



Royal College
of Nursing

Becoming and being a nurse consultant:

towards greater effectiveness through a
programme of support

RCN Learning and Development Institute Research Project

Dr Kim Manley CBE, at the start of the research: Head of Practice Development, RCN Learning and Development Institute, currently: Co-Director England Centre for Practice Development and Senior Research Fellow Canterbury Christ Church University

Dr Angie Titchen, Institute of Nursing Research, University of Ulster

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Dr Kim Manley CBE, at the start of the research: Head of Practice Development, RCN Learning and Development Institute, currently: Co-Director England Centre for Practice Development and Senior Research Fellow Canterbury Christ Church University

Dr Angie Titchen, Institute of Nursing Research, University of Ulster

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Foreword

This important study examines the developing role of nurse consultants. It explores how these nurses can further improve their practice, and that of their colleagues, in order to benefit patient care and build on the patient experience. Unlike any other study, it also involved aspiring nurse consultants to see how they could be more fully prepared to take on such critical roles.

It also looks at how the role of nurse consultants – still relatively new in today’s health service – can be embedded into the culture of health providers. It explores how organisations can take maximum advantage of the expertise and influence that these nurses have in bringing about change at both a strategic and day-to-day level. The study demonstrates how nurse consultants achieved real change, and answers the all important question: “how did they do it?”

The power of this study lies in the way it went about collecting information. Using an ongoing programme of action-learning over 18 months, the research team was able to establish a cycle of collecting evidence, analysis and action, which enabled nurse consultants to change their practice as they went along. Individual experience was developed into useful theory about what best practice looks like. Moreover, this unusual approach established the nurses as more than just the subjects of research; they became active participants; researching, analysing and drawing conclusions from their own and others’ practice. The whole project became a collective enterprise.

Although initial research was carried out under the previous government, the study’s findings remain relevant – perhaps even more so – in today’s climate of efficiency savings and budget cuts. With their multiple roles and experience, nurse consultants can help health care providers deliver better care and create a culture where the needs of patients are put at the very heart of delivering care.

Dr Peter Carter

Chief Executive & General Secretary
Royal College of Nursing

Becoming and being a nurse consultant: towards greater effectiveness through a programme of support

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Executive summary

1. The context for the nurse consultant project

This report is the culmination of a 24-month collaborative research project which involved a small research team working with nurse consultants (NCs) and aspiring nurse consultants (ANCs) across England. The research was undertaken through the Royal College of Nursing (RCN). We, the authors, undertook the research during the early implementation stages of the then Labour Government's NC initiative, between 2002 and 2004.

The project team accompanied the nurses as they became both individual practitioner-researchers of their own practice and members of a critical research community. They investigated what was important to them in their everyday practice, which is:

- putting the role of the NC into practice, specifically the:
 - expert practice function
 - professional leadership and consultancy function
 - education, training and development function
 - practice and service development, research and evaluation function
- developing their effectiveness
- demonstrating their impact
- developing the support processes necessary in helping them to develop other nurses in their personal and professional journeys.

Before this project, very little research existed on NCs, and none in relation to ANCs. The project's origin lay in:

- a doctoral study exploring the NC role,

linking necessary qualities, attributes and processes to the outcomes of person-centred and effective care and a workplace culture that sustains these (Manley, 2001)

- the RCN's *Expertise in practice project* (Manley et al., 2005)
- the political context of the time.

Much of the research literature concerning NCs developed in parallel with the project or since its completion.

The aims of the project were to:

- enable NCs and ANCs to become more effective through a programme of support (including action learning) which focused on developing expertise across the range of nurse consultant functions
- facilitate ANCs in developing expertise in all NC functions
- examine the impact of the programme of support on NCs and ANCs
- explore the impact of NCs through evaluation approaches that can be used in the workplace
- cascade development by developing facilitation skills that will help prepare future NCs.

The selection process began in spring 2002, and the initial first meeting of project participants took place at a combined workshop in July the same year. The last workshop was held in December 2004. In between, there were other workshops and 18 action learning sessions. Participants joined one of three cohorts across England¹: two cohorts comprised of NCs and one consultant midwife: one of which was a local set in

¹ Initially the project aimed to be UK-wide but because of the scarcity of nurse consultants at the time in Scotland, Wales and Northern Ireland, the project ultimately focused on England.

Nottingham, and the other rotated around sites across England. The third cohort was based in London and included ANCs and a midwife from around England.

The authors acknowledge the delay between the data collection, its concurrent analysis, and the overall final analysis and compiling of the report. This delay was due to long-term illness and subsequent work commitments. However, we argue that the findings of this project are still extremely relevant to developing and evaluating the NC role today, particularly in relation to research impact assessment and the quality, innovation, productivity, prevention (QIPP) agenda (see 7.8 and 7.9 below).

2. Research approach, selection, participant profiles and ethical considerations

The project used emancipatory action research (EAR) (Grundy, 1982) integrated with fourth generation evaluation (Guba and Lincoln, 1989). This approach influenced the project's selection process and methods, because participating NCs and ANCs needed to consent to becoming practitioner-researchers ie researching their own practice and participating in the project processes.

The research approach and subsequent methods were selected for three reasons:

- the research team's values, beliefs and expertise were consistent with the project's focus of collaborative inquiry, and the integration of practice and practitioner development with refining theory through evaluation (Binnie and Titchen, 1999; Manley, 2001)
- the selected methodologies would fulfil the aims of the project and answer questions arising from the literature review, particularly from the perspective of NCs and ANCs about their roles and what is important to them

- the project would continue to refine and build expertise using the approach taken in the RCN's Expertise in practice project (EPP) (Manley et al., 2005).

The main difference between this study and the EPP was that practitioner-researchers were involved throughout, from collection to analysis, interpreting findings and developing theories. However, unlike the EPP study, practitioner-researchers were not designated their own critical companion, although critical companion processes were used by the project facilitators. Participants were not expected to produce a portfolio of evidence to support this project as they had in the EPP.

Of the 20 NCs recruited to the project, one withdrew before it started and three never attended action learning; these were replaced by two late starters drawn from a waiting list. Of the 11 ANCs, two never attended the project and were replaced from the waiting list by two late starters. Of the 11 ANCs who started the project, four withdrew actively or passively.

3. Methods, analysis and theory construction framework

Two main processes (methods) supported the NCs and ANCs in researching their own practice over an 18 month period:

- monthly action learning sets (within cohort meeting days), which included reflection in and on practice ie the presentation and critique of data gathered during the previous period, and time allocated for addressing negotiated needs and collaborative analysis
- six-monthly collaborative workshops when all three cohorts came together.

In total, 40 critical incidents were presented in action learning; 23 from NCs and 17 from ANCs. These were later linked to the

emerging themes from the meta-analysis.

During workshops and learning sets, practitioner-researchers used a framework developed by the research team to facilitate the development of theory from practice, by identifying:

- trigger concepts influencing the presenter's work
- the goals they were trying to achieve
- the strategies they undertook to achieve their goal
- evidence of goal achievement
- related theory.

We used four workshops for all three cohorts to come together and work as a collaborative community, analysing and working with the data (three one-day events, and one two-day residential event). We used a concerns, claims and issues (CCI) tool as a starting point for negotiating the focus for each day, as well as for data collection and analysis.

Two other tools were used by a small number of practitioner-researchers at the end of the study: qualitative 360 degree feedback developed within the RCN's EPP (Manley et al., 2005; Garbett et al., 2007) and reflective reviews (after Johns, 1995).

We analysed all data sets thematically. As each one was presented at a meeting/workshop, we captured the essence of what was important to the nurses in it, and established a theme from each set. We analysed each theme to ensure it was comprehensible and accurate. Both practitioner-researchers and the research team took part in this analysis as part of each meeting/workshop.

Four overarching themes were identified from combining the data. These themes were used to develop in-depth examples of the data. The themes were:

- the role of the NC

- the impact of the context on NCs and ANCs
- outcomes
- project processes.

The research team undertook a final meta-analysis which captured the start and end points of three journeys (see 4.2 below) taken by NCs and ANCs as they strived towards:

- becoming practitioner-researchers, and integrating learning and inquiry into their everyday practice
- achieving greater effectiveness in their roles
- achieving organisational effectiveness.

4. Moving towards being a practitioner researcher

To achieve the research aims and enable participants to contribute to answering the relevant questions, we supported participants in becoming practitioner-researchers. While this study uses knowledge created in the EPP (Manley et al., 2005; Hardy et al., 2009) to facilitate individuals in their practitioner research, it also contributes new understanding around how to enhance participants' contribution to theoretical development at the collective, community level.

We found that the journey towards becoming fully skilled practitioner-researchers was a complex one, and participants had to learn how to engage in EAR. We identified their starting points on this journey, how learning strategies were facilitated, and the outcomes in developing knowledge, skill sets and the professional artistry required to integrate learning and inquiry.

Those running the action learning sets were experienced in delivering work-based learning, practice development and practitioner research. They used holistic,

enabling approaches to facilitation (Titchen, 2004; Rycroft-Malone, 2004; Manley et al., 2005). They used 10 principles (Manley et al., 2009) to develop a learning and inquiry culture, develop participants' praxis skills and sustain a commitment to the project.

At the start of the study, participants' questions about action learning and practitioner research showed that some were unfamiliar with the concept of integrated learning and inquiry. Despite these gaps in knowledge, participants nevertheless took responsibility for managing the project, both individually and collectively.

Participants subsequently demonstrated evidence of developing into practitioner-researchers through becoming active learners as well as facilitators of others' active learning.

We conclude that the strategies used by the facilitators to help participants on their journeys were effective. Participants had to overcome difficulties in practitioner-research at both individual and collective levels. Yet our evidence suggests they were able to undertake rigorous practitioner research with the support of these facilitation strategies – inspired by the 10 principles identified (Manley et al., 2009). The participants were strongly engaged in the action research and project management, and felt supported and valued by the project.

Participants were, however, concerned about the project coming to an end, and asked where support for future practitioner-research would come from. Employers and researchers will have to address this if they are to demonstrate the continuing effectiveness of the NC role.

5. Sailing down the river: moving towards greater effectiveness in multiple roles

The key focus for participating NCs was that of being an NC, whereas for the ANCs, it was on becoming an NC. The project explored the experience of participants as they applied the attributes of a practitioner-researcher to their work and other roles.

Although in theory the NCs were clear about their complex and interacting roles, their colleagues and their organisations were not. Moreover, the nurses needed to develop and balance their multiple roles and to demonstrate further how effective they were within their organisations.

The NCs' first step was to recognise that they needed to develop their own understanding of the multiple NC roles and their interplay before they could demonstrate their role's effectiveness to their organisations. So they analysed the ambiguity towards the role at service and strategic levels, going on to clarify what the NC role could and should be, allowing them to negotiate strategically with their organisations about how it should work.

NCs then turned their attention to developing knowledge and skills. They expanded their capacity to demonstrate the effectiveness of their multiple roles, gathering evidence using a variety of tools to show their organisations their achievements. For some, this was an arduous journey because their research skills were underdeveloped. Those who already had higher degrees were better able to show their effectiveness within the timescale of the project.

Participants found that the research and evaluation part of the NC role was the most difficult to demonstrate achievement in, due to resource constraints and the requirements

of ethical committees. They were able to show the positive effect of interaction between multiple roles on influencing patient care at a strategic level. Dilemmas remain about the level NCs should focus their energy on – strategic or clinical.

The starting point for the ANCs was how to become an NC, because there were no career development pathways in place. They developed strategies for assessing themselves for the role, finding mentors and/or gathering qualitative 360 degree feedback on the role and how it could be developed. By doing this, ANCs moved towards developing new NC posts in their organisations, achieving positions in other organisations, or further developing their skills for career progression.

6. Wiring them in: the impact on others, the organisation and service

For NCs, workplace activity became the principle resource for learning. They became more effective in their roles, creating recognisable impact and achieving tangible change.

To achieve positive outcomes for patients and services, as well as study participants themselves, NCs and ANCs first had to develop facilitation skills as active learners and inquirers into their own practice, focusing on developing their own effectiveness. They then moved on to help their colleagues, through enabling individuals and teams to be more effective.

Through developing these skills, NCs earned credibility. People began to recognise what they had to offer; as a result, they became valued for their contribution to services.

NCs improved organisations' access to NCs' potential: they made explicit the role's potential; achieved support and credibility; and embedded the role in their organisations.

The impact that the NCs and ANCs had on workplace culture and services led to:

- a greater person-centred focus
- achievement of best practice
- strategic influence from practice through changing the workplace culture and influencing the strategic agenda.

Thus, they improved services to patients.

7. Being and becoming a nurse consultant: towards greater effectiveness through a programme of support – discussion, conclusion and recommendations

This study provided support for NCs and ANCs as they grappled with new roles through research, using EAR and fourth generation evaluation. The research team helped participants to build the facilitation skills they needed to develop and demonstrate their own effectiveness and to foster the effectiveness of others, while at the same time transforming practice towards a culture which sustains effective, person-centred services.

Participants showed they had become practitioner-researchers, developed greater effectiveness in their multiple roles, and through these processes had demonstrated their impact on others, organisations and services.

Practitioner-researchers showed that they were able to achieve clarity around the NC role in their organisations. They demonstrated greater effectiveness as clinical, professional, political and strategic leaders, educators and facilitators of work-based learning, and as researchers. As the project went on, they used critical incidents from their own practice to demonstrate how patient care could be improved, presenting a complex array of evidence at executive and strategic level.

The study concludes that the facilitation skills based on 10 principles, (Manley et al., 2009) are central to achieving transformation in practice, when combined with the NCs' multiple roles, and with leadership that is transformational, strategic and political.

There is much in common between this study's outcomes and that of others concerning NCs. However, the one major difference has been in using a research approach that helps develop effectiveness while the research is underway. This approach involves learning in and from practice, being a research-practitioner and using facilitation processes to increase effectiveness in others – so transforming practice. The study also used these facilitation skills with ANCs. No other studies have researched ANCs.

