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An evaluation of the Advanced Clinical Practitioner role in Jersey: a cross-sectional survey

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Declaration

I hereby declare that this thesis is my own work and effort and that it is has not been submitted elsewhere for any award. Where other sources of information have been used, they have been acknowledged.

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Acronyms and Abbreviations

ACP	Advanced Clinical Practitioner
AHP	Allied Health Professional
AP	Advanced Practice
APPN	Advanced Practice Physiotherapy Network
GoJ	Government of Jersey
HCJ	Health and Care Jersey
HCPC	Health and Care Profession Council
HEE	Health Education England
HRA	Health Research Authority
JCC	Jersey Care Commission
NHS	National Health Service
NMC	Nursing and Midwifery Council
RCN	Royal College of Nursing

Abstract

Background: Advanced Practice is a distinct level of practice utilised in multi-professional roles including nurses and AHPs. Advanced Clinical Practitioners (ACPs) are employed across various specialities within healthcare, forming an integral part of the local workforce. Advanced practice is underpinned by the 4 pillars of clinical practice, leadership and management, education and research. Frameworks exist to provide clear understanding of the capabilities; however, the understanding of the role is inconsistent.

Project design: A service evaluation was conducted using a quantitative cross-sectional survey. Data were analysed using descriptive statistics and content analysis.

Findings: Findings provided an understanding of the ACP role in relation to the 4 pillars of practice. Key interpretations indicate varying levels of understanding of the ACP role. Some practitioners self-identify as ACPs yet do not demonstrate working at this level whereas others can demonstrate working at this level, but do not have appropriate job titles to reflect this, implying a mismatch between the understanding of the role and employment expectations. While individual experiences identified support from clinical teams, there were shortfalls in support from the organisation and gaps in governance procedures.

Conclusion: This evaluation has explored how ACPs understand their role in relation to the 4 pillars. Variation exists in how this is understood with differing levels of interpretation and evidencing of capabilities across the pillars. Findings suggests there a lack of governance, policy and supervision to support roles, and poor understanding advanced practice across healthcare settings. Understanding of the pillars needs improving and prioritisation of governance, supervision and leadership is vital to inform workforce development, policy and optimisation of advanced practice roles.

Chapter 1: Introduction and Background

1.1 Introduction

This dissertation aims to provide an overview of the Advanced Clinical Practitioner (ACP) role in Jersey. In this chapter, the terms advanced practice (AP) and ACP will be defined, and the context of AP in Jersey will be discussed in relation to its importance for healthcare reform, therefore supporting the rationale for the chosen topic. Having set the context, a project question is posed and the objectives outlined. The chapter will conclude with an overview of the structure of the dissertation.

1.2 Defining Advanced Practice

The ACP role has become a cornerstone of healthcare workforce transformation and plays an integral part of healthcare delivery as supported by the NHS Long Term Workforce Plan (NHS England, 2023). An ACP refers to registered health professionals working at an AP level. Advanced practice is defined as a level of practice characterised by a high degree of autonomy and complex decision making, utilising skills and knowledge developed beyond initial professional training. AP must be underpinned by master's level education or equivalent experience and is defined by the four pillars of practice: outlined by the Multi-professional Framework for Advanced Practice (NHS England, 2025) and the Multi-professional Framework for Advanced Clinical Practice in Jersey (Government of Jersey, 2021). The four pillars of practice are:

1. Clinical Practice
2. Leadership and management
3. Education
4. Research

1.3 Background

Whilst AP is not currently regulated, the multi-professional framework for advanced practice (NHS England, 2025) provides guidance for this role. Although ACP roles were traditionally adopted by nurses, it is now widely delivered by a variety of professionals including Pharmacists and Allied Health Professionals (AHPs). Area-specific AP standards have been developed, such as the United Kingdom Musculoskeletal Advanced Practice standards (Musculoskeletal Partnership Group, 2022) to guide the various professions. Whilst there is no statutory register for ACPs, regulation relies upon organisational governance and professional codes of conduct from the base profession, such as the Health and Care Professions Council (HCPC) or the Nursing and Midwifery Council (NMC).

The aim of ACPs is to enhance patient care, improve access to service and support workforce sustainability by enabling practitioners to work across traditional professional boundaries. In the climate of increasing pressure on health systems the evidence to support AP roles is continually building (Wood and Hyde, 2023). Whilst there is evidence supporting the clinical and cost effectiveness of ACPs (Kennedy, Robarts and Woodhouse, 2010; Evans *et al*., 2021; Vedanayagam *et al.*, 2021; Lafrance *et al.*, 2023; Stilwell, 2024) the understanding of the implementation and governance of the role is emerging (Evans *et al*., 2021). A study by Fothergill *et al*. (2022) conducted a large-scale evaluation of the governance, education and support of ACPs across England. This study was the first of its kind to examine ACPs collectively across geographical and professional settings and highlighted a wide variation in implementation, alignment to the four pillars of practice and levels of supervision.

Although ACPs are now formally recognised within NHS governance structures, this does not directly translate to other organisations, and the perception and uptake of ACPs in other jurisdictions remain comparatively outdated. This study intends to evaluate the ACP role in Jersey by examining the current local workforce and how they relate to the four pillars of advanced practice.

Initial controversy with ACP roles appears to have been overcome and there is now a large volume of ACPs across the UK. Although the definition of advanced practice has been historically ambiguous, the development of frameworks and standards are helping to embed the advanced practice narrative into the business planning process. Across a wider context, the role has been adopted globally with countries such as Canada, New Zealand and some European countries enforcing regulation and protection of the ACP title.

1.4 Local context

Jersey is a small jurisdiction island with its own independent government, and health care system. With a population of around 103,000 (Government of Jersey, 2025a) and distinctive geographical location, Jersey has its own unique challenges. Whilst evidence-based practice is integral to Health and Care Jersey (HCJ), local procedures do not necessarily align with the NHS. There has been delayed adoption of ACP roles in Jersey compared to the United Kingdom (UK). For instance, the first ACP Physiotherapist was appointed in Jersey in 2023, whereas this role has been established within the NHS for many decades (Advanced Practice Physiotherapy Network (APPN), 2024).

HCJ is a newly integrated health and social care department of the Government of Jersey (GoJ) established in 2025. Unlike the NHS model, healthcare in Jersey is regulated by the Jersey Care Commission (JCC) and combines elements of both private and public systems. In this model, primary care is delivered through private general practice and incurs a cost to service users, whilst secondary and certain community services are funded by the GoJ and provided primarily by HCJ. Additional secondary and community care services are delivered by smaller organisations such as Family Nursing and Home Care (FNHC). This structure creates a mixed system of both private and publicly accessible services, with multiple lines of organisational responsibility. It is currently unclear what proportion of the local workforce is made up of ACPs, and their scope and skillsets remain poorly understood. Furthermore, there is no unified approach to governance and quality assurance for ACP roles within local establishment and those working at an AP level, are not necessarily employed as ACPs.

Alongside governance challenges, Jersey's geographical position as an island presents additional obstacles. The relatively small local population makes recruitment into niche and specialty roles difficult. These challenges are compounded by off-island recruitment barriers, as relocating appropriately qualified staff often involves significant financial costs and social implications for delegates. The development and support of ACPs in Jersey is therefore vital to support the specialist workforce and maintain workforce sustainability. If ACPs are seen as valuable, autonomous and integral to service delivery it will boost the positive narrative and attract future candidates.

In 2024, an exploratory survey was conducted to identify the number of clinicians in Jersey working at a higher level of clinical practice (Holbrook, 2024). The survey invited all clinicians believed to be working at a higher level to provide feedback about what they regarded as important for future CPD and what developments were needed for AP in Jersey. Fifty-five responses were collected from a range of professions working at various levels. This survey was not limited to those working in ACP roles and did not follow a systematic research-based approach. Therefore, it cannot fully inform governance or role-specific implementation. This service evaluation will address this gap by providing a more rigorous, ACP-focussed approach.

The UK large-scale research by Fothergill *et al*. (2022) was the first of its kind to research the principles behind current ACP governance, education and support. This study analysed a national survey that gathered data from individual ACPs, NHS provider organisations and trusts adopting an inclusive multidimensional approach. Whilst Fothergill *et al.*'s (2022) findings are generalisable to the ACP population in England, there has been no similar research into smaller independent jurisdictions such as Jersey. Given the differences in governance, geography, workforce, policy, and the latent uptake of ACP roles into the local workforce, further research is required to support the development of local ACPs. Exploring this topic in Jersey will provide contextual relevance where previous findings cannot be directly applied locally.

Local policy identifies the need for service redesign to include specialist workforce planning across healthcare (GoJ 2025a), and this evaluation will provide evidence for the modernisation of healthcare in Jersey. Understanding local ACP roles will optimise their contribution to healthcare and ensure safe, effective and sustainable practice which mirrors the values and ethos of HCJ. The importance of investing in AP is highlighted in the Health and Care Jersey Quality Account 2024 (GoJ, 2025b). Despite this recognition, there is a limited understanding of the current ACP workforce. Engaging directly with ACPs will enhance colleague involvement and experience. It will also help inform policy and strategic initiatives such as service redesign, workforce planning, and informing local health policy (GoJ, 2025b; GoJ, 2026). Establishing understanding of AP in jersey is fundamental to shaping the islands healthcare future. Without the shared foundation, meaningful progress, informed policy development and cohesive system-wide advancement cannot be achieved.

1.5 Project Question

To identify the major elements of the topic, a PICO template (Table 1.1) was used to align structured measurable outcomes (Aveyard, Payne and Preston, 2016).

Table 1.1: PICO template

PICO		
Population	• Age 18+ • Currently working in Jersey • ACP, ACP trainee or self-identifying as working at AP level • Professionally registered • Willing to participate	ACPs in Jersey
Intervention (exposure, feature or characteristics being evaluated)	• ACP role structure • Job description and job plans • Level of autonomy • Training and support • Professional and educational background • Engagement with the 4 pillars	Understand and experience role
Comparison	• Evaluation of ACPs in other jurisdictions • Evaluation of other professional roles in Jersey • Experiences of ACPs in differing specialities	Core principles of AP

	• ACPs with different training/experience	
Outcomes	• Role evaluation • Understanding of roles in relation to AP	Understanding of role

The question therefore is: *How do ACPs in Jersey understand and experience their role in relation to the core principles of advanced practice?*

The study aims to explore and evaluate the roles of ACPs in Jersey with a focus on their understanding of the role in relation to advanced practice.

The study has the following objectives:

1. To map the existing roles of ACPs in Jersey and identify association between professional and educational background, job title, and scope of practice
2. To describe how ACPs in Jersey define and understand their role within the clinical and organisational contexts
3. To identify ACP's engagement with the 4 pillars of advanced practice
4. To identify specific training trajectories, supervision and support systems for ACPs
5. To evaluate overall trends, strengths and gaps in the roles of ACPs in Jersey to be able to inform workforce development and policy within Jersey's health and care system

1.6 Project Structure

Chapter 1 has described AP and the contextual position of ACPs in healthcare. It has provided a background of the governance of AP and the discrepancies between healthcare settings. To understand the wider ACP workforce, a systematic literature review has examined the evidence and current concepts which are outlined in chapter 2. Chapter 3 describes the project design, including the planning and implementation methods used. The aims and research objectives are outlined, and ethical considerations are discussed. Survey findings are objectively presented in chapter 4 using tables and graphs to illustrate findings.

Themes and correlations are explained in relation to the research question. Results are discussed in chapter 5 to summarise findings and important observations. Strengths, weaknesses and implications for practice are addressed. The final chapter summarises findings and draws conclusions to the study's objectives. Recommendations for implementing findings are outlined.

Chapter 2: Literature review

This literature review evaluates the content and quality of existing research and has informed the development of this study. The systematic approach taken to retrieve the available literature is outlined, followed by an appraisal of the retrieved literature.

2.1 Search Strategy

To identify key search terms the PICO framework was revisited (Table 1.1). Key search terms (Table 2.1) were entered into electronic databases, truncated where necessary and combined using Boolean logic. CINAHL complete, Medline and Cochrane review data bases were chosen to provide access to academic resources relevant to medicine, nursing and allied healthcare.

