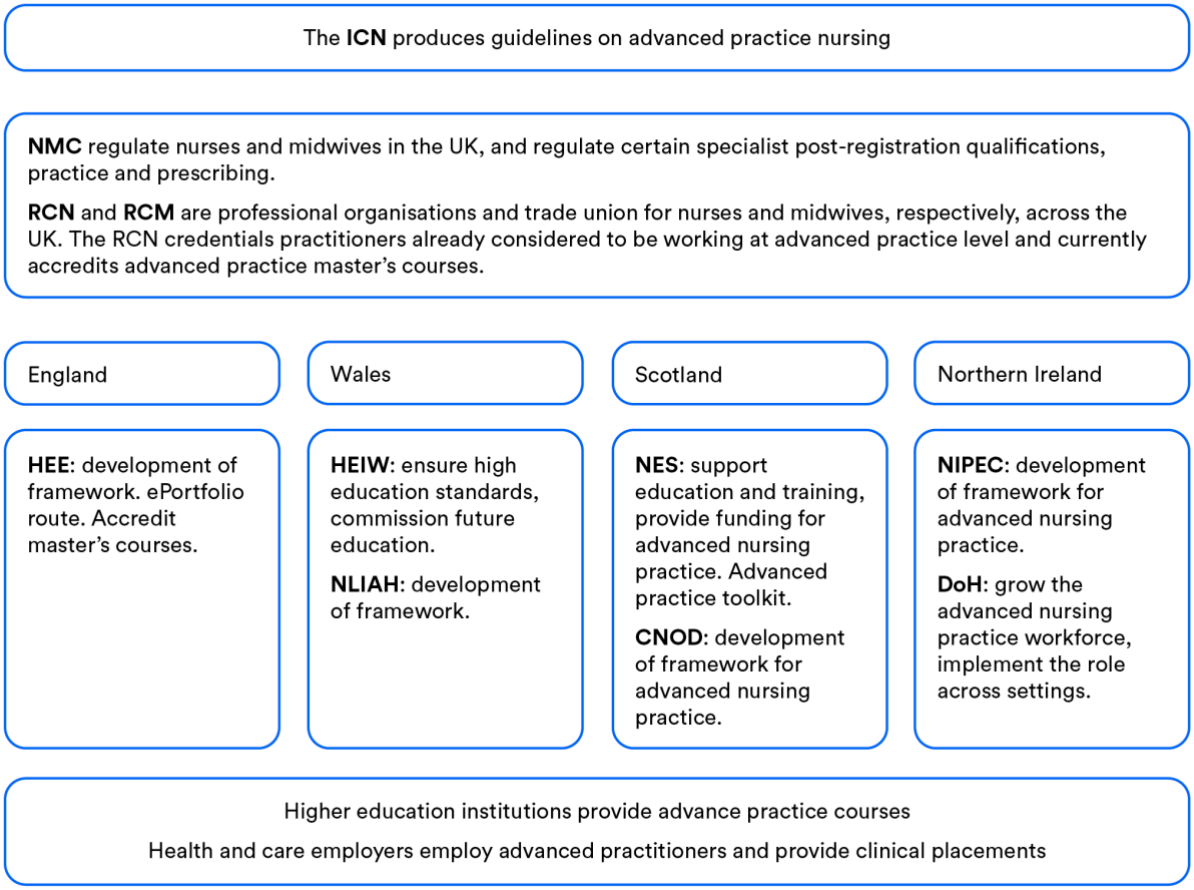


Notes: This is not intended to be an exhaustive list of policies but rather an indication of the development of advanced practice in the UK. CHRE = Centre for Health Research and Education (now Professional Standards Authority), HCPC = Health & Care Professions Council, HEE = Health Education England, NMC = Nursing & Midwifery Council, SCPHN = specialist community public health nurse and UKCC = United Kingdom Central Council for Nursing, Midwifery and Health Visiting (now Nursing & Midwifery Council).
Source: Nuffield Trust.

Advanced practice is a fast-moving landscape. In the UK, the drivers for developing advanced practice have been both ('top-down') national policy ambitions and ('bottom-up') demand from employers and the professions. The need to provide improved patient care and to create more fulfilling roles has tended to motivate innovators in nursing practice. The policy drivers have tended to be framed around providing a more flexible workforce, increasing capacity and reducing costs, and partly in response to the reduced availability of doctors and the increase in the number of people living with long-term conditions. The recent *Delivery Plan for Recovering Urgent and Emergency Care Services* in England, for example, committed to 'continue to increase the number of advanced practitioners in priority areas including in emergency care'.[22] Alongside the recent publication of the advanced clinical practice in midwifery capabilities framework[23], this demonstrates how advanced practice roles are still evolving today. Focusing just on hospital and community services in England, data collected for this study show that there has been nearly a four-fold increase in the number of nurses and health visitors recorded as having a job role 'advanced practitioner'.[24]

The implementation and oversight of advanced practice nursing and midwifery in the UK are complex, with various organisations involved in development, commissioning, education, standard setting, assurance and oversight (see Figure 2). It is also notable that organisations not usually associated with nursing have moved to provide courses and credentialling for advanced practitioners, including a number of the Royal Colleges.[25]

Figure 2: National organisations with key responsibilities for advanced practice



Notes: This list of organisations is not comprehensive. CNOD = Chief Nursing Officer Directorate, DHSC = Department of Health and Social Care, DoH = Department of Health, HEE = Health Education England, HEIW = Health Education and Improvement Wales, HSC = Health and Social Care, ICN = International Council of Nurses, NES = NHS Education for Scotland, NIPEC = Northern Ireland Practice Education Council for Nursing and Midwifery, NLIAH = National Leadership and Innovation Agency for Healthcare, RCM = Royal College of Midwives and RCN = Royal College of Nursing.
Source: Nuffield Trust.

Scale of advanced practice in the UK

Given that there is no clear definition of advanced practice for nursing and midwifery, it is impossible to be precise about how many nurses and midwives are practising at advanced level. However, data from NHS hospital and community services in England suggest there were, as at May 2022, more than 4,900 nurses and health visitors (under 2%) with a recorded job role of 'advanced practitioner' and more than 3,100 with a job title suggesting

an advanced practice role.[*] However, we have been informed that this could represent a significant underestimate of the true level of advanced practice, with some interviewees suggesting that as many as 8% of nurses could be working at an advanced level.[†] There were also a small number of midwives with advanced practice-related roles (seven) or titles (27) within the NHS administrative data.

In Scotland, there were some 791 advanced nurse practitioners as of September 2020, which represented a 23% increase in three years.[26] We could not identify similar data from Wales or Northern Ireland.

To explore advanced practice and what this looks like in the UK, we looked at job adverts across the four devolved countries of the UK. Less than 2% of advertised nursing roles in Wales and Northern Ireland were advanced roles.[‡] In both England and Scotland the corresponding percentages were 5%. Notably, 26% of nursing roles advertised in general practice in Scotland were advanced roles, compared with 3% of advertised hospital roles in Scotland. No advanced midwifery roles were advertised across the UK in the timeframe examined (the month of October 2022).

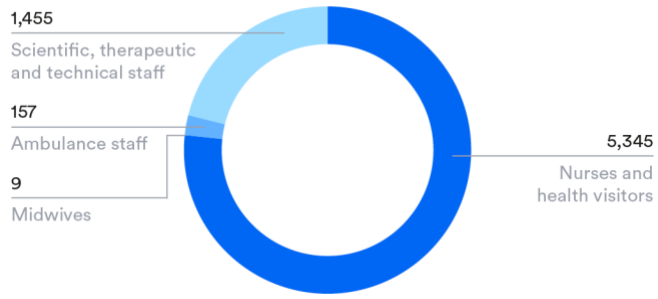
By comparison, across the 15 professions that the Health & Care Professions Council (HCPC) covers, around 2,000 allied health professionals considered themselves to be practising or working towards advanced-level practice across the UK in 2021.[27] Data collated for this study – albeit limited, due to availability, to NHS hospital and community services in England – show that these other staff groups account for a significant proportion of staff recorded as working in 'advanced practice' job roles (see Figure 3), with radiography and operating theatres being common care settings.

[*] Staff with a job title containing either 'advanced clinical practi*', 'advanced nurse practi*' or 'advanced midwi*'.

[†] Based on there having been around 572,000 registered nurses as at September 2022.

[‡] We searched NHS Jobs in England, Wales and Scotland and HSC Jobs in Northern Ireland, using the terms 'advanced clinical practitioner', 'advanced nurse practitioner' and 'advanced midwifery practitioner'. We conducted the search on 24 October 2022 and used the total number of advertised nursing roles in each nation as the denominator.

Figure 3: Number of NHS hospital and community staff in England recorded as working in 'advanced practice' roles, as at May 2022



Note: Excludes non-clinical and support staff groups.
Source: Data provided by NHS Digital.

About regulation

The regulation of health and social care professions is intended to protect the public from the risk of harm from the provision of health and social care services. As part of this, regulators are supposed to consider how to promote professional standards and maintain public confidence in the professions.[28] Regulation can take many forms. At the most formal end of the spectrum, there is 'statutory regulation', which is when professionals are registered with their respective professional regulatory body by law, meaning it would be an offence for someone to describe themselves as a regulated health care professional without the appropriate registration.[29] Where professions are regulated, the intention is that the regulator acts in a way that is proportionate, consistent, targeted, transparent, accountable and agile.[30]

Statutory regulation may not always be appropriate as it could be disproportionate to the risk the profession poses; it is also typically not sufficient assurance in itself. The governance of professional practice can, in this respect, be considered in tiers, from self-regulation to team regulation, employment regulation and statutory regulation.[31] In the absence of more formal regulation, greater responsibilities fall on individual practitioners – including their need to be aware of their own limitations and recognise the parameters of their scope of practice – and on employers – in assuring themselves that the practitioners they employ have adequate preparation and receive sufficient ongoing support.[32]

Professional regulation plays a vital role in setting and enforcing the standards of professional behaviour, competence and ethics underpinning the day-to-day interactions patients and the public have with the NHS and the variety of other health and social care services within the UK.[33]

General overview of regulation in the UK

Currently, there are nine regulators in the UK that regulate 34 health professions by law.[34] Professional regulation is a statutory system but is independent from government. The Professional Standards Authority (PSA) oversees the operation of these regulators but is not accountable for their individual performance.

While much of health and care policy is devolved, the system of professional regulation operates – for most professions – on a UK-wide basis. The Commission on Scottish Devolution suggested that professional regulation was best dealt with across the UK as a whole to provide clarity and assurance to service users and support the mobility of professionals between the four UK countries.[35] An exception is social work, which is regulated by different councils in the different countries, although they have agreed a Memorandum of Understanding around regulation and the approval of educational courses.[36]

The cost to the individual being regulated varies widely between professions. Professional regulators receive no government funding so they rely on the fees that registrants pay. In 2023, annual registration fees ranged from around £118 for the HCPC to £690 for the General Dental Council for dentists. The annual NMC registration fee was £120, with an additional £25 for any recordable qualifications, including prescribing.[37] In a survey of professionals that the HCPC covers, the most commonly cited perceived disadvantage for the regulation of advanced practice (which around two-thirds of respondents noted) was the increased cost of regulation.[38]

At the time of writing this report, the UK government was consulting on changes to the regulation of health care professionals. Currently, each regulator has its own legislation, and the proposals include ambitions to make these broadly similar so that they have near-identical powers. The proposed changes to the legislative framework are also intended to provide regulators with greater autonomy.[39] The regulatory reforms being proposed also include draft legislation that will allow the General Medical Council (GMC) to regulate physician associates and anaesthesia associates, who currently are only covered by voluntary registers that the Royal College of Physicians and the Royal College of Anaesthetists respectively run.[40]

Overview of the current regulation of nursing and midwifery in the UK

The Nursing & Midwifery Council (NMC) is the regulator for nurses and midwives in the UK and nursing associates in England. *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*[41] sets out the standards of practice and behaviour expected of all health care professionals registered with the NMC. Additional information – for those specialising in different areas – is provided on entries in the NMC register via a series of annotations, which mostly denote specialist or recordable qualifications, including as a specialist practitioner in a particular area of practice (such as general practice or mental health nursing) or in prescribing.