Our results gave new insights into improving participant contribution to theoretical development at a collective level. We were also able to compare the results of this study with the EPP's. Our recent research did not use critical companionship, but the EPP had demonstrated that rigorous practitioner inquiry was improved by providing support from critical companions, who helped participants complete a portfolio of evidence (Titchen, 2000). Comparison leads us to conclude that the standard of practitioner research is greatly enhanced by using critical companionship.

For organisations to really embed the NC role so services to patients benefit, it is imperative that they:

- understand the full concept and value of NC posts
- give the post the organisational authority required
- recognise the skills required when developing others for these posts, and how outcomes are dependent on the skills and experience possessed

- provide ongoing support to develop the full range of skills and roles required in the job.

For higher education, the study highlighted the need to:

- include development of facilitation skills, and the skills associated with multiple roles and leadership, within postgraduate courses
- value the achievement of these skills when they are reflected in practice outcomes to the same level as academic results
- work with providers to increase the number of work-based learning opportunities provided and help develop the skills necessary to facilitate this in the workplace.

Policy makers, departments of health and commissioners were advised to note McIntosh and Tolsen's conclusion to their 2008 research: '... that it would be regrettable if the important contribution to leadership provided by NCs was in any way diminished ...' (p227). NCs should not be overshadowed by a focus on modern matrons, advanced practice and specialist nurses. All these levels and roles are required, but if services are to fulfil current policy aspirations of providing safe and effective services with increased productivity, then it is important to build in funding for more NCs. NCs and their expertise in a range of skills will be a powerful force in creating and sustaining change at the patient-provider interface.

As previously discussed, there has been a delay in finalising this report. However, the findings of this project are still relevant. The contribution NCs can make in the current context is more important than ever before. They have expertise in developing a workplace culture of effectiveness that sustains person-centred, safe and effective care right along the patient pathway. Organisations have yet to take full

advantage of the complete potential of the NC role. Current government reforms continue to raise the importance of the patient experience, and safe and effective care, in tandem with increasing productivity and innovation (NHS Improvement, 2010; QIS, 2010). More than any other role, NCs possess the full range of integrated expertise necessary to achieve this agenda in practice. NCs can bridge expert nursing practice with learning, evaluation and measurement in the workplace, as well as provide clinical and political leadership. They can, therefore, build a culture where quality practice and services are both developed and maintained. However, to achieve this potential, organisations must:

- recruit NCs with the full skill set required or provide the support to develop this quickly
- understand and recognise NCs' value and contribution at executive level.

This study is also relevant for the new Research Excellence Framework as it becomes embedded across the UK (HEFCE, 2010). The research approach and resulting framework for theorising from practice will contribute new insights in social impact, illustrating the inter-relationship between inputs, actions, outputs and impact.

Finally, a wider relevance of this study is the pattern of journeys from role ambiguity to clarity and negotiation. This understanding can be applied to any new role in any field.

Recommendations

Policymakers, governments and commissioners should:

- promote and endorse the NC role as the pinnacle of the clinical career ladder in nursing, one that bridges practice, education and research
- increase the funding for appointing NCs within career modernisation

- recognise the role of facilitation skills in achieving quality, productivity and patient-centred services
- commission programmes that develop these skills in senior clinical leaders and higher education.

Employers should:

- appoint more NCs with the full range of skills required to transform practice and services
- support those NCs without the full range of skills required in developing these promptly
- ensure that NCs have the strategic authority and the ongoing support necessary to achieve their full potential
- actively implement succession planning for aspiring NCs, so that they can develop the full range of skills required to become an NC.

Universities should:

- build in opportunities to develop facilitation skills in postgraduate courses in nursing and midwifery
- provide opportunities for health care providers to use and develop expertise in work-based learning through academic and practice partnerships
- continue to provide opportunities for NCs to develop their research and evaluation expertise.

Researchers should:

- note that the EAR used here is integrated with fourth generation evaluation and critical companionship approaches. The insights are developed into initiating action research cycles, and creating theory from practice is tested and refined
- when planning to use qualitative 360 degree feedback with patients and users, make sure that sufficient planning time is given to enable ethical considerations to be fully addressed

- ensure that the 10 principles of facilitation are tested with other clinical leaders, but also within different research designs, which compare the impact of these principles against other approaches to transforming workplace culture
- ensure that a portfolio and qualitative 360 degree feedback is integrated with programmes designed to help ANCs prepare for an NC role.

1

The context for the nurse consultant project

1.1 Introduction

This report is the culmination of a two-year research project that involved a small research team of three working with nurse consultants (NCs) and aspiring nurse consultants (ANCs) across England. The research was led by Kim Manley and Angie Titchen on behalf of the Royal College of Nursing (RCN). We undertook the research during the early stages of implementation of the then Labour Government's NC initiative, between 2002 and 2004. The team accompanied nurses as they became both individual practitioner-researchers examining their own practice, as well as members of a critical research community investigating what was important to them in their everyday practice. That is:

- putting the role of the NC into practice
- developing their effectiveness
- demonstrating their impact
- developing the support processes necessary for helping them develop others in their personal and professional journeys.

The research approach selected was one of researching 'with' rather than researching 'into' participants. These NCs and ANCs were co-researchers alongside the small research team. The team was simultaneously researching how to best support the practitioners in their journeys towards continuing effectiveness in their practice.

1.2 Background

In 1999, the serving Prime Minister Tony Blair (then Leader of the Labour Government) announced the introduction of

the NC role in response to a lack of clinical career pathway for senior nurses and the consequent need to keep expertise at the bedside (Department of Health, 1999b). National Health Service (NHS) Executive England set out guidance for NHS trusts in recruiting and appointing NCs (Department of Health 1999a), followed by similar action from the Scottish Executive, Wales and Northern Ireland respectively. NCs were then introduced into the UK NHS as part of the modernising strategy outlined in the *National Plan* (2000).

Nurses practising at higher levels were seen as key to reforming the health service, with particular emphasis on their working across professional and organisational boundaries, as outlined in the chief nursing officer's *10 key roles for nurses* (Department of Health, 2002). At the same moment, the Bristol Royal Infirmary Inquiry (BRII, 2001) highlighted a need for change in practice and team culture to develop a health service that was well led through programmes of training and support for clinicians.

NCs have expertise (Manley, 1997, 2001, 2002) in:

- the practice of nursing for a specific client group
- developing a learning culture
- practice-based research approaches and evaluation
- providing consultancy from clinical to organisational levels
- transformational leadership
- facilitating individual, team and organisational learning, cultural change, practice and service development.

In their position statement, recruitment and selection strategy for NCs, the UK Department of Health (DH) structured the role around four functions:

- expert practice
- professional leadership and consultancy
- education, training and development
- practice and service development, research and evaluation.

This descriptor guided the NHS trusts' bidding process to the England regions and other UK countries. Bids were expected to include support and development mechanisms for these new roles, although in practice this was not a reality for many (Nurse Consultants Network, 2001; Guest et al., 2001).

The number of NCs initially appointed was fewer than hoped, because not enough candidates had the required pre-requisites. As a result, when the project started there was increased interest in preparing ANCs, supporting existing NCs and in exploring methods to achieve this.

1.3 Nurse consultant: the historical context

In the 1970s, the Royal College of Nursing (RCN, 1975) first proposed a new role, the clinical nurse consultant, supported in studies by Ashworth (1975) and Kratz (1976). But the idea failed to gain acceptance (Albarran and Fulbrook, 1998). As a defined role, the NC re-emerged in the British literature as nurse consultant/consultant nurse and developed with the work of Pearson (1983) in the fledgling nursing development unit movement of the early 1980s, and of Wright (1991-1994). The NC role was put into operation extensively, but not researched, by Wright (1991, 1992, 1994a, 1994b) and subsequently by Marr (1993) in the Tameside Nursing Development Unit, where

the role was dominated by its focus on clinical practice.

Simultaneously, the literature focused on the consultancy role of the nurse, derived from the development in the United States of clinical nurse specialists prepared with masters degrees (Oda, 1977; Blake, 1977; Stevens, 1978; Kohnke, 1978; Lareau, 1980; Norton, 1981). The consulting role as an explicit area of expert nursing practice was identified by Fenton (1984), in addition to seven domains of nursing practice identified by Benner (1984). The role emerged out of the many examples given of masters prepared nurses consistently providing expertise and guidance, both formally and informally, to other health care providers' (Benner, 1984, p.265).

Wright in 1992, writing about his role as an NC within a nursing development unit, drew on aspects of the clinical consultancy model and the more sophisticated mental health consultancy model (Caplan, 1970; Gallessich, 1982). Being an NC involved working in a range of roles and as an educator. Wright emphasised the need for a strong nursing vision and the role of the NC in facilitating it. Both Pearson (1983) and Wright (1994b) argued strongly that NCs should have extensive expertise and knowledge in their particular speciality. NCs should also have a hands-on role in nursing practice, which Pearson and Wright believed enhanced clinical credibility and enabled effective role-modelling.

The term 'nurse consultant' has been used interchangeably with advanced practitioner since the mid 1990s by nursing development units (Manley, 1997). In 1990 the term 'consultant practitioner' was used by the UKCC to describe an advanced practitioner who continued to develop their expertise (Berragan, 1998). The terms 'consultant nurse' and 'nurse consultant' have been used interchangeably since Tony Blair's announcement to implement the posts on a

wide scale, however Manley had previously identified the historical differences between the two (Manley, 1996). Consultant nurse aligns with an internal model where the role-holder practises nursing and is at the pinnacle of the clinical career ladder. Nurse consultant, in contrast, had previously been linked to an external self-employed business model, where the person is providing consultancy on some aspect of nursing to a client – for example, workforce (Keane, 1989). This person may not necessarily have a clinical caseload or be working in the clinical environment.

In this report the term nurse consultant has been used.

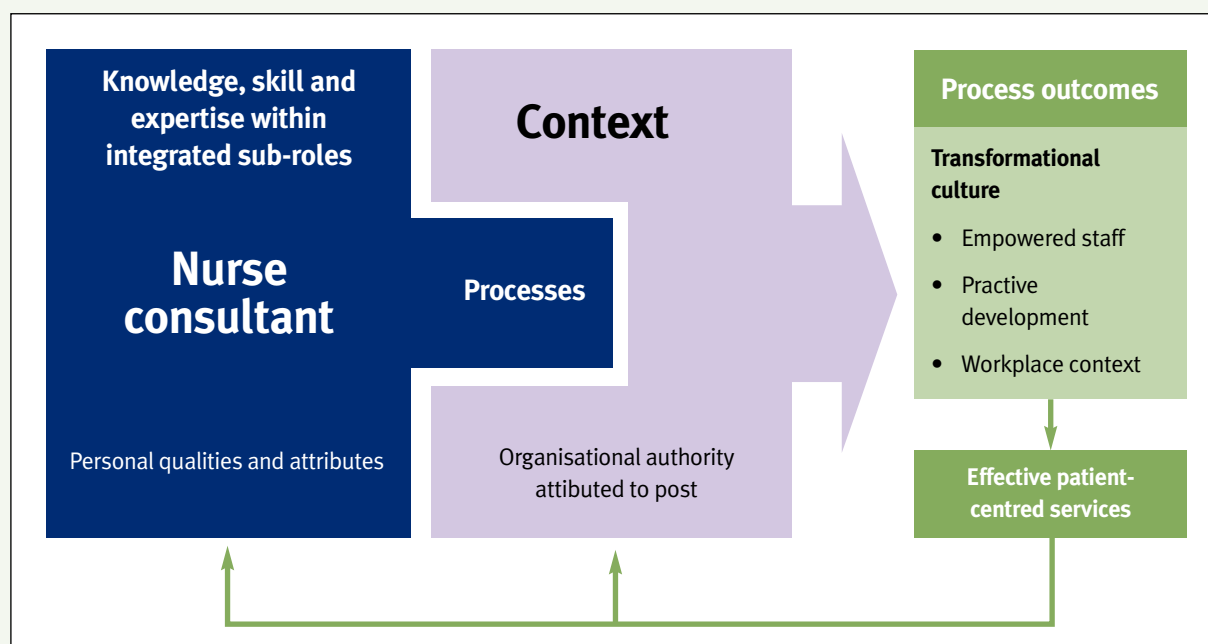
1.4 Research on the nurse consultant role

Very little research existed on NCs before the inception of this project. The earliest research on the NC role was a three-year action research study, also within a nursing development unit, based in a critical care unit. This study defined the NC's role

attributes, processes and outcomes, achieved within a conceptual framework (Manley 1997, 2000a and b, 2001, 2002). Manley (2001) was able to demonstrate the achievement of a sustainable transformational culture in the unit where she undertook her work. A transformational culture is one that demonstrates staff empowerment, continuing practice development (with its focus on providing care which is patient centred, evidence based and continually modernising), and a focus on maintaining individual and team effectiveness. Manley (2001) recognised that NCs do not achieve success in isolation but in collaboration with others.

Much of the literature has therefore developed in parallel with our project or subsequently to it, including evaluations commissioned by the DH in England (Guest et al., 2001, 2004), Scotland (McIntosh, 2004), and Northern Ireland (Health, Social Services and Public Safety, 2005). Emerging research literature has therefore been integrated with a discussion about the findings in the final chapter of this report.

Box 1.1 NC (insider practice developer): conceptual framework highlighting the relationship between nurse consultant attributes, processes, context and outcomes (Manley, 2001) (detailed in Box 1.2 and Box 1.3)



1.5 Project origins

As well as the historical context, two specific research projects involving members of the same research team influenced the project's conception and focus.

The first was a doctoral study (Manley, 2001) spread over 12 years which involved researching and putting into operation the NC role in practice, using emancipatory action research (EAR) (Grundy, 1982). This study pre-dated the government-led

initiative of 1999 and led to the development of:

- a preliminary conceptual framework (Manley, 1997)
- a refined conceptual framework (Manley 2001, 2002) that linked the attributes of the NC and the processes used to achieve a transformational culture².