Table 2.1: Search Terms

Search	Search Term	Synonyms (searched using "OR")
1	Advanced Clinical Practice	Advanced clinical practice or advanced practice or advanced clinical practitioner or ACP or extended scope practi*
2	Evaluation	Evaluation or Assessment or review or analysis or effectiveness or experience or perception or characteristics or perspectives
3	Role	Role or Responsibilities or competencies or scope or job or position

A systematic search strategy (Hart, 1998) was applied to databases on EBSCO host and results were combined using "AND". This provided 691 results from CINAHL complete and Medline, none were found on the Cochrane database. Backwards chaining principles identified a further 4 papers. Search limiters excluded resources not written in English, or those written more than 5 years ago, leaving 131 results. Studies were screened by title and abstract for relevance, resulting in 19 records being accepted for a full text review. Further appraisal of the full-text studies was undertaken, and those considered relevant were screened using the CASP (2018) critical analysis guidelines. At the final stage, 4 papers were excluded due to poor quality evidence or irrelevance, resulting in 15 papers

for critical review and discussion. A PRISMA chart (Aveyard, Payne and Preston, 2016; Page *et al*., 2021) was created to outline this process (Figure 2.1).

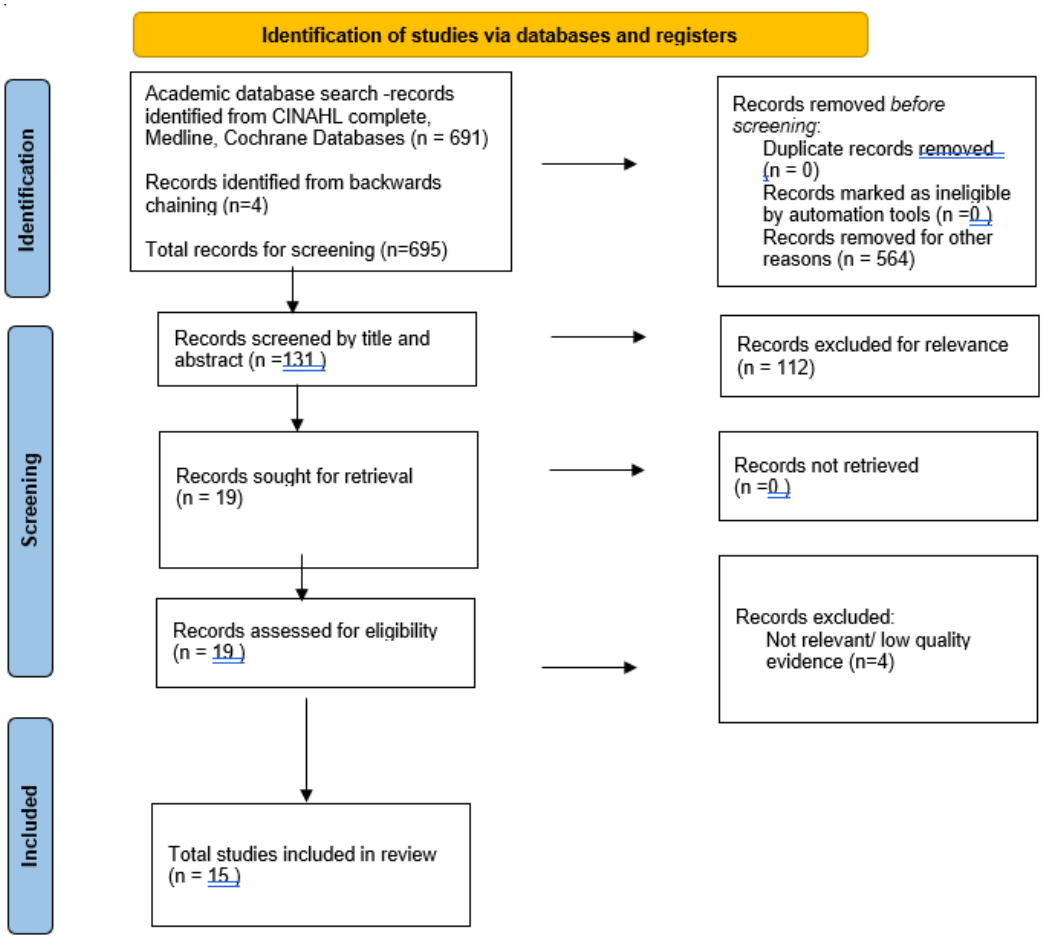

Figure 2.1: PRISMA chart

2.2 Literature Review

Many papers explored factors that facilitate or hinder the implementation and development of ACPs. In a scoping review undertaken to characterise the outcomes, impacts and implementation challenges of ACPs in the UK, Evans *et al*. (2021) gathered evidence from 191 papers using a complex and robust strategy spanning 13 online databases. This study provides comprehensive coverage of the literature using credible methodological guidance frameworks. An outstanding finding across Evans *et al*.'s (2021) study was job title standardisation. This was a barrier to successful implementation of the role which was found to feed poor

clarity of scope of practice and capabilities. This was closely linked with variances in education and training pathways, and it was proposed that standardisation would enhance job clarity. A similar concept is also explored by Lawler, Maclaine, and Leary (2020) who found that employers often have unclear expectations and lack of understanding of this level of expertise. Their survey had a large sample (n=528) and mixed-methods approach to explore insights via interviews, providing good credibility. However, findings should be interpreted with caution, as they reflect the perceptions of the workforce rather than those in managerial positions. Discrepancies between the views of clinicians and managers have yet to be formally investigated within current literature.

As ACPs have an expected level of practice, not a protected title, Lawler, Maclaine and Leary (2020) reported that confusion remains regarding the clarity and structure of the role for both ACPs and employers, with reference made to job titles. In a study by Harris *et al*. (2021) the job descriptions of diagnostic radiographers advertised in the NHS were examined. Harris *et al*. (2021) recognised wide variations in job titles within the profession and found that many posts advertised as 'advanced' did not reflect the principles of the multi-professional framework (NHS England, 2025). Therefore, despite the presence of 'advanced' within job titles, assumptions cannot be made that practitioners in these posts are truly advanced practitioners or working at an advanced practice level. Although Harris *et al*. (2021) used a small sample (n=42), it is unclear how representative this is of the radiographer workforce at the time. The study does not indicate whether this number reflects a substantial proportion of the total job advertisements, leaving its representativeness uncertain.

In an analysis of job descriptions, Snaith *et al*. (2023) expanded on the importance of job titles and conducted a profiling study of the contemporary ACP role. They identified 143 roles across a range of specialities, recruited comparably to those selected by Harris *et al*. (2021). However, Snaith *et al*. (2023) excluded posts that were restricted to a single profession which may have resulted in the omission of valuable data from well-established ACP roles. When profiling ACP roles it is important to recognise that job descriptions may not fully capture the qualifications or backgrounds of individuals who are eventually appointed to the

role. A key strength of Snaith *et al*.'s (2023) study is the inclusion of a comprehensive data set representative of an expanse of English regions; however, the exclusion of postings from other UK countries limits the generalisability of findings. The use of content analysis offers objectivity when identifying differences in job title and responsibilities. Snaith *et al*. (2023) reported that only 71.4% of posts used the ACP title, with numerous variations influenced by the practitioner's base profession. 76% of posts placed no restrictions on the professional background of applicants while a master's degree qualification was specified as being essential for 58.4% of the roles, which is not consistent with AP guidance of the time (Health Education England, (HEE), 2017). This highlights ambiguity about job titles and shows that education and pay scales are variable. This has implications not only for role clarity and consistency, but also for research design as it complicates efforts to achieve comprehensive and representative samples.

Poor understanding of ACPs was further explored by Drennan *et al*. (2022) in a qualitative examination of staff perceptions. Interviews across nineteen health services engaged clinicians and senior managers reporting contrasting views on factors perceived to hinder the development of ACP posts. Although the interviewers appeared to recognise potential discrepancies between the groups, these were neither systematically examined nor explicitly reported within the study's findings. What was evident, was concurrence with other studies (Evans *et al*., 2021; Fothergill *et al*., 2022; Snaith *et al*., 2023) that confusion about ACP roles was seen as an inhibiting factor for role development. When considering implementation of ACP roles in services within which they do not yet exist, the views of senior staff towards ACPs is influential (Brimblecombe and Nolan, 2021) therefore clarity and acceptance of the role must be a consideration. Brimblecombe and Nolan (2021) conducted a qualitative study of 20 staff members who were interviewed through focus groups and semi-structured interviews to explore factors influencing the development of ACP roles within mental health services. The limited literature specifically within mental health services suggests that roles are still emerging in this area. The specialised context of mental health combined with a participant sample comprised of 50% nurses provides depth, whilst limiting the ability to apply these findings more broadly.

Furthermore, the absence of ACPs from the participant group means the study lacks insight from those directly undertaking the role. The use of hand-written notes for interviews also introduces potential for inaccuracies in data. Despite these limitations, factors that were identified as important to the development of ACP roles such as understanding of the role, attitudes towards ACPs, and development and training challenges, mirror findings from the broader ACP literature (Cooper and Lidster, 2021; Evans *et al*., 2021; Rath *et al*., 2021; Fothergill *et al*., 2022; Oliveira *et al*., 2022; Snaith *et al*., 2023; Assolari *et al*., 2025) suggesting that barriers in mental health settings reflect wider ACP challenges. Brimblecombe and Nolan (2021) also note difficulties in identifying funding for ACP posts, which is a recurring theme from the literature, and financial barriers are reflected in the views of ACPs themselves (Evans *et al*., 2021; Drennan *et al*., 2022; Oliveira *et al*., 2022; Lawlor and Leech, 2024). Drennan *et al*. (2022) suggest that the drive for finance may be influenced by workforce shortages and retention and emphasises that securing engagement of senior leaders is vital.

Fothergill *et al*. (2022) report on a national survey that was distributed by HEE in 2019 to primary care organisations, NHS provider organisations and trusts and included staff identified as working at AP level, as an ACP or ACP trainee, regardless of their job title. 4013 responses from a variety of professional and educational backgrounds provides strong representation of the ACP population. A CASP appraisal indicated rigorous methodology and extensive distribution. Within this, 125 different job titles are reported, demonstrating the breadth and diversity of ACPs but there were inconsistencies across many domains. More than half of ACPs were trained to master's level but there was variable coherence with the 4 pillars of AP, levels of supervision and support, and formal regulation. Professional development appeared to be self-driven with inconsistent governance approaches, contributing to frustration and demotivation among staff. With only 2 years between the introduction of a harmonised definition of advanced practice (HEE, 2017) and survey distribution, revisiting these realms would determine if contemporary practice is now more aligned with formal guidance.

A study by Lavery, Morrell-Scott and Flewitt (2025) explored the perceptions of trainee ACPs regarding the 4 pillars of practice. They concluded that the clinical pillar was the most important, regarding clinical competence as vital requirement for AP. Although this study gives insight into trainee's perceptions of professional identity and role clarity, the small (n=29) single-site sample based on self-selection lacks demographic depth and absence of qualified ACP perceptions limits the interpretation of results.

A systematic review of AP therapeutic radiographers conducted by Oliveria *et al*. (2022) demonstrated an extremely comprehensive search strategy across multiple databases. A PICO-based search utilised broad comprehensive terms with explicit inclusion criteria. Standardised guidance was used and tools to review data quality clearly justified their conclusions. Oliveria *et al*. (2022) demonstrated the positive clinical and organisational impact of AP radiographers providing evidence to support national frameworks and workforce planning. With focus on a different specialism, Denton *et al*. (2023) present a narrative synopsis of the current evidence base and safety profile of Advanced Critical Care Practitioners (ACCPs). Although a narrative review is deemed suitable for interpretation of a wide breadth of information, this methodology is more prone to bias then systematic reviews. Denton *et al*. (2023) does not provide detail of the search process, limiting transparency and reproducibility. The review asserts parity in safety outcomes for ACCPs compared with other advanced practice roles; however, this claim is not substantiated within the paper, as no comparative analysis with studies on ACP safety profiles is provided. Furthermore, a substantial proportion of the safety evidence cited originates from previous work by the same author, raising concerns of bias and limited diversity of sources. Denton *et al*. (2023) conclude that a single regulator for multi-base professionals is neither feasible nor realistic, despite the growing acceptance for AP roles.

Similar critical limitations are evident in the work of Lawlor and Leech (2024) who examined responsibilities and competencies in a scoping review of 35 studies. Analysis was restricted to radiography but provided a comprehensive overview of the role internationally. They reported challenges in defining scope within radiation therapy and although reference was made to the 4 pillars of practice, no

measurable data was identified in relation to this. Although a comprehensive search strategy was utilised with clear reporting of the characteristics of findings, searches were limited to only two data bases and did not include quality appraisal. In comparison, a scoping review by Assolari *et al.* (2025) used a methodologically detailed approach using validated search protocols and thorough data synthesis to provide understanding of the roles of AP nursing in surgery. Although Assolari *et al*. (2025) include fewer studies (n=20), those included are mostly expert opinions and critically appraised with scoring systems to provide transparency. With a robust collection of evidence, Assolari *et al*. (2025) draw conclusions about educational and regulatory gaps and provide recommendations based on international evidence calling for global agreement of AP standards for nurses.