Specialist community public health nurses (SCPHNs) are required to maintain their nursing or midwifery registration, in addition to their SCPHN registration, and their field of practice (for example, health visitor or school nurse) is also indicated on the SCPHN portion of the register.

In addition to the maintenance of the register, the NMC sets educational and professional standards, which also help to guide professionals, employers and higher education and other institutions. The NMC is also responsible for investigating concerns about individuals and their fitness to practise.

Overview of the current regulation of advanced practice in the UK

The NMC does not currently specifically regulate advanced practice in nursing and midwifery. Instead, The Code governs all nursing and midwifery practitioners. This has previously been thought to be sufficiently comprehensive and flexible to cover the professionals acting at the different levels of competency and skill that it covers.

However, the issue of whether advanced practice in nursing and midwifery should have additional regulation and what form this might take has been debated for many years. The NMC has twice discussed the possibility of beginning work aimed at demonstrating the need for the regulation of advanced practice, in 2005 and 2011, but did not proceed to make any changes. But as part of its 2020–25 strategy it is considering whether additional regulation is needed.[42]

In 2021, the HCPC – which covers 15 other health care professions in the UK – published a review on advanced practice, which suggested that there is no 'consensus that additional regulation is the right solution to the issue at this time'.[43] But the HCPC, while not moving to introduce full regulation, agreed to continue to monitor the developing advanced practice landscape, while also taking a leading role in the development of a definition and guiding principles for advanced practice.

We heard from stakeholders that there could be a risk of unintended consequences for other professional groups from the NMC alone pursuing the regulation of advanced practice as the role expands across allied professionals. There was a general consensus from the workshops that a multi-professional approach should be taken and a 'two-tiered system' should be avoided. In fact, a survey relating to professions that the HCPC covers found that 'difficult[y] to regulate multi-professional practice' was one of the most commonly cited perceived disadvantages of or challenges to regulation (which 54% of the 3,716 respondents cited).[44]

Regulatory approaches

Current approaches by regulators to post-registration qualifications broadly fit into four categories:

1. **Controlling the use of particular specialty titles.** The General Dental Council records those who have received a certification on completion of a Royal College specialist programme and passed the examination – while only those who are on the 'specialist list' can call themselves a 'specialist', this does not prohibit others from providing specialist care.

2. **Controlling entry to particular types of practice.** The NMC and some other regulators annotate their registers to denote practitioners who have qualified as independent or supplementary prescribers, with only those with the appropriate qualification on the register legally able to do this practice.

3. **Providing information.** The NMC annotates its register with specialist practitioner qualifications (SPQs) to denote additional learning. The specialist job titles are not protected.

4. **Entitlement for appointment.** Doctors taking up NHS consultant or GP posts must be on the GMC's specialist and GP registers.[*,45]

To help demonstrate the range of regulatory approaches, more detail on these and on the regulation of some other clinicians in the UK, including physician associates and anaesthesia associates, is given in Table 3 in Appendix B.

Overview of international practice on regulation

Most nations with nurses working at a similar advanced practice level as nurses in the UK have greater regulation. A cross-country comparison identified 11 countries with significant similar scopes of advanced practice as in the UK and, of these, Finland was the only one (as with the four UK countries) not to specifically regulate advanced nursing practice. Countries in the comparison that regulate the role include Australia, Canada, the Netherlands, New Zealand and the US.[46] Looking more broadly than those 11 countries, across countries where advanced-level practice is less developed, there is even less consistency on whether the roles are regulated, with Figure 4 highlighting which countries are known to have, and not have, statutory regulation.

[*] Doctors who held a post as a consultant in oral and maxillofacial surgery in the NHS immediately before 1 January 1997 are an exception to this requirement. In addition, specialist registration is not a legal requirement for consultant posts in foundation trusts.

A number of different approaches to regulation are seen internationally:

- The majority of countries across Europe have some variation in the advanced practice role, although, in many cases, the role is still emerging and is not regulated. Hungary is an outlier in this sense. Legislation, including title protection for 'nurse practitioner', was put in place in 2016 before implementation of the role, with MSc courses enrolling students from 2017 onwards.[47] Similarly, the Ministry of Education and Research regulates advanced practice roles in Norway, despite the roles still being developed and implemented.[48]

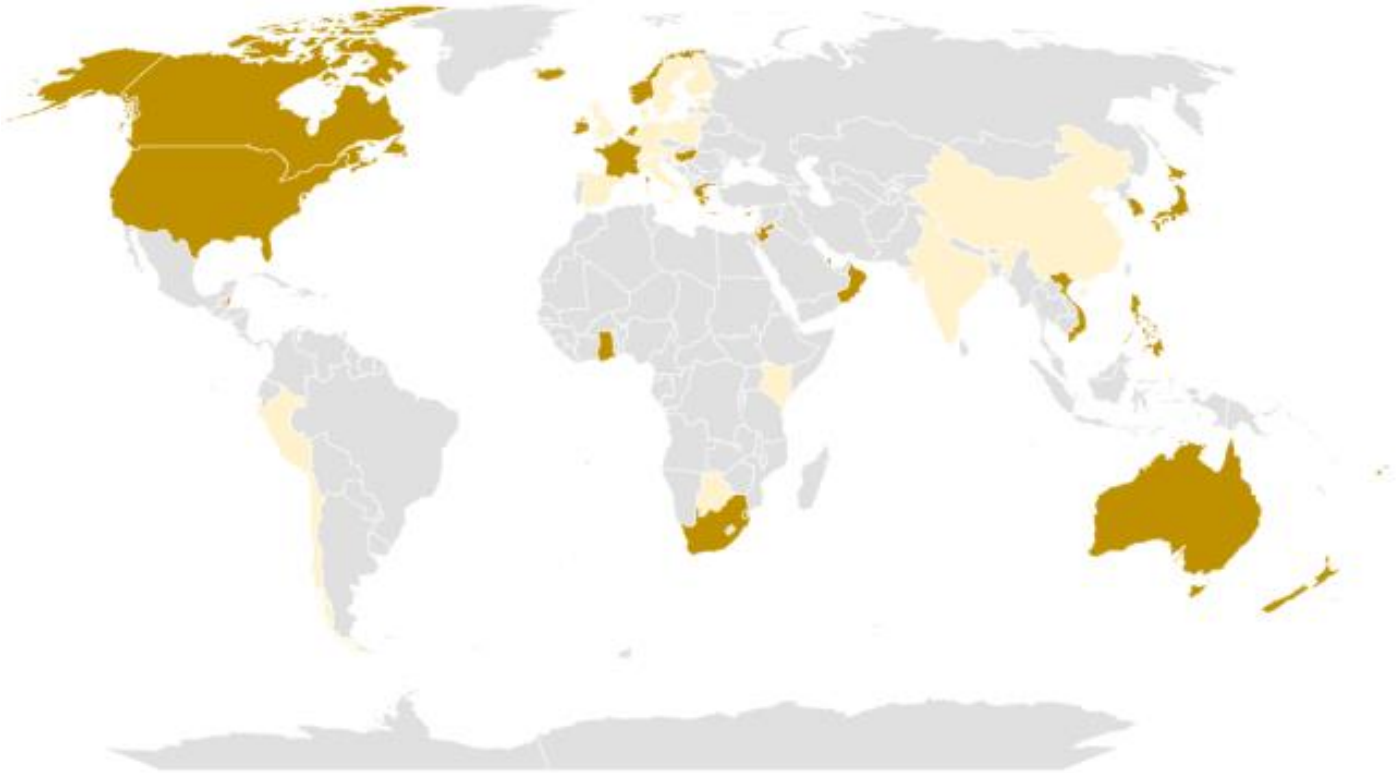
- There are a number of European countries where the nurse specialist role is regulated whereas advanced practice is not. However, in the majority of these countries, advanced practice roles are seen as emerging roles, with higher education programmes still being established. Such countries include Austria, Belgium, Germany, Iceland and Spain.[49]

- Ireland and the Netherlands regulate advanced practice, including the scope of practice, standards for education and title protection. Notably, the title 'nurse specialist' is the protected title in the Netherlands as the 'nurse practitioner' title could not be translated into Dutch. Additionally, France and Switzerland are in the early stages of developing and implementing regulation for advanced practice.[50]

- Outside Europe, Singapore and South Korea have implemented and regulated the 'advanced practice nurse' role. This is defined as a combination of both the clinical nurse specialist and nurse practitioner role, thus there is no differentiation between the two levels of practice.[51,52]

- Ireland has separate regulation for advanced midwifery, as well as nurse, practitioners.[53]

Figure 4: Examples of the regulation of advanced practice internationally



Note: A dark brown colour represents the existence of statutory regulation of advanced practice, a light beige colour represents the absence of such regulation and grey represents countries with no information available in the underlying data source. Source: Nuffield Trust analysis based on the Association of Advanced Practice Educators (AAPE). See Ladd E, Miller M, Wheeler K, Wainaina S, Aguirre F and others (2020) 'A global SWOT analysis of advanced global nursing: policy, regulation and practice'. https://doi.org/10.21203/rs.3.rs-113320/v1. Accessed 26 April 2023.

Across the international examples, as well as there being different breadths of regulation, there are various models of regulation, particularly in terms of who takes responsibility. From country to country, there are a range of different types of bodies that have taken a lead on licensing, accreditation, credentialling and education, with variation in whether some regulation is also at a national or regional level (see the example of the US in Box 1).[54] In Ireland, the Nursing and Midwifery Board of Ireland regulates advanced nurse and midwife practitioners. The board is responsible for approving educational providers, determining standards of practice and title protection. Similarly, in Australia and New Zealand, national boards of nursing and midwifery carry out credentialling.[55]

Box 1: Responsibilities in the US

In the US, the regulation of advanced practice occurs at the state level, with each state board determining the scope of practice.[56] The recent implementation of the 'consensus model', a newly developed regulatory model that aims to standardise the education, certification and licensure of advanced practitioners across the US, has seen the involvement of a number of organisations. These include independent accrediting agencies, of which there are three that accredit nursing programmes across the US,[57] to ensure quality in content and outcomes. Additionally, certification organisations are responsible for carrying out job analysis and subsequently developing a certification exam.