(See Boxes 1.1, 1.2 and 1.3).

² Transformational culture: a workplace culture that is person-centred and continually modernising.

Box 1.2 The NC's knowledge, skills, expertise; personal qualities and attributes; and processes

Knowledge, skills and expertise in integrated subroles

('Know-how' and 'know that')

- Nursing practice as a generalist/specialist.
- Research and evaluation in practice.
- Practice development and the facilitation of structural, cultural and practice change.
- Education and learning in practice.
- Consultancy: clinical to organisational.
- Management, leadership and strategic vision.

Personal qualities and attributes

- Being patient-centred.
- Being available, accessible generous and flexible.
- Being enthusiastic.
- Being self-aware and attuned to others.
- Being a collaborator and a catalyst.
- Having a vision for nursing and health care.
- Being a strategist and demonstrating political leadership.
- Academic criteria.

Processes

- **Transformational leadership processes**
 - Developing a shared vision.
 - Inspiring and communicating.
 - Valuing others.
 - Challenging and stimulating.
 - Developing trust.
 - Enabling.
- **Processes of emancipation**
 - Clarifying and working with values, beliefs and assumptions, challenging contradictions.
 - Developing critical intent of individuals and groups
 - Developing moral intent.
 - Focusing on the impact of the context/system on practice as well as practice itself.
 - Using self-reflection and fostering reflection in others.
 - Enabling others to 'see the possibilities'.
 - Fostering widening participation and collaboration by all involved.
- **Practising expertly as a practitioner, researcher, educator, consultant and practice developer**
 - Role modeller.
 - Facilitating individual, collective and organisational learning.
 - Facilitating change, practice and service development.

Box 1.3 The components of a transformational culture and related cultural indicators

Components of a transformational culture	Cultural indicators
Staff empowerment	<ul style="list-style-type: none"> • Continuing development of practice and self-knowledge. • Altered ways of working through self-knowledge. • Practitioners are self-energising and self-organising. • Staff have a clear sense of purpose. • Practitioners communicate freely, question, challenge and support each other. • Practitioners take responsibility for developing own practice and introducing innovation. • Formal and informal systems that foster critical thinking are evident.
Practice development with its focus on patient-centredness and quality services	<ul style="list-style-type: none"> • The needs of service users is the focus of continuous developmental work. • Patient-centred care is designed around the needs, concerns and experiences of patients/users. • Activity is focused directly on practice and how knowledge and skills are used in practice. • Activity at the patient/client interface matches activity at organisational and strategic interfaces. • Changes are evident in individuals and culture. • Teams are enabled to develop knowledge and skills. • The focus is on emancipatory change. • Evidence used to inform decision-making is drawn from policy (local to global), propositional knowledge, personal knowledge, craft knowledge, local theory and patient's own personal knowing. • Evidence is also generated from practice through systematic and rigorous approaches at individual and collective levels.
Workplace context	<ul style="list-style-type: none"> • Quality is everyone's concern. • Joined up values and beliefs are realised in action. • A strategic fit with the environment re: local, national, global policy (strategic appropriateness). • Positive change is a way of life, constantly addressing and anticipating changing health care needs through adaptability and flexibility, internally and externally. • Decision-making is transparent, participative and democratic. • Staff participation is fundamental to the infrastructure and reflected in a spirit of shared governance. • A focus on developing the leadership potential of all staff. • All stakeholders are valued.

The second project influencing our study was the RCN's Expertise in practice project (EPP). This was a six year, UK-wide study (Manley et al., 2005; Hardy et al., 2009) exploring one of the key functions of the NC – the expert practice function. It explored

the mechanisms for:

- developing expertise
- supporting practitioners in articulating their expertise through critical companionship (Titchen, 2000) and

- action learning (McGill and Beaty, 1997)
- accrediting expertise using EAR (Grundy, 1982) and fourth generation evaluation (Guba and Lincoln, 1989).

The research processes/methods used in these two earlier projects informed the NC project's methodology.

Funding for the project was drawn from two sources: an internal research fund of the RCN Institute and external monies derived from the research assessment exercise. This provided a research assistant (Rachel Rowe) and travelling costs for participants. The two other members of the research project team (Kim Manley and Angie Titchen) and the administrator (Trisha Berhardt) were core-funded staff in the RCN's practice development team.

1.6 Project aims

The project aimed to:

1. enable NCs and ANCs to become more effective through a programme of support (including action learning), which focused on developing expertise across the range of NC functions
2. facilitate ANCs in developing expertise in all the functions of the NC
3. examine the impact of the programme of support on NCs and ANCs
4. explore the impact of NCs through using evaluation approaches that can be used in the workplace
5. cascade development through developing facilitation skills which will help prepare future NCs.

The project sought to achieve its aims through using the research method EAR (Grundy, 1982) integrated with fourth generation evaluation (Guba and Lincoln,

1989). This approach influenced the project's selection process and methods, because participating NCs and ANCs needed to consent to becoming practitioner-researchers ie researching their own practice and taking part in the project. Participants would also be co-researchers with the project team, working collaboratively towards the overall project aims.

1.7 Values and beliefs of the project team

The project team recognised that, in relation to the role of the NC:

- the leadership potential of the NC is central to their role
- expertise in processes associated with each of the functions of the NC is necessary to achieve sustainable cultural change in a modern NHS; these processes revolve around skilled facilitation of others and the clinical team
- the provision of formal mechanisms of high support and high challenge (critical companionship, clinical supervision/coaching/mentorship) are necessary for NCs, as for all practitioners, to enhance and enable ongoing effectiveness in the workplace
- the organisational context can enable or inhibit the work of the NC
- ANCs need support in developing evidence of their readiness for an NC post, by focusing on succession planning and networking opportunities with NCs.

The project team recognised that, in relation to the research approach selected:

- participatory approaches are more likely to engage participants in transforming their practices in the workplace, thus integrating all the stages of the research

process with evaluation and implementation

- the ultimate purpose of a participatory research approach is human flourishing, for the participants themselves as well as for the beneficiaries of practitioner research ie the patients and users (Titchen and Manley, 2006)
- the participants, as practitioner-researchers, are experiencing and developing the processes necessary to help them become more effective, to demonstrate their effectiveness and also to help others to achieve the same aims
- the practitioner-researchers can generate theory at both an individual level as well as a community level (individually in relation to their day-to-day practice and collectively as part of a community of practitioner-researchers critiquing practice as a group)
- the processes of action research are the same ones that contribute to enabling ongoing critique of effectiveness in daily work.

The aims of the research were therefore linked to this research approach in several ways:

1. Developing expertise in practice-based research approaches enables NCs and ANCs to build and develop the necessary skills to be active in their own learning and inquiry and demonstrate personal and professional effectiveness.
2. NCs who develop the necessary skills for maintaining personal and professional effectiveness enable others to develop their effectiveness.
3. The presence of these skills, combined with personal attributes and expertise within the multiple roles of the NC, enables a workplace culture to develop

that provides effective patient-centred services.

1.8 Project overview and stages

The selection process for project participants began in spring 2002. The first meeting of participants took place at a combined workshop in July the same year, with the last meeting taking place in December 2004. In between, there were other workshops, and 18 action-learning sessions.

Participants joined one of three cohorts across England³. Two cohorts comprised NCs and one consultant midwife; one of which was a local set in Nottingham, and the other rotated around sites across England. The third cohort was based in London and included ANCs and a midwife from around England. These cohorts ran as action learning sets, with Kim Manley facilitating the Nottingham and London cohorts, and Angie Titchen facilitating the other. Rachael Rowe, research assistant, acted as a participant recorder for all three.

Two one-day workshops and one two-day residential session were interspersed at six-monthly intervals, to enable participants from the three cohorts to come together with the research team as a critical community. These events enabled collaborative analysis of, and theory creation from, data emerging across the critical community⁴. The final meta-analysis of the data was undertaken between 2006 and 2008.

The authors would like to acknowledge the delay between the data collection, its concurrent analysis, and its overall final analysis and reporting. The delay occurred

³ Initially the project aimed to be UK-wide but because of the dearth of nurse consultants at the time in Scotland, Wales and Northern Ireland the project ultimately focussed on England.

⁴ The critical community comprised all participating NCs, ANCs and the research project team comprising the two facilitators and the research assistant.

because of long-term illness and subsequent work commitments. However, we argue that the project findings set out in the final chapter are still extremely relevant.

1.9 Project accountability

The project team was accountable to the RCN Institute's Research and Practice Development Committee, which critiqued the original proposal and received six-monthly reports through the project. In addition, the team submitted a multi-centred ethics committee proposal concerning the collection of data from the participants' patients and colleagues, which was approved.

1.10 Overview of the report structure

The report is structured as follows:

Chapter 2 explains the selected research approach, specifically EAR and fourth generation evaluation, explains the selection process and outlines the participants' profiles.

Chapter 3 describes the research processes or methods used and the analysis undertaken by the participants as individuals, as well as those used by the collective research community. The chapter also outlines ethical challenges experienced and concludes with an overview of the research findings which structure the subsequent three chapters.

Chapter 4 describes the journey undertaken by NCs and ANCs as the research team drew on 10 principles of work-based learning to support participants in developing their facilitation skills, learning in and from practice, and inquiring into their own practice. We argue that these skills are necessary for transforming practice.

Chapter 5 describes the first steps NCs took in understanding that their multiple roles and the interplay between them required more development and balancing before they could demonstrate effectiveness of the role to their organisations. It describes how role clarity was demonstrated in others and strategies were identified for drawing on these multiple roles with others.

The focus for the ANCs was on becoming an NC in an NHS where career development pathways for NCs had not yet been explored.

Chapter 6 builds on the findings of the previous two chapters. It demonstrates the outcomes NCs achieved as a result of building skills in developing their own effectiveness and that of others, so as to make an impact on the culture and service to patients.

Chapter 7 summarises the main findings of the project in the context of existing research. It also includes a reflection on the research approach and its limitations. It highlights the implications of the research for policy-makers, government, commissioners, employers, universities and other researchers that may wish to build on what we have learned in using our particular research approach. The chapter concludes with key recommendations for stakeholders.

2

Research approach, selection, participant profiles and ethical considerations

2.1 Introduction

This chapter describes the research approach and the rationale for using it, as well as explaining how participants were selected, their profile and the ethical challenges experienced.

2.2 The research approach

EAR (Grundy, 1982) underpinned by critical social science, integrated with fourth generation evaluation (Guba and Lincoln, 1989), provided the project's philosophical framework.

2.2.1 Emancipatory action research (EAR)

Action research has three purposes, to develop:

- practice collaboratively
- practitioners and organisations
- refined theory.

(Carr and Kemmis, 1986; Grundy, 1982; Elliott, 1991).

It integrates evaluation through spirals of collaborative planning, implementation, and then reflection on action which informs subsequent spirals of action. This study generated and refined theory about the concept of the NC, the support necessary to develop NCs' effectiveness and demonstrate their impact, and the support required to prepare ANCs.

EAR focuses on:

- the barriers experienced both internally and externally, and the strategies required to dismantle them in developing practice

- critique – a concept linked with a school of thought known as critical social science, associated with the aims of:
 - enlightenment: developing self-knowledge about how we act and why
 - empowerment: developing approaches, strategies and motivation from increased self-knowledge to bring about better ways of behaving and working
 - emancipation: actually putting these strategies into practice.

(Fay, 1987)

Three criteria constitute the action research approach:

1. EAR is normally concerned with: 'social practice susceptible to improvement through deliberate strategic action' (Grundy and Kemmis, 1981). This is linked with an intention to improve something or implement a change. This intention is reflected in the questions that researcher-practitioners may ask. For example, 'how' questions are often used – how do I/we develop a common vision about something, then develop and evaluate it? (Binnie and Titchen, 1999; McCormack, Manley, Wilson 2004; Titchen and Manley, 2007).

The 'something' we want to improve through this study is NC practice, its development and impact. This is reflected in questions such as: how do we demonstrate our effectiveness? How do we best support NCs and ANCs? Such questions are deliberate and strategic.

2. The research is characterised by a spiral

of interrelated cycles involving planning, acting, observing, reflecting and theorising. These are systematically and self-critically implemented. Such spirals of activity can relate to one's own individual action or the action of a collective community (see Binnie and Titchen, 1999; Manley, 2001; Titchen and Manley, 2006).

3. 'The involvement of those responsible for practice in each moment of activity, widening participation as the project involves or affects others, and maintaining collaborative control of the process ...' (Grundy and Kemmis, 1981; Titchen and Manley, 2007). It is in this area that fourth generation evaluation provides practical mechanisms for identifying and including stakeholders, as well as for identifying what is important to them.

2.2.2 Fourth generation evaluation

Fourth generation evaluation (Guba and Lincoln, 1989) is an approach with a commitment to empowering different stakeholder groups and ensure sharing of information between them. Stakeholders are defined as those who have a stake in the NC project or NC practice.

As well as identifying stakeholders, focusing on their concerns, claims and issues is central to this evaluation approach. These concerns, claims and issues can inform the focus and direction of action within a framework of EAR.

- A concern is: '... any assertion that a stakeholder may introduce that is unfavourable to the evaluand ... (Guba and Lincoln, 1989, p.40). The evaluand in this study is NC practice and the programme of support provided.
- A claim is: '... any assertion that a stakeholder may introduce that is favourable to the evaluand ...' (p.40).

- An issue is: "... any state of affairs about which reasonable persons disagree ..." (p.40).

It is the evaluator's role (in this case the research team and practitioner-researchers) to unearth and address concerns, claims and issues within an evaluation, so that they become a tool used at every meeting of participants and the research advisory group.