To understand the perceptions of competency, a study by Cooper and Lidster (2021) explored how this is evidenced by practitioners enrolled on a master's programme. This qualitative study identified disparity between definitions of 'trainee' and 'qualified' ACPs, highlighting ambiguity about the benchmark for qualified ACP status. The formal recognition of specific skills, training and knowledge were discussed, with differing feelings towards the multi-professional framework (NHS England, 2025) and its interpretation was considered subjective. Variable interpretation of the framework is also noted in other studies (Lawler, Maclaine and Leary, 2020; Cooper and Lidster, 2021; Evans *et al*., 2021; Snaith *et al*., 2023) suggesting that although the framework is adopted and promoted at an organisational level, the initiative has not yet achieved widespread buy-in from the workforce. Cooper and Lidster (2021) also note disparity of perceptions of the clinical portfolio completion, questioning the basis upon which ACP status is commonly assessed. They used semi-structured interviews (n=6) which are highly appropriate for analysing perceptions and meaning, however their sampling method is questionable. Although small samples are acceptable for qualitative research, using convenience sampling of nurses within one university limits representativeness and generalisability.

Rath *et al*. (2021) conducted a study that targeted members of the APPN with a questionnaire to evaluate current context and implementation of AP physiotherapy. Given that physiotherapists working at an AP level are

predominantly members of the APPN, this sample can be considered highly representative, however it is limited to this professional group. Appropriate methods of thematic analysis and coding were adopted, and issues within Physiotherapy were similar to those found elsewhere, such as title confusion, differing educational expectations and barriers such as infrastructure and support. However, findings from cross-sectional studies such as this may be biased towards respondents who are highly engaged or highly despondent and relies heavily on self-report. Rath *et al*. (2021) concluded that an AP physiotherapy framework is required, which is synonymous with research within other professions (Fothergill *et al*., 2022; Olivera *et al*., 2022; Lawlor and Leech, 2024).

CASP principles suggest that systematic reviews require a highly defined question, explicit search strategy and transparent study selection, all of which are demonstrated in a robust review of international competence and capability conducted by Tawiah *et al*. (2024) specifically within physiotherapy. This systematic review followed a rigorous search process covering a wide range of databases and thorough search terms. The review incorporated a substantial proportion of grey literature offering meaningful insight into contemporary practice and results were presented clearly and transparently. A competency and capability framework for AP physiotherapy was proposed from a global perspective, offering valuable recognition of standardisation for the profession and providing the basis for education and training. Contemporary conceptualisations of competence encompass knowledge, skills, behaviour and cultural and interpersonal collaboration (ScienceDirect, 2025) and cannot be regarded as a one-size-fits all construct. So, although attempts have been made within specific professions to define competence and capabilities of ACPs, the current available literature does not provide adequate understanding across all professions. Many scoping reviews have attempted to capture specific areas of advanced practice (Assolari *et al*., 2025; Tawiah *et al*., 2024; Denton *et al*., 2022; Oliveira *et al*., 2022) and whilst these papers offer valuable context and overview, further research is needed to establish clear, consensus-driven guidance within specialties. However, it is worth considering whether such standardisation might inadvertently dilute the essence of ACP as an overarching, umbrella concept.

2.3 Conclusion

There is a lack of evidence for defining the roles of ACPs. Although some systematic and scoping reviews provided high level evidence (Oliveira *et al*., 2022; Lawlor and Leech, 2024; Assolari *et al*., 2025), profession-specific studies are not generalisable to the accepted definition of AP (NHS England, 2025). Most literature is descriptive and small scale. The multi-professional nature of ACPs encompasses a diverse range of health professions and is therefore likely to contribute to the heterogeneity of the evidence base. While pockets of evidence exist for Physiotherapy, Radiography, and certain nursing sub-specialties, large-scale, robust studies are needed to strengthen understanding of ACP roles both nationally and globally.

To date, Fothergill *et al*. (2022) provide the only largescale research examining AP as an entity and its findings reflect the common themes emerging from the wider published literature. Literature findings are drawn primarily from UK or international contexts meaning their findings cannot be assumed to translate directly to local practice in Jersey. Although the multi-professional framework (NHS England, 2025) provides guidance for the definition and scope of AP, the research suggests there are still challenges in consistent implementation and understanding. There is a need for a consensus-driven approach to competency, capability and alignment with national frameworks, but how to achieve this is unclear.

Understanding of how ACP roles function in practice across different professions and jurisdictions is unknown. This gap in evidence directly underpins the rationale for the present service evaluation in Jersey. Local government cannot rely on external information to inform local decision making as UK studies will overlook the unique local healthcare system and workforce. A local evaluation is therefore needed to understand ACP roles, to discover whether clinicians have good understanding of national frameworks and to understand how local organisation structures and professional training may influence ACP deployment. The next chapter will describe how the Service Evaluation is conducted.

Chapter 3: Project Design

3.1 Introduction

Having set the background to the project and explored the literature, this chapter will present the design and how it was undertaken. It will begin with outlining the philosophical underpinnings and then explicate the methods of data collection and analysis.

3.2 Philosophical basis

Positivism is a philosophical approach that infers all genuine knowledge is determined by reason and logic. It is founded on the understanding of facts and evidence and is historically associated with the physical sciences, rather than social sciences. The philosophy emphasises objectivity enabling reality to be measured and studied impartially. Positivism affirms that knowledge is based upon positive data of objectivity and replication in a world of universal laws. Understanding is obtained through systematic and empirical investigation of facts and findings to inform and justify hypothesis (Park, Konge and Artino, 2020).

To understand the ACP role, determining key fundamentals such as profession, educational attainment, and time attributed to the four pillars of AP can be plotted with hard data. Empirical verification will identify patterns amongst variables using statistical analysis to generate objective, quantifiable data (William, 2024) and firmly positions it within a positivist paradigm.

3.3 Methodology

With the purpose to assess performance, evaluations are not based upon specific criteria or standards, but aim to understand, describe and improve an existing service (NHS, n.d.). This project aims to understand the role of ACPs in Jersey; therefore, a service evaluation is appropriate. The NHS Health Research Authority (HRA) provide a decision tool which confirms this project aligns with the definition of a service evaluation, and not primary research (NHS HRA, 2025b). While the

HRA decision tool does not consider this research, methodology will follow research principles for rigour and quality.

A quantitative, non-experimental methodology using a cross-sectional survey design allows identification of prevalence, patterns and associations between roles (Lee, 2025). This uses a deductive approach to make observations (Bruce, Pope and Stanistreet, 2008) and aligns with positivism in the search for objective truth and empirical evidence (William, 2024).

To understand the roles of ACPs in Jersey, the objective is to analyse and observe the roles as they are naturally occurring, rather than providing an intervention, therefore a non-experimental design was chosen. Although specific relationships may be difficult to interpret with a non-experimental design (Novosel, 2023), an experimental method would be unethical as it would require manipulation of a professional role. Altering training, responsibilities or scope of practice would not uphold the principles of non-maleficence (Varkey, 2021) by introducing clinical risk, hindering staff integrity and causing workplace disruption. Non-experimental designs offer valuable insights in real-world contexts where experimental approaches are unfeasible. This study utilises these strengths to provide insight into important features within a natural, non-interventional setting (Research Rebels, 2026).

3.3.1 Conceptual Framework

As a Service Evaluation, this project focuses on practical outcomes. By clarifying the key constructs, a conceptual framework defines what is being evaluated and grounds outcomes in established concepts. As service evaluation does not follow specific guidelines or criteria, the utilisation of a conceptual framework helps establish the fundamental structure demonstrating the theory of the evaluation and explaining areas of interest (Bowling, 2023). The conceptual framework (Figure 3.1) used in this project draws on previous research and theories to explain why exploration of the roles of ACPs is important. The central outcome of the project is ACPs' understanding of their role in Jersey and this can be shaped by three inter-related domains of influence:

- Individual factors such as professional background - including professional group and education level
- Professional context such as professional identity, perceived autonomy, scope of practice
- Local organisational context such as role setting, organisational support, role clarity and direction, access to education and training

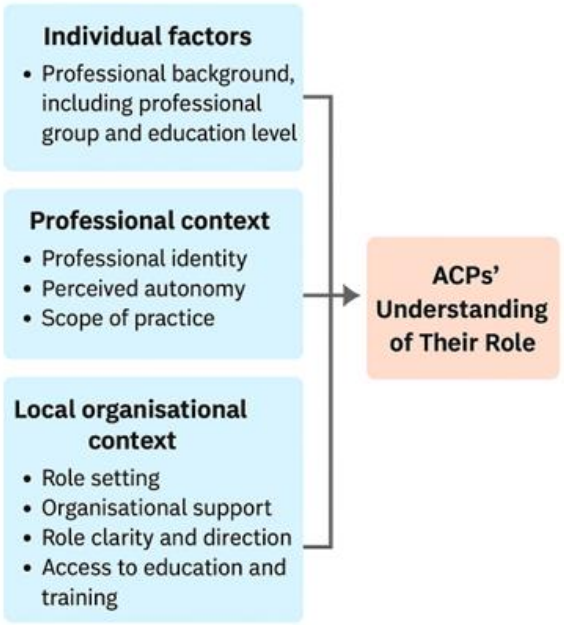

Figure 3.1: Conceptual Framework

3.4 Methods

3.4.1 Data collection Methods

Quantitative data allows objective determination of variables and a description of trends, attitudes and opinions and allows empirical evaluation of the question at hand (Creswell and Creswell, 2008). It enables statistical analysis to identify correlations, which is particularly relevant in the context of quality assurance and resource allocation within organisations (Macfarlane, 2019).

A cross-sectional survey was constructed within Microsoft Forms. This format is supported by the organisation, enables easy customisation and is compliant with local GDPR regulations (Jersey Legal Information Board, 2018). Surveys are well suited to descriptive non-experimental designs and are effective when wanting to

explore a standardised set of questions with objectivity (Bruce, Pope and Stanistreet, 2008). With a well-defined population, questions will have consistent meaning to respondents within the ACP population (Robson, 2016). Surveys are valid, reliable and easily replicated (Park, Konge and Artino, 2020) and provide categorical, ordinal and interval data.

Using a self-completed online survey enables fast turnaround in data collection providing practical advantages. Themes were developed from a previous study that explored roles of ACPs in England (Fothergill *et al*., 2022) and by adapting questions the Jersey context is suitably recognised. The survey was designed systematically with the conceptual framework in mind to include predominantly closed question answers that required participants to select the most appropriate answer from a list, and open-ended questions that required short free-text answers.

A limitation of quantitative data is that it can over-generalise findings and provide limited insight into individual experiences (Bowling, 2023). To mitigate this, the survey included an open-ended question to allow participant-led responses. However, considering the overall aim of the research question, quantitative data remains the most suitable approach for addressing the core focus.

3.4.2 Pilot Study

A pilot study was conducted in which four clinicians were invited to complete the survey. To preserve the target sample size, pilot participants included non-ACPs with relevant experience and ACPs outside Jersey.

Pilot participants were asked to provide feedback about the questionnaire completion process enabling assessment of question clarity and internal consistency (Creswell & Creswell, 2018). Feedback was used to inform final survey revisions such as interpretation issues and technical errors to enhance validity (Bowling, 2023). Feedback was received about time taken to complete the survey to enable generation of an estimated completion time for participants.

3.4.3. Data Management Strategy

While a robust data management plan (Appendix I) cannot ensure absolute confidentiality, it significantly enhances data protection and compliance with legal and institutional standards (Jersey Legal Information Board, 2018; GoJ, 2026). The UK Data Protection Act (2018) and the Data Protection (Jersey) Law 2018 requires that data be kept only for as long as necessary. Contextual details indirectly identifying participants were generalised or omitted. Personal data was stored securely, and findings were reported collectively rather than individually.

3.4.4 Data analysis methods

Describing variables and enabling pattern recognition helps understand the current state and summarises current occurrences, making it relevant for this study. It allows for description of findings as opposed to testing of a hypothesis or generalising to a larger population (Jones and Goldring, 2021). Alternative methods such as inferential statistics were discounted as the question does not require testing of a hypothesis or generalisation of findings to a wider population. Therefore, descriptive statistics was the most appropriate method to summarise data, identify patterns, and explore potential correlations between variables without implying causality.