Each state board will then provide the licensing of advanced practice registered nurse roles. Licensing involves the state board's final review of the nurse in question to verify that they have gone through the required educational preparation, including an accredited course and a national certification.[58] Individual state boards are also now responsible for 'grandparenting' (recognition of previous learning and experience) in their state.[59]

The experience of implementing regulation has also varied from country to country. There are examples of a reasonable level of consensus across educators, certifiers, accreditors and boards of nursing, even across different jurisdictions, being achieved elsewhere.[60] Other efforts have also appeared to deliver international consensus.[61] However, the route to implementing regulation is far from consistent. While the Netherlands went from introducing advanced practice to making relevant legal changes – initially as a pilot before later being formally enacted – in a comparatively short time span, other countries' reforms have taken longer. In particular, in New Zealand, a decade passed between a bill first being proposed and its first reading. As one paper has noted, 'reforms [are] often lengthy and controversial, opposed by physicians or other stakeholders'.[62]

International comparisons can be instructive and we have included additional detail from selected countries at the end of this chapter (see Table 1). However, it is important to note that the nature and effect of the regulation of advanced practice in other countries are not always well described in the literature, and the contexts can be quite different from that in the UK, so it is not always clear how translatable international solutions would be for the UK.

Evidence on the effectiveness of regulation

Despite a comprehensive search, we found that international research on the effect of the regulation of advanced practice in nursing and midwifery was limited in terms of being scarce and lacking formal evaluations of regulation itself. Where it exists, we have reported it in the chapters that follow. However, this report should be read in the context that there is limited understanding from published evidence on how regulation might address the issues and achieve the benefits promised from advanced practice. This is particularly an issue in midwifery as – despite the long-standing consultant midwife role – there is less specific evidence relating to

considerations of the regulation of advanced practice in this profession, in part because the scale of this level of practice is currently smaller than in nursing.

Table 1: Comparison of the regulation of advanced practice nursing in selected countries

	Regulated role	Regulation	Requirement for registration	Revalidation
The US	Advanced practice registered nurse	SOP by state Title protection	MSc from accredited programme Certification exam 4–6 years' clinical experience	Continued educational requirements
Canada	Nurse practitioner	SOP by province Title protection	MSc from approved programme Certification exam 3 years' clinical experience	Continued competence programme Practice review 2 years post registration Practice review every following 5 years
Australia	Nurse practitioner	SOP national Title protection	MSc from accredited programme Portfolio based on set of national standards	
New Zealand	Nurse practitioner	SOP national Title protection	MSc from approved programme Panel assessment/viva Portfolio based on national standards 4 years' clinical experience	Supervised for first year of practice Complete assessment every 3 years demonstrating hours in development and practice
Ireland	Advanced nurse practitioner	SOP national Title protection	MSc from approved programme Portfolio based on national standards 7 years' clinical experience	
Netherlands	Nurse Specialist	SOP national Title protection	MSc from approved programme 2 years' clinical experience	
Singapore	Advanced Practice Nurse	SOP national Title protection	MSc from accredited programme Certification exam	Supervised during first year of practice via a structured internship
South Korea	Advanced Practice Nurse	SOP not regulated Education regulated Specialty areas regulated	MSc from appointed programme Certification exam 3 years' clinical experience	

Notes: This table focuses on nursing (and not midwifery) due to the scope of the underlying data sources. AANP = American Association of Nurse Practitioners, NPAC = Nurse Practitioner Association of Canada and SOP = Scope of Practice.

Sources: Ladd E, Miller M, Wheeler K, Wainaina S, Aguirre F and others (2020) 'A global SWOT analysis of advanced practice nursing: policy, regulation, and practice'. https://doi.org/10.21203/rs.3.rs-113320/v1. Accessed 26 April 2023. Scanlon A, Bryant-Lukosius D, Lehwaldt D, Wilkinson J and Honig J (2019) 'International transferability of nurse practitioner credentials in five countries', *Journal for Nurse Practitioners* 15(7), 487–93. International Council of Nurses (2020) *Guidelines on Advanced Practice Nursing*. ICN. www.icn.ch/system/files/documents/2020-04/ICN_APN%20Report_EN_WEB.pdf.

Chapter 2: Definition and recognition of the advanced practice role

In this chapter, we consider how the advanced practice role is defined, its recognition by people using services and the public, and protection of the title. This area has important direct regulatory relevance, for example in ensuring against potential harm to the public and of damage to public confidence if roles are not well understood and job titles are misused or used inappropriately.

Defining advanced practice

There is no single definition of 'advanced practice' used internationally, with substantial variation in the role titles used.[63] In Australia and New Zealand, for instance, 'nurse practitioners' are included in the Standard Classification of Occupations,* based on tasks, qualifications and skill level.[64] Some degree of variation is to be expected given that advanced practice roles are implemented differently across countries based on population need and workforce planning, and therefore developing a common definition would be challenging and somewhat limiting.[65] However, even the basis for defining the role differs, with some definitions predicated on generic notions of practice, particularly those of 'independence' and 'autonomy' as a practitioner, while others rely on classifications associated with qualifications, and some are based on tasks and/or skills.[66]

The lack of consensus on the basis for defining roles has an impact on the regulation of advanced practice as it has implications for what assurances might be required around, for example, education, scope of practice, recognition of prior learning and experience, and evidence of ongoing continuing professional development. This is a theme throughout our report and explains, at least in part, the level of variation we highlight in the preparation and employment of advanced practitioners.

There is very limited international consensus on the definition of advanced practice in midwifery. This is hardly surprising given how few midwives currently work with an advanced practice job

* This was developed for organising occupation-related information to support, for example, policy development and review, human resources management, and research.

title. That said, in England, a recent framework sought to map the definition of advanced clinical practice to midwifery to demonstrate that this level exists.[67] Unlike in nursing, there are few countries that have more established advanced practice in midwifery than the UK; however, the Nursing and Midwifery Board of Ireland (equivalent to the NMC) has developed standards for advanced practice in midwifery.[68]

Implications of inconsistent definitions

We heard a number of concerns about the current lack of consistency in the definition of advanced practice, including in relation to:

- the migration of staff across the four UK countries
- overseas recruitment
- distinguishing between other categories of practice
- consistency with other professions.

First, the potential impact on the **migration of staff across the four UK countries**, if there is significant divergence in how the advanced practice role is defined and understood, was raised as a concern. Many nurses and midwives move between the countries of the UK over the course of their careers; for example, around a quarter (24%) of UK-trained NMC registrants with an address in Wales trained elsewhere in the UK.*[69] As already discussed, the frameworks for advanced practice differ between the four UK countries. More material differences are evident in employers' apparent understanding of the role (see the section 'Employers' responsibilities' later in this chapter, page 36).

Similarly, given the current reliance on **overseas recruitment**, careful consideration is needed to ensure that there is appropriate recognition of advanced practice across international borders. Currently, half of professionals joining the NMC register for the first time trained outside the UK.[70] For registered nurses and midwives, the NMC recognises the professional qualifications of those who have trained and worked abroad to facilitate the migration of health care professionals. However, this is typically for registration rather than for additional qualifications. Any mutual recognition of advanced practice is complicated by the vast array of different titles used[71] and also because what might be considered advanced practice elsewhere (for example, specialist nurse practice) would not be recognised in the UK.[72] We were not able to capture within our research how advanced practitioners recruited from overseas were typically appointed and recognised in the UK. Across the published literature, a strong case is made for an international standardised title to support greater clarity over the advanced practice role, with standardised titles and use of the International Standard

* Corresponding figures are 2% of NMC registrants with an address in England trained elsewhere in the UK, 6% of registrants in Scotland and 16% of registrants in Northern Ireland.

Classification of Occupations system suggested as ways to also improve data availability and monitoring.[73,74]

Another concern we heard around inconsistent definitions was around **distinguishing between advanced practice and other categories of practice**, including existing specialist, enhanced and consultant levels of practice within nursing and midwifery. The question of specialist versus advanced is particularly difficult, as advanced practice education is often aimed at ensuring that practitioners are independent decision-makers and can relate this to their specialist area of practice such as the Emergency Department. We heard different views on the implications for consultant-level practice and whether statutory regulation should cover it. Some suggested that consultant-level practice would just be part of the continuum of advanced practice and reflect further professional development for individuals, whereas others suggested that, for consistency, there would also need to be the regulation of consultant-level practice. A survey on advanced practice across allied health professions found that 'consultant practitioners' were least likely of any staff group captured to support the regulation of advanced practice (64% compared with 78% across all respondents*).[75]

Ensuring – if deemed necessary – **consistency with other professions** was also raised as a concern with regards to definitions. In 2021, a UK review on advanced practice across allied health professionals found that 'there is neither consensus about what advanced practice is (a necessary precursor to regulation) nor consensus that additional regulation is the right solution to the issue at this time'.[76] As noted earlier, advanced practice frameworks covering nurses in England and Wales are multi-professional whereas they are nurse-specific in Scotland and Northern Ireland.

Setting standards and the scope of practice

To help define the advanced practice role and ensure it is well understood and recognised, the respective regulators can play a part in setting standards and producing guidance for a profession. In particular, the Professional Standards Authority suggests that the regulator:

- maintains up-to-date standards for registrants, which are kept under review and prioritise patient- and service-user-centred care and safety
- provides guidance to help registrants apply the standards, and ensures this guidance is up to date, addresses emerging areas of risk and prioritises patient- and service-user-centred care and safety.[77]

* Figures related to 204 consultant practitioners and 2,904 of all respondents who indicated support.

Advanced practice and the existing scope of practice

A key consideration is whether the nature of the work of advanced practice is 'fundamentally different' from that at initial registration. If it is, it would include going beyond what might be expected in terms of career progression within a given scope of practice and where there is a significant change in the nature of risk to people using services from advanced practice roles.[78]

Some told us that advanced practice falls within the existing scope of practice of nurses and midwives. Indeed a Council for Healthcare Regulatory Excellence report from 2009 suggested that 'often what is termed advanced practice reflects career development within a profession and… the activities professionals are undertaking do not lie beyond the scope of existing regulation'.[79] A recent framework on advanced clinical practice in midwifery in England also suggested that current NMC proficiencies for midwives[80] meet or partially meet all advanced practice capabilities within the clinical pillar but critically not the other three pillars of advanced practice.[81]

However, we also heard views and identified literature suggesting that advanced practice falls outside the existing scope of practice of nurses and midwives. One study, albeit published back in 2016, noted the broad scope of advanced practice in the UK, with England, Scotland, Wales and Northern Ireland among the 11 countries of 39 surveyed where nurses in primary care conducted all of: prescriptive authority, medical diagnoses/advanced health assessments, ordering tests, medical treatment, responsibility for a panel of patients, referrals and being a first point of contact. In fact, nurses in the UK are doing more work traditionally conducted by physicians than nurses in most other countries.[82]

A survey of advanced practitioners that included allied health professionals found that two in five (41%) felt they were working outside the traditional scope of practice of their registered profession.[83] Notably, both the expectation to work beyond their scope of practice and an inability to work to their full scope of practice were raised in an international survey of advanced practitioners.[84] Informal practice (referring to task shifting, which is not regulated or addressed in other non-regulatory governance) has been highlighted in one paper as an argument for regulation, and countries such as the Netherlands have since acted on this argument, going on to introduce additional regulation.[85] However, based on survey respondents, the same paper found no evidence of informal practice in the UK.