The project team developed expertise in using this tool through the project and, with the practitioner-researchers, was able to refine its use so by the end of the project a clearer connection could be made between fourth generation evaluation and EAR. How the tool was used is described more fully in Chapter 3.

2.2.3 Rationale for selection of the research approach

The research approach and subsequent methods were selected for three reasons:

1. The values and beliefs of the research team focused on collaborative inquiry and the integration of practice and practitioner development with refinement of theory through evaluation (Binnie and Titchen, 1999; Manley 2001). These are consistent with EAR (Grundy, 1982). The team made three assumptions:
 - Transformation of practice and practitioners requires the use of learning and research approaches, which mean working collaboratively with participants as co-researchers, rather than undertaking research into the participants.
 - Theory can be generated by critiquing and researching one's own practice, through which one can answer the research questions.
 - The theory created will be of value to other NCs and ANCs, as well as those

who support them in their development as practitioner-researchers.

Fourth generation evaluation was chosen because of its focus on stakeholders providing a practical mechanism for integrating stakeholders into EAR. This evaluation approach is also underpinned by empowering principles consistent with EAR (Guba and Lincoln, 1989).

2. The selected methodologies would fulfil the aims of the project and answer research questions arising from the

literature review – specifically, NCs’ and ANCs’ experience of their roles and what is important to them. The project aims are linked to the research questions and approach below (see Table 1).

3. The final reason for selecting EAR, integrated with fourth generation evaluation and its associated methods, is to continue to refine and build expertise using it. This approach was previously used in the RCN’s EPP (Manley et al., 2005).

Table 1 Project aims and research questions

Project aims	Research questions	Link with research approach
1. Enablement of NCs and ANCs to become more effective through a programme of support (including action learning) which focuses on developing expertise across the range of NC functions.	<ul style="list-style-type: none"> • What is the nature of NC work? • How can NCs and ANCs be supported to become more effective in their work? 	EAR is about helping co-researchers (be that the NCs, ANCs, or the research team) research their own work, both individually and collectively, for the purpose of developing their practice, themselves and others as well as generating theory of value to others. The approach starts with how NCs, ANCs and the research team experience and envision their roles. Fourth generation evaluation helps to identify the stakeholders that are relevant to NCs and ANCs and provides a mechanism to find out what is important to these stakeholders.
2. Facilitation of ANCs to develop expertise in all the functions of the NC.	<ul style="list-style-type: none"> • How are ANCs effectively prepared? 	EAR enables spirals of action, reflection, evaluation and theorisation to occur in relation to what is important to ANCs and how they are helped.
3. Examination of the impact of a programme of support (including action learning) on NCs and ANCs	<ul style="list-style-type: none"> • How can NCs and ANCs be supported to become more effective in their work? 	EAR and fourth generation evaluation through spirals of action, reflection and evaluation and the involvement of stakeholders generates data that can demonstrate impact on personal and professional effectiveness.
4. Exploration of the impact of NCs through using evaluation approaches that can be used in the workplace.	<ul style="list-style-type: none"> • How can nurse consultants be helped to demonstrate their impact? 	EAR and fourth generation evaluation through spirals of action, reflection, evaluation and theorisation and the involvement of stakeholders generates data that can demonstrate impact on others and the service.

2.2.4 Refinements in using the methodology

This project set out to develop the research approach from its use in the EPP.

The main differences between this nurse consultant study and the earlier EPP are that practitioner-researchers were involved in the full cycle of action through to collaborative analysis, interpretation and creating theory from the project data.

Other differences were:

- needs-led workshops were included as well as action learning
- practitioner-researchers were not designated their own critical companion, although critical companion processes were used by facilitators

Table 2 illustrates this continuum towards full collaboration and other differences which are explained more fully in Chapter 3.

Table 2 Similarities and differences between EPP (Manley et al., 2005) and the nurse consultant study; bold italics highlight subtle practical differences between the two projects

Design	RCN EPP	RCN NC project
Research aims	<ul style="list-style-type: none"> • To develop a recognition process for expertise. • To further refine our understanding of expertise in British nursing and its different specialities. • To begin to explore the outcomes of expertise. 	<ul style="list-style-type: none"> • To develop effectiveness and demonstrate impact of NCs and ANCs. • To facilitate ANCs to develop expertise in all the functions of the NC. • To examine the impact of a programme of support on NCs and ANCs. • To explore the impact of NCs through using evaluation approaches that can be used in the workplace.
Research approach	EAR and fourth generation evaluation.	EAR and fourth generation evaluation.
Selection of practitioner-researchers	Most were self-selecting against criteria.	Self-selecting against criteria.
Designated practitioner-researchers	<ul style="list-style-type: none"> • Expert practitioners investigating the nature of their own expertise. • Critical companions developing their role. • Research team: <ul style="list-style-type: none"> (a) facilitating other practitioner-researchers (b) developing the professional recognition process for expertise. 	<ul style="list-style-type: none"> • NCs developing and evaluating their role, nature of their work and impact. • ANCs developing their effectiveness and evidence for NC role. • Research team: <ul style="list-style-type: none"> (a) testing out theoretical and practical insights about facilitating practitioner-research gained in the EPP. (b) supporting ANCs in developing their role.
Help with being practitioner-researchers provided by:	<p><i>Critical companions.</i> Peers in action learning. Research team.</p>	Peers in action learning. Research team.
Other co-researchers	<p><i>Users, carers</i> Interdisciplinary team in healthcare setting. Pilot phase stakeholders. Critical review panel involved in recognition process.</p>	Interdisciplinary team in health care setting.

Design	RCN EPP	RCN NC project
Processes	Action learning and negotiated needs led work. <i>Critical companionship.</i>	Action learning and negotiated needs led work. <i>Workshops.</i>
Tools	Qualitative 360 degree feedback. <i>User/care narratives.</i> <i>Observation of care.</i>	Reflection in and on practice. Qualitative 360 degree feedback.
Data sets arising	<i>Expert practitioner portfolios.</i> <i>Critical companion portfolios.</i> Action learning set data. Critical review panel meeting field notes and panel's reports on portfolios.	Action learning set data. <i>Concerns, claims and issues.</i> <i>Practice strategies for specific issues and theorisation.</i> <i>Reflective reviews.</i> <i>Workshop data.</i>
Who analysed the data	Expert nurses analysed their own data in developing their portfolios of evidence of expertise. Research team analysed all data sets as a whole (meta-analysis).	NCs and ANCs analysed: 1. own data 2. <i>project data collaboratively</i> Project team undertook meta-analysis.
Theory development and methodological development	Research team created theory from meta-analysis. Expert nurses theorised own practice.	<i>NCs and ANCs developed collaborative practice theory.</i> Project team completed theory development using NCs and ANCs practice theory.
Report presentation	Research team.	Research team.

- participants were not expected to produce a portfolio of evidence as part of the project. In the EPP, developing a portfolio was part of a process which led to RCN accreditation of NCs' expertise.

Our project also aimed to clarify and explain the relationship between EAR and fourth generation evaluation more fundamentally, with the project team researching its own use of the methodology. The insights that emerged are covered in Chapter 3.

2.3 Practitioner researchers and the critical community: concepts and implications within the context of the research approach

There were three different groups of co-researchers in this study:

- NCs who were researching and investigating their own practice as practitioner-researchers, with regard to becoming more effective and demonstrating their impact
- ANCs who were researching and investigating their own practice as practitioner-researchers, with regard to developing evidence of their increased effectiveness and readiness for NC roles
- the research team, made up of two senior research facilitators and a research assistant, who were:
 - researching and investigating how to help and support the NCs and ANCs in their aims through using the selected approach
 - further developing the research approach by building on their experience of the RCN's EPP

- maintaining administrative control of the project with the aid of an administrator who provided part-time support.

‘Participants in EAR are termed co-researchers because they participate in and contribute to the study in some way ...’ state Manley et al. (2005). ‘This is different from traditional research approaches where the researcher is considered an objective expert, gathering information from the research subject. In the context of this study, co-researchers as partners shared knowledge and power so their views and perspectives were accorded equal status to others.’

The co-researchers were able to help shape the project’s development by:

- collaboratively engaging with the research team
- negotiating how to capture data
- gathering and analysing data as it emerged through the project, both individually and collectively.

Being a co-researcher encouraged participants to become involved and integral to all aspects of the process. It allowed joint reflection and reciprocal learning between all involved. These opportunities ranged from working individually on reflections of practice, exposing one’s own reflections to critique within action learning sets, working collaboratively within one’s own action learning sets, and working collaboratively on workshop days which involved all co-researchers and the research team.

2.4 The recruitment and selection process

The research team initially intended to recruit NCs and ANCs from all four UK countries, but this was not possible because of the then dearth of nurse consultant posts in Scotland, Wales and Northern Ireland

(resulting from slower policy implementation than in England). Participants were therefore drawn predominantly from England, although other countries were not excluded. Within the resources available, we envisaged three cohorts of eight to ten NCs/ANCs.

We used four methods of recruitment:

1. Information provided to a convenience sample – a group of 10 NCs in the Mid-Trent region who had previously approached the RCN Institute for support in action learning. This group was a discrete group already working together. Subsequently they became Cohort 1 – the Nottingham group.
2. Information provided to the members of an NC network about the project. This network was a free, volunteer database for all those who were NCs, ANCs, interested in supporting NCs or who had a policy interest (the network was a joint initiative between the RCN and the Foundation of Nursing Studies, and members could search for information about other NCs’ specialisms or practice development projects).
3. Information provided to all RCN members through RCN Bulletin newsletter.
4. Information provided to the British Association of Critical Care Nurses which at the time had the largest number of appointed NCs compared with other specialisms, numbering over 50.

The criteria for inclusion within the project were:

- voluntary participation
- willingness to attend all the monthly action learning sets and collaborative workshops
- willingness to join an action research study as a co-researcher

- support from a line manager.

The response exceeded the number of places available and so selection was made according to the following criteria:

- those who applied first
- achieving equitable representation wherever possible across:
 - different specialisms
 - England regions.

We compiled a waiting list and drew on it in the early part of the project to replace participants who did not proceed after the first workshop or early sessions. The first workshop day (5 July 2002) provided participants with detailed information about the project, its research approach and its processes, so that potential participants could make informed judgements about the commitment they would be making during the 18 month project.

2.5 The profile of participants and participation through the project

2.5.1 Speciality and geographical location of participants recruited

Appendix 1 provides details about the nursing speciality and geographical location of the two NC cohorts recruited and the cohort of ANCs.

2.5.2.1 Nurse consultants

Of the 20 NCs recruited for the project, one withdrew before its commencement and three never attended action learning; these were replaced by two late starters drawn from the waiting list.

Of the 18 NCs who commenced the project, eight NCs actively or passively withdrew for the following reasons:

- three attended only one/two sessions and stopped coming without notice or explanation
- three, including one late starter, withdrew a third of the way into the project due to work commitments
- two developed serious illness: with one having to withdraw a third of the way through the process. The other unfortunately passed away.

Ten (55.5 per cent) of the 18 NCs continued with the project. It is interesting to note that neither of the two NC late starters continued with the project.

Aspiring nurse consultants

Of the initially selected 11 ANCs, two never attended the project and were replaced from the waiting list by two late starters. Of the 11 ANCs who commenced the project, four withdrew actively or passively:

- one late starter left after two sessions because the project competed with a prescribing course that was mandatory for their work
- two attended just one session, and then did not attend again
- one withdrew after six months and moved overseas.

Seven (63.6 per cent) of the 11 ANCs continued with the project, including one late starter.

2.6 The ethical challenges of using the research approach within the context of a practitioner-researcher model

EAR is dedicated to acting morally and justly. Such action is reflected in the concept of praxis, which is concerned with committed and informed action (Grundy, 1982) by practitioners. With emancipatory approaches, the commitment is also to change systems that work against justice and equity. The potential for research facilitators to exploit and manipulate participants does exist (Grundy, 1982), although this can be minimised through making explicit the project criteria for trustworthiness, working collaboratively and openly, making explicit values and beliefs, and developing a critical community where critique, challenge and support are the norm.

The ethical issues involved are complicated when researching professional practice.

One of the biggest challenges of this project hits at the heart of being a practitioner-researcher and helping others to be so. By its nature, emancipatory/transformational action research is an ethical endeavour, yet the context in which such research operates may itself be an ethical constraint.

One paradox is that both ethical and professional practice would be characterised as systematic and rigorous if one is trying to develop one's effectiveness in daily practice. One might be theorising about practice, using and justifying different types of evidence, and being involved in supervision. But by using these processes and calling them research, one brings into play the complicated processes for ethical approval required for any research that carried out in a clinical environment. As a result, barriers can arise which work against developing and

researching our own practice. Whether something – for example, undertaking patient stories – is called research or audit, may determine whether it requires approval from the local research ethics committee (LREC). The time and bureaucracy involved in obtaining approval from either local or multi-centred research ethics committees (LREC/MREC) hinders practitioners when trying to incorporate the views of other stakeholders in research.

For example, NCs in this study who chose to obtain feedback from colleagues using qualitative 360 degree feedback raised issues. Good ethical practice in using such a tool includes respecting the choices of individuals if they decide not to respond or wish to remain anonymous. Given that we took this ethical approach, one chair of a LREC suggested that if the work was called audit in the final report then LREC approval would not be required. However, the NCs concerned held their ground, stating the study was not audit but 'action research'. Therefore, it was clear that approval would be required. So the research team submitted an ethics proposal for approval to cover all the participants. The time it took to receive approval meant that it was almost impossible for the NCs to use 360 degree feedback before the end of the project, although three NCs did succeed through pure perseverance. Guest et al's 2004 study had found the same problem, with the need for similar LREC/MREC approval and research governance support preventing them from using extensive stakeholder feedback in their study.