For short-answer qualitative free-text responses, content analysis was used to categorise data and convert into frequencies (Pope and Mays, 2020). Content analysis is a systematic method for examining communication content and therefore an appropriate method of analysis for the open text responses. This approach allows structured interpretation of participants views, enabling identification of themes and patterns whilst maintaining reproducibility in the coding process (Krippendorf, 2019). An audit trail was maintained that documented coding decisions for quality assurance purposes.

3.4.5 Participants and Recruitment

Purposeful sampling enables selection of the most informative participants by ensuring recruitment is based on their relevance to the objectives, rather than through random selection (Stratton, 2024). ACPs in Jersey would not be adequately reached with random or convenience sampling. Although randomisation within the purposeful sampling target would reduce bias, due to limited availability of participants a non-random method of selection was used to optimise participant numbers and ensure inclusion of the entire professional group.

The ACP population may be difficult to identify as not all those working at advanced practice level hold a reflective job title and others work outside the predominant organisation (Robson, 2016). A large proportion of the clinical work force are employed by HCJ, but others work in organisations such as FNHC and private General Practice (GP) settings. To maximise sample size, snowball sampling was employed to help identify additional participants who meet the inclusion criteria but were not reached during initial recruitment. However, this approach was used with caution to avoid compromising validity. Being referred by another ACP does not guarantee suitability, but the assumption is that due to the nature of participating ACPs they will have a good understanding of the inclusion criteria.

Typical survey response rates vary depending on the survey type, population accessibility and research type. Wu, Zhao & Fils-Aime (2022) report that typical response rates for online surveys is 44.1% and this can be increased by ensuring a clearly defined and refined target. Other research suggests that survey response rates should ideally reach around 60% (Fincham, 2008) to 67% (Wilson *et al*., 2023) to enhance validity and reliability. Pre-contacting participants has shown increased engagement and response rates, but ethical caution must be considered for coercion. To optimise responses, a follow up email was sent to participants who had not responded after two weeks. Given the small pool of available participants in this study, achieving a high response rate is particularly important to ensure findings are representative and meaningful.

Invitations to participate in the study were sent out via email to those that met the inclusion criteria (Table 3.1).

Table 3.1: Inclusion and Exclusion criteria

Inclusion Criteria	**Exclusion Criteria**
• Age 18+ • Currently working in Jersey • ACP, ACP trainee or self-identifying as working at advanced practice level • Professionally registered (e.g. HCPC, NMC, GPs)	• Not currently practicing • Outside Jersey • Not registered • Not identified as working at AP level • Not self-identifying as working in an ACP role

To capture all potential participants, a process of participant identification was used (Table 3.2).

Table 3.2: Participant identification

Contacting department heads	Managers from each professional area were asked to identify staff meeting the criteria. This included: • Lead AHP of Adult Therapies • Chief of Primary Care • Chief Nurse • Lead Midwife • Chief Pharmacist • Operational lead of FNHC
Using data from a previous survey	A survey was conducted within HCJ (Holbrook, 2024) that intended to reach employees who were working at an advanced, consultant and specialist/enhanced clinical practice level in Jersey. The survey was sent out to all staff identified by Human Resources (HR) with these terms in their job titles. Within this, 17 staff were identified as either being employed as an ACP, trainee ACP, or self-identified as working at advanced practice level, who were then included in the target sample.
HR job title lists	In November 2025 the HR department provided an updated list of employees with "advanced" in their job title. The list was screened and 8 employees working at AP level were included.
Snowball sampling	To identify ACPs who may not be captured through other means, participants were invited to share the study information with colleagues who also meet the criteria. This method enables identification of individuals who work in different organisations or in roles where the ACP title is not consistently applied. Identification of ACPs from professional networks was also utilised.

3.5 Quality Assurance and Ethical issues

Although this project was an evaluation, upholding the principles of the research process optimises project quality. With consideration of the study's nature and associated ethical implications, integrity and credibility was upheld throughout the process. A risk assessment (Appendix II) and quality assurance checklist (Appendix III) were used to identify ethical and quality considerations.

The General Medical Council (GMC) (2022) identify five fundamental principles for ethical research: respect, protect, benefit, integrity and excellence. These guide the conduct of research and underpin the key ethical considerations within the evaluation. These considerations align with the four fundamental principles of ethics: beneficence, non-maleficence, autonomy and confidentiality (Ashcroft, 2007). These principles put the safety of the individual at the forefront of consideration (Varkey, 2021) and are upheld within the guidance provided by the NHS HRA (2025a). The principles of ethics are interwoven throughout the project design with many areas of overlap. Adherence to the Robert Gordon University (RGU) Research and Ethics Policy (RGU, 2014) and relevant ethical guidance (NHS HRA, 2025a; GMC, 2022) was ensured and RGU School Ethics review panel scientifically reviewed the project to ensure rigour and ethical soundness (Appendix IV).

3.5.1 Beneficence

The principle of beneficence promotes the best interests of the person, and ensures welfare and benefit are upheld. This study offers participants opportunity to reflect on their professional experiences, contribute to service improvement, and influence future governance and training pathways which will benefit patients, staff and the organisation. By sharing insights, participants help raise awareness of the ACP role and support its development within Jersey's healthcare system.

3.5.2 Non-maleficence

Non-maleficence is the duty to avoid harm and to prevent unnecessary risk. To uphold this, data was anonymised and not shared beyond the author and

academic supervisor (Jersey Legal Information Board, 2018). A risk assessment (Appendix II) identified data breaches as a potential risk, but a detailed data management strategy was employed for mitigation. Despite anonymity of results, absolute confidentiality could not be guaranteed within the context of a small jurisdiction allowing potential risk to the individual or the organisation, therefore, survey design allowed participants to skip questions or provide neutral responses. Results were aggregated for analysis, and findings were reported collectively.

It was considered that participants may experience emotional distress or anxiety from reflecting on workplace challenges, or in anticipation of repercussions if anonymity was compromised. Therefore, participants were provided with information to support wellbeing should this occur (Appendix V). Survey completion may impact staff productivity due to time demands; therefore, survey length was limited to minimise this.

An important aspect of non-maleficence is managing potential role conflict, particularly in relation to the dual position of the researcher as both a staff member with access to internal communications and as a Master's student conducting research. This issue was acknowledged in the risk assessment (Appendix II), and strategies to ensure transparency and obtaining appropriate permissions were applied.

Ethical frameworks (GMC, 2022; NHS HRA, 2025a) require consideration of vulnerability, even in professional cohorts. Although ACPs are not considered a vulnerable group ordinarily, hierarchical pressures and a small professional community may create contextual vulnerability therefore considerations for anonymity, voluntary participation and survey design have been carefully considered. As the project is being carried out independently, there will be no impact on employment or appraisal.

3.5.3 Autonomy

Autonomy in ethics refers to a person's right to make voluntary, informed decisions. To uphold autonomy and beneficence, participants were provided with a Participant Information Sheet (Appendix V) explaining the purpose of the study

and background context. Potential risks and benefits of participation were outlined to facilitate consideration of potential implications before consenting to participate. Participants were informed of their right to withdraw their data at any point prior to data analysis, as outlined in the information sheet. Consent was obtained before commencing the survey and participants could not proceed beyond the consent page without confirming they had read and agreed to the terms (Bowling, 2023).

Permission to access staff emails was granted by the HCJ Information Governance Manager. Additional considerations regarding organisational risk were made, particularly potential for reputational damage. To address this, a clear dissemination plan was employed to ensure findings are shared responsibly, with sensitivity to organisational context, and in collaboration with relevant stakeholders to maintain trust and uphold professional standards.

3.5.4 Justice

To ensure fairness and equity, a standardised recruitment and inclusion process was used to eliminate favouritism, convenience, and coercion, thereby upholding the principle of justice. The study includes all subgroups of ACPs, and all eligible participants were provided with the same information and opportunity to participate.

To avoid coercion, participants were only formally contacted twice in an initial email invitation and one follow-up email if the survey was not responded to within the two-week period. There were no financial incentives offered for this study.

The project was conducted with integrity, professionalism, and discretion within the workplace to ensure professional boundaries were maintained. While the study has potential to reveal disparities within the workforce, these insights were used constructively to inform improvements rather than cause individual detriment, thereby upholding fairness and equity in line with the principle of justice.

3.6 Conclusion

This chapter has outlined the project design using a cross-sectional survey of ACPs in Jersey. The following chapter will present the findings of the survey using descriptive statistics and content analysis to identify patterns in role experience.

Chapter 4: Findings

Data has been analysed using descriptive statistics and findings will be presented in this chapter.

4.1 Data Analysis Methods

An open-ended question gathering data on experiences was analysed using content analysis to ensure systematic, structured interpretation whilst maintaining reproducibility and reducing bias. This method was used to group similar comments together into categories and to seek meaning from the content (Krippendorf, 2019).

4.2 Demographical data

Data collection was via an online survey distributed to staff working in a variety of healthcare settings and organisations within Jersey. Purposeful sampling was used to include all who had self-identified or had been identified by their organisation as working at an AP level. From an identified population of 45 staff, 22 responses were received, giving a response rate of 49%. Respondents were from a range of professional groups and settings.

41% (n=9) of respondents were aged between 40 and 49 years, 27% (n=6) were aged between 30 and 39 years, 27% (n=6) were aged between 50 and 59 years and 5% (n=1) were aged between 20 and 29 years. 95% (n=21) of respondents were female and 5% (n=1) were male.

4.3 Professional Backgrounds

Most responses were from nurses (n=15, 68%) with physiotherapists being the next largest group (n=3, 14%). There was a single response from staff in pharmacy, radiography, occupational therapy and sonography, each representing 5% of responses.

Respondents reported on their highest level of qualification (Figure 4.1). The highest level was doctorate level (n=1), and this was achieved by a consultant

nurse. Responses indicated that 63% (n=17) had a full master's qualification either in ACP or another area or were due to complete a full master's qualification in the current year. Three respondents' (14%) highest level of qualification was a postgraduate diploma; however, it was unclear whether respondents were in the process of completing a master's degree or if diploma level was the final exit point. One participant in a consultant role reported their highest qualification as postgraduate diploma and justified not having a doctorate qualification as AP recognition had been achieved through a route other than formal credentialing.

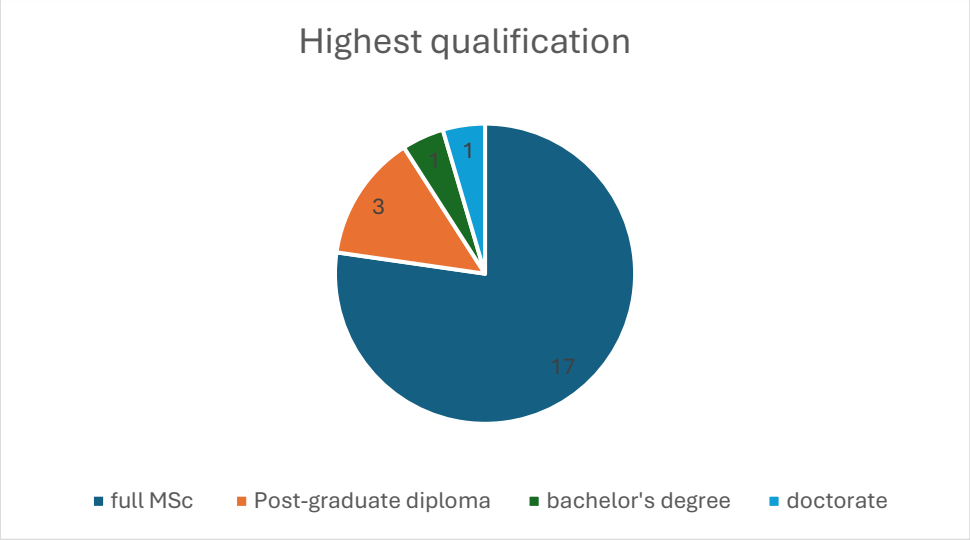

Figure 4.1: Highest level of qualification

Two respondents with a full master's degree identified as working as a trainee ACP. These respondents do not have an ACP job title and only one reported having a portfolio that mapped to the 4 pillars of practice. 13 nurses held a master's degree or higher, 8 of which (62%) were in ACP. 4 of the 7 AHPs held master's qualifications (57%) all of which were in other specialist areas.

Various areas of the health service were represented in the survey (Figure 4.2), with the largest area being secondary acute care (n=13, 57%). Two respondents selected "other" and this has been included within secondary non-acute care. One respondent worked in both primary care and inpatients. Overall, 23 areas of practice were represented.