International experience on the scope of practice

The regulation of advanced practitioners in the US highlights some key lessons around the scope of practice, in particular around the importance of flexibility (see Box 2 on page 33). The issue of restrictive scope of practice has often been raised as a concern in the literature, with restrictive regulation suggested as a hindrance to the development of the advanced practitioner role, creating additional barriers to care and limiting workforce

expansion.[86,87] Moreover, although International Council of Nurses' guidance states that 'each country where the Nurse Practitioner is well developed needs a robust scope of practice', the guidance does recognise the challenges associated with this, including the need for a strong understanding of context within a country (which, in itself, might be challenging given the reasons already noted in this report).[88]

Box 2: Scope of practice for nurse practitioners in the US

The scope of practice of the nurse practitioner (the title used in the US to cover advanced practice) is regulated in the US. The responsibility for this sits with individual state boards of nursing and, currently, states fall into one of three categories:

- full scope of practice (allowing nurse practitioners to practise independently and to the full extent of their training and education)
- full scope of practice with a transition period (whereby a physician in practice oversees newly qualified nurse practitioners)
- restrictive practice (whereby nurse practitioners must have physician oversight to carry out tasks including diagnostics and prescribing).[89]

Boards of nursing can establish and develop the scope of practice through endorsing an existing scope of practice statement previously defined by a national organisation (for example, the American Association of Nurse Practitioners and individual national organisations for specific clinical areas such as critical care and acute care) or, alternatively, develop a state-specific scope of practice informed by key stakeholders.[90] Of note, the current implementation of the 'consensus model' (a national framework approved by an array of stakeholders) in the US includes endorsing the full scope of practice. This is arguably the most significant barrier to the model's implementation, with legislative changes required and a general resistance to a full scope of practice in states that currently have restrictive practice.[91]

Individual organisations can still grant privileges to nurse practitioners, allowing them to work outside their defined scope of practice, which can include tasks such as admitting patients.[92,93] As such, scope of practice, while regulated, is still potentially a source of confusion for employers across the US.[94]

Redefining scopes of practice is possible but typically challenging. In the US, the nurse practitioner's scope of practice has been repeatedly modified since the role was first established. Such changes to the scope of practice have been made in response to the increased health needs of the population, promoting access to care and technological advances. As the scope of practice was modified, educational programmes were adapted in response to these changes.[95]

The task of defining the scope of practice goes beyond this continuous modification process. A restrictive scope of practice has implications across the health system, including limiting service users' access to primary care, as highlighted in a number of studies.[96] Namely, states where nurse practitioners operated with a full scope of practice had improved access to and use of primary care services alongside a larger nurse practitioner workforce.[97,98] This is primarily down to states with restrictive practice requiring physician oversight. Physician oversight is often considered negatively in the literature due to the additional barriers and burdens it creates.[99]

Practitioners' recognition of the scope of practice

All health professionals have duties from the core Code/Standards documents of their respective regulatory body to practise safely and effectively. If practitioners do not recognise their scope of practice, there is a risk of unwittingly practising where they lack the necessary competence, thereby possibly compromising patient safety and bringing their profession into disrepute.[100]

A 2009 report on advanced practice from the Council for Healthcare Regulatory Excellence (the predecessor to the Professional Standards Authority) to the four UK health departments concluded that 'the activities professionals are undertaking do not lie beyond the scope of existing regulation… registrants have a duty only to practise where they are competent to do so'.[101] Health Education England made a similar argument in its 2017 framework for advanced clinical practice, which proposed that 'practitioners working in advanced clinical practice roles must be aware of their own limitations and through this, recognise the parameters of their scope of practice'.[102] Similarly, the Scotland framework emphasises how advanced practitioners must show awareness of their own limitations in clinical competence.[103]

The 2009 report mentioned above noted that there was no systematic evidence from fitness-to-practise proceedings to suggest that advanced practitioners were unwittingly practising where they lacked the necessary competence. However, we heard reports of practitioners both unwittingly and consciously acting without the necessary competencies and skills. In a survey of allied health professions, more than half of respondents (55%) perceived 'assurance to self of knowledge and skills' as a benefit of the regulation of advanced practice.[104]

Use of title

There is a potential risk of harm to the public and of damage to public confidence if a practitioner does not have the skills and experience that their job title conveys. As a result, certain job titles and functions can be protected so that only an appropriately registered professional can legally use or undertake them. Regulators are expected to manage the risk of this not happening 'in a proportionate and risk-based manner'.[105] The International Council of Nurses recommends that title protection 'should be considered a requirement of the regulatory and credentialing process' in its advanced practice guidelines.[106] For example, Australia, Canada, Ireland and New Zealand all protect the advanced practice title. Conversely, Finland and Sweden do not have title protection for the role although, notably, in both these countries the role is in its infancy.[107]

The NMC currently covers four protected titles: 'registered nurse', 'midwife', 'nursing associate' and 'specialist community public health nurse'. Attending a woman in childbirth is also a protected function (except in an emergency or as part of training).*

The 2009 report to the four UK health departments mentioned earlier suggested that 'regulatory bodies should only use their power to statutorily restrict a title or function to those with approved credentials where the safety of patients and the public is not adequately upheld by other systems of governance'. The authors were unconvinced of the need to protect advanced practice titles at that time and, further, suggested that:

> *annotations without protection of title or function, and so which serve not to protect the public directly but to denote professional status, add little to the ordinary human resources checks by employers to ensure applicants have the credentials necessary for a particular job or to existing regulatory requirements that professionals only practise where they are competent to do so.*[108]

Protection of title was consistently raised throughout our engagement with stakeholders and experts. A 2017 study found 323 posts recorded as holding titles such as advanced nurse practitioner or specialist nurse who were not even registered with the NMC.[109] Our own analysis for this study – albeit limited to data on hospital and community services in England, which we were able to access – shows that, as of May 2022, there were 25 clinical support staff (non-regulated roles) with an advanced practice job title† and 147 with an 'advanced practice' job role. Of particular concern, we heard of examples of individuals:

- using the 'advanced practice' title in a particularly autonomous setting on the basis of having completed a half-day course and not meeting the published definitions for the role
- failing the full relevant advanced practice master's course but still returning to their job and continuing to use the 'advanced practice' title.

It is not clear how widespread this practice is and we heard that such circumstances may be less likely in some of the UK countries than others; however, they remain concerning given the reliance on employer organisations to provide assurance.

* This means that only a registered midwife or registered medical professional can legally 'attend a woman in childbirth' other than in an emergency or during training.

† A job title containing either 'advanced clinical practi*', 'advanced nurse practi*' or 'advanced midwi*' in our searches.

While issues around the use of title were consistently raised in our research, there was not always a clear consensus on the solution. We also heard that, given the costs and barriers to entering a regulated profession, protection of advanced practice might just cause clinicians and employers to use an alternative title, so such formal regulation might not necessarily remove the problem. However, we also heard that, in Northern Ireland for example, the issue of the misuse of job titles had been mostly resolved through negotiation and agreement with employers and, similarly, an exercise in Wales largely addressed inconsistencies in job titles. A further challenge is that the title of 'nurse' is not protected in the UK.

Employers' responsibilities

Whatever the statutory approach, regulators cannot provide all the information and assurance on an individual's fitness for a particular job and so employers will always have to take their own assurance over whether an applicant's experience and qualifications are appropriate. Previously, the predecessor of the Professional Standards Authority suggested that having robust organisational governance arrangements was the most effective means of controlling for risks to patient safety.[110] Equally, each of the four UK countries' frameworks on advanced practice outlines employers' responsibilities:

- The framework for advanced clinical practice in England is very focused on the role of the employer as guarantor of the qualifications, suitability, scope of practice and oversight of the practitioner.[111]
- The framework for advanced practice in Wales underlines the responsibilities of employers in ensuring the role is implemented safely – including making arrangements for professional support and setting suitable expectations for the role, based on national standards.[112]
- The Scottish framework provides guidance for employers on their fundamental responsibilities. This includes developing a robust job description and ensuring individuals have the required qualifications and clinical supervision.[113]
- The Northern Ireland framework is generally limited on the role and responsibilities of the employer, focusing more on outlining the requirements of the role.[114]

Variation in job descriptions, requirements and characteristics

When employing advanced practitioners, employers can use job descriptions to provide assurance that the professional they appoint has the necessary knowledge, skills and other attributes to be fit for the particular purpose.[115] However, our review of adverts found that there is substantial variation in job titles, job descriptions and banding, with these

inconsistencies most notable in England.[*] It is important to note that a degree of variation is expected in order that the role fits with local needs and also that some adverts did provide well-structured, well-defined person specifications and role overviews. But the differences we identified (which also include differences in educational requirements, as covered in Chapter 3, section 'Educational curricula', page 41) likely reflect the variable extent of understanding of the role:

- Some employers have well-established frameworks and guidance on advanced practice, guided by a clear **understanding of the role**, but this is not always the case, with some areas and employers not having a clear understanding. We also heard that understanding of the role varies by clinical area, often dictated by the visibility of the role, which is something that has also been noted internationally.[116]

- **Required experience** varied across job adverts. Generally, more experience[†] was required for a role in hospital settings such as emergency care, urgent care and specialist wards. The level of experience required for the role varied between no experience and a limited number of roles that required previous experience as an advanced practitioner. A general person specification seen across job adverts was the rather unspecified 'experience in a clinical field'.

- The **pay level (banding)** of advanced practice roles varies within and between the four UK countries. We identified advanced practice roles at Agenda for Change bands 7, 8a and 8b without any clear indication from the job description why these should be different. From the adverts we reviewed, roles in Scotland were typically at band 7 whereas in England and Wales there was a relatively even split between roles at band 7 and band 8a. In Northern Ireland, roles were uniformly advertised at band 8a. A similar job adverts review across England identified variation in banding between sectors, with a smaller percentage of band 7 roles being advertised in the acute setting. [117]

These findings are not unique to the UK, with an international survey identifying a lack of organisational understanding of the role.[118] This includes the US where, despite regulation, roles are still not properly defined in some primary care practices, resulting in variation in clinical responsibilities.[119] The 'credentialling' model used in Australia and New Zealand does appear to offer benefits to both employers and employees, being effectively a contractual agreement about an individual practitioner's scope of practice, the level of service to be provided and what support the employer will offer to enable safe service

[*] During the month of October 2022, we reviewed 32 jobs advertised on NHS Jobs across the UK, including supplementary person specifications and role overviews (where provided). Job titles included 'advanced clinical practitioner', 'advanced nurse practitioner' and 'advanced midwife practitioner'.

[†] This ranged from 18 months to five years.

delivery. This effectively means that both employer and employee have a robust understanding of the job and its component tasks.

Chapter 3: Pathways into advanced practice

This chapter looks at the regulatory considerations regarding the educational requirements for advanced practitioners in nursing and midwifery, as well as methods for recognising prior learning and experience and also ongoing support.

Education and training

The international expectation is that advanced practice nursing requires a higher university degree at master's level. This is currently the usual standard for entry into advanced practice in nursing and midwifery in the UK as well. Regulators can play a role in providing assurance over the quality of courses. To do so, they can, for example, set standards of education and training and approve the institutions and programmes.[120] Where a regulator oversees a programme, the expectation is that it takes assurances that the education provider and programme are delivering professionals who meet the regulator's requirements for registration, and takes action where there are concerns.