In the earlier EEP action research study, co-researchers experienced similar issues. Subsequently, the research team recommended that practitioner-researchers should have access to protocols they can use to investigate their own practice, which are evidence-based and do not need repeated ethical approval (Manley et al., 2005). In the earlier study it was necessary

‘ ... to develop research protocols for tools, such as qualitative 360 degree feedback and user narratives, as well as observation of care, in order to develop multi-centred research ethics proposals. These protocols were designed by the action research team, practitioners, and critical companions to enable the practitioners to develop research dialogues with their stakeholders and to enable critical companions to observe them in practice. Again, these are actions that would normally be everyday practice within a critical community. However, because there is a critical intent to transform individuals, teams, organisations or communities and to create new knowledge, there is a need to convince research ethical committees that such activities should be exposed to ethical committee critical review and not be brushed under the covers by such committees as audit ... ’ (Manley et al., 2005).

A MREC proposal was submitted and approved for the NC project, but because of the collaborative nature of the project it was unclear what data the NCs and ANCs would want to collect from others about their professional practice until some way through the project. This is because the project processes focused on establishing what is important to NCs and ANCs, and therefore could not be predicted in advance. The decision to submit to an ethics committee meant enormous hurdles to be overcome, making the collection of data from colleagues and patients difficult.

This is our paradox:

- Wanting action research into professional practice to be seen as research by ethical committees.
- Recognising that the delay involved will impact on practitioners’ efforts to continually become more effective in their work.

We therefore further recommend that research-based protocols are developed in this and other action research studies for

areas such as patient narratives and stories, observations of practice and 360 degree feedback. These could be used by future practitioners researchers and submitted to ethics committees to reduce the delay⁷.

2.7 Conclusion

We have set out the reasons for our choice of research approach, particularly in relation to how it builds on earlier experiences of using the same approach in the RCN’s EPP. But in this study:

- practitioner-researchers were involved in the full cycle of action, including the collaborative analysis, interpretation, and theorising of the project data
- needs-led workshops were included in addition to action learning
- practitioner-researchers were not designated their own critical companion, although critical companion processes were used by facilitators
- portfolio development was not made an expectation (in the EPP this had led to RCN accreditation of expertise).

⁷ These research protocols were eventually developed within the RCN’s Workplace Resources for Practice Development (RCN, 2007) as part of an action research study with Addenbrookes NHS Trust and additionally the protocols for the Expertise in Practice Project were published in Hardy (2009).

3

Methods, analysis and theory construction framework

3.1 Introduction

This chapter describes and explains the processes, methods and tools used in the EAR approach and fourth generation evaluation, and provides insights developed from their use.

We also describe how data was derived. This includes the framework used, which was refined during the project to accommodate additional information from action learning. The framework linked trigger events, strategies for action, achievement of goals and existing theory, illuminating our unfolding understanding and enabling us to develop theory from nursing practice.

We describe the data sets – the raw data from different sources – and the key themes derived from the primary, secondary and tertiary analysis.

3.2 Overview of project processes/methods

The two main methods used to support the NCs and ANCs in the research of their own practice during the 18-month project were:

- monthly action learning sets (within cohort meeting days), which included reflection in and on practice, the presentation and critique of data gathered during the previous period, and time allocated for addressing negotiated needs and collaborative analysis
- six-monthly collaborative workshops at which all three cohorts came together.

At these forums, the research team worked with the co-researchers, helping them to research their own practice and

collaboratively participate in the process – from generating questions and data, to undertaking analysis and theorising.

Unlike the previous RCN EPP, which also used this methodology (see Chapter 1, Table 2 in Manley et al., 2005), the co-researchers in this study were not requested to select a designated critical companion although the research drew on the principles of critical companionship – a helping relationship (Titchen, 2000).

3.2.1 Action learning incorporating reflection on action, being critical, critical dialogue and the developing shared meaning and understandings

3.2.1.1 Overview of the process

The monthly action learning sets for each cohort typically ran between 10.30am and 4pm, and were interspersed by six-monthly collaborative workshops. They were held from August 2002 until November 2003. Each cohort requested up to three further meetings, which informally extended the project until April 2004.

Although the monthly meetings were termed action learning, these were in fact cohort meetings which contained a number of negotiated components reflected in the structure outlined in Box 3.1. These were underpinned by agreed ground rules developed at the first meeting.

Box 3.1 Typical components and structure of cohort meetings

- Brief update from each person.
- Use of the concerns, claims and issues tool.
- Negotiation of agenda and focus of meeting arising from collaboratively theming concerns, claims and issues.
- Validation of previous notes, updating action points, revising agenda.
- Time allocated for action learning (presentation of data and preliminary analysis).
- Time allocated for analysing action learning data from six months onward (the data presented by all set members at that meeting).
- Time allocated for exploring negotiated needs identified from concerns, claims and issues.
- Evaluation.

Initially, Angie Titchen and Kim Manley facilitated the process for the cohorts, but in the spirit of collaborative inquiry this responsibility became shared by, and rotated around all, cohort members.

The research assistant acted as participant observer but was responsible specifically for:

- audio recording the meeting (with permission from participants)
- compiling a set of meeting notes (rather than transcribing) from the audiotapes which were validated at the subsequent meeting
- undertaking initial theming for verification by set members in the first six months
- maintaining an audit trail of events.

3.2.1.2 The process of action learning for helping participants to become more effective

Action learning is a key mechanism for enabling practitioners to develop their personal and professional effectiveness (Cunningham; 2000a, 2000b), as well as for gathering evidence to demonstrate this development (Manley et al., 2005). Action learning is a continuous process of learning and reflection, supported by colleagues, which leads to getting things done (McGill and Beaty, 2001). It is one way of enabling practitioners to take action in the workplace and to overcome the many barriers that work against transformation. As a formal mechanism, it enables critique and reflection – essential attributes of an effective workplace culture which promotes staff empowerment, practice development and the achievement of quality patient services (Manley, 2001). Manley (2001) highlights these emancipatory processes as central to the role of nurse consultants in achieving cultural change. They are also influential in helping others learn from their experience through critical companionship (Titchen, 2000).

Action research is linked to action learning and structured reflection. In this study these all share the processes of enlightenment, empowerment and emancipation (Fay, 1987). These emancipatory processes are used to help individuals and teams free themselves from internal and external constraints, oppressive structures, and the taken-for-granted assumptions in everyday practice.

Working with action learning processes also gave our cohorts the opportunity to draw on multiple ideas and perspectives from the wider group. In addition, it allowed them to develop a common vision and the skills to provide support and challenge, which are necessary to change and sustain a culture of effectiveness.

An action learning set is a group of people working together for a concentrated period in a continuous process of learning and reflection (McGill and Beaty, 1992). Structured reflection in and on practice is central to the process, and aims to uncover tacit knowledge gathered through people's work experience previously difficult to articulate (Schon, 1983).

The action learning component of our cohort meetings involved individuals presenting critical incidents important to them in their work.

Members then helped the presenter analyse the incident, through providing high levels of challenge and support, using a framework (after Johns, 1995) to:

- unpick the critical incident, identifying the key question they wished to address
- uncover the 'taken-for-granted' aspects in the incident
- identify the internal and external factors impinging on the incident
- help the presenter to:
 - identify strategies
 - explore consequences
 - capture action points emerging from the process
 - clarify learning.

In total, participants presented 40 critical incidents in action learning; 23 from NCs and 17 from ANCs (see Appendix 2). We later linked these to emerging themes from meta-analysis.

At later meetings, the presenter then reported their findings about the action they had taken, its impact and effectiveness. Using the verified notes cohorts then undertook a joint analysis of each presentation (McTaggart, 1991; Prideaux, 1995), revisiting this over time to review the achievement of stated action points. They

used a framework developed by the research team to identify:

- trigger concepts influencing the presenter's work
- the goals they were trying to achieve
- the strategies they undertook to achieve their goal
- evidence of goal achievement
- related theory.

This framework also provided the structure for recording the sources and locations of evidence for each aspect (triggers, goals, achievements, etc). Using critique, NCs and ANCs were able to examine and evaluate their work using personal insights and the insights of others, helping them to learn more about what they did well, and to develop different ways of practising.

Initially, the facilitators supported the set members in developing expertise in using these processes. They acted as models for the set members, as well as coaching them, so that members could gradually become full collaborators in the practitioner research process.

3.2.1.3 Theory analysis framework for data emerging from action learning

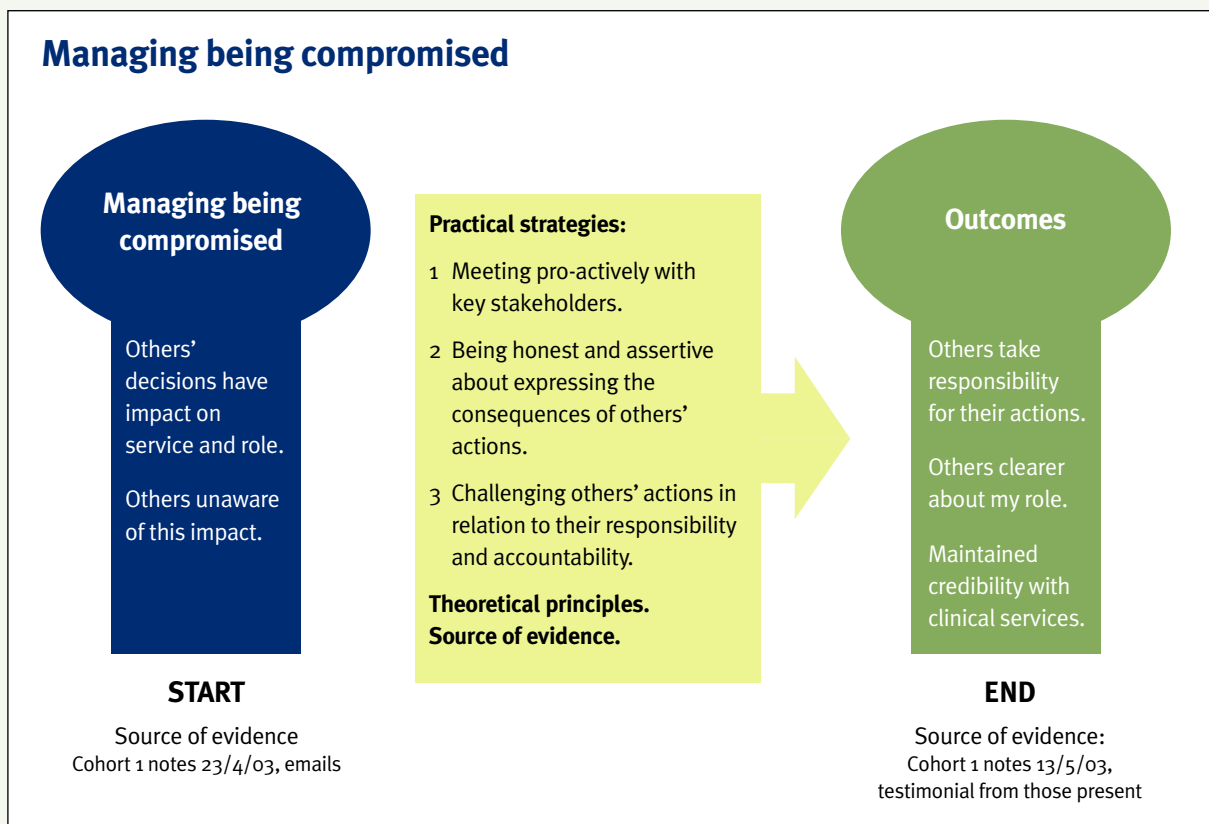
The framework referred to above was designed to capture and theorise practice development in an earlier action research study (Binnie and Titchen, 1999). It was refined and presented to co-researchers to help the NCs and ANCs understand how analysis of their own practice could contribute to generic theory. We also used the framework to capture similarities and differences of the cohorts.

We revised the framework several times as it was used, culminating in the full framework outlined in Figure 3.1. This uses an example, 'managing being compromised', to demonstrate how it worked. The theoretical framework demonstrates the trigger issues

(start) presented by one or more practitioner-researchers. Through the action learning process and across all the cohorts, a number of strategies were identified that were documented, tried and refined in practice over a period of time. The outcomes resulting from their implementation are also identified.

At each stage in the framework, we collated evidence from a number of different sources to substantiate the issue, the strategies used and the outcomes achieved. We also considered theoretical principles set out in literature to strengthen understanding of the issue or to challenge the theory in response to practical experience.

Figure 3.1 Framework for theorising



3.2.2 Workshops

Four collaborative workshops (three single days and one two-day residential workshop) enabled all three cohorts to work together as a collaborative community when analysing the data. Each workshop began by using the concerns, claims and issues (CCI) tool as a basis for deciding the work of the day. Each workshop also had a specific purpose.

3.2.2.1 Workshop 1

Workshop 1 marked the beginning of the project in July 2002. The workshop brought together all participants so they could:

- capture the concerns, claims and issues at the beginning of the project
- develop a common vision about the NC role
- be given information about the project
- learn about the commitment and expectations required for action learning, so they could make an informed decision about whether to participate.

All participants clarified their values and beliefs about the NC role, so we could all explore how these related to, or influenced, actual practice (Warfield and Manley, 1990). The workshop allowed development of a common vision, as befitting an EAR approach (Manley et al., 2005).

3.2.2.2 Workshop 2

Workshop 2 took place six months into the project in January 2003. It included progress updates from each cohorts, exploration of workplace cultures using collage, and planning time for presentations at RCN Congress. The main focus was on analysing the data from the cohorts, using notes and a provisional analysis by the research assistant. Co-researchers worked in six groups of three – one from each cohort – to analyse the same data sets, namely the themes arising from concerns, claims and issues and from action learning.

We also introduced the framework for theorising the results of action learning (see Box 3.1).

3.2.2.3 Workshop 3

Workshop 3 was a two-day residential session held in June 2003, a year into the project. In advance of the workshop, NCs and ANCs looked at their learning and leadership styles using a range of tools. However, the workshop took on a life of its own. Using the CCI tool (Table 3.1) led to sessions on joint analysis and a re-negotiation of the content of the two days. The resulting creative expressions and data analysis informed the findings chapters (Chapters 4, 5, 6) and the final meta-analysis.