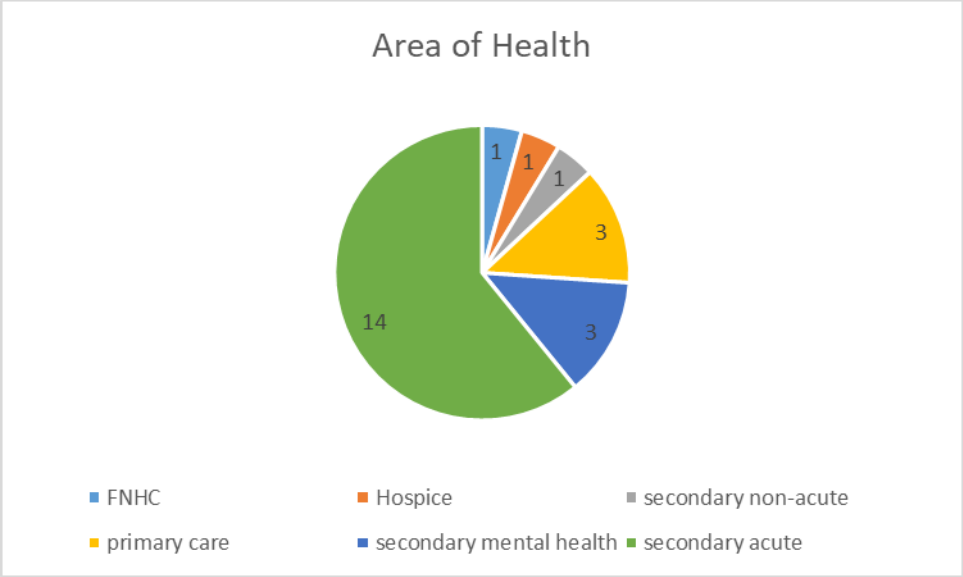

Figure 4.2: Area of health worked in

Professional background information was represented by respondents' clinical specialities (Table 4.1). Cardiology represented the largest clinical speciality (n=5) and palliative care/oncology being the next (n=3). All other specialities were represented by a single participant. The variety of areas was vast suggesting a broad sampling frame with cross-disciplinary representation.

Table 4.1: Respondents' clinical speciality

Cardiology	5
Palliative/oncology	3
Mental health	2
Musculoskeletal services	2
Paediatrics	1
Older people	1
Community	1
Diagnostics	1
Urology	1
Pain	1
Alcohol and drugs	1
Dermatology	1
Medical imaging	1
Obstetrics & gynae	1
Renal	1
Respiratory	1

Of the 5 respondents working in cardiology, all held a minimum of master's level qualification. However, only one had an ACP job title which highlights inconsistencies within roles.

4.4 Formal accreditation and level of practice

Before proceeding with the questionnaire, participants were asked to indicate whether they were currently working at an advanced practice level. Two respondents initially reported that they were not working at this level. However, subsequent responses contradicted this as in later questions, they reported themselves as working at an AP level. Similarly, another participant stated they do not work at an AP level yet declared they have formal ACP accreditation. Respondents were asked how they defined their level of practice and 64% (n=14) identified as working at an ACP level, 14% (n=3) identified as working at trainee ACP level, 14% (n=3) identified as working at consultant practitioner level and one working at Clinical Nurse Specialist (CNS) level which is considered enhanced level by the Royal College of Nursing (RCN, 2026a).

Survey results (Figure 4.3) indicate that that 59% (n=13) of respondents did not have any formal accreditation. Of the 4 respondents who had an ACP job title, only one had formal accreditation via the NHS from an accredited programme. The 7 respondents who had formal accreditation displayed varying degrees of ACP identity. One participant did identify as an ACP, two provided a neutral response, and the remaining 4 stated they identified as an ACP or strongly identified as an ACP. Five of the accredited respondents (70%) felt that the ACP title accurately represented their work. Whilst 3 respondents indicated that they had formal accreditation, it was unclear who provided this.

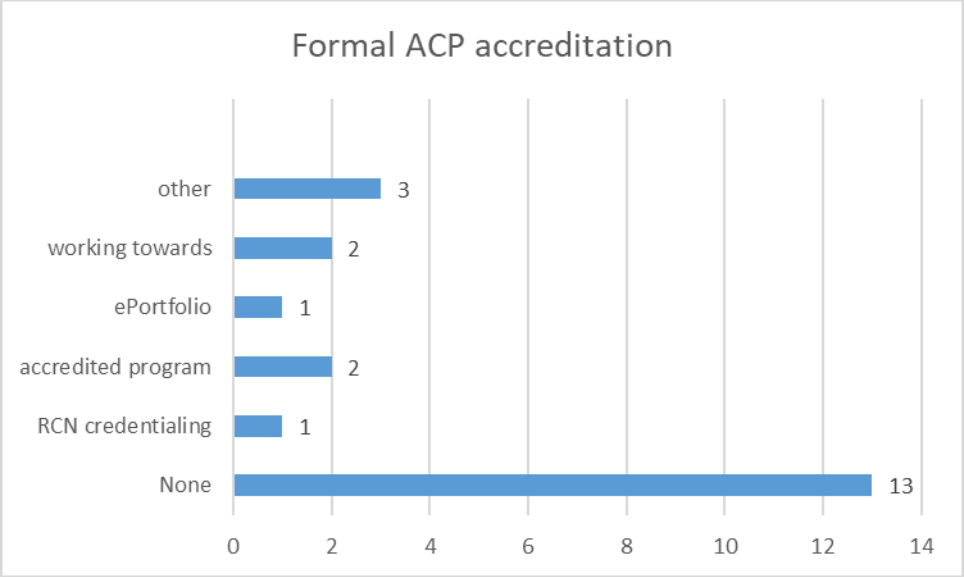

Figure 4.3: Formal accreditation

4.5 Job Titles

For some respondents, job title was key to understanding ACP. However, it is known that not all clinicians working at an advanced level of practice have a corresponding job title (Evans *et al*., 2021; Harris *et al*., 2021; Snaith *et al*., 2023). Of the 22 respondents, only 4 (18%) had an ACP job title, with a variety of other job titles described (Table 4.2). All ACP job titles included an indication of their speciality, for example "ACP in T&O", as did many of the non-ACP job titles. Several respondents identifying as working at advanced level held CNS job titles. CNS was the largest group (n=8) within which there was large variation of titles often including a speciality, for example "CNS in palliative care".

Table 4.2 Reported job titles

Clinical Nurse Specialist (CNS) - of varying specialities	8
Advanced Clinical Practitioner (ACP)	4
Staff Nurse	1
Senior Staff Nurse	1
Principal Physiotherapist	1
Mental Health Practitioner	1
Emergency Nurse Practitioner	1
Department manager	1
Consultant Radiographer	1
Consultant pharmacist	1
Consultant Nurse	1
Advanced Practice Sonographer	1
Advanced Physiotherapist	1

Of those who did not have an ACP job title, 82% (n=17) reported that they did not feel supported by the organisation to practice at an advanced level. The most common barrier to attaining an ACP job title (Figure 4.4) was considered the requirement for job re-evaluation (n=9, 25%) and lack of job opportunities (n=7, 19%). Other responses included reasons such as financial restraints, poor understanding of the role, frequent changes in management, lack of leadership and discrepancies with pay grades. When looking at professional group responses collectively, there seems to be no link between the background profession and the barriers to achieving ACP job title.

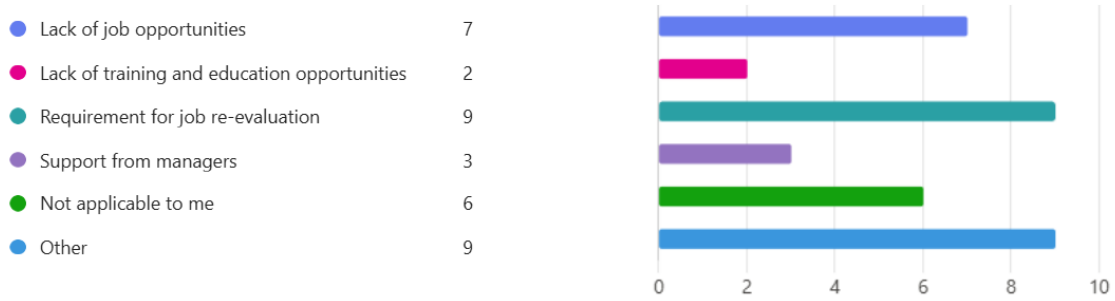

Figure 4.4: Perceived barriers to ACP job titles

4.6 Understanding of the pillars

Respondents could align their role more closely to the 'clinical practice' and 'leadership and management' pillars. They demonstrated good comprehension in these domains by only responding to statements with a positive or neutral response. Respondents felt confident to make autonomous clinical decisions (strongly agree = 63.6%, agree = 31.8%) and could clearly define their clinical scope of practice in their roles (strongly agree =45.5%, agree = 45.5%, neutral = 9.1%). They were asked to report what proportion of their time is spent on patient-facing activity. Responses ranged from 20-29% (n=1, 5%) to 90-100% (n=3, 14%) with the most frequent response being 70—79% (n=14, 32%) and 80-89% (n=14, 32%). Across all respondents, the average proportion of time spent on patient-facing activity was 75%. This good comprehension of the clinical pillar aligns with high proportion of time spent in the domain suggesting this is a priority for participants.

Similar responses were observed in the 'leadership and management' domain with all respondents feeling confident leading teams or influencing change (strongly agree = 45.5%, agree = 45.5%, neutral = 9.1%). Respondents reported active contribution to service development and quality improvement (strongly agree=54.5%, agree = 40.9%, neutral = 4.5%).

In relation to the education pillar, one respondent did not feel that teaching and support of others was recognised as part of their role. However, this participant reported a significantly higher proportion of time spent delivering training to others (70-79%) than all other respondents suggesting a discrepancy between their activity and their role expectations. One participant responded neutrally with regards to teaching and support recognition within their role, and all other responses were in strong agreement (50%) and agreement (40.9%). Almost all respondents (90%) felt confident to deliver education to colleagues or students. Two respondents gave neutral responses (9%); both are from those with ACP job titles from whom one would anticipate familiarity of this within their role. Time spent delivering training appeared to occupy a proportion of hours that complemented the average time not spent on patient-facing activity. The most

frequent reported time spent delivering training was 10-19% (n=8, 36%), the highest amount being 80-89% (n=1, 5%) and the lowest amount being none.

Although the research pillar received overall positive responses, it appeared to be the most variable when compared with other pillars. Two respondents reported not being involved in any audit, research, or evaluation activities (9.1%) despite later stipulating that this was included in their job description. This implies misalignment between job description and activity and the inability to evidence they are working at an AP level. Two respondents gave neutral responses (9.1%); other respondents indicated involvement as strongly agree (50%) and agree (31.8%). A similar distribution of positive responses was observed when asked about understanding of roles in relation to research activities with all those engaging in research also reporting understanding (n=7, 31%) or strongly understanding (n=14, 66%) of how research and evidence underpin clinical decision making.

A range of research related activities were identified (Figure 4.5). The most common-activity was quality improvement (n=19, 28%) followed by audit (n=18, 26%) and service evaluation (n=15, 22%).

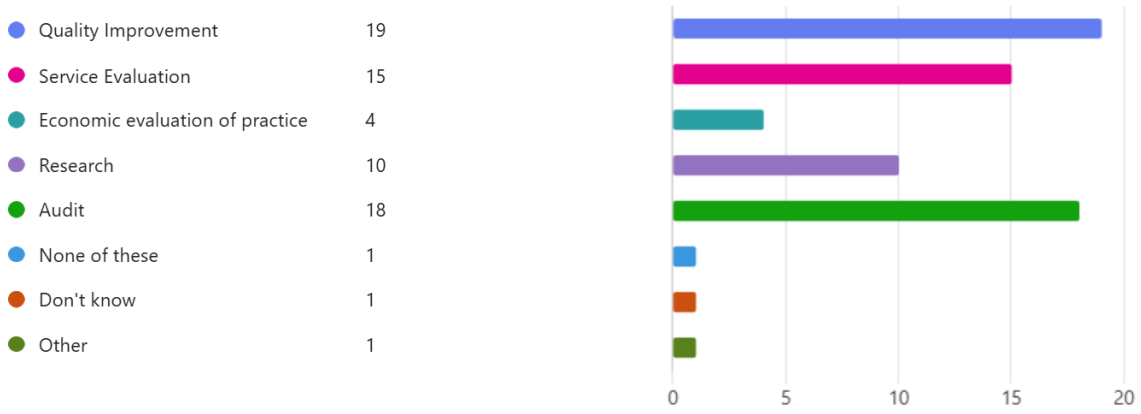

Figure 4.5: Areas of research involvement

One participant stated they were unable to engage in research activity due to staff shortages, and another stated they did not understand how research underpins clinical decision making. These responses show poor understanding and lack of

evidence of this pillar within their roles, meaning that they are not working at an advanced practice level, despite self-identifying as so.

