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ORIGINAL ARTICLE

Advanced practice nurses' experiences and well-being: Baseline demographics from a cohort study

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Abstract

Aims: To create a cohort of advanced practice nurses from across the UK and to report the initial questionnaire including demographics, work experiences and well-being.

Background: In the UK, advanced nursing practice is not regulated. This has led to the concern that advanced nurses are working in very different ways with different levels of autonomy and support.

Methods: Participants were recruited via university and Royal College of Nursing mailing lists, and social media adverts. They completed the initial questionnaire about their background and workplace, work experiences, credentialing and well-being.

Results: A total of 143 nurses were recruited to the cohort and 86 completed the survey. Over 40 job titles were reported, across five pay bands. Job title was not correlated with pay band (p = .988). Participant well-being was not significantly different from the UK general population, but they reported high rates of work-related stress (44.2%) compared with the National Health Service national average (37.9%).

Conclusion: There is a wide disparity in pay, which is not reflected in title or setting. The high levels of work-related stress require further exploration.

Implications for nursing management: The range of experiences reported here should encourage managers to evaluate whether title, pay and support mechanisms for Advanced Practice Nurses in their organisations align with suggested national standards set by Royal Colleges and government departments.

KEYWORDS

advanced practice nursing, nurse practitioner, Nurse's role, well-being

1 | BACKGROUND

The International Council of Nurses defines 'A Nurse Practitioner/Advanced Practice Nurse (APN)' as a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which she/he is credentialed to practice. A master's degree is recommended for entry level (ICN, 2008). It is a nursing role that has been implemented globally (Schober & Affara, 2006). However, despite the International

Council of Nurses definition, there has been confusion and ambiguity around job titles, scope of practice, regulation and required qualifications (Lowe, Plummer, O'Brien, & Boyd, 2012;Mantzoukas & Watkinson, 2007).

In the UK, the role has been deployed in a wide range of settings and is commonly referred to as advanced nurse practitioner, but unlike some other countries, it is not a protected or regulated title. Consequently, APN may mean different things in different areas of the National Health Service (NHS) (King, Tod, & Sanders, 2017). Advanced nurse practitioner roles have expanded vastly and encompass a wide range of titles and job descriptions. As a result, practitioners with the same job title have different qualifications, skills and responsibilities. In addition, there is uncertainty about how many APNs there are in the UK (HEE, 2019;Maier, 2015). A previous study identified that approximately 10% of the nursing staff in a large acute hospital were working at an advanced level (East, Knowles, Pettman, & Fisher, 2015), but it is unclear whether this can be seen as representative of other sectors such as primary care or mental health. Although a master's degree in advanced practice is recommended by Health Education England (HEE, 2017), it is not compulsory. Generally, the role involves boundary blurring with the undertaking of tasks and judgements traditionally carried out by doctors (Nancarrow & Borthwick, 2005), with autonomous practice often involving diagnosing and prescribing treatments (Brook & Rushforth, 2011;Latter, Maben, Myall, Young, & Baileff, 2007).

This absence of consensus has implications for the reputation of nursing and safety of patients (Brook & Rushforth, 2011). There have been attempts at standardization within several countries (Schober & Affara, 2006). The United States moved towards Federal standardization because of variation at the state level, developing a consensus model for the regulation of education, licensing, accreditation and certification of APNs (NCSBN, 2008). Attempts at defining competency standards have also been made in Australia and New Zealand (NCNZ, 2017;NMBA, 2016). The governance of APNs in the UK has been employer-led; however, the Royal College of Nursing has introduced a credentialing framework for APNs (RCN, 2018). This is a way of demonstrating competency for nurse practice at an advanced level. However, it is not compulsory, nor is the Royal College of Nursing, the only organisation to offer a credentialing scheme (FICM, 2019;RCEM, 2017). Attempting to address variation, Health Education England has developed standards for advanced clinical practice, focusing on roles with a high level of autonomy that use the four pillars of advanced practice: management and leadership, clinical practice, education and research (Health Education England, 2017). Although Health Education England standards are multiprofessional, this study focuses on nurses only.