While recognising that there were key issues for individuals' own action learning, the workshop participants agreed to focus on the two priorities, namely:

1. "What are the products/outcomes I want from this project?" This was also linked to "What do I have to do/not do in relation to each product?"
2. Looking at the evidence, data analysis so far.

Work on the first issue led to identification of outcomes NCs and ANCs wanted, and what was and was not available.

Work on the second issue culminated in their agreeing an action plan and a glossary of terms to support consistent use of language, which had been raised as a concern.

The practitioner-researchers undertook a cognitive mapping exercise assessing how they felt in relation to the project's aims. In response to the statement: "I feel I am able to demonstrate/evaluate my impact as a consultant/aspiring nurse consultant and further increase my effectiveness.", the researchers indicated their position on a

Table 3.1**Themes arising from a collaborative analysis of Workshop 3: claims, concerns and issues**

Claims	Concerns	Issues
<ul style="list-style-type: none"> • Feel supported. 	<ul style="list-style-type: none"> • Timescales. 	<ul style="list-style-type: none"> • What are the products?
<ul style="list-style-type: none"> • Feel valued. 	<ul style="list-style-type: none"> • Decreasing and transient attendance. 	<ul style="list-style-type: none"> • What factors influence participation?
<ul style="list-style-type: none"> • All cohorts coming together is a positive experience. 	<ul style="list-style-type: none"> • Working with the project's data. 	<ul style="list-style-type: none"> • How do we go about gathering the evidence.
<ul style="list-style-type: none"> • Having legitimate development time. 	<ul style="list-style-type: none"> • Project's profile. 	
<ul style="list-style-type: none"> • Clarifying career direction. 	<ul style="list-style-type: none"> • Comparative low status compared with medical counterparts. 	
<ul style="list-style-type: none"> • Developing nurse consultant skills. 		
<ul style="list-style-type: none"> • Achieving personal outcomes. 		
<ul style="list-style-type: none"> • Achieving project group outcomes. 		
<ul style="list-style-type: none"> • Nurse consultants improve care. 		

cognitive map. Their range of experience extended from feeling strongly unable to demonstrate and evaluate their effectiveness (indicated by --) to feeling very positively that they could demonstrate and evaluate their effectiveness (indicated by ++).

Figure 3.1 summarises the responses to this mapping. They also developed justifying statements to substantiate their perceived position. These statements provided valuable data for understanding participants' position.

Figure 3.1 Cognitive mapping: perceived positions of NCs and ANCs about the statement "I feel I am able to demonstrate/evaluate my impact as an NC/ANC and further increase my effectiveness."

Strength of feeling	--	-	+	++
Number of responses	0	0	9	1

3.2.2.4 Workshop 4

The final workshop took place in December 2003 to close the project and celebrate achievements. As usual, the CCI tool was used to start the day and then the workshop focused on:

- analysis of the themes arising from action learning and identification of overarching themes (Appendix 2) and the claims, concerns and issues (Appendix 3 and 4)
- concept maps derived from action learning

- a conceptual framework for NCs and related mapping tools
- early development of standards for the consultancy and researcher role in practice
- identification of metaphors that reflect personal experiences of the project
- preparation for reflective reviews as a summative evaluation of the project from a personal perspective.

3.3 Specific tools used to generate data by the co-researchers

In addition to the cohort meetings and the collaborative workshops, three specific tools were used:

- CCI tool
- qualitative 360 degree feedback
- reflective review.

These tools helped to identify issues of significance, guide the project's direction, generate data about their roles from the perspective of others, and gather data about their ongoing learning and experience of the project processes.

The first tool (CCI), has already been defined (Chapter 2) but is further explained below. The other two were used at the end of the study.

3.3.1 Concerns, claims and issues (CCI)

Chapter 2 explains the focus on concerns, claims and issues of stakeholders is central to fourth generation evaluation. The stakeholders in this context were primarily the NCs, ANCs and the research team – all were co-researchers. Other associated stakeholders were involved – namely colleagues within the NCs' role set. Firstly, they contributed to qualitative 360 degree feedback (Garbett et al., 2007). Secondly,

they were involved through the collaborative actions undertaken by the participants in their workplaces.

Methodologically, the CCI tool was introduced to strengthen EAR when working with stakeholders. It also provided a model for stakeholder involvement for NCs and ANCs to use in their daily work with others to achieve a culture that values all and seeks to develop a common vision (Manley, 2001).

The **CCI** tool was used initially for:

- brainstorming **claims** about the:
 - NC role/own role if an ANC
 - own practice
 - project processes.
- brainstorming **concerns** about the
 - NC role/own role if an ANC
 - own practice
 - project processes.
- brainstorming **issues** in the form of questions that needed to be asked about what reasonable people may agree concerning the:
 - NC role/own role if an ANC
 - own practice
 - project processes.

CCI were themed collaboratively to inform the agenda that action research should focus on. The approach had been used in the EPP (Manley et al., 2005), but we became more sophisticated in using it for this project as we refined our understanding of the relationship between EAR and fourth generation evaluation. CCIs proved to be a tool providing specific, practical help with the impetus and direction of the action research spirals.

Concerns and issues have a close relationship to each other, with issues often being a more developed concern in the form of a question. Such questions were

predominantly action orientated. For example: “How do we raise the profile of NCs?”; “How do we engage a key stakeholder group?”; or “How do we influence the strategic agenda?” We discovered that by using CCI as a tool we could reach a consensus about the focus of collaborative activity. Research questions derived from the issues acted as triggers for spirals, from the perspective of the collective community or from an individual’s practice.

Action research includes a spiral of interrelated cycles of: planning; acting; observing and reflecting, which are systematically and self-critically implemented (Grundy, 1982). Hart and Bond (1995) state these cycles are not linear, but are more open-ended and process-driven, as one would expect through an empowering approach. However, the three strands of research, action and evaluation in action research interact within a dynamic process, where sometimes they are so tightly interlinked they may be indistinguishable, while at other times one may dominate (Elliott, 1991; Hart and Bond, 1995). Our insights from using CCIs helped to identify a process for highlighting triggers to this spiral of activity, so that each spiral is initiated by a ‘how’ question.

While we tended to use claims (positive assertions) to identify celebratory outcomes, in future projects claims could be used to develop action hypotheses requiring testing, again as the impetus for an action research spiral (see Binnie and Titchen, 1999).

Appendices 3 and 4 set out the collaborative analysis resulting for claims, concerns and issues.

3.3.2 Qualitative 360 degree feedback

360 degree feedback is based on the principle of: ‘... the systematic collection and feedback of performance data on an individual or group, derived from a number

of the stakeholders in their performance ...’ (Ward, 1997:p.4).

Qualitative 360 degree feedback was a tool developed with co-researchers in the EPP (Manley et al., 2005; Garbett et al., 2007; Hardy et al., 2009) to obtain qualitative feedback rather than numerical data from the nurse participant’s role set (colleagues and patients/users). A specific research protocol was developed to involve users as co-researchers within the process. The EPP generated valuable feedback for the practitioner-researchers about their effectiveness and the areas for ongoing development.

In the NC project, many participants showed interest in using this tool to gain feedback. But the developing research governance agenda meant it proved a difficult undertaking in terms of obtaining ethics approval. A flow chart (Appendix 5) was developed to help participants plough through the minefield of obtaining ethical committee approval.

While a small number of our practitioner-researchers were not required to submit an ethics proposal (following consultation with their R&D teams), many were requested to do so. As the amount of work involved in submitting to an LREC is extensive, the research team decided to develop and submit an MREC proposal. The lack of familiarity of these committees with our research approaches meant approval took considerable time. This was demotivating many participants. Three NCs completed a 360 degree review, and one further published this as a qualitative review within a journal article.

3.3.3 Reflective reviews

Reflective review was developed by Johns (1995) as an evaluation tool following a period of clinical supervision, using structured reflection in and on practice to:

- capture the main focus of reflections over a period of time
- capture evidence of learning and change in practice over time
- identify barriers and enablers to reflection over time
- inform future structured reflection.

A reflective review includes a number of key questions (see Box 3.2) that guide analysis – in this case, of data captured over the course of the study .

Five NCs completed reflective reviews, and these were shared and critiqued at cohort meetings. Analysis was undertaken at the end of the project by the research team (see Appendix 6).

3.4 Data and data analysis

All data sets were thematically analysed. This does not involve counting the number of items that present. Rather it involves authentically capturing the essence of what is important and verifying these essences. This approach involved participants and research team working with the data from a number of sets in cohort meetings and workshops. The emergence of categories and themes inductively from each data set were discussed and tested for clarity and comprehensibility by the practitioner-researchers who had provided the data. Primary, secondary and tertiary levels of analysis took place within the action learning sets and workshops. The final meta-analysis was completed by the research team, and the draft report sent for contestation to all practitioner-researchers.

Box 3.2 Questions guiding the reflective review (after Johns, 1995)

1. What were your hopes, fears, expectation for the nurse consultant project?
2. What are the consequences (positive and negative) of being involved in the nurse consultant project for:
 - yourself?
 - your colleagues/team?
 - your patients/users?
 - your service?
3. What internal factors have influenced your participation in the project?
4. What external factors have influenced your participation in the project?
5. When analysing your evidence what are the key work themes emerging for you?
6. What have you learnt from being involved in the project about
 - yourself?
 - your role as a NC/ANC?
 - action learning?
7. From your analysis of work themes in question 5 what are the areas you would want to focus on in action learning in the future?
8. Any other action points emerging?
9. Prepare a paragraph for your manager (informed by the above analysis) that identifies how being in the nurse consultant project has begun to:
 - contribute to developing a work-place culture that is person-centred, effective, and
 - evidence-based, **and/or**
 - contribute to the organisation's vision and or strategic objectives.

Table 3.2 The data sets used for analysis, how the analysis was undertaken and by whom

Footnotes link to the relevant appendix for the audit trail for each data set

Data sets	Primary analysis	Secondary analysis	Tertiary analysis
Action learning notes	Themes identified around the focus of critical incidents brought to action learning within each cohort identified. Analysis: Researcher practitioners and research team facilitators in each cohort.	Themes identified around the focus of critical incidents brought to action learning across all cohorts . Analysis: Researcher practitioners facilitated by research team.	Refinement of data themes. ⁸ Analysis: Research team.
Action learning notes	For each critical incident the following data was extracted within each cohort : <ul style="list-style-type: none"> • key questions • internal and external factors • strategies • consequences, • action points. Analysis: Researcher practitioners and research team facilitator.	Each incident was further analysed within each cohort and themes transferred to a theoretical framework to reflect its: <ul style="list-style-type: none"> • triggers • goals • strategies • evidence source • relevant theory. Analysis: Researcher practitioners and research team facilitator.	Themes across the theoretical framework for similar triggers were synthesised across all the cohorts . Analysis: Researcher practitioners and research team.
CCIs	Each cohort themed its own <ul style="list-style-type: none"> • claims • concerns and issues combined. Analysis: Researcher practitioners and research team facilitator.	All claims ⁹ and combined concerns and issues ¹⁰ themes emerging from all cohorts and workshops identified. Analysis: Researcher practitioners and research team.	Synthesised with all data analysis into key themes. Analysis: Research team.
Workshop notes	<ul style="list-style-type: none"> • Expressed values and beliefs. • Hopes fears, expectations. • Cognitive mapping. • Products and outcomes. Analysis: Practitioner researchers and research team.	Framework generated for focus of NC. Analysis: Undertaken by Cohort 3.	Synthesised with all data analysis into key themes.
Reflective reviews	Categories and themes identified for each individual reflective review. Analysis: Research team.	Common categories and themes identified across all individual reflective reviews. ¹¹ Analysis: Research team.	Synthesised with all data analysis into key themes. ¹² Analysis: Research team.

8 Appendix 2 Final analysis of critical incident themes

9 Appendix 3 Final analysis of claims across study

10 Appendix 4 Final analysis of concerns and issues across study

11 Appendix 6: Final analysis of reflective reviews

12 Appendix 7: Synthesis of all data themes into one framework

Table 3.2 summarises how the data sets were used for analysis and what was done at each level of analysis. It also shows who undertook the analysis. Footnotes link to the relevant appendix for the audit trail of each data set. The categories and themes resulting were synthesised into one framework (see Appendix 7).

Four overarching themes were identified and were used to develop in depth examples of the data:

- role of the NC
- impact of the context on NCs and ANCs
- outcomes
- project processes.

A final meta-analysis was then undertaken by the research team (see Appendix 8) to capture starting points and end points of the three journeys taken by NCs and ANCs, as they strived towards:

- becoming researcher practitioners, integrating learning and inquiry into their everyday practice (A in Appendix 8)
- achieving greater effectiveness in their roles (B in Appendix 8)
- achieving organisational effectiveness (C in Appendix 8).

The processes we identified as influential in helping NCs and ANCs on their journeys were integrated with examining the process of becoming a researcher-practitioner. This was in turn guided by a continuum identified for integrating learning and inquiry as an active learner – one of the main characteristics of a contemporary view of work-based learning (Manley et al., 2009).

4

Moving towards being a practitioner researcher

4.1 Introduction

Participatory research approaches are more likely to engage participants in simultaneously transforming their workplace practice, and researching the ends and means of that transformation. In this study, we valued participants as practitioner-researchers, experiencing and developing processes to help them achieve and demonstrate their effectiveness as NCs or as ANCs, and to help others to do the same. We also claimed, from our previous research and practice development work, that processes of action research are parallel to those that enable an ongoing critique of effectiveness in everyday work.