When evaluating role clarity and professional identity, results were evenly distributed with responses ranging from strongly agree to strongly disagreeing with reflective statements about the role. Role definition within the organisation, colleague understanding, self-identification with the role and role differentiation, demonstrated a range of responses (Figure 4.6). However, most respondents felt that the ACP title was an accurate reflection of their roles.

Figure 4.6: Role clarity and professional identity

4.7 Governance

In exploring respondents' understanding of the governance structures for ACPs in Jersey, they were asked about their understanding of the multi-professional framework for advanced practice (NHS England, 2025). Most respondents reported a "fair amount" of knowledge of the framework (n=12, 55%) with a further 27% (n=6) having a "great deal" of knowledge. One participant had heard of it but did not know anything about it, and another had never heard of it. When asked specifically about the multi-professional framework for Jersey (GoJ, 2021) there was a 50% split between those who knew where to access the framework, and those who did not.

In relation to governance structures for ACPs in Jersey, 64% (n=14) said that they were not aware of the governance structure and 32% (n=7) stated that there was not one. One participant indicated that they were aware of the

governance structure in Jersey which was an unexpected finding as although there is a local multi-professional framework (GoJ, 2021) there is currently no local policy or governance structure in place. Only 30% (n=8) of respondents were aware that there was a Practice Lead for AP, responsible for implementing the governance structure. These findings demonstrate a lack of insight and understanding of the governance and organisational structure of AP in Jersey.

When exploring supervision and organisational support, respondents believed there was no governance structure and did not feel enabled by organisational policy to practice at an AP level (49%). 81% (n=17) of respondents report no provision of formal guidance structure for supervision. Likewise, multiple respondents described limited CPD opportunities and only one participant was involved in professional discussion forums. Those that report having formal guidance receive this mostly from their professional or clinical leads, with one participant, an occupational therapist, receiving formal supervision from an-off island professional due to lack of appropriate supervision being available in Jersey. Survey responses create some confusion about supervision as other parts of the survey indicated that respondents received adequate supervision or support when needed (40.9% strongly agree, 40.9% agree). However, this does not appear to link with any specific professional group or title. It also does not fit with the frequency of supervision, which varied greatly (Figure 4.7).

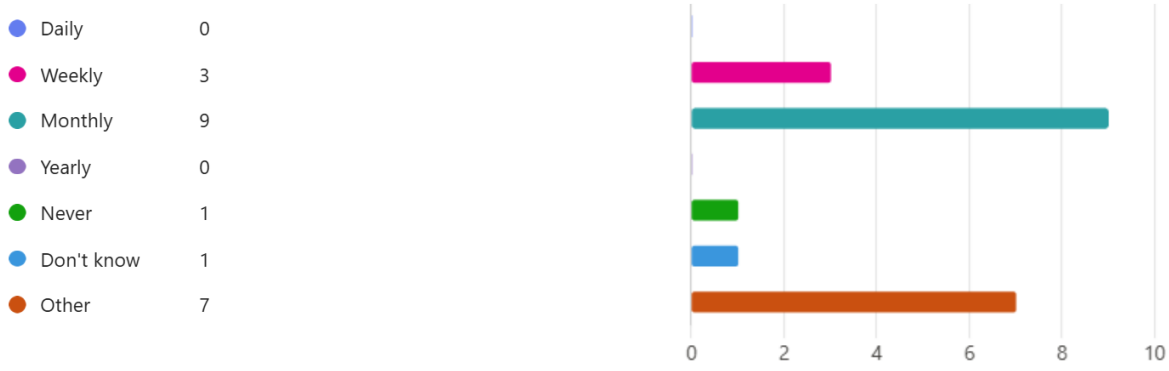

Figure 4.7: Frequency of supervision

4.8 Experience of the ACP role

Content Analysis identified five main categories from 15 respondents (68%) sharing their experience of working at advanced practice level (Table 4.3). Categories were professional development, support, governance, and organisational factors. Whilst many staff highlighted positive experiences, these appeared to be in the context of their own team. Responses highlighted areas requiring further development and common challenges experienced by respondents and categories that emerged were supported by the findings from the quantitative elements of the survey, which highlighted shortfalls within the same these areas.

4.9 Conclusion

This chapter has presented the findings and analysed the data gathered from the survey. The findings have provided insight into the experiences of ACPs in Jersey in relation to the 4 pillars of practice. Key factors that influence implementation and understanding have been identified and explored. In the next chapter, findings will be discussed in relation to the wider literature.

Table 4.3 Categories from open-ended question

Category Name	Description	Frequency	Example quotations
Professional development and support	Although several ACPs felt supported and accepted by their peers, many noted that this had taken a long time to establish and this did not appear generalisable to the wider ACP population. Many respondents described a lack of formal supervision and support systems. Professional development is described as self-directed with no structured approach or direction from the organisation. One participant shared that they had requested opportunities to attend professional meetings and conferences, but these requests were not acted upon.	8	”not receiving supervision or support for this role” “informal and unstructured” “There needs to be a more formal structured approach and direction” “great support within my department… in particular my manager” “I feel very well supported on the day-to-day clinical work” “no CPD, conference or professional meetings despite the need and requests”
Governance and role development	Recurring concerns relate to inconsistent or absent governance. Several staff express desire for a structed approach to reduce variability and to bring the AP workforce together with formal direction. Concerns regarding portfolio management were highlighted, with some ACPs suggesting that portfolios should be routinely reviewed and formally requested to ensure practitioners are consistently meeting the required standards of practice. Those who mentioned the portfolio process appeared supportive of its use. A widespread perception of insufficient role development within the organisation was evident. Emotional investment	7	“hoping this role will materialise in the future” “I am frustrated about the lack of development” “I am concerned about the governance around our roles. No-one has asked us to complete a portfolio, or prove that we are working at advanced practice level” “I am frustrated about the lack of development in all of these areas”

	in the role was demonstrated with feelings of frustration with delays in role progression and leadership.		"Working at an advanced level in Jersey is highly challenging" "frustrating at every level on a daily basis."
Understanding and acceptance of the role	Some respondents felt the role was not fully understood by colleagues and not recognised by the organisation. Fair pay and job title appropriateness were reported as variable and unacknowledged. Many clinicians felt the work they do at an AP level is not recognised, with allegations of hospital managers evading formal recognition of clinicians working at AP level to avoid having to pay them accordingly. Several staff reported feeling poorly understood and undervalued within the organisation. One staff member felt challenged by poor understanding of the role by patients, as well as medical colleagues.	6	"I feel the role is poorly understood and undervalued in my organisation" "[there is a] requirement for practitioners to practice at an ACP level, however this has not been recognised by the organisation" "It took a long time to accepted as an advanced practitioner" "It is disappointing to have worked so hard in my career and for it not to be recognised"
Organisational factors	Lack of recognition and understanding appears to be linked to several organisational issues. Limited job availability and ongoing staffing shortages were described as barriers to the development of ACP roles. Respondents also expressed frustration that, despite holding the appropriate qualifications, they did not feel recognised or supported to progress into ACP positions. Multiple development needs at an organisational level are identified, including the need for clearer supervision and governance guidelines, more structured opportunities for development beyond individual clinical specialties, and improved	4	"lack of structure around the ACP roles within the organisation" "staff shortages - not allowing time for teaching or research" "I do not 100% feel supported from the management team and wider organisation to progress me into a role" "The ACP role to date has been driven by those working at that level who fought for years for role review, fair pay and change in job description"

	organisational recognition and understanding of advanced practice.		
Positive feedback	Some respondents feel valued and accepted, but this appears to be on a more team-based level and in isolated cases.	2	"Today we are well accepted as part of the team" "I have had great support within my department to develop and maintain my advanced practice… my manager has been very supportive and has a clear understanding of the value advanced practice can add"

Chapter 5: Discussion Chapter

This chapter will discuss the significance of findings in relation to the project question. Implications for practice will be considered and limitations discussed.

5.1 Interpretation of findings

5.1.1 Job titles and role definition

Despite respondents self-reporting as working at an advanced practice level, not all had corresponding job titles. Some participants were able to demonstrate advanced level practice but were not recruited into roles with an ACP title, questioning whether there is an organisational need for practice at this level. A job title is not a requirement of working at advanced level. Advanced practice is recognised as a level and not necessarily limited to a job title one is employed into; however, practitioners have to meet all of the advanced practice capabilities.

Job titles are important for providing understanding and transparency for patients and staff (Gallacher, 2024). Although a job title is suggestive of knowledge and skill, it does not provide role definition. For example, "Clinical Nurse Specialist" and "Advanced Physiotherapist" infer different experience and qualifications, but this does not necessarily transpire to role performance. Job title variability has been found elsewhere (Fothergill *et al*., 2022; Evans *et al*., 2021; Harris *et al*., 2020) with findings highlighting inconsistencies in recognition and scope of the role (Snaith *et al*., 2023). It is possible for staff to be working at the same level of practice, despite different job titles. Respondents claimed that job re-evaluation and limited job opportunities as the biggest barriers to achieving an ACP job title. The multi-professional framework (NHS England, 2025) recognises that practitioners can achieve working at an advanced level of practice regardless of job title and this was demonstrated by respondents who were not currently employed in ACP roles

but self-identified as working at advanced practice level and had achieved formal ACP accreditation.

Whilst the multiprofessional framework (NHS England, 2025) outlines the capabilities for advanced practice, roles differ according to the speciality or organisational context. Common themes exist, but defining the role of an ACP therefore will be largely individual. To learn now ACPs understand their roles, respondents were asked to identify characteristics including area of speciality, level of practice, job description and capabilities. Some ACP roles will be more easily defined than others, such as those that have specific competencies outlined by independent organisations such as the RCN (2026b), the MACP which offers accreditation for musculoskeletal physiotherapists, and the Royal College of Emergency Medicine who provide credentialling for Advanced Critical Care (Denton *et al*, 2023). Noblet *et al*. (2025) outlined a framework for levels of practice within physiotherapy to provide clarity across jurisdictions and this should be considered within workforce and service planning. Although Noblet *et al*.'s (2025) study is specific to physiotherapy, similar overarching guidance is provided by the NHS regarding the continuum of advancing practice and how this is defined (HEE, 2022). Such guidance is a valuable resource for integration into local governance.

5.1.2 Understanding and engagement with the 4 pillars of practice

Most respondents were familiar with the framework (NHS England, 2025) but few had awareness of the Jersey framework (GoJ, 2021). If respondents are not aware of the existence of guidance, then conclusions cannot be made about their understanding of it. However, as practice frameworks inform quality assurance (Klein, Seelbach and Brannan, 2023) this adds to the argument that understanding is lacking and there are gaps within local governance. The continuum of advancing practice spans enhanced, advanced and consultant levels, with each mapping to the 4 pillars (NHS England, 2025).

It is a requirement of advanced practice to meet all advanced practice capabilities across the 4 pillars, therefore understanding of this is vital.

Respondents tended to focus on the clinical pillar, and it came across as the most understood. They attributed the largest proportion of their time to clinical, and this finding is synonymous with literature on the wider ACP workforce (Lavery, Morell-Scott and Flewitt, 2025; Fothergill *et al*., 2022; Evans *et al*., 2021). The ACP role in Jersey is relatively new compared to other jurisdictions. Practitioners transitioning into ACP roles from enhanced roles where the clinical pillar is prominent, explains why respondents have more focus on the clinical pillar. The clinical pillar is often favoured during practitioners' earlier stages of their career (Lavery, Morell-Scott and Flewitt, 2025) and as practitioners progress through the continuum of advancing practice, emphasis of all the pillars is necessary. Some respondents reported spending 90-100% of their time on patient-facing activity, leaving no time for the other pillars, making it impossible for them to be working at an advanced practice level.

ACPs in Jersey demonstrated poorer understanding of the research pillar as found elsewhere (Cooper and Lidster, 2021; Fothergill *et al*., 2022; Lawler, Maclaine and Leary, 2020; Snaith *et al*., 2023). While they may not be engaging with 'doing' research, they are engaged with quality improvement, such as service evaluation and clinical audit. Although these are not research, they are built on a foundation of research and are underpinned by research principles (NHS HRA 2025a). However, respondents appeared to make these links to the capabilities within the research pillar. Respondents who did not engage in any research activity reported a lack of understanding of how research and evidence underpin clinical decision-making, inferring a poor understanding of advanced practice. Practitioners cannot claim to work at an advanced practice level if they do not understand the capabilities and are not able to map their practice to them.