While the NMC regulates pre-registration nursing and midwifery education programmes and certain post-registration programmes and qualifications, this is not the case for advanced practice. Instead, there has been a degree of competition to provide assurance. For example, both the Royal College of Nursing and, in England, Health Education England offer accreditation for approved university programmes, but there is no obligation for institutions to undergo any accreditation process (although under a new scheme, graduates wishing to receive a 'digital badge' will have to complete a suitably accredited programme).[121] While such accreditation introduces some standardisation, some stakeholders expressed concern around these arrangements, particularly the potential conflict of interest between Health Education England as a commissioner of educational programmes and as an accreditor of institutions. While these processes offer a degree of assurance to both students (that the course meets their educational needs) and employers (that graduates are able to work safely at the level required), the lack of regulator-approved programmes means that the expectation and burden of assuring employees rest with the employer. The different scales and context mean the situation is somewhat different in the other UK countries and, at the extreme, Northern Ireland only recently expanded to have a second educational provider for advanced practice.

Where regulators do have a role in professionals' post-registration development – such as for non-medical prescribing, the NMC's specialist practitioner qualifications and the

specialist and GP registers for doctors – the regulatory bodies have mechanisms to take assurance of the relevant qualifications.[122,123] As the predecessor to the Professional Standards Authority previously noted, 'this is crucial to the integrity of the register as an authoritative source of the information it provides on a professional, for the public, employers and others, which is an essential part of effective regulation'.[124]

A survey on advanced practice, albeit for professions that the HCPC covers, found that three-quarters (75%) of managers responding perceived 'assurance to employers of knowledge and skills' as an advantage of the regulation of advanced practice. Moreover, a similar proportion of respondents (72%) suggested that 'greater consistency in education and training standards' was a perceived benefit of regulating advanced-level practice.[125]

Internationally, there are different models for accrediting advanced practice courses, including the following:

- In the US, there are three national programme accreditors.[126] Each one is an independent organisation responsible for ensuring courses meet national standards. Course accreditation is an essential part of the newly implemented consensus model and all programmes now have to be accredited before enrolling students. Once accredited, accrediting organisations monitor them to ensure any changes still fall within national standards. Accreditation grants boards of nursing the confidence that an individual has obtained the required educational underpinning for licensing, thus facilitating the process.[127]

- Canada has one national accrediting body, but the accreditation of postgraduate programmes is not mandatory. Instead, the advanced practice programmes must be approved by provincial regulators. Voluntary accreditation only began in 2019 and a limited number of courses have gained accreditation. Introducing additional accreditation on top of the programme approval progress was seen as burdensome, especially for smaller programmes.[128]

- The Nursing and Midwifery Board of Ireland is responsible for approving educational providers, while a separate body carries out the mandatory accrediting of programmes.[129]

Some employers do not require an MSc (or ePortfolio) as a condition of employment for advanced practice roles. In a job adverts review conducted in 2021 across England, 58% of reviewed job adverts for advanced practice required a MSc.[130] Of the job adverts we reviewed, such examples were in general practice and typically stated that an individual had to be willing to work towards a qualification. For example, one advert for an advanced clinical practitioner role (band 8a) required an 'advanced practice qualification or willing to work towards MSc'. While some adverts included 'MSc or equivalent', it was not clear what would be considered as 'equivalent'. There are, for example, differences between the four devolved countries in their frameworks for higher education, and international comparisons can be difficult. A previous study looking specifically at advanced practice across other

health professions identified one programme with course content considered to be undergraduate degree level (Framework for Higher Education level 6) as master's level (Framework for Higher Education level 7).[131]

Educational curricula

Content

During our analysis of educational curricula, we found that there is demonstrable variation in the content of MSc programmes, particularly the emphasis placed on each of the four 'pillars of practice' (clinical practice, leadership and management, education, and research). As may be expected, programmes tend to be clinically focused, while research tends to be covered in the form of a dissertation. Providers offer teaching and management/leadership modules less consistently and these modules are often indicated as being optional. It should be noted, however, that some programmes embed the four pillars throughout each module.[*132]

There is also variation in the clinical placement components of advanced practice programmes. For example, advanced practice programmes can differ in terms of the number of expected hours on placement and the learning activities these placements entail.[133] As with pre-registration nursing and midwifery courses, countries with regulation of advanced practice vary in terms of the number of supervised clinical hours of practice, with, for example, there being 500 hours in Ireland, 500–800 hours in the US and 700–950 hours in Canada.[134] Some involved in our research, including from the higher education sector, suggested there could be value in having regulations on the minimum level of the clinical component of advanced practice programmes.

The clinical aspect of a programme is, of course, important. As the advanced clinical practice framework in England posed in 2017, 'clinical training must acknowledge the importance of time and experience to build confidence in decision making and the management of risk'.[135] Similarly, the Northern Ireland framework notes that 'programmes have a significant emphasis on clinical acumen'.[136,†] However, we heard from some stakeholders who suggested that a challenge to providing additional clinical content and skills training in programmes was a lack of time available within the curricula.

Prescribing

There is variation in terms of the inclusion of prescribing modules. Previous research – not limited to nursing and midwifery – found that around half of advanced practice

[*] Note that the analysis focused on 31 unique education programmes, of which at least six did not cover nursing or midwifery.

[†] The Scotland and Wales frameworks do not explicitly discuss the clinical aspect of MSc programmes.

programmes included the non-medical prescribing module as either mandatory (nine of 31) or optional (five).[137] In Northern Ireland, non-medical prescribing is a prerequisite for entry onto the advanced practice MSc programme. Elsewhere, courses may offer prescribing as optional, to account for those individuals who have already completed their non-medical prescribing course.

Specificity of programme

The question of the specificity of the programmes and the extent to which they should be tailored to individual groups of professionals as well as to specific (specialty) settings was particularly vexing for interviewees, with a range of opinions often strongly expressed. Some interviewees, particularly in England, felt that the professions should embrace the multi-professional 'advanced clinical practice' approach to further education and training, while others (speaking in the context of advanced nurse practice specifically) felt that education based on a deep understanding of nurses and nursing offered self-evident benefits to people using services and professionals alike.

The advanced clinical practice framework in England states that education should be specific for 'specialty, sector and setting'.[138] Interviewees were divided on whether this was the correct approach or whether the focus should be on more generic skills, such as assessment, diagnosis and prescribing. While the advantages of speciality- or setting-specific programmes were widely acknowledged, it was clear that this approach disadvantaged nurses working in very small specialties, where it was difficult, or even non-viable, to develop specific programme content or to teach to a very small number of students. This problem, it was felt, could be overcome by high-quality clinical supervision, although the difficulty of finding clinical supervisors for niche areas was also acknowledged.

Some acknowledged that specialty-specific education and training were potentially limiting the degree to which advanced practice nurses (in particular) could transfer from one clinical area to another in future, such as moving from emergency medicine to intensive care. That said, such arguments are premised on the principle that advanced practitioners should be more generalist (and therefore likely to be redeployed) as opposed to specialist (and therefore typically remain within a clinical area), which is something that national and local workforce planners should be determining.

The balance between specialty-specific and more general/transferable instruction has also proven problematic internationally. In some countries, advanced nursing practice was originally specialty-specific, but has since become more general. Conversely, in the US, population-specific courses predominate and there has been a significant expansion of the type and number of courses offered. Across jurisdictions, this has created problems with consistency of role across clinical settings, as well as concerns about advanced nursing practitioners practising in areas outside of their training.[139] Some commentators have felt that the latter concerns impeded the response of certain organisations to the Covid-19 pandemic.[140]

On education and training, the trade-off between ensuring the consistency and standardisation of programmes and allowing flexibility in programme content was a common theme. The weight of opinion was that having more standardisation of programmes would be helpful while still allowing for scope for variation.[141] Previous research has suggested that international minimum standards for education, alongside bridging programmes, would facilitate the international transferability of the role.[142]

Entry requirements

There are current inconsistencies in the entry requirements for advanced practice programmes in the UK. Typically, programmes require a 2:2 undergraduate degree although often with additional options around providing evidence of academic ability. In some cases, candidates are expected to be in a trainee position; other programmes expect candidates to already be working in advanced practice roles or sometimes employed in a role which can develop into an advanced practice role.

There is also variation in the years of post-registration clinical experience required (often two to three years) and whether this is in a particular setting or service. Academics raised concern about the variation in the number of years of post-registration experience required before entering MSc programmes. In Ireland, the expectation has been for seven years' post-registration experience, including five years' experience in the chosen area of specialist practice.[143]

Educational supervision

During their preparation as an advanced practitioner in the UK, individuals are expected to be supported by an identified educational supervisor in their workplace. This may be a senior colleague working at consultant level or another appropriately qualified practitioner. Other staff may also be involved in supporting this supervision.[144] One small-scale study with advanced practice students at a London university identified that the vast majority (84%) of students felt their supervisors (who were mainly physicians) had a good understanding of the advanced practice role. However, the study identified notable variation in the amount of time spent with clinical supervisors and, universally, participants commented on the need for more protected time.[145] Supervision was mentioned repeatedly as a challenge throughout our stakeholder engagement. Specifically, stakeholders in some regions discussed difficulties with finding supervisors with the right skill set. To fill this gap, individuals suggested a more consistent offer of a multi-professional approach to supervision. The challenges of suitable supervision could exacerbate regional disparities; specifically, services in rural areas were raised as those that might struggle in this respect.

Equality, diversity and inclusion

Many stakeholders expressed the risk that the current shortages of opportunities to be supported to go on an advanced practice programme could have equality, diversity and inclusion

implications. In particular, in many cases, the ability to be enrolled on an advanced practice programme requires the individual to have an organisational and clinical 'sponsor', and the informal nature of securing these might bring about the risk of some groups being less able to access supervision. That said, we also observed that some master's programmes appeared to have a diverse uptake.

Concerns were expressed that smaller organisations, which suffer disproportionately from service and financial pressures and hence arguably might benefit most from developing alternative workforce models, might encounter the most difficulties in doing so. This barrier would potentially hold for social care too. Given that populations served by smaller hospitals tend to be older and experience more deprivation, this could further increase inequalities in access to health care.[146]

Assessment and examination

There is a recognition that the formal assessment of achievements of capabilities expected at advanced practice level is important. To ensure such assessments are valid, there needs to be a range of appropriately trained assessors and supervisors.[147] While there are internal approval processes and in some cases external accreditation for courses, solely relying on the completion of an external course as evidence for registration as an advanced practitioner does potentially raise a risk around quality control. Effectively, whoever oversees the quality of the university course becomes the arbiter of the standards for advanced nursing practice. This is not atypical internationally for advanced practice in nursing. However, there are other models:

- The bar for entry to higher levels of practice within most professions (medicine, law, finance and so on) is examination by the relevant professional body, although many also require the undertaking of a designated course in preparation.
- The most notable exceptions to this are Canada and the US, which also require an external examination for registration as an advance nursing practitioner.
- Medicine in the UK is moving to a single examination before registration (for both university leavers and overseas recruits), bringing it into line with North America.

With other forms of advanced practice that require both a course and an examination, we heard that examination pass rates vary markedly by course (so quality is variable). Moreover, we heard that certain courses for physician associates have been withdrawn because of the low pass rates for the external examination.