Nevertheless, we found that many participants in this study were unfamiliar with learning and research approaches that involve working collaboratively as co-learners and co-researchers, and with creating new knowledge through critiquing and researching their own practice. In order to achieve the research aims and enable participants to answer the research questions (see Chapter 2), we needed to develop participants into practitioner-researchers. While using knowledge created in the EPP (Manley et al., 2005; Hardy et al., 2009) to facilitate practitioner research in individuals, this study contributes new understanding about how to enable theoretical development at the collective, community level.

This chapter maps out the complex journey of preparing participants for the ethical endeavor of engaging in emancipatory/transformational action research, starting points, facilitation of learning strategies used, and outcomes in developing

knowledge, skill-sets and the professional artistry of integrated learning and inquiry.

One participant's map (Workshop, June 2003)



4.2 Setting off

At the outset, participants asked about action learning and practitioner research, showing their unfamiliarity and uncertainty. Although they did have gaps in knowledge, skill-sets, and the professional artistry of integrated and reciprocal learning and inquiry, participants nevertheless took responsibility for managing the project, both as individuals and collectively.

4.2.1 Unfamiliarity and uncertainty

Predominant hopes, fears, and expectations for the study showed that this was unknown territory for participants (see Table 4.1), but these also showed that the participants were clear about their learning and professional development needs.

Table 4.1 Participant hopes, fears and expectations

Hopes	Fears	Expectations
<ul style="list-style-type: none"> • Learning from others about the role (RR 1-5). • To be challenged, identify strengths and weaknesses and be supported (RR 1, 3, 4). • Learn about action research and action learning (RR 1, 3, 4). 	<ul style="list-style-type: none"> • Lack of theoretical understanding (RR 1, 2, 3). • Workload and commitment (RR 1, 2, 3). 	<ul style="list-style-type: none"> • Demonstrate my effectiveness/review my role (RR 1, 3, 5). • Help me fulfil my role, critique role so as to shape it (RR 1, 3, 4). • Skills and professional development (RR 1, 3, 4).

Participants indicated uncertainty in their early concerns with the project processes and approach: “How will I do this on top of a busy workload?” (Workshop 5/7/02); “I feel unsure/hesitant about the project” (C1 4/9/02); “Trying to get to grips with the project information” (C1 4/9/02); “Where am I going, what are we doing?” (C1 7/8/02); “The unknown” (C2 30/10/02).

A few months later, after experiencing action learning, some participants were still feeling “unsure of the process, especially reflection” (C1 28/10/02) and were experiencing difficulty in challenging.

“Difficult to challenge if you don’t understand the area/topic being presented.” (C1 28/10/02)

“Need to increase level of challenge/what is challenge?” (C1 28/10/02)

One NC reflected:

“At the start there appeared to be a lot of ‘going over old ground’. Several questions struck me. Was it:

- part of group formation?
- part of lack of consistency of group membership?
- part of me not being able to focus on me enough?
- part of me being irritated by other participants who were not ‘grasping the issues’. But whose issues?” (RD 5/9/02).

“I think it was all of the above, plus:

- a need for all to get to grips with an unfamiliar process
 - our inexperience at ‘doing action learning’ – that is, asking clarifying questions etc and therefore focusing ourselves
 - Angie’s caution with steering us too closely when we needed experiential learning time
 - our role confusion/overload/etc and the emotional investment in our anguish
 - the need to ‘trust the process’ (AT quoted in RD 4/11/03).”
- (C3 Reflective review 4).

Early concerns about being a practitioner researcher focused on the evidence, language and theory development. Uncertainty about gathering evidence was not about the methods to gather evidence, but around what type of evidence to gather and finding the time to do it:

“Finding time to focus on evidence collecting and finding the right evidence.” (Workshop 10/6/03)

“Evidence – time to do this – structured process needed.” (C1 13/5/03)

“Can anyone help me to structure my time or be more organised in gathering evidence tips etc?” (Workshop 10/6/03)

Unfamiliarity with theoretical and methodological language and with underpinning theory was evident:

“Language – understanding models and theoretical frameworks.” (C1 28/10/02)

“How important is good understanding of the theory/literature?” (C1 20/11/02)

“Hesitant about theoretical issues.” (C1 20/11/02)

A haiku (a Zen poem), written by participants, infers that a clear understanding of practice development (PD) was not held at the beginning of the project:

Ideas evolving
PD processes unfolding
Practices transformed.

(Workshop, June 2003).

In addition, most participants appeared not to have fully developed the skills for the mindful, intentional action that is essential for any form of expertise and, in this case, practice development and practitioner research.

4.2.2 Underdeveloped praxis skills

Praxis – intentional action with a moral intent – is central to undertaking transformational action research (McCormack and Titchen, 2006). Participants’ moral intent in this study was the improvement of patients’ experiences of care. Praxis is increasingly understood to be enabled by professional artistry, which is described as the hallmark of expertise in nursing practice and its facilitation (Titchen, 2000), transformational research (Titchen and Higgs, 2007; Titchen and McCormack, 2008) and active learning (Manley et al., 2009; Dewing, 2008).

Currently undergoing theoretical development, professional artistry

comprises seven interacting dimensions:

- qualities
- praxis skills
- multiple intelligences
- creative imagination
- multiple discourses
- artistic and cognitive critique
- transformational use of self.

These dimensions work together through blending, melding, interplay, synthesising, synchronising, balancing and attunement. We found that participants’ praxis skills of blending knowledge/evidence and engaging in different ways of knowing, needed development, as shown in Story 4.2. In this study, meta-cognitive ways of knowing (thinking about thinking processes) and reflexive ways of knowing (self-knowledge and awareness of impact of self in interaction with others) were of particular importance.

Story 4.2 Unable to sort out the wood for the trees

“Action learning – it took a while for me to realise that it would not ‘solve my problems for me’ but provide a vehicle for reflection and planned action ... I was all over the place – in a real muddle at times, which did not facilitate the process. I tried to tackle too much and then found myself unable to sort out the wood from the trees. I took far too long in organising my thoughts into a coherent framework, finding it really difficult to explain what I did, or what the issues were for me [meta-cognitive knowing]. I wanted to blame the [action learning] process, or the fact that my role was ‘different’ and the concept difficult for others to understand, when, in fact, my behaviour mirrored what was happening in the workplace. [reflexive knowing].”

(C1 Reflective review 2)

The praxis skills of deliberately discriminating and seeking out different kinds of knowledge and evidence (book knowledge and evidence created by research and scholarship, professional craft knowledge sourced from practice experience and personal knowledge gained through life experiences) to use in practice were not fully developed in all participants.

4.2.3 Taking responsibility for project management

Participants displayed a genuine commitment to ensure that the project was successful. In the early days, they showed this by being involved in decisions about the venue for meetings, equity of travel time, travel expenses, attendance, time commitment and motivation. Key concerns were:

“Lack of numbers attending.”
(C1 7/8/02)

“Will we (newcomers) get up to speed?” (C1 28/10/02)

“Keeping non-attendees up to date.”
(C2 11/9/02)

“What has happened to the people who aren’t here – reasons for dropping out?” (C2 17/12/02)

4.3 Facilitation of work-based learning and practitioner research processes

The action learning set leaders (Kim and Angie) are experienced facilitators of work-based learning, practice development and practitioner research, and use holistic, enabling facilitation approaches (Titchen, 2004; Rycroft-Malone, 2004; Manley et al., 2005). They used 10 principles for facilitating work-based learning (Manley et al., 2009) to develop a learning and inquiry culture, and participants’ praxis skills, and to sustain a

commitment to the project. These principles are consistent with the relationship, intuitive-rationality and facilitation domains of professional craft knowledge of the critical companionship conceptual framework (Titchen, 2004).

Stocking up for the journey (Participant workshop, June 2003)



4.3.1 Principle 1: Developing a learning and inquiry culture

The first step was to prepare and develop an integrated learning and inquiry culture, and to develop our participants for adult learning and work-based learning. This work involved the facilitators gaining a sense of the current level of understanding and experience of action learning of the participants, so they could tailor explanations accordingly. For example, as action learning is about learning from experience, the facilitators encouraged participants to bring evidence from their work place to the sessions.

4.3.2 Principle 2: Negotiating the learning objectives and action to be taken to achieve individual and collective goals

As participants were at different levels of understanding, it was a challenge for the facilitators to enable everyone to take part equally. They facilitated the process by encouraging participants to identify their own strengths and weaknesses and set personal learning objectives and goals for the project. For example, ANCs were supported in undertaking self-assessments and using available frameworks, which helped them to be more discriminating in their career plans. They were also encouraged to identify priorities for their own development and for the collective research aims.

4.3.3 Principle 3: Optimising the use of appropriate resources

When the time was right and participants were ready, the facilitators introduced learning, practice development and practitioner research tools and processes to help participants – for instance, to create effective workplace cultures and to use stakeholder approaches in their role development. The facilitators also offered opportunities for participants to gain familiarity with the tools and help them to assess their own learning. For example, through exploring the frameworks available for self-assessment and providing evidence, participants recognised that the RCN standards for accrediting facilitators could be used as a tool (Workshop, June 2003).

They used the standards for providing feedback on the facilitation skills they were developing through action learning. This experience helped them to see this feedback as a source of evidence to be used to contribute to portfolios for professional accreditation. They could see how the integrated nature of learning and inquiry worked. In addition, the process enabled

them to contribute to developing of a theorisation of practice framework (see Box 4.3) which they then used to apply their own and collective evidence. The facilitators also encouraged participants to choose spaces and places for working together that would enhance motivation and inspire, optimising the use of the available resources.

4.3.4 Principle 4: Helping participants to learn opportunistically in the group learning situation

Participants agreed to bring evidence to action learning sets from their own practice, in the form of reflections, stories and critical incidents. It had also been agreed that all set members would ask clarifying, critical and facilitative questions in a climate of high challenge and high support. This created many opportunities for surprising, and sometimes unexpected, learning for all. To draw on the expertise in the sets, the facilitators supported other set members in learning from the discussions.

4.3.5 Principle 5: Role-modelling and articulating own professional knowledge about being an active learner, facilitator of active learning and practitioner researcher

Manley et al., (2009) describe a continuum of active learning. At one end, active learners are willing, prepared to learn, and motivated. They actively listen and learn from others and from their own experiences, and take initiative in identifying self deficits. Towards the other end of the continuum, they recognise, expose, critically review and evaluate the different types of knowledge underpinning work (practice epistemology) and purposefully integrate them, and they collaboratively testing current knowledge and co-constructing new knowledge through learning and inquiry. So within the action learning sets and workshops, the facilitators consciously modelled the attributes, pointed them out and explained the professional craft knowledge behind them.

The facilitators intentionally modelled and articulated facilitation skill sets that cross over from learning to inquiry. For example, they used different kinds of questions offering high challenge and support and then pointed out the differences in the questions and their impact on learning. Facilitative questions: are open in nature (see Stories 5.2 and 5.4 in Chapter 5); help to deconstruct and reconstruct situations; expose problems in situations previously considered unproblematic; reveal assumptions, similarities and differences, contradictions, dilemmas and paradoxes; challenge ideas, interpretations, feelings; and open up new horizons. In this way, the facilitators showed participants how to appreciate learning and inquiry as a reciprocal process, demonstrating how asking such questions is essential to successful inquiry and transformation of practice.

Other key examples of modelling and articulation were the craft of self-assessment, professional development, or research tools and processes within action learning. For example, consultancy tools (Caplan, 1970; Schein 1988), leadership inventory for transformational leadership (Kouzes and Posner, 1987), clinical expertise standards (Manley et al., 2005), the fourth generation evaluation tool CCI (Guba and Lincoln, 1989) and the thematic analysis of evidence by stakeholders were used.

4.3.6 Principle 6: Enabling the integration of knowledge and ways of knowing to develop professional artistry and praxis through using cognitive and creative approaches

Praxis requires the integration of knowledge to inform our practice. For example, facilitators highlighted theories relevant to being or becoming an NC, learner, facilitator and practitioner-researcher and showed how participants had blended that theory with their own practice experience to create

professional knowledge, or vice versa. The facilitators also pointed out the ways that they or the participants were engaging in different ways of knowing. For instance, the cognitive knowing used in analysing or deconstructing a situation, contradiction or paradox, or the meta-cognitive knowing involved in knowing what you are doing and exerting a critical control over that action. Meta-cognitive knowing, for example, helps to recognise you are engaging in reflexive knowing about your own self-awareness of your impact in this situation.

Cognitive and creative approaches were used to help participants to become more aware of their professional artistry and develop it intentionally to improve their praxis. For example, one participant was helped, through critical questioning, to identify the different knowledge she used in a specific situation, and to use this to develop an effective strategy for action that enabled praxis – see Box 4.3. This participant used metaphor and word imagery in her analysis of different types of knowledge and their intended use. This was a result of the facilitator emphasising the power of language to communicate clear and unavoidable messages to the executive board of her trust.

4.3.7 Principle 7: Using a wide range of styles, processes and skills that match participants' level of knowledge and the context in which they are working

A wide range of styles, processes and skills was used according to the level of participants' knowledge. The facilitators recognised the need to prepare participants for work-based learning. They helped preparation for reflexivity through questioning and feedback, developing constructive behaviour change and providing appropriate resources.

At the beginning, facilitators intentionally worked using ideas of critical

companionship (Titchen, 2000) to get to know participants as people as well as professionals. This meant they could develop genuine partnerships to achieve what participants wanted within their own organisations and the collective goal of the research. The facilitators were using concepts of particularity, reciprocity and mutuality to tailor their facilitation strategies to these people, at this time, in these contexts. As participants went through the research, there were often times of “emotional investment in our anguish” and that required the facilitators to engage in graceful care, using presence (being there), being authentic and offering moderated love (professional love within boundaries).

Towards the end of the project, the facilitators were working at the more sophisticated levels of consciousness-raising, identifying problems, self-reflection and critique about professional artistry. They offered opportunities for, and expression of, the experience of being an active learner and practitioner researcher, using creative visualisation, poetry, painting and clay work. Then they helped participants to use of these creative expressions in a cognitive critique and evaluation. Collective theory creation was facilitated by modelling and pointing out meta-cognition, which is essential for analysing and interpreting evidence and by facilitating critical dialogue. The facilitators also engaged in the more technical skills and processes of project administration and management.