Although respondents stated a strong ability to clearly define their scope of practice, this is questionable due to how they demonstrated understanding of the 4 pillars. If respondents are failing to understand and map to all 4 pillars, it is difficult to justify that they are working at this level. Understanding of managers is equally important. If those recruiting ACPs do not understand the capabilities, then it is difficult to see how their vision for service development does or does not include ACPs. Practitioners will not be able to understand and fully implement the role if those in managerial positions lack insight.

5.1.3 Governance structures

Respondents demonstrated poor understanding of governance structures and awareness of organisational leadership and policy, with many not being aware that an island Practice Lead for Advanced Practice is in position. Although this does not directly infer an absence of measures, it suggests knowledge needs improving. Clinical governance is comprised of many components and there are various ways in which it may be approached. It is possible that some governance systems relevant to ACPs are integrated within other hierarchical systems of the organisation, for example incident reporting or audit forums. Whilst these systems may not be identified as ACP-specific, ACPs interact with them and there is an expected level of autonomy. Specific governance capabilities are outlined in the multiprofessional framework (NHS England, 2025) therefore those working at an advanced practice level have responsibility to ensure sound governance is upheld. Although employers are responsible for overall governance, ACPs must engage with processes that exist, but findings suggest that ACPs are not aware of what these are.

Supervision, CPD opportunities and professional forums are considered key components of sound clinical governance (Macfarlane, 2019) and findings are inconsistent within the local ACP population with links made to unclear accountability and leadership. The desire for clearer guidance on role development and recognition of advanced practice is common in the wider

literature (Lawler, Maclaine and Leary, 2020; Rath *et al*., 2020; Evans at al., 2021; Fothergill *et al*., 2022; Drennan *et al*., 2022; Oliverira *et al*., 2022; Snaith *et al*., 2023; Tawiah *et al*., 2024) and supports the need for improved governance and structure. Fothergill *et al*. (2022) report that governance structures are of high importance for ACP development and their integration into organisational structure, therefore this must be integrated locally. Although the multi-professional framework (NHS England, 2025) provides definition for advanced practice, due to unique healthcare systems and independent government, Jersey must establish its own policies and procedures, in alignment with national recommendations and international professional competencies. Absence of an islandwide development plan for advanced practice does little to instil confidence on organisational buy in for its support. This absence further supports a case for prioritisation of organisational policy and improving staff awareness, which has been evidenced to influence workforce recruitment and retention (Alkan, Cushen-Brewster and Anyanwu, 2024).

Regulation of advanced practice is an ongoing debate and currently relies on local governance. Formal regulation of advanced level nursing practice has been agreed in principle by the NMC but is currently on hold whilst regulatory reform is planned (RCN, 2026c). Other professions currently do not formally regulate ACPs but speciality credentialling is possible through organisations such as the MACP or Royal College of Emergency Medicine. The Centre for Advancing Practice offers an accreditation process via programme or ePortfolio accreditation (NHS, 2026), but this is not mandatory for those working in advanced practice. Whilst not all respondents indicated that they had accreditation, they expressed a desire for formal recognition. In the absence of local governance structures, independent accreditation may be reassuring to confirm achievement of advanced practice level and guide those within roles. However, without local organisational and governance support, respondents wishing to achieve formal accreditation are faced with significant barriers.

While a masters' programme is delivered on island it is 'advancing practice' rather than 'advanced practice' and it is not accredited. The ePortfolio route is not available to those employed outside of the NHS. Accreditation via specialist routes has been described as challenging for staff due to lack of support and guidance, and poor senior insight and understanding into alternative routes from mentors. Elements of advanced practice, such as Independent Prescribing is regulated, and practitioners with this authority must be registered with the HCPC and JCC to legally do so. However, being an independent prescriber does not make you an ACP. With Jersey being an independent government, it is possible that a statutory register for those working at an advanced level of practice could be implemented locally, and this needs to be considered from an island-wide government perspective.

5.1.4 Challenges within the ACP role

Challenges included professional development and support, governance, understanding and acceptance of the role and organisational factors, all of which are acknowledged in current literature (Lawler, Maclaine and Leary, 2020; Brimblecombe and Nolan, 2021; Evans *at al*., 2021; Drennan *et al*., 2022; Lawlor and Leech, 2024; Lavery, Morrell-Scott and Flewitt, 2025) However, the degree to which these factors impact the workforce in Jersey does not align to findings elsewhere as the ACP experience in Jersey is different. Challenges from patients and medical colleagues were reported and if the role is to be fully embedded in Jersey, while institutional and cultural resistance is still experienced, one cannot expect the public to be able to embrace this either. This is a major barrier to successful implementation of the role as clinical outcomes are hugely influenced by patient-satisfaction and confidence in clinicians (Nuffield Trust, 2025, West and Dawson, 2012).

Staff shortages and time pressures restricting research and teaching were reported. Although some respondents were able to map their capabilities to these areas, for those without an ACP job title it may be that protected time

for research and teaching was not required for the role into which they are employed. Encroachment of non-clinical responsibilities was evident across the population which negatively impacts ACPs by diluting their ACP identity and preventing them from fulfilling their scope of practice. This suggests that these roles not truly aligned with the definition of advanced practice and that responsibilities across all 4 pillars not prioritised within them.

Other barriers and challenges such as opportunities for job re-evaluation and career progression have been raised within the context of the organisation, and although local policy has recognised the need for service re-design and modernisation (GoJ, 2025a; GoJ, 2025b; GoJ, 2026), it appears that this is yet to be translated into current practice.

5.1.5 Supervision and Education

Due to an absence of a supervision policy, there are discrepancies between what is expected from those in ACP roles and what is offered. Independent Prescribing, a key element of the advanced practice role, requires supervision (Royal Pharmaceutical Society, 2021) but there is no governance to support this. Despite this, respondents felt supported within their own teams, if not the wider organisation. This could indicate that on the interface between patients and clinicians where there is an established line of responsibility, often with a medical consultant, support from colleagues does exist. However, there are concerns about lack of training and formal support particularly evident in specialist areas where there may be only one ACP or within a professional group that is relatively new to advanced practice. Self-sought initiatives such as off-island supervision and self-directed learning are in evidence. With a large range of clinical specialities represented under the advanced practice umbrella, and a large variance of educational backgrounds, the need for a collaborative approach, cohesive support structures and oversight is essential to ensure standardisation and quality assurance.

Although a portfolio is not mandatory within the multiprofessional framework for advanced practice (NHS England, 2025) as a standard of good practice it would serve as a method to help identify learning gaps and inform education. Several respondents reported maintaining a portfolio that mapped their practice to the 4 pillars, using this to inform appraisals and as a form of self-directed learning. By providing evidence of learning needs the requirement for educational opportunities, both formal and informal, can be recognised and acted upon.

5.2 Interpretations and Key Contributions

Having discussed and interpreted the key findings, several topics have emerged that inform how ACPs understand and experience their role. There are varying levels of understanding of the ACP role in Jersey with some practitioners self-identifying as ACPs who do not demonstrate working at this level, with evidence to suggest this is due to poor understanding of the requirements of advanced level practice and what this truly means. Some practitioners are claiming to work as ACPs but do not understand it's true meaning. There are also practitioners who can demonstrate working at an advanced level of practice but do not have appropriate job titles or roles to reflect this. There is a mismatch between understanding of advanced practice from clinicians and managers, what is expected of practitioners and what they are being employed to do. Inappropriate role utilisation, poor understanding and appreciation of advanced level practice within the organisation is attributing to this. If managers do not understand advanced practice, then successful workforce planning and appropriate recruitment is impossible.

5.3 Limitations

A limitation of this service evaluation is the small sample size. However, in an island with a small population the sample size will be finite. It is well known that the identification of ACPs is challenging due to inconsistencies in

governance and regulation, the involvement of different healthcare organisations in Jersey and variations in job titles (Evans *at al*., 2021; Fothergill *et al*., 2022). While the 49% response rate to the survey is encouraging, the overall survey population was small. Therefore, the results can provide a useful overview of responses, but it is acknowledged that these have been interpreted with caution. It is recognised that potential participants may have declined to respond to the survey as they did not feel they met the inclusion criteria, thus providing some justification for the non-responders. Future studies may accomplish better engagement as the understanding and embedding of the local ACP population improves. As there are no records of ACP posts and postholders across healthcare providers in Jersey, previous databases, word of mouth and self-identification were used to identify participants, which was a limitation of the sampling strategy. It is possible that not all those working at an advanced practice level may have been reached or those who were included did not fully understand the expectations of advanced level practice.

A limitation of purposeful sampling is researcher bias and over interpretation of results (Stratton, 2024). This was mitigated by adopting transparency throughout the process. Influences and conflicts were discussed with the project supervisor and background information was provided within the participant information sheet (Appendix V). Descriptive statistics were used to minimise bias, but use of this alone may limit interpretation as it shows what respondents choose, but not why. Oversimplification of complex issues using quantitative information can lead to limited insight into the individual's experience, as motivations and feelings are not explained (Bowling, 2023).

A revised order of questions may have clarified understanding, as some responses seemed conflicting. For example, respondents were asked if they were involved in any audit, evaluation or research activity and two respondents either disagreed or strongly disagreed. However, in a later question, the same respondents indicated they were involved in all three.

Discrepancies may not have occurred, and interpretation may have been improved had the questions relating to research been asked consecutively. Revised wording could have improved consistency, for example, using the same wording when referring to the different multi-professional frameworks (NHS England, 2025; GoJ, 2021) would have enabled fairer comparison of understanding. These flaws were not detected by the pilot study therefore a larger pilot cohort with advanced practice understanding should be considered for future studies.

5.4 Implications for Practice

Understanding how ACPs consider and experience their role has highlighted clear trends and commonalities. There is variable understanding of the role in relation to the 4 pillars, which is the essence of advanced practice. There is good awareness of the existence of the multi-professional framework (NHS England, 2025) but this is not adequate, it must be understood and implemented. Alignment with specific ACP capabilities has not yet fully translated into the local ACP population.

Discrepancies in understanding of the 4 pillars raises concerns about how respondents regard their role and if they are meeting all the capabilities of advanced practice. Not all respondents were able to demonstrate understanding or engagement with the education or research pillars, which raises question about whether respondents fully understand that this is a requirement for advanced practice, or whether they are just not fulfilling these roles entirely. The variable engagement with the 4 pillars may also be due to role clarification. Although respondents may identify themselves as working at an advanced practice level, if the organisation does not require them to do this, there may not be scope for this to be feasible within their role. If their role does not require them to work across the 4 pillars, then their role should not be considered as ACP.

Although advanced practice does not require a specific job title, this undoubtedly contributes to the understanding of the healthcare community as to the expectations of practitioners within these roles. Very few respondents hold an ACP job title, which may influence how these roles are implemented. Without a specific ACP job title, practitioners may find it harder to justify their position and access the support systems necessary. It may also explain why inconsistencies are observed in mapping to the 4 pillars, professional development opportunities and governance. An organisational approach to understanding advanced practice, irrespective of job title will help reconcile these difficulties.

It is unclear who is ensuring that those in ACP roles, and those claiming to work at that level, are meeting the national standard requirements. Additionally, it must be ensured that posts with an ACP title have an actual role requirement for working at that level. There are voids in organisational understanding of advanced practice and to standardise the level of practice, this should be considered in the context of quality assurance and governance. An agreed process is needed for ensuring a level of practice is upheld, and without this in place, how ACPs experience their roles will continue to be inconsistent. Streamlining of governance processes is essential, but whether a formal validation or accreditation process is adopted to truly validate those working at advanced practice level needs to be considered by the organisation. Once a unified approach is agreed, the organisation will be better enabled to support advanced practice in alignment with national guidance.

Lack of support and supervision and poor governance awareness was a recurring and salient finding reflecting a significant gap within the roles of ACPs. Provisions must be made to improve organisational factors and governance to have a direct impact on the effectiveness and value of ACPs. Within the context of the organisation, factors such as role title and recognition, structured support and supervision and understanding of governance procedures is poor. Although this does appear to be the consensus

across the ACP population, representatives from organisations outside of HCJ may not have been adequately represented in the survey, and further exploration of the differences between various organisations may establish understanding of variances.

How ACPs understand their role is multicomponent. To enhance this, all aspects including governance, understanding of the multiprofessional framework and role requirements, must be aligned for role optimisation.

5.5 Conclusion

Having discussed the interpreted findings in relation to the literature, the project question has been addressed. The next chapter will conclude the dissertation with a summary of findings and recommendations.