Recognition of prior learning and experience

In addition to demonstrating competence and capability at advanced practice level through a master's programme, some existing nurses and midwives have been able to have their

prior learning and experience recognised. This so-called 'grandparenting' of current practitioners who completed their education in advanced practice before the approval process was introduced has been a significant challenge across jurisdictions. Consideration is needed to agree what skills, qualifications and experience should be recognised. Research published in early 2021 suggested that there was confusion around demonstrating equivalence with undertaking a master's programme.[148]

In England, Health Education England (through the Centre for Advancing Practice) has been developing a portfolio approach for those wishing to have their previous education taken into account. The first cohort has completed the portfolio-supported route and funding has been secured for a second and third cohort. The portfolio route is voluntary and the number of places in each cohort is limited. Wales also offers a similar portfolio route, and following completion individuals are placed on the Advanced Practice Database.[149] In Ireland, those with a qualification from an advanced practice programme that is not approved can still be registered by demonstrating they meet the advanced practice standards through a portfolio.

However, such approaches for evidencing equivalence through experience are not being consistently developed across all UK countries. Currently, Scotland and Northern Ireland do not offer a portfolio route; within their frameworks both countries list the MSc as the only route to practise. Up until the end of December 2022, nurses working at advanced practice level but without a full master's could be credentialled by the Royal College of Nursing through the transitional pathway, which would remove the expectation to complete the master's in the future.[150]

Continuing professional development and ongoing support

Regulators are expected to have proportionate requirements to satisfy themselves that registrants continue to be fit to practise.[151] Once again, responsibilities lie with professionals working at a level of advanced practice – who have a responsibility for their ongoing continuing professional development – and employers – who will need to ensure there are appropriate development opportunities available. There is a recognition that current organisational provisions of support and continuing professional development may need improving, including through additional professional support mechanisms, strengthened management lines of accountability and an improved appraisal process.[152,153]

A survey by the Association of Advanced Practice Educators found that 29% of trainee and advanced clinical practitioners in England who responded to the survey thought their line manager did not understand their role.[154] The same survey found that only three-quarters (75%) had access to clinical supervision.[155] Additionally, information on supervision provided within roles was notably limited in reviewed job adverts.

Such issues are not unique to the UK; it is likely that limitations around supervision and support are seen internationally. However, a recent paper noted that Australia, Canada, New Zealand and the US all have continuing education requirements for advanced practitioners.[156] In Canada, nurse practitioners must complete a continued competency programme each year. Additionally, individuals are required to undertake a full practice review two years post-registration, then every following five years. A nurse practitioner carries out this review and requirements vary from province to province.[157]

We heard views that the regulatory revalidation process could provide greater assurance. To remain on the register, nurses and midwives need to demonstrate that they are maintaining safe and effective practice by revalidating once every three years. Broadly speaking, revalidation, while still a relatively new aspect of professional regulation, has been suggested as providing an opportunity to help drive improvements in professional practice and the quality of care.[158,159] Currently, the NMC register is not updated if an individual is no longer using a post-registration qualification; this is likely to change as part of the review of revalidation planned for the next NMC strategy period (2025–30). RCN credentialling, however, allows individuals to be re-credentialled after three years on the directory of nurses if they can demonstrate advanced-level practice and continuing professional development. However, this credentialling is only available to those who hold an MSc.[160]

Chapter 4: Patient and service user safety

In this chapter, we discuss the evidence around the risk of harm from advanced practice. Given the focus of this report is on regulatory perspectives, this might be expected to be the most substantive part of the report. However, while there is recognition that 'there is a possibility that professionals taking on new roles and responsibilities could put people at risk',[161] the evidence around harm to people who receive services from advanced practitioners is limited.

While the purpose of this report was not to comment on the merits of advanced practice, it is important that any evidence of risk of harm under the current regulatory arrangements is not interpreted as a commentary on the potential advantages in developing advanced practice in nursing and midwifery. Indeed, many papers have been published on how patient safety can be enhanced through advanced practice.[162,163,164]

Evidence of risk to people who use services

The argument made against the introduction of statutory regulation of advanced practice in 2009 hinged on the fact that there was, at that time, 'no systematic evidence, from fitness to practise cases or other sources, regarding whether professionals are taking on new roles and responsibilities where they are not competent to do so and thereby putting the safety of patients at risk'.[165] A recent study on advanced practice was also unable to find substantial evidence of risk to patients and the public because of advanced-level practice, albeit with the exception of one Prevention of Future Death report* that a coroner had issued, which suggested that the governance of the advanced level of nursing practice in that case had presented a degree of patient safety risk.[166]

However, it is important to note that this lack of systematic evidence could be because it is unclear who is an advanced practitioner (or not), making it very difficult to uncover such evidence. A recent paper highlighted that there is a lack of robust data on patient safety outcomes in relation to advanced-level practice either in the UK or internationally.[167] In this respect, an absence of evidence should not be considered as evidence of absence, and one

* These are sent to the people or organisations who are in a position to take action to reduce the risk of death in the future.

paper noted that, generally, a lack of evidence on risk to the public does not mean there is no risk. This is an area where more research is urgently needed.[168]

In fact, notwithstanding the benefits of advanced practice, there is some evidence pointing towards a potential risk to patient safety if not used appropriately. For example, a previous analysis of 800 Prevention of Future Deaths notices identified seven (1%) from 2014 to 2017 that pertained to advanced practice and highlighted issues around a lack of clarity around these roles and public protection.*[169] A broader analysis conducted for our report found that common work of advanced practice across professions, particularly diagnosis and prescribing, appeared in around one in five (20%) of such notices, although an advanced nursing practitioner would not have carried out all of this practice. Certainly the work can be complex, with previous international research, in particular, noting that advanced practice roles have changed significantly and moved more towards/overlapped with the medical profession.[170,171]

We also heard concerns about whether the current assurances would be sufficient if there was an increase in advanced practice roles. Specifically, some people we spoke to suggested that, as the numbers expand, the number of practitioners who could represent a risk to people using services may increase, but there is little evidence to confirm this view.

Potential high-risk settings

Although the published evidence on how risks might vary depending on what type of service the advanced practitioner is working in is limited, many participants in our research suggested that there was increased risk of harm to people who use services in some settings. Some told us that this was, in part, because some types of employers may be less able (or even willing) to meet their responsibilities around taking assurances on advanced practice roles. However, others suggested that advanced practice might be inherently riskier in some services due to, for example, less supervision or existing understanding of the scope of practice of advanced practice staff. While not necessarily the case across the whole of the UK, we heard that advanced practice in general practice could carry particular risk, and care homes and out-of-hours services were also mentioned as settings that face challenges.

Albeit limited, evidence from the US backs the notion of certain clinical environments being more problematic than others. A recent review of medical malpractice claims found that while advanced practitioners were named substantially less often than physicians, a higher proportion of claims naming advanced practice nurses were paid (32% versus 8%), with procedures in outpatient settings carrying the most risk.[172] A further report found that while adverse incident and professional liability claims involving advanced nursing practitioners

* However, separately, in some of the Prevention of Future Deaths notices reviewed, advanced practitioners were part of the response to the issues raised, reiterating that advanced practice can potentially be used to enhance safety.

were more common in outpatient settings, particularly office practice settings, the 'severity'* was much higher for incidents in neonatal, school and acute care settings.[173]

Those involved in our research thought that certain types of employment arrangements were more problematic than others. Some identified agency work, particularly in England, as potentially carrying more risk. While we did not identify any direct evidence, we heard of agencies, for example, not requiring full master's qualifications (rather, a certain number of credits or modules) to take up an advanced practice role. The 2009 report on advanced practice to the UK health departments noted agency staff particularly, and where a professional's primary relationship is not with an employer it would be the agency's responsibility to ensure the individual is 'appropriately qualified to do so and will have adequate systems in place to uphold the safety of patients'.[174]

Investigating concerns and taking action

Regulators can play a role in investigating complaints about registered professionals or patient safety and decide whether they should be allowed to continue to practise. In the year to March 2022, the NMC received 5,291 concerns; of the referrals dealt with in that 12-month period, 109 resulted in the professional being struck off the register, 124 resulted in suspensions, 61 in imposing conditions of practice and 37 in cautions.[175] There is no data specifically on advanced practitioners but, as numbers are already small, any statistically significant differences would be unlikely.

While professional regulators can play an important role in investigating concerns around fitness to practise, some have suggested that the processes are hamstrung or, as a parliamentary briefing put it, 'hampered by legislation that is widely regarded as being out-of-date. The Government has made changes to the legislation of individual regulators, but reform to date has largely been conducted in a piecemeal fashion through the use of delegated legislation'.[176] Hopefully, the current reforms being consulted on will have a more positive effect.

Of course, professional regulatory bodies are not the only actor here, with 'systems regulatory bodies, employers and professionals themselves all [having] crucial roles in ensuring patient safety through governing practice of the health professions'.[177]

Public understanding

Part of the role of regulators is to promote and maintain public confidence in the profession in question. This requires public understanding, but the importance of such understanding does not end there. If a person is to receive care, they need to give their consent to the treatment. This must be an informed decision and some stakeholders raised concerns about whether a lack of

* Measured as the average paid indemnity for claims that closed with a payment of $10,000 or greater.

public understanding of the advanced practice role means that they might not be sufficiently informed about the clinician to provide such consent.

The public's understanding of what constitutes advanced practice, including the scope of practice, education and training of practitioners, is unclear. While our research did not involve the public directly, the inconsistencies in how the advanced practice title is used mean there is little basis to assume there is anything but limited public understanding. The review on advanced practice that the HCPC commissioned concluded that the level of public understanding was unclear and that great national advocacy was needed.[178] Previous qualitative research with patients, carers and other members of the public found that while people were unclear what 'advanced' said about the professional, it was assumed to relate to career stage and some found it inspired confidence.[179] A survey from the Association of Advanced Practice Educators in England found that two in five (42%) of trainee and advanced clinical practitioners thought that patients did not understand their role.[180] Similarly, respondents to an international survey identified a lack of understanding of the role as a barrier to allowing practitioners to work within their full scope of practice.[181]

However, a survey on advanced practice, albeit for professions that the HCPC covers, found that only half of respondents thought that regulating advanced-level practice would have the advantage of providing greater understanding and clarity to the public (patients and people using services).[182] While media campaigns and other forms of messaging around advanced practice have been recommended to achieve a wider public understanding of the role[183], there would be choices to be made about who should be leading on this and, indeed, whether it should be UK-wide. Some told us that awareness of the role is only really derived from lived experience of receiving care from an advanced practitioner. This is reflected in the US where public understanding of the role only improved through the increased visibility of nurse practitioners.[184]

Chapter 5: Benefits, risks and options

This chapter reviews the benefits and risks of the regulation of advanced practice in nursing and midwifery that we identified in our research, captures the overall weight of opinion of our interviewees and focus group attendees, and explores the regulatory and other options available to the NMC.

Overview of benefits and risks

During our research we identified a range of potential benefits and risks of the regulation of advanced practice, as expressed in the interviews and focus groups and found in the international literature (see **Table *2***).

Table 2: Key benefits and risks of the regulation of advanced practice in nursing and midwifery

Potential benefits	Potential risks
Creating a clearer pathway to career progression	Financial and time implications for individual practitioners
Improving retention of nursing staff in clinical practice	Financial and logical implications for the NMC as an organisation
Protection of advanced practice title	Problem of 'grandparenting'
Leads to better role recognition – by both the public and other medical professionals	Process may dissuade international graduates
Clear definition of scope of practice	Process may encourage existing advanced practitioners to leave/retire early
Sets standards for education	Failure to resolve inconsistencies and anomalies already in the system (within and across professions) may lead to inequalities and dissatisfaction for professionals and the public
Sets standards for employers	May limit the development, flexibility and deployment of the future workforce
Improving the UK's ability to compete in a global market for the most skilled nurses	
Safeguarding people who use services	
Increasing accountability – individual and employer	

Discussion of some key potential benefits of regulation

The perceived benefits of regulation were almost universally framed as being the mechanisms for resolving the inconsistencies in and confusion over advanced practice in the UK. For example, there is a multiplicity of routes to advanced practice, and increasing numbers of educational programmes of differing types, with assurance provided by various bodies, leading to jobs with substantial variability in terms of pay and oversight by employers. Regulation, which it was presumed would define what 'advanced practice' is (and is not), was seen as a way of rapidly bringing consistency across employers and the professions.