4.3.8 Principle 8: Enabling a working relationship/partnership built on mutual trust and high challenge and high support through paying attention to the whole person and processes as well as outcomes

Given that mutuality, or working with, was central to the EAR and a holistic approach to facilitation, the facilitators ensured that all processes were democratic, collaborative,

inclusive and participative. For example, priorities, content and processes used in action learning and at the workshops were always determined by the cohort or whole group respectively. Trust between facilitators and participants was built by developing person-centered professional relationships in which a real care and concern for the participant was made clear by the facilitators. Mutual trust was facilitated by collaboratively establishing ways of working together to enable participants to challenge in a supportive way. It was necessary for the facilitators to model this and help participants to develop critical questioning and feedback skills, using body, emotional and creative intelligences to present challenge in ways that encouraged growth rather than be experienced as criticism. Trust in the process emerged as facilitators and participants together learned to know themselves, to trust themselves and each other, and to take risks with processes and outcomes that were unknown.

4.3.9 Principle 9: Facilitating rigorous organisational, cultural and practice changes at individual and collective levels through practitioner research

This principle is self-evident in the intent of this project. While it was not necessary to be an NC (or even a nurse – Angie is a physiotherapist by clinical background) to be able to facilitate the action learning and workshops, it was necessary for the facilitators to have extensive experience of bringing about such changes through practitioner research at both levels. This helped the facilitators, for example, to support participants through the difficulties of integrating learning and inquiry into their busy working day.

4.3.10 Principle 10: Collaborating in project administration and management

During the project, we had a series of temporary administrative assistants

resulting in various administrative difficulties. This required a collaborative response to the problem. Facilitators helped participants to maintain motivation and sustain their commitment to the project processes and management. There was, for instance, a collaborative response to the practicalities of not everyone attending each set, by planning how to bring people up to speed and to ensure that the project would complete on time.

In the next section, we present evidence indicating that putting these facilitation principles into action appears to have been effective in helping participants to become practitioner-researchers.

4.4 The learning journey towards practitioner research

This section illustrates the participants' journeys towards being practitioner-researchers.

Land in sight (Participant, Workshop June 2003)



4.4.1 Becoming an active learner and facilitator of active learning

Despite participants' initial difficulties coming to grip with action learning, they soon experienced how the processes had helped them at work:

“How do we create a common vision

about this project that can be transferred to all of our work?” (C1 11/9/02)

“How will the project develop in tandem with me and my role as well as help me facilitate development of others?” (C1 20/11/02)

It was clear early on that the project processes were helping participants to pose significant ‘how’ questions, to experience transfer of learning to the workplace, and appreciate the integral roles of learning, transformation and inquiry. However, over time their concerns surfaced about the difficulties of integrating learning and inquiry in the workplace:

“Am I going to have time (even with time management) to complete the project?” (Workshop 10/6/03)

“How are we going to meet the timescale in view of MREC and passage of the proposal through local ethics?” (Workshop 10/6/03).

There was evidence that participants found action learning an effective method for work-based learning and development:

“It provided the opportunity for professional development and self reflection on my role. I was able to explore my role in a challenging, supportive environment.” (C3 Reflective review 5)

“Reflecting on my situation has motivated me on to action points.” (C1 and C3 22/7/03)

“Group has helped me to focus and complete priorities.” (C1 23/9/03)

“Action learning has taken me further in action than critical reflection on my own.” (C3 23/9/03)

These quotes also show how action learning

encouraged participants' desire to learn from each other. Those below reflect how it helped participants to facilitate others' learning and to become familiar with action research:

"Action learning set provides me with tools to facilitate others' role development." (C1 12/12/02)

"I have experienced and used different facilitation techniques." (C1 Reflective review 3)

"I have learnt that role modelling is not enough. What is required is that we explicate our actions and our strategic thinking pathways to others, a) so they can see its conscious activity, demonstrate our intentionality, and not just 'she's a natural/it's easy for her' and devalue these [praxis] skills, b) so they can learn the strategies themselves, and c) it also re-emphasises the need for 'practice with feedback'." (C3 Reflective review 4)

"I learnt about action research. I learnt how to evaluate practice." (C3 Reflective review 5)

"We have engaged in genuine critical dialogue which has generated new thinking and theory." (C3 29/8/03).

NCs and ANCs discovered for themselves a number of key insights fundamental to acquiring skills in developing self and others. These insights were the ability to:

- question one's own work and the provision and receipt of high support and high challenge: "I now question my work, role and behaviour in more depth. I have developed skills of facilitation and recognise how to challenge and support others" (C1 Reflective review 1)
- identify assumptions: "The need to clarify assumptions and this can only be done where they are recognised" (C3 Reflective

Review 4)

- identify and articulate the problems within a situation: "That problem identification is key" (C3 Reflective review 4)
- The need for feedback: "I do need instant feedback" (C3 Reflective review 4).

Feeling supported was recognised as a crucial pre-requisite to developing these skills, as identified by one NC:

"On reflection some of my comments in the action learning notes read negatively, being framed in an unhelpful and subjective way. I believe this is because I have felt safe enough in the group to express my thoughts and frustrations as a means of 'getting things off my chest' and then turning to more productive action plans to positively address the issues in question when back in the workplace. At times the project has been the only place where I have been able to do that, as I did not want to feel judged and unprofessional." (C1 Reflective review)

Feeling supported is also important in achieving change in practice (covered more in Chapter 5 and Chapter 6):

"I have learnt about the importance of therapeutic teams and social processes being the key to change more so than organisational structures." (C3 Reflective review).

4.4.2 Using resources appropriately

The ANCs' experience of undertaking a self-assessment using available frameworks (see Appendix 9) led all of them to become more discriminating in their applications and career plans, as well as questioning whether they wanted to be an NC:

"I'm starting to question whether this is the career pathway for me – I'm not enjoying it. I am blocked." (C2 25/02/03)

“I feel more discriminatory when I look at nurse consultant posts.”
(C2 25/02/03)

“I feel that being part of this group has enabled me to look at the nurse consultant post in the primary care setting and bring it forward for debate.” (C2 25/2/03)

“Has helped me clarify my career pathway.” (Workshop 10/6/03)

“Have decided to look at nurse consultant post in PCT.” (Workshop 10/6/03).

ANCs recognised there were tools to assist them in their development:

“I have recognised there are some tools that have been developed to assess ourselves against the nurse consultant role.” (C2 27/11/02).

The NC cohorts identified developmental tools that were available to assist them in their development, for example in how to understand the research continuum in practice (see Appendix 10).

4.4.3 Developing dimensions of professional artistry

There was some evidence that participants came to demonstrate professional artistry as practitioner-researchers. For instance, one NC analysed her evidence using the theorisation framework and by so doing demonstrated her meta-cognitive and reflexive knowing (see Box 4.3 and Box 4.4). Her analysis highlights her skill in using multiple discourses to achieve her moral intent of bringing to the attention of her trust’s executive the realities of being a patient in that trust. For example, she used ‘language to create images’ and expressed ‘issues of quantity rather than quality’ to get the message across using creative language underpinned by a quantitative discourse that executives were familiar with.

She demonstrates how she blends transformational use of self with credible evidence and information through ‘humour, mischief, irony, presence, comportment, bluntness and honesty, feistiness, all information substantiated, use of silence and stillness, use unpredictable behaviours to keep people’s attention – keep them on their mettle’.

Box 4.3 An NC's analysis and theorisation of her praxis

	Trigger concepts	Strategies	Outcomes
Theorising	Re-presenting patient care.	<ul style="list-style-type: none"> • Draw on different knowledges (detailed in Box 4.4). • Overall broad strategy (detailed in Box 4.4). 	<ul style="list-style-type: none"> • To re-charge to focus on looking after people. • To enable people and their families to be part of the process. • To look after people effectively/appropriately.
Evidence	<p>Claim – NC 21/10/03</p> <p>“My role is essential to put over to senior managers the issues surrounding what it takes to look after people in the acute sector – current ways of working do not cater to patients’ needs. My status in the institution means I have access to the senior managers, I use skilled interpersonal interventions to get my points across. It is my job to enable a drawing together of ‘data’, patient experience, staff exp etc”</p>	Reflective account (C3 Reflective review 4).	“In my portfolio – I have source that the director of nursing – present during a presentation I made to trust board on this topic, found the material powerful. It stimulated the trust board to spend a whole morning on their ‘away day’ talking about patient issues – an uncommon topic of discussion at such events. He felt it gave him useful material to pursue patient focussed issues – like the use of the term essential care, and to plug these into strategic direction to enable him to pursue trust strategies which are patient-centred – for example, pushing for more staff, with certain levels of skill, putting nursing high on the agenda etc.”

Box 4.4 NC's strategy of drawing on different types of knowledge

<p>Trigger: re-presenting patient care</p> <p>Strategy: draw on different knowledges</p> <ul style="list-style-type: none"> • Those grounded in my experience. • Use of language to create images. • Exploring cultures of care. • Expressing issues of quantity rather than quality. • Linking this into the espoused strategic direction of the trust. • Linking into political issues. • Resource issues. • Training education issues. • Targets. • Network issues. • Research base. 	<p>Overall strategy:</p> <ul style="list-style-type: none"> • Articulate clearly the patients’ conditions – that is: <ul style="list-style-type: none"> - spiritual - food and water - comfort/care - the people available - the physical environment. • To describe the above and its implications for patient care/outcomes. • Link all of the above to the wider agenda. • Wire this into the executives’ own rhetoric using local, regional and national knowledges and research bases. • Use quotations of patient stories. • Use my craft knowledge of patient trajectories. • Wire these into the implications for patients. • Use of personal knowledge – use of colourful language, ‘stuff’, humour, mischief, irony, minifisms, presence, comportment, bluntness and honest, feistiness, all information substantiated, use of silence and stillness, use unpredictable behaviours to keep people’s attention – keep them on their mettle, personal power strategies. • Facilitation strategies – all of the above – and their use to enable people to engage in the substantial nature of the discussion, enable to ask questions, use of challenge and a grasp on saliency to challenge. • Use of particularity – know where people are coming from, ask them. Then wire in the presentation to their concerns, tailor it to them. • Wiring in – engage in the process. • Connect, energisation. <p style="text-align: right;">(C3 21/10/03)</p>
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Another indication of professional artistry was participants' use of creative imagination and expression as evidence, showing the essence of their journeys through the project, and which can be seen throughout this chapter.

Practitioner researchers flourishing as tall poppies within complexity (Facilitator, workshop, June 2003)



4.4.4 Becoming a practitioner researcher

While evidence at the individual level of practitioner-research was gathered in the workplace and reflected upon, analysed and theorised in action learning, work at the collective level of practitioner research began in earnest at the second workshop.

A change in energy was palpable as participants in the three cohorts came together to engage more confidently in praxis as practitioner-researchers working together on EAR. The location, a country house, with large airy rooms and big windows overlooking formal gardens and parkland, made them feel valued. They also felt positive about the cohorts coming together again and welcoming back those who had been unable to attend action learning for a while. There was a growing excitement about collecting, and catching up with, the evidence (see Box 4.5).

Box 4.5 Looking at the evidence – data analysis so far June 2003 residential workshop)

Analysis completed

Analysis of:

- concerns, claims and issues to date
- experiences presented
- strategies used
- outcomes/goals aspired to.

Analysis to do:

- analyse notes (past) re-presentations in action learning
- critical dialogue
- dates for CCI template
- descriptors of the concepts
- process outcome impact links
- consistent language and meaning re concepts, themes and starting points.

Participants were pleased to see the progress that colleagues were making with the 360 degree tool to evaluate the effectiveness of their multiple roles. By collaboratively creating tools for development, theoretical tools and frameworks, and a glossary of theoretical terms, they believed they achieved “universality through sharing” (Workshop 10/6/03), “exciting method/theoretical developments” (Workshop 10/6/03), continuation of learning and developing and “new thinking through critique”.

They marked their progress in understanding of knowledge, theoretical and methodological terms and ideas in the following haiku poems:

Kim/Angie talked in riddles
While we just sat and fiddled
Now we understand

The fish were drowning
Scum in the pond is clearing
Frogs are now jumping

We've said goodbye to
Our winters of discontent
Fruits of knowledge are ripening

We've got lots of stuff
With which to build a clear view
Of infinity

(Workshop, June 2003)

This evidence makes it clear that participants were taking responsibility for the action research. When they evaluated their progress towards the products/outcomes of their research, they felt they needed to do more work to demonstrate effectiveness:

“I feel that I have achieved some very real progress in terms of leading/developing practice but I am only just acquiring the tools (via the project) to demonstrate effectiveness.”
(Workshop June 03)

“I still feel I can further increase effectiveness through creative ways of working.” (Workshop June 03).

In relation to taking responsibility for the research, participants posed such questions as:

“What will all our roles be in the project report?” (Workshop 10/6/03)

“How do the products of the project work in practice?” (Workshop 10/6/03).

Throughout the project, the development of participants' criticality shone through. At the final workshop, participants questioned whether research standards developed were possible to meet in today's busy contexts; they considered issues of bias in the study and they were concerned that there were no “further opportunities for testing out the theory” (Workshop 9/12/03).

Participants asked questions about raising the project profile, such as: “How will project findings be fed into the national agenda?” (C2 16/8/02); “How will we share the

project's findings and raise its profile?” (Workshop 10/6/03). They also recognised that “Management is unaware of the project's aims and objectives and that it is difficult to sell it in a climate of competing priorities” (Workshop 10/6/03).

4.5 Experiences of the action research

While all internal factors in the study influenced participants' experience and participation of the project positively, external factors were both positive and negative (see Box 4.6). For example “