The UK NHS implemented the Agenda for Change pay scale in 2004 (NHS, 2004). This placed all non-medical staff on a unified grading scheme to ensure equal pay for equal work across the many different professions and organisations that provide NHSs (Staines, 2009). There are different pay bands for different roles requiring different skills, responsibility and qualifications. A newly qualified registered nurse should be employed on band 5 (see Table 1). However, as there is no agreed role definition of APN in the UK it does not have a specified band. This means APNs are employed at the discretion of the employing organisation and it can choose which band (and therefore levels of pay, annual leave and other terms and conditions) APNs receive. The Royal College of Nursing has recommended APNs be placed on band 8a, but this is not compulsory (RCN, 2012). As UK APNs are not specifically registered as such, we do not know how many there are, where they fit in the pay structure, what level of education they have, or how the role overlaps with other roles such as nurse consultant.

TABLE 1 National job profiles from National Health Service Employers—examples of the Agenda for Change banding structure as it relates to nurses

Example job role	AfC band	Starting salary 2019/20
Support worker	2	£17,652
Support worker, higher level	3	£18.813
Associate practitioner/ nurse associate	4	£21,089
Registered nurse	5	£24,214
Nurse specialist/ nurse team leader	6	£30,401
Advanced nurse/ nurse team manager	7	£37,570
Modern matron	8a	£44,606
Nurse consultant	8b	£52,306
Nurse consultant, higher level	8c	£61,777

Note: www.nhsemployers.org/pay-pensions-and-reward.

Studies show that APNs contribute to high levels of patient satisfaction, improved health status and outcomes, enhanced condition management and efficiency. In a systematic review of the efficacy of APNs in primary care, evidence indicated increased levels of patient satisfaction relative to care provided by a medical practitioner (Horrocks, Anderson, & Salisbury, 2002). Positive outcomes emanating from APN care have also been demonstrated in the specific fields of ambulatory care (Martin-Misener et al., 2015), transitional care (Donald et al., 2015) and gerontological nursing (Morilla-Herrera et al., 2016). Despite this evidence, there is little research aimed at understanding the scope and prevalence of the APN role on a national and international basis. It is apposite to undertake research that seeks to explore the range of APN positions in nursing along with attempts to identify where the role is located, its impact and outcomes for those undertaking the role. Health Education England has recently commissioned a survey to better estimate the numbers of advanced clinical practitioners (not just nurses) in the UK and how their roles are compared with the four pillars of practice (HEE, 2019). However, to the best of our knowledge there has not been an attempt to understand the APN role over time.

1.1 | Aim

This research aimed to examine APN workplace experiences and well-being, including perspectives on support and regulation.

Specifically, this paper will do the following:

- Report the initial baseline findings and demographic characteristics of the APN cohort in the UK.
- Evaluate how participants' job titles and setting are related to pay band.
- Evaluate participants' workplace well-being.
- Evaluate participants' workplace support such as supervision.

2 | METHOD

2.1 | Design

This study was conducted through survey research of advanced practice nurses in the UK.

2.2 | Sample/Participants

Registered nurses who identify their role as advanced practice were eligible to join the cohort. Given the lack of standardization of the role, this may cover many job titles.

Nurses were approached in three ways: (a) the Royal College of Nursing sent emails about the research to their list of credentialed nurses, (b) Higher Education Institutions were asked to send emails to the alumni of their advanced practice master's degrees, and (c) we posted information about the research on Twitter and Facebook. Specifically, Facebook forums aimed at APNs (Royal College of Nursing Advanced Nurse Practitioner Forum, Advanced Clinical Practice Forum for South Yorkshire and Bassetlaw, and the Advanced Practice UK Forum). The emails and posts contained links to the participant information sheet, hosted on a publicly available website, and the consent form, hosted on Google forms. The host institution has a business contract with Google ensuring participant information was confidential.