Alongside this, the regulation of advanced practice was seen as a mechanism that would promote nursing and midwifery and improve retention at a time of record numbers of nurses and midwives leaving the workforce. The promise of increased status and better pay, it was argued, would, in turn, attract more staff into these roles, both locally and internationally, as well as helping to retain staff in clinical roles.

Such professional issues were far more frequently mentioned as potential benefits than concerns relating to the public, their perceptions and their safety. Indeed, some struggled to articulate how regulating advanced practice might benefit the public directly and pointed to relatively high levels of confidence the public tend to have in the health care professions in the UK as a whole.

The 'regularisation' of advanced practice in nursing and midwifery, it was hoped, would also encourage employers to consider the needs of these employees more seriously. Putting in place mechanisms for better oversight and governance, improving the educational offer and clarity about pay and career progression were all seen as potential benefits.

Discussion of some key potential risks of regulation

The financial and time costs involved in introducing advanced practice were the most commonly mentioned risks of regulation. Many considered these in terms of the costs to the individual, particularly the optics of asking practitioners to register a second time in order to continue in their current roles in a time of financial uncertainty. The burden of potentially requiring more clinical supervisors and assessors was also raised as a perceived challenge.

The potential resource and financial implications for the NMC as a regulator were also mentioned, although mostly by those who were involved in professional regulation. While it was thought that prospective regulation might prove complex to set up, but easy to manage, the time and logistical effort to verify and approve retrospective applications ('grandparenting') were likely to be considerable, with significant resource implications (see below).

The process of introducing any form of 'grandparenting' – that is, retrospectively considering whether an applicant's education, skills and competencies enabled their registration as an advanced practitioner – was thought to be potentially difficult and an area of very high risk. That such processes are being used in England and Wales currently could provide a welcome opportunity to further explore the feasibility considerations. Setting the bar too low, in terms of both standards and the level of evidence required, risks insufficiently qualified professionals being included on the register. Setting the bar too high could potentially deter practitioners from registering. There is evidence that increasing the regulatory burden on health care professionals makes them more inclined to leave the workforce.[185,186]

The issues around grandparenting were thought to similarly apply to overseas recruits, with some highlighting a risk that if the process for having previous advanced practice experience abroad checked was too long, complicated or expensive, then this could act as a deterrent to applicants. To this point, it is worth reiterating that currently half of professionals joining the NMC register for the first time trained outside the UK, although we do not know what proportion of these were or are working in advanced practice roles.

Some in existing nursing fields, particularly mental health nurses who were approved clinicians and specialist community public health nurses (SCPHNs), expressed concerns around the introduction of specific regulation of advanced practice. The origins of their concerns were broadly similar, in that they are both groups of practitioners who require additional training that is recognised on the NMC register and whose jobs entail autonomous practice. They considered themselves to meet the commonly accepted definition of 'advanced practice'. Both groups expressed concerns that additional regulation of advanced nursing practice without ensuring that the educational frameworks and regulatory requirements for mental health approved clinicians and SCPHNs were brought into alignment would result in their being 'left behind' or 'left out' by their own regulator. More generally, this is an issue that was also raised in the NMC's development of post-registration standards.[187,188]

Finally, while many felt that clearly defining the scope of advanced practice would benefit the professions (particularly nursing), some warned that being too specific or narrow in the definition might actually hinder the development of new roles in the future and limit the future flexibility of the workforce.

We also note that while not specifically mentioned as a 'risk' of regulation, some raised the question of whether or not it is necessary for the NMC to regulate advanced practice. The Code on professional standards[189], it was noted, currently accommodates several types of practitioners operating at different levels of practice. The Code makes explicit that practitioners must practice 'within the limits of [their] competence', which makes it clear that individuals without the necessary training, competencies and skills should not be practising in an advanced role. Moreover, there is nothing in The Code that would not equally apply to advanced practitioners as all other types of professionals covered by The

Code. Nobody in our research expressed a clear view on whether or not additional regulatory considerations could or should be added into The Code specifically.

Wider considerations

The problem of whether advanced practice represents an innovation in professional working or whether it is a form of role substitution for doctors was rarely touched upon in most conversations. However, it needs consideration. Indeed, most of the opposition internationally to advanced practice nursing comes from those in the medical profession who have tended to view infringement on their territory with alarm, although of the few doctors we interviewed, none expressed a negative opinion. Moreover, in other countries such as Australia and the US there is more direct competition between physicians and advanced practitioners for fees for service. While many interviewees were keen to define advanced practice in a rigid manner, the literature suggests that keeping definitions nebulous and limited to 'outer scope' might avoid the types of conflicts and rhetoric that overshadowed the introduction of advanced practice nursing elsewhere, particularly in the US.

A small number of interviewees voiced concerns that extending any task shifting (undertaking activities that doctors have traditionally delivered) too far within any definition of the scope of practice might erode the value of nursing as a discipline in its own right. They pointed to the conceptual and pedagogical differences between medicine and nursing and the difficulty of reconciling these both theoretically and in everyday practice.

While it was not raised in the interviews, we note the potential legal ramifications of defining advanced nursing practice in a way that could be construed as role substitution. A recent rapid UK policy review of gross negligence manslaughter in health care highlighted a number of subtle but important differences between doctors and other health care professionals as handled by both the courts and the relevant regulators.[190] Consideration needs to be given to the recommendations of the report to avoid both miscarriages of justice and improper prosecutions.

The literature on the introduction of regulation is possibly instructive on three other points. First, a number of problems that arise from regulation do so as a result of changes to remuneration schemes (governmental or otherwise). This did not appear as a topic in our discussions, as nurses are rarely (if ever) paid by fee-for-service schemes in the UK, unlike advanced practice in Australia and the US. However, in jurisdictions where this does occur, subtle inconsistencies in regulation can be magnified over time into substantial inequalities in income for similar levels of care provision, and accompanying discontent.[191]

Second, working with employers, of all types, over the implications of changing regulation will be critical. As the predecessor to the Professional Standards Authority noted, employers should not see any additional steps that regulatory bodies take as providing all the necessary information on the professional practice of any individual.[192] Changes to

regulation do not absolve the employer of responsibility; rather, they share and apportion the risks between themselves and the regulator.

Finally, the literature strongly suggests that the paths to regulation are typically longer, more convoluted and more expensive than regulators initially anticipate. Certainly, changing aspects of the regulation of health care professions can be highly challenging and resource-intensive.

Options

There are a number of options available to the NMC with regards to the regulation of advanced practice, as set out below. While stakeholders generally expressed the view that the clinical pillar of advanced practice is the most important one when it comes to additional regulation, we heard there would need to be consideration on how to recognise and value the level of practice of those in educational or research roles.

1. Keep the existing statutory regulatory framework as it is.

With the coming legislative changes to the regulation of health care professionals in the UK, there is an argument for keeping the existing statutory regulatory framework as it is, at least in the short term. The proposed introduction of new legislation that gives regulators similar powers and greater autonomy would supposedly give the NMC more flexibility in *how* it regulates. Hence, there might be prudence in waiting for this legislation and seeing how it is applied to other professional groups. Given the national and international moves towards uniformity across the health care professions, the NMC might wish to explore changes to cross-regulatory working with regard to advanced practice, rather than making changes that may put it out of step with other regulators. During such a period there could be continued development wider assurances of accreditation and credentialling by various professional bodies and employment and commissioning practice.

2. Develop annotation of the existing NMC register for advanced practice qualifications or evidence of equivalence.

Annotation of the NMC register could be undertaken by one or more of the following mechanisms:

- prospective annotation, for all those who complete the mandated requirements from a given date onwards
- voluntary annotation
- compulsory annotation.

Annotation of the register with, for example, appropriate advanced practice qualifications, could potentially bring about many of the benefits of regulation, but with possibly less risk.

It would be commensurate with how the register is already maintained. The experience of other regulators suggests that while prospective annotation can be difficult to set up, the process of registering recent graduates of approved courses can be semi-automated and is relatively easy to administer in the longer term.

Both prospective and voluntary annotation would mean that employers would still be able to employ people without annotation into advanced roles (or call the roles something else), but there would be an added impetus for employers to ensure that future employees were appropriately trained for the job. To employ people inappropriately might open them up to increased liability in the event of medical misadventure. The introduction of any form of grandparenting would still need to be carefully considered, as would the issue of how the quality of any candidates would be assured and uniformly applied.

Implementing such a change would potentially have implications and require groundwork. As noted earlier, the predecessor to the Professional Standards Authority suggested that:

> *annotations without protection of title or function, and so which serve not to protect the public directly but to denote professional status, add little to the ordinary human resources checks by employers to ensure applicants have the credentials necessary for a particular job or to existing regulatory requirements that professionals only practise where they are competent to do so.*[193]

3. Develop a second tier of regulation for advanced nursing and midwifery practice.

From an international perspective, a separate register for advanced practitioners, based on competencies (as assessed by an examination and/or a portfolio) and administered by a national regulator, is generally viewed as offering the most advantages, to both the public and the profession. This is closely followed by national regulation, based on curriculum. Regardless of the form used, it is worth reiterating that the paths to 'full' regulation tend to be complex and time-consuming.

Details on what international regulation looks like in practice tend to be vaguely described in the literature. However, domestic examples would be the specialist list of the General Dental Council and the general practice and specialist registers of the General Medical Council. It is important to note that while the last two are effectively compulsory registers, the specialist list of the General Dental Council is voluntary – dentists do not have to join a specialist list to practise in any particular specialty, but they can only use the title 'specialist' if they are on a list.

The caveats above about grandparenting and assurance of qualification would apply even more strongly to this option.

Opinions on changing regulation

The consensus from the interviews and focus groups was that some form of specific regulation was needed for advanced practice in nursing and midwifery and that the status quo was not satisfactory. While most midwifery stakeholders we spoke to held this view for their profession, the smaller number and less-established nature of advanced practice in this area mean we cannot be as conclusive. However, even the most ardent reformists tended to frame the drives towards change as about advancing the profession, rather than suggesting that the current Code on professional standards was insufficient to safeguard people who use services. Moreover, most interviewees had difficulty in articulating what changes to The Code would be needed and all conceded that there would be significant financial, logistical and practical barriers to the introduction of change, particularly if this was to take the form of a second tier of regulation.

Many thought that the introduction of an annotation on the NMC register would be a reasonable compromise. This promises some benefits – a boost to the profession, clear standards for educational attainment and job descriptions, and improved patient safety – without major revisions to other aspects of regulation. Those who articulated a desire for the introduction of a second tier of regulation often did so because they viewed the system as being in need of wholesale reform, which would then remove the historical irregularities and anomalies left over from previous rounds of reform.

Other routes to strengthening advanced nursing and midwifery practice

It is instructive to note that most interviewees, when urged, accepted that there might be routes to achieving their professional goals other than through the reform of statutory regulation.