Chapter 6: Conclusion and Recommendations

This chapter will conclude the service evaluation by summarising the findings and making recommendations for future practice and research.

6.1 Summary of key findings

Service evaluation using a cross-sectional survey design has enabled a baseline understanding of the professional and educational backgrounds of practitioners in Jersey to be established; associations with job title and scope of practice have been mapped. Whilst some participants have clear understanding of the role, others despite self-identifying as working at an advanced practice level, could only demonstrate partial understanding.

The clinical pillar appears to be the most understood and applied within roles and was most frequently identified as integral to ACPs. There appeared to be more ambiguity and struggle to identify with the education and research elements of their role. Given the requirement for ACPs to map to all four pillars, these findings are suggestive of respondents not fully understanding or working at an advanced practice level.

Overall, governance structures were unclear. Participants indicated poor understanding of local governance and highlighted gaps in organisational structures, which may be contributing to inconsistency across roles. Wide variation in supervision, job titles and role recognition was demonstrated. Some participants reported working within a supportive team with good recognition of their role. However, the concerns and frustrations highlighted by others appear to outweigh positive experiences with many concerns regarding lack of formal support and leadership.

Findings from this Service Evaluation will help inform workforce development and policy to facilitate the optimisation of ACPs in Jersey and recommendations have been proposed.

6.2 Recommendations

Recommendations have been categorised at organisational level, service level and general:

6.2.1 Organisational recommendations

1. Development and implementation of local ACP policy and structure. This should be underpinned by clear accountability and responsibility frameworks.
2. Provide support for practitioners to achieve formal ACP accreditation.
3. Organisational review of job titles and job re-evaluation to ensure alignment with national definitions and to ensure consistency across the range of healthcare organisations and professions within Jersey.
4. Implementation of regular, island-wide advanced practice forums to include staff from island healthcare organisations. This will support a platform for sharing of knowledge, learning experiences and peer support, and to ensure widespread joined-up governance.
5. Develop and implement of a centralised approach for optimal monitoring of ongoing competency and clinical safety. This will ensure ACP requirements are met and improve role understanding.
6. Provide support for managers and practitioners to understand the concept of advanced practice, how practitioners map to the framework, and how this links with roles and responsibilities within their areas.
7. Explore discrepancies between the perspectives of clinicians and managers about advanced practice to understand the barriers that have not been fully examined in this evaluation.

6.2.2 Service level recommendations:

1. Develop a standardised support structure for those working in AP. This may include clinical supervision arrangements that support workplace training with clear identification of competency assessment systems.
2. Identify mentors and staff with appropriate experience and qualifications to guide development of trainee ACPs and facilitate ACP role progression.
3. Establish relationships with specialist off-island centres or mentors in specific clinical specialities to support ACPs in Jersey working in relative isolation.
4. Utilise existing local sharing and learning events as a platform for increasing the profile and understanding of AP.
5. Implement practices to support the development of the research and education pillars. This may include seeking out opportunities to collaborate with UK organisations that have already well-established practices in these areas, engaging local consultants to facilitate research, and exploring the provision of on-island training/educational opportunities.

6.2.3 General recommendations

This Service Evaluation provides a springboard for research in this area to further understand the roles of those in relation to advanced practice. Following the actioning of recommendations, re-evaluation of ACPs in future will further enhance the understanding of advanced practice in Jersey and identify the trajectory of change and reform within healthcare.

6.3 Conclusion

As a small jurisdiction with relative freedom from the restraints of large NHS structures and financial burdens, Jersey is well-positioned to implement healthcare workforce reforms. There is a growing body of ACP roles across the island where the role is understood and there is departmental infrastructure to support this. However, governance underpins the essence of quality and safety (Macfarlane, 2019) and this Service Evaluation has identified the priority that needs to be given to this implementing this. A governance structure can positively influence role understanding, standardisation, and professional development, all vital to the success of the ACP role in Jersey.

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Appendices

Appendix I: Data Management Strategy

All identifying information (e.g. names, role, work locations) will be removed to ensure anonymity. Contextual details that might indirectly identify participants (e.g. work specific location, profession) will be generalised or omitted. Any personal data that is used to identify and contact participants will be stored in a password-protected file. No personal data will be shared, and findings will be reported collectively and not on an individual basis.

Data will be retained in accordance with Jersey law which requires that data be kept only for as long as necessary, in line with the UK Data Protection Act (2018) and the Data Protection (Jersey) Law 2018. For the purposes of this study, data will be retained for 10 years following its use, typically after the completion of the dissertation. Survey data will be deleted within 24 hours of the data being transferred to the password-protected file. Only the securely stored version on the password-protected computer will be retained for research purposes, in accordance with the approved data retention and destruction schedule.

Data for storage will be kept in the password protected file with a deletion date on it. After the retention period, all data will be securely destroyed: digital data will be permanently deleted. The study will also follow RGU's Research Data Management Policy (2021). If the project lead leaves HCJ before the deletion date, in accordance with the Government of Jersey Code of Practice, this will be communicated to the HCJ information governance lead, and it is the project lead's responsibility to delegate the deletion. In the case of student research this will be to my academic supervisor. If my academic supervisor leaves, they are responsible for ensuring the delegation of the deletion process to the information governance lead.

Appendix II: Risk Assessment Table

Risk	Likelihood	Impact	Mitigation Strategy
Data breach or loss of confidentiality	Medium	Major	Use encrypted, password-protected files; anonymise survey responses; restrict access to data to researcher and supervisor only.
Participant identification due to small sample size	Medium	Moderate	Aggregate data in reporting; avoid publishing identifiable job titles or departments; allow neutral response options.
Emotional distress from reflecting on workplace challenges	Low	Moderate	Provide contact details for wellbeing support (e.g. Speak Up Guardian, Wellbeing Team); allow participants to skip questions or withdraw.
Perceived career impact or social repercussions	Low	Moderate	Ensure anonymity; clarify in the Participant Information Sheet that responses are confidential and will not affect employment.
Survey fatigue or time burden	Medium	Minor	Limit survey to ~20 minutes; pilot test for timing and clarity; send reminders with flexible completion window.
Low response rate	Medium	Minor	Use snowball sampling; engage department heads; send follow-up reminders; highlight value of participation.
Technical issues with survey access or completion	Low	Minor	Pilot test survey; provide contact for troubleshooting; ensure compatibility with common devices.
Risk of role conflict due to dual position as staff and MSc student accessing staff emails.	Low	Minor	Clearly define boundaries of access, seek appropriate permissions, and maintain transparency.

Risk to organisational reputation	Low	Moderate	Implement a dissemination plan that ensures findings are shared responsibly and in collaboration with stakeholders

Appendix III: Quality Assurance Checklist

Project Tile: An evaluation of the Advanced Clinical Practitioner (ACP) role in Jersey: a cross-sectional survey

Criteria	Achieved	Notes
Clearly specified aims and objectives	Yes	
Appropriate and robust methodology	Yes	
Clearly specified outcome measures and outputs	Yes	
Good skill mix within project team	Post graduate study	Researcher and academic supervisor
Evaluator - external or internal? If external, contract should clearly state insurance responsibilities	Yes	RGU ethical approval gained Information governance approval from HCJ
Appropriate involvement of service users and or stakeholders	Yes	
Ethical issues identified	Yes	
Risk and issues registered	yes	
Accurate costing	N/A	
Represents good value for money	N/A	
Clear plans for dissemination	yes	
Clear plans for implementation of recommendations	yes	
Fits Health Research Authority (HRA) criteria of an evaluation	yes	
Assessed by Hannah McCormack & Moyra Journeaux		Date 12.11.25

Appendix IV: Ethics review panel approval

Name: Hannah McCormack

Date: 07.01.26

SERP reference number:25-29

Dear Hannah,

Research proposal name: **An evaluation of the Advanced Clinical Practitioner (ACP) role in Jersey: a cross-sectional survey.**

Thank you for submitting your application for ethical approval. The School of Nursing, Midwifery & Paramedic Practice Ethics Review panel has now reviewed the above research proposal. Your proposal has been approved. You may go ahead with your research.

SERP approval is valid for 1 year from the date of this letter. If your data collection period progresses beyond 1 year please notify the SERP convenor.

Please include your SERP reference number in a footer on all documents related to your study.

If you require further information please contact the committee by email at SNMP-SERP@rgu.ac.uk

Yours sincerely

N Adams

Dr Nick Adams
The School of Health ethics co-convenor on behalf of the committee.

Appendix V: Participant Information

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being completed and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part.

Thank you for reading this.

What is the purpose of the study?

The aim of the study is to find out about the advanced practice role in Jersey. It is being conducted as part of a research project for a Master's level dissertation at the Jersey Faculty of Health Education via their partnership with Robert Gordon University. I would like to explore your understanding of the advanced clinical practice role in relation to the four pillars of practice. The more responses received the better we can understand what is working well and where improvements can be made.

A written report will be produced at the end of the project. The findings will support advanced practice roles in the future.

Why have I been chosen?

You have been chosen because you have been identified as working at an advanced practice level Jersey.

Do I have to take part?

Responding to this survey is entirely voluntary. If you would like to withdraw your consent, you are able to do this before the point of data analysis. You do not need to provide a reason. If you have any questions prior to completion of the survey, please contact me directly.

What will happen to me if I take part?

If you choose to take part in the study, you will be asked to provide consent before beginning the survey. After reviewing the Participant Information Sheet, you will be directed to a consent section where you will need to confirm your agreement to participate. Once consent is given, you will be able to proceed with the survey questions. The survey should take approximately 15 minutes to complete, depending on your responses. All data collected will be anonymised, and no personal information will be shared. Findings will be reported collectively, without identifying any individuals by name.

What are the possible disadvantages and risks of taking part?

Due to the small size of the Advanced Clinical Practitioner workforce in Jersey, some responses may be potentially recognisable. However, the survey includes options that allow you to respond in a neutral or non-identifiable way, helping to maintain your anonymity while still contributing valuable insights.

There are no disadvantages or risks foreseen in taking part in the study, but it is possible that you may feel stress, or concern. If you feel that you are negatively impacted by this survey then you may wish to contact the HCJ speak Up Guardian (https://www.gov.je/working/workingforthestates/pages/freedomtospeakupguardian.aspx) or contact the Government of Jersey Wellbeing team via WellBeing@gov.je.

What are the possible benefits of taking part?

By participating in this study, you will be contributing to service improvement and will help inform future governance and training pathways. By completing this survey, you will be raising awareness of the ACP role and supporting its future development within Jersey's healthcare system.

What if something goes wrong?

If you have any concerns about the survey or need more information, please contact me directly (details below).

If you are unhappy with any part of this and wish to complain formally, you can contact my module lead, the Jersey Faculty of Health Education Dean of Nursing, Midwifery and AHP Education or Robert Gordon University's Data Protection Officer (details also provided below).

Will my taking part in the study be kept confidential?

All information provided will be handled in the strictest confidence and data will be stored secured securely according to local GDPR guidelines and Data Protection (Jersey) Law 2018. All data will be anonymised, and no personal data will be shared beyond the researcher and academic supervisor. Data will be stored securely on password-protected systems and only the researcher and academic supervisor will have access.

What will happen to the results of the research study?

The findings will be written up as part of a Master's dissertation and presented at a dissertation conference to an invited audience.

The results will also be written into a report and will be disseminated at several key forums including local ACP forums and HCJ training days.

Who is organising and funding the project?

This is an un-funded project. The project is being conducted by myself, Hannah McCormack, a postgraduate student on the MSc Advancing Practice degree at the Jersey Faculty of Health Education in partnership with Robert Gordon University.

Robert Gordon University is the sponsor for this study.

Further information and contact details

If you have any questions or would like more information, please contact:

- **Project Lead:** Hannah McCormack h.mccormack@rgu.ac.uk
- **Module Leader:** Dr Moyra Journeaux m.journeaux@health.gov.je
- **Jersey Faculty of Health Education Dean:** Dr Hazel McWhinnie h.mcwhinnie@health.gov.je
- **Data Protection Officer:** dp@rgu.ac.uk

Who has reviewed this study?

This study has been reviewed and approved by the School of Health Ethics Review Panel (SERP) at Robert Gordon University.

Use of personal information (GDPR statement)

Robert Gordon University is the data controller for the personal data you provide. The university will process your personal data for the purposes of conducting this study in line with data protection legislation. Your data will be handled securely and confidentially. Personal information will be anonymised, and any published results will not identify you.

Further information on how the university manages personal data, including your rights, can be found at: https://www.rgu.ac.uk/about/governance/information-governance/data-protection.

Thank you for your interest in this research. Please progress to the consent form below if you wish to participate.