Recruitment was undertaken during a 6-month period (September 2018–March 2019). This process took several months as we recruited from each method consecutively. Recruitment was closed after each method had been given the opportunity to reach APNs and given them time to sign up. The cohort will continue to recruit at discreet times over the next three years. Reporting follows the STrengthening the Reporting of OBservational studies in Epidemiology (STROBE) guidelines (von Elm et al., 2007).

2.3 | Data collection

Once participants had completed the consent form, they were sent the survey in an online format (Google form). Paper formats were available on request. The data set consisted of a survey containing questions about their role, organisation, experiences, well-being and demographics. Completion of this survey allowed participants to opt in to a prize draw to win a voucher (there will be a new draw each year).

Cohort participants were sent an initial email and then one follow-up if they did not complete the questionnaire. Reasons for non-response were not recorded, and non-respondent rates cannot be calculated because of the nature of the recruitment methods. The same survey will be sent every year from 2018 to 2021.

2.4 | Core Data set

The data set began with questions about the nurse, their role (title, pay band, specialty, evaluation, teaching, leadership and research), their organisation (management structures, supervision, peer networks, accessibility of training and development) and views about credentialing.

The survey included the Short Warwick and Edinburgh Mental Well-being Scale (SWEMWBS) (Tennant et al., 2007), which is a validated measure of well-being, for which clinical and population norms have been published. SWEMWBS total score must be converted for comparison with other research, but conversion tables have been published by the scale's authors (Stewart-Brown et al., 2009). It will be possible not only to see how the cohort's well-being changes over time but also, where appropriate, to make comparisons with other populations. Permission to include the SWEMWBS was received from the University of Warwick.

The data set also included some questions from the NHS staff survey. Questions were included that comprised nine of the nationally reported key findings (KF) (Picker Institute, 2017; see Table 2). Permission to use the questions from the NHS staff survey was received from the Picker Institute.

The wider research team considered all of the NHS staff survey questions but only included those associated with well-being, job satisfaction and patient experience, as these were considered the most relevant without overburdening the participants. The NHS staff survey is not validated but is one of the largest workplace surveys in the world and has been completed every year since 2003 (Picker Institute, 2020).

Demographic questions (age, gender, ethnic background, sexuality, disability and work-related stress) were also included.

2.5 | Data analysis

Analysis of the survey was descriptive to discover who we have recruited and what types of organisations they work in, their experiences of work and their current well-being. Analysis also sought to explore the relationship between several independent variables and well-being and satisfaction scores.

Variations in Agenda for Change pay band may be linked to job title and setting; as such, it is possible primary care APNs are paid more highly to reflect the lower level of medical support in that setting (McConnel, Slevin, & McIlfatrick, 2013). For this reason, bivariate correlations were performed on job title and pay band, and

TABLE 2 National Health Service staff survey key finding domains included in the core data set for the cohort study

Key finding code	Key finding descriptor
1	Staff recommendation of the organisation as a place to work or receive treatment
2	Staff satisfaction with the quality of work and care they are able to deliver
4	Staff motivation at work
7	Percentage of staff able to contribute to improvements at work
8	Staff satisfaction with level of responsibility and involvement
9	Effective team working
14	Staff satisfaction with resourcing and support
17	Percentage of staff feeling unwell due to work-related stress in the last 12 months
32	Effective use of patient/service user feedback

setting (primary or secondary) and pay band. They were also performed to see whether line manager profession correlated with setting, ability to influence change or well-being.

Job titles were simplified for analysis. For example, all variants of advanced nurse practitioner, those for a specialist area or advanced clinical practitioners (an advanced practice role that can be filled by other professions not just nurses), will be considered to be APNs, although non-nurses could not complete this survey.