The NMC could, regardless of any decisions regarding regulation *per se*, make use of other levers, such as engaging and influencing employers to develop consistency in roles and governance/safeguards through future professional liaison, and engaging with educators to promote consistency and quality in education delivery across advanced practice programmes. Northern Ireland and Scotland's apparently successful attempts to develop and implement a joined-up system of service and educational needs assessments matched to the commissioning of educational places, alongside robust governance and accountability arrangements, suggest that statutory regulation is not necessary to improve consistency in approaches across stakeholders.[194]

It has been suggested that other regulatory bodies should be encouraged to be more vigilant in ensuring that practitioners are appropriately employed, with structures in place for oversight and governance. This is particularly the case in England, for example, with the Care Quality Commission (CQC), which already has the power to ensure that staff have the qualifications, competence, skills and experience to keep patients safe, as well as oversight of a broad range of providers outside of the NHS. There is an argument for a broad, cross-national strategy to

address the issues across advanced practice, involving the respective UK departments of health, royal colleges of nursing, royal colleges of midwives, royal medical colleges, higher education providers and employers (including from outside the NHS and general practice). Certainly employers – who currently carry substantial responsibilities – could be supported through strengthening the existing mechanisms around, for example, the accreditation of courses and credentialling of individuals.

Employers carry responsibility and vicarious liability for practitioners, and must be responsible for ensuring that all advanced clinical practice roles, both those that are existing or those of the future, do not compromise safety. Policies and processes may need to be modified to reflect this.[195]

Meeting expectations for good regulation

The Professional Standards Authority (PSA) has recommended a more preventative approach to regulation, including an improved understanding of situational factors in cases where harm occurs.[196] Our view is that changes to the nature of advanced practice – particularly in nursing, with more practitioners undertaking higher-risk cognitive and diagnostic tasks, often working in isolation from other colleagues, without robust oversight and governance – suggest that the risk of harm to patients receiving advanced practice care has increased and that additional regulation might be useful in improving patient safety and driving employers and professions to build better working cultures and practices.

To meet the standards that the PSA has set, more work would need to be done, especially to assess the working lives of advanced practitioners, the behaviours that regulators are seeking to foster and what the most appropriate regulatory interventions should be. This would require, as the PSA has suggested, the development of a framework for deciding the level of assurance or regulation required for advanced practice, based on the associated hazards, that was consistent and coherent.

Any resulting proposals for changes to regulation, regardless of its form and scope, would need to meet the other standards of the PSA – being proportionate, consistent, targeted, transparent, accountable and agile.[197] Given these standards, it is difficult to see how the NMC could seek to regulate advanced nursing practice in isolation, without due consideration being given to other types of practice that could be considered to be ‘advanced’ that the NMC already covers (SCPHNs) and to the problem of distinguishing between and appropriately regulating (if required) other forms of nursing practitioner (clinical specialists, consultant practitioners and extended scope practitioners). This suggests that while annotation of the NMC register would be the most pragmatic way to address at least some of the hazards of advanced nursing practice, there is the risk that this form of limited change might make the NMC’s overall regulation less consistent and coherent.

Concluding remarks

The need for the regulation of advanced practice was previously held to be unnecessary, on the grounds that there was no evidence of risk to the public with the current system of regulation. While the evidence on the scale of advanced practitioners harming patients remains limited (see Chapter 4), the absence of evidence is not evidence of absence. Advanced practice commonly involves complex activities and tasks, and we have identified a lack of assurances around employment and education in some instances.

The stated vision of the NMC is to help assure 'safe, effective and kind nursing and midwifery practice that improves everyone's health and wellbeing'.[198] Its core function is to regulate, which it does through the promotion of higher education and professional standards, the maintenance of its register of professionals eligible to practise and the investigation of concerns about those on the register.

While the proposition to introduce some form of regulation for advanced practice undoubtedly falls within the jurisdiction and role of the NMC, it must be acknowledged that the regulatory landscape for advanced nursing internationally and for all forms of advanced practice across the UK is highly complex and evolving. Little is known about the impact of regulation on nurses and midwives, although the NMC has commissioned ongoing research to understand professionals' views about the benefits and risks of advanced practice and what role regulation might play within this.

Key considerations in the development of any regulation would need to include the following:

- The level of risk that advanced nursing and midwifery practice poses to people, across the full range of current practice, needs to be investigated. Regulatory interventions need to be matched to the possible level of harm. The trend is towards 'light-touch', rather than heavy-handed, regulation.

- The implications of shifting responsibility for taking assurance on advanced practitioners' skills and experience, which sits almost entirely with employers, to being shared with the NMC as the regulator, need to be explored.

- Any proposed regulation needs to meet the PSA's principles of good regulation, which is that regulators should act in ways that are proportionate, consistent, targeted, accountable and agile.

- The feasibility of, and opportunities for, gaining consistency need to be thought about, given the current anomalies that already exist in the regulation of the nursing and midwifery professions, the subtle differences in frameworks for advanced nursing practice between the devolved UK countries and the widespread

changes to the regulation of other forms of advanced practice in the UK and internationally.

- If a curriculum-based approach is chosen for entry onto the register for advanced practice, consideration will need to be given to how the NMC can assure itself that standards for education and professional proficiency are met across the wide variety of programmes available from a multiplicity of providers, some of which are not traditional universities.

- While patient safety is an important driver for moving towards additional regulation in the UK, much of the impetus appears to stem from other professional concerns. While some of these, such as setting educational standards, sit well within the remit of the NMC, some thought needs to be given to whether other interventions might be useful instead of, or needed alongside, statutory regulation.

- The costs and complexity of the introduction of any new form of regulation are not to be underestimated. The issue of the costs and complexity of any additional processes in relation to professionals and whether these might act as a barrier also needs to be closely considered. Implementation is also often longer than anticipated – typically there is a run-in period whereby the new arrangements are voluntary or prospective (just covering the newly qualified), with five years being the usual minimum. This also needs to be taken into account.

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Appendix A: Methodology

For this report we:

- undertook a literature review of evidence on the regulation of advanced practice in nursing and midwifery, screening 1,379 titles and abstracts and reviewing 35 full texts
- carried out virtual workshops with representatives from Northern Ireland, Scotland and Wales and an in-person workshop in England and conducted a larger number of one-to-one interviews with key experts and stakeholders (see below for a list of organisations we spoke to)
- conducted a comprehensive search for job adverts and reviewed 32 of these to understand the characteristics of the roles being advertised
- analysed various administrative data, including some bespoke information we requested from NHS Digital.

Stakeholders we spoke to, included**:** Aneurin Bevan University Health Board; Association of Advanced Practice Educators; Cardiff University; Chief Nursing Office, Scotland; Chief Nursing Office, Wales; Council of Deans of Health; Department of Health, Northern Ireland; Foundation of Nursing Studies; General Medical Council; Hallam Medical; Health Education and Improvement Wales; Health Education England; HEE Advanced Practice Group; Institute of Health Visiting; International Council of Nurses; King's College London; London South Bank University; NHS Education for Scotland; NHS Employers; NHS Improvement (Advanced Clinical Practice Steering Group); NHS Providers; NHS Scotland; NHS Wales; Northern Ireland Practice Education Council for Nursing & Midwifery; Office for Health Improvement and Disparities; Public Health Wales; Queen's Nursing Institute Scotland; Registered Nursing Home Association; Royal College of Midwives; Royal College of Nursing; Royal College of Nursing, Northern Ireland; Royal College of Physicians; School of Nursing, University of Wolverhampton; UK Armed Forces & Defence Nursing Advisor; Unite; University of Dundee; University of East Anglia; University of Southampton; University of Wolverhampton

Appendix B: Examples of regulatory approaches for clinical roles

Table 3: Examples of regulatory approaches for UK clinical roles

Clinical role	Description of role	Current number	Protected title	Regulator	Requirement for registration	Revalidation
Medical doctor	Requires a medical degree, with graduates able to work in more than 50 different specialties.	359,200	Physician; doctor of medicine; licentiate in medicine and surgery; bachelor of medicine; surgeon; general practitioner; apothecary; and titles implying GMC registration	GMC	Successful completion of a medical degree recognised by the GMC.	Once every 5 years. Doctors take part in an annual appraisal and produce a portfolio of evidence. This is assessed by a 'responsible officer' or 'suitable person' who makes a revalidation recommendation to the GMC.
Nurse	Provides health care to people, specialising in one or more of the following fields: learning disability, adult, children's or mental health nursing.	716,100	Registered nurse – *not nurse*	NMC	Successful completion of a nursing programme approved by the NMC.	450 hours of practice and 35 hours of continuing professional development (CPD) over three years. Five pieces of practice-related feedback and written reflective accounts.
Midwife	Works with women through every stage of pregnancy, labour and postnatal care.	40,900	Midwife	NMC	Successful completion of a midwifery programme approved by the NMC.	450 hours of practice and 35 hours of CPD over three years. Five pieces of practice-related feedback and

						written reflective accounts.
Physician associate, anaesthesia associate	Provides medical care under the supervision of a doctor. Individuals have a generalist medical education.	Previous estimates suggested around 3,000 qualified physician associates in the UK and 300 anaesthesia associates in the NHS	Physician associate and anaesthesia associate *(a 3-year transition period will be in place after which it will become an offence to use these inappropriately)*	Proposals being consulted on for GMC to regulate these groups	Completion of a postgraduate programme quality-assured by the GMC. An RCP national exam for physician associates.	Unknown; a revalidation process is not expected to be ready until 2 to 3 years after regulation of these groups commences.
Nursing associate	Works with registered nurses to provide care. Often a transitioning role to registered nursing. England-only role.	7,900	Nursing associate	NMC	Successful completion of a nursing associate programme approved by the NMC.	450 hours of practice and 35 hours of CPD over three years. Five pieces of practice-related feedback and written reflective accounts.
Specialty community public health nurse (SCPHN)	A registered nurse or midwife working in a public health role.	29,600	Specialist community public health nurse	NMC	Registered nurse or midwife. Successful completion of an SCPHN course approved by the NMC.	450 hours of practice and 35 hours of CPD over three years. Five pieces of practice-related feedback and written reflective accounts.
Special practitioner	Recorded separately for different branches of nursing (for example, adult	22,900	Specialist practitioner is a recordable qualification on the NMC register.	NMC	Completion of a specialist practice	There are currently no revalidation

	nursing or general practice).				qualification (SPQ) approved by the NMC.	requirements around these qualifications.
Nurse prescriber	A community practitioner nurse prescriber, an independent nurse prescriber or a supplementary nurse prescriber.	98,000	Community practitioner nurse prescriber and nurse independent prescriber are recordable qualifications on the NMC register.	NMC	Successful completion of a prescribing programme from an approved education institution.	

Notes: Current numbers are rounded to the nearest 100. The figure for medical doctors is as at March 2023, while the figures for groups covered by the NMC are as at September 2022. CPD = continuing professional development, GMC = General Medical Council, NMC = Nursing & Midwifery Council, RCP = Royal College of Physicians and SPC = specialist practice qualification.
Sources: NMC register, September 2022, UK tables. BMA (2022) 'Medical associate professions briefing'. www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/medical-associate-professions-briefing. Accessed 26 April 2023.

Nuffield Trust is an independent health charity. We aim to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

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Published by the Nuffield Trust.

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