Correlations of line manager (in the UK, this is the person with direct managerial oversight of the nurse) and clinical supervisor (in the UK, this is the person who oversees the nurse's clinical work) with well-being and setting were also performed using the Pearson's correlation. Pearson's correlations between NHS staff survey KFs and well-being were carried out. Any significant correlations were added to a multivariate linear regression (ANOVA—assumptions were met). To compare mean values for SWEMWBS to the general (UK) population, an independent-sample *t* test was performed. All statistical tests were performed using the SPSS statistical package. There were no missing data as all fields were compulsory and had to be completed to submit the form.

2.6 | Validity and reliability/Rigour

Wherever possible, we used validated measures such as SWEMWBS that would allow us to compare our sample with the wider population (the NHS staff survey).

Recruitment was a challenge, as it is not currently known how many APNs are working in the UK; therefore, we recruited from a variety of sources.

2.7 | Future directions

This paper reports the findings from the first survey of a four-year cohort study. The same annual questionnaire will be sent to participants every year to explore how their environment and experiences have changed. We will also conduct semi-structured qualitative interviews with a subsection of participants each year. These interviews will allow us to address areas of interest and unpack complex details that the questionnaire is not sensitive enough to fully explain.

3 | RESULTS/FINDINGS

3.1 | Profile of participants

The cohort currently has 143 participants, and 86 (60%) have completed the survey.

We recruited 80 people from the Royal College of Nursing credentialed list (out of a list total of 220, which is a response rate of 36%), 60% (n = 52) of all those completing the first questionnaire. Sixty-three came from the social media posts and HEI emails. Their demographic characteristics are summarized in Table 3.

Due to a lack of standardization, it is difficult to definitively say who is or is not an APN. Therefore, anyone who self-identified as an APN was included. Nurse registration was mandatory so non-nurses could not complete the form.

3.2 | Job titles

Participants have a wide range of job titles with over 40 listed, and many people had multiple job titles, but the most common was a variation on advanced nurse practitioner (e.g. for a specific clinical

TABLE 3 Participant demographics

Category	Participant number (%)
Gender	73 (85) female
Age	72 (85) over 40 years
Ethnic background	79 (92) white British
Sexual orientation	78 (91) heterosexual
Disability	16 (19) report long-standing health condition or disability
Work-related stress	38 (44) had felt unwell in the last year as a result of work-related stress

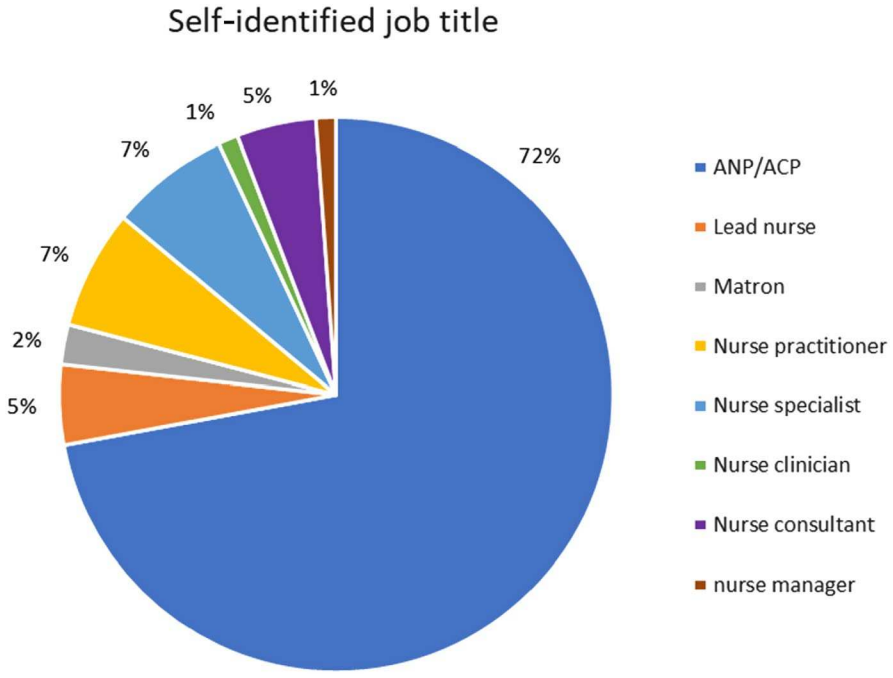

FIGURE 1 Job titles represented in the cohort [Colour figure can be viewed at wileyonlinelibrary.com]

area) (73%) (Figure 1). Other common titles included variations on advanced clinical practitioner, nurse consultant and nurse specialist. Also represented were matron, nurse practitioner, lead nurse, nurse manager and nurse clinician.

The Nursing and Midwifery Council divides UK nurse registration into four fields: adult, children, learning disability and mental health. In the cohort, 90.7% had adult registration, 4.7% child registration, 2.3% mental health registration and 2.3% multiple registrations (adult and child). There were no learning disability nurses in the cohort. The Nursing and Midwifery Council register reports 77.2% adult, 7.3% child, 2.5% learning disability and 13.0% mental health registrations. The Nursing and Midwifery Council does not report how many nurses hold multiple registrations.

In this cohort, 52% of participants work in primary care settings.

Nurses received their line management and clinical supervision from different professional groups (Table 4). There was no correlation between setting (primary or secondary care) and line manager profession (p = .578). There was no correlation between well-being and line manager (p = .681) or clinical supervisor (p = .724) profession. Nor was there a statistically significant relationship between the profession of the line manager and the NHS staff survey KF7 around staff ability to contribute to improvements at work (p = .867; Table 4).

3.3 | Roles and work experiences

Pay band (NHS Agenda for Change or equivalent) ranged from 6 to 8c, which represents a wide disparity in pay and responsibility. The most common was band 8a (42.5%). There were a small number of participants who were self-employed or partners in a general practice and who therefore did not receive a salary via the standard NHS Agenda for Change pay structure.

There was no correlation between job title and pay band (p = .988) or job title and whether staff worked in primary or secondary care settings (p = .217).

One of the definitions of the APN role is that it covers the four pillars of practice: clinical, leadership, teaching and research (Health Education England, 2017). All participants undertook clinical work, almost 80% agreed they had a leadership role, 82% agreed they had a teaching role, but only 55% reported undertaking research.

TABLE 4 The profession of the Advanced Practice Nurses' (APNs') line manager and clinical supervisors

The professional role of APNs' line managers and clinical supervisors:	Line manager		Clinical supervisor	
	Number of APNs	%	Number of APNs	%
Doctor	23	26.7	52	60.5
Nurse	39	45.3	28	32.6
Management	20	23.3	1	1.2
I don't have one	4	4.7	5	5.8
Total	86	100.0	86	100.0

TABLE 5 The key finding (KF) results for the National Health Service (NHS) 5-year national average, all nurses from 2017 and the cohort

Key finding (KF)	UK NHS 5-year national trend mean	2017 UK NHS staff survey nurses mean	Advanced Practice Nurse cohort mean (*SD*)
KF1: Staff recommending the organisation as a place to work or receive treatment	3.70	3.76	3.94 (0.81)
KF2: Staff satisfaction with the quality of work and care they are able to deliver	3.91	3.79	4.03 (0.76)
KF4: Staff motivation at work	3.88	3.99	4.21 (0.52)
KF7: Percentage of staff able to contribute to improvements at work	69%	75%	71%
KF8: Staff satisfaction with the level of responsibility and involvement	3.87	3.97	4.09 (0.65)
KF9: Effective team working	3.73	3.88	3.74 (0.78)
KF14: Staff satisfaction with resourcing and support	3.31	3.30	3.44 (0.76)
KF17: Percentage of staff who have felt unwell as a result of work-related stress in the last 12 months	37.9%	41%	44.2%
KF32: Effective use of patient/service user feedback	3.68	3.77	3.76 (0.78)

3.4 | Credentialing

We asked participants whether they had joined the Royal College of Nursing credentialing scheme: 57% were in the scheme (we expect this to be higher than is representative due to our recruitment strategy; see Discussion).

Five participants had either joined the Royal College of Emergency Medicine credentialing scheme or were in the process of joining it because they thought it more relevant to their practice in emergency departments.

3.5 | Staff survey

Nine of the NHS staff survey KFs were included in the questionnaire. For seven of these, the response is reported on a 5-point Likert scale where 5 is the most positive response. Two were given as a percentage. For KF7, a higher percentage is better; for KF17, a higher percentage is a worse outcome. For all but KF17, the cohort scored more positively than the national average (for all occupational groups). For KF17, the cohort reported higher levels of work-related stress than average (see Table 5 for details). Means have not been compared statistically as the NHS staff survey data are not released with standard deviations (Table 5).

3.6 | Well-being

Despite the incidence of work-related stress (see Table 2), the average score on the SWEMWBS was 22.96. This is not significantly different from the general population (independent *t* test $T = 1.5286$, $df = 7{,}280$, SE of difference = 0.422, $p = .126$, 95% CI −0.184 to 1.476). There was no significant correlation between setting (primary or secondary care) and either the SWEMWBS or reported incidence of feeling unwell due to work-related stress.

All the KFs and Agenda for Change banding were significantly correlated with SWEMWBS score so a multiple regression was run to investigate (the assumptions were met). These variables (KFs and banding) statistically significantly predicted SWEMWBS score ($F(10,69) = 4.645$, $p = <.001$, $R^2 = .402$).

4 | DISCUSSION

The APN cohort currently has 143 members, they reported over 40 job titles covering five pay bands within the NHS (and additional ones outside the Agenda for Change structure), highlighting the need for the UK to learn from international attempts to regulate and standardize the APN role (NCNZ, 2017;NCSBN, 2008;NMBA, 2016). Most APNs worked in adult services or general practice. Areas such as mental health and learning disability were underrepresented.

Agenda for Change is the NHS pay structure for all non-medical staff. In 2012, the Royal College of Nursing recommended that an autonomous APN should be on Agenda for Change band 8a (RCN, 2012). The role of Agenda for Change is to standardize pay and role descriptions across the UK to ensure staff in different parts of the country are remunerated equitably for doing the same role (NHS, 2004). Band 8 is split into four (a, b, c and d) and is usually for senior and managerial roles. Research has shown that the RCN's advice was not adhered to with pay ranging from 6 to 8a (Fawdon & Adams, 2013;Marsden, Shaw, & Raynel, 2013). Seven years after the publication of the RCN's guidance, we have discovered there is still a large discrepancy in pay and seniority for APNs, ranging in our sample from 6 to 8c. This represents a broad range of pay and responsibility. Band 6 nurses would usually be recognized as experienced but not necessarily senior nurses, whereas 8c would be expected to have very senior management and leadership responsibilities. This difference represents a potential pay

difference up to £42,169 (bottom of band 6 to top of 8c—2019/20 NHS pay scale) between nurses employed as APNs within the NHS. If nurses with the same job title have (presumably) very different job descriptions leading to very different pay scales, this is confusing for staff, managers and patients. It risks devaluing the title and role of APN.

The Health Education England competencies for advanced clinical practitioners (Health Education England, 2017) cover all four pillars of advanced practice, and advanced practitioners should be capable of meeting all of them. In this cohort, 45% of participants are not engaged in research. Health Education England do not intend that the four pillars should be applied equally and different advanced practitioners in differing roles will be expected to vary how much of each pillar they are involved in. However, these findings are of concern and require further exploration in future studies.

Findings related to pay disparity and issues with the research and evaluation 'pillar' of advanced practice mirror the findings of East et al. (2015). Their study took place several years ago and only in one UK acute Trust. The findings of the current study show that these challenges persist and are experienced in a range of health care settings across the UK.

A high percentage of our participants were involved in the Royal College of Nursing credentialing scheme. This should not be considered representative of the UK picture. Due to the difficulty in locating APNs, we targeted the Royal College of Nursing's list of credentialed practitioners directly (60% of participants heard about the study via the Royal College of Nursing). However, we also recruited non-credentialed APNs through social media. Over the next four years, we will use the cohort to further investigate the attitudes of APNs to credentialing.

Despite higher than the NHS average levels of reported work-related stress, participants reported levels of well-being similar to those of the general population. This is different from findings with newly qualified nurses who, after only 6–12 months of nursing, report significantly lower levels of well-being compared with the general population (Wood, Mason, French, & Weich, 2019). One possible explanation is the level of autonomy inherent within the APN role. There is research (Salminen, Andreou, Holma, Pekkonen, & Mäkikangas, 2017) that suggests people are better able to cope with stressful work if they have a sense of control over that work and some agency in the role.

4.1 | Limitations

The strengths of this cohort are the length of participant follow-up and the diversity of recruitment methods used to reach a wide variety of APNs. This is important as we do not actually know how many APNs there are in the UK (HEE, 2019). Potential sources of bias include the fact that we did not have control over which HEIs contacted their alumni on our behalf. The Royal College of Nursing emails were sent only to credentialed nurses, but other methods (particularly, social media approaches) enabled the participation of those who have and have not credentialed, reducing the risk of this bias in the cohort. The online forums and social media recruitment may have appealed more to a younger audience. However, 85% of our participants are over 40.

One significant issue is that the total number of APNs in the UK is unknown, so it is impossible to estimate our efficiency in recruiting. We do not know whether we recruited more APNs than other job titles because that is representative of the national picture, or because our use of the 'advanced practice' terminology meant nurse consultants and other advanced roles did not identify themselves as potential participants.

As with any postal or online questionnaire, there is a weakness in that not everyone who signs up to the cohort completed the annual survey. Currently, we have a 60% completion rate for the surveys.

4.2 | Implications for nursing management

The findings from this study give managers the opportunity to evaluate whether title, pay and support mechanisms for APNs in their organisations align with suggested national standards set by Royal Colleges and government departments. Whilst the UK lacks compulsory national standards, organisations can self-regulate to ensure they use their APNs in the best possible way.

Ensuring APNs are working to their competencies and not being underused or asked to work beyond their capabilities will mean value for money for the organisation and the best possible experience for patients and APNs.

If APNs are to fulfil the recommended four pillars of advanced practice, they need protected time to undertake the non-clinical aspects of the role: leadership, teaching and research. This must be considered by managers when implementing new roles and developing existing ones and incorporated into appraisals and ongoing development plans. An APN with no role in leadership, teaching or research is an advanced clinician but not an APN.

5 | CONCLUSION

This APN cohort will provide a valuable resource for understanding the roles and experiences of advanced practice nurses in the UK over a four-year period.

Initial results show that being an APN still means vastly different things in different places. Across the UK, a wide range of titles are applied to APN roles, there is a large pay range, which is not reflected by title or setting, and APNs undertake varying proportions of the elements of the four pillars. The implications for nurses working in different roles with the same job title are potentially serious. There needs to be an increase in standardization of APN roles to support APN well-being and promote patient safety.

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AUTHOR CONTRIBUTIONS

EW drafted the paper, collected and analysed the data and contributed to the survey and protocol development. MS assisted with the statistical analysis. PA, RK, SR, MS, AT and TR contributed to the survey and protocol development. All authors read and approved the final manuscript.

ETHICAL APPROVAL

This research was reviewed by the Institutional Ethics Committee and given approval on 3 September 2018 (ref number 022736). Informed consent to participate was received from all participants. This research was carried out in accordance with the principles of the Helsinki Declaration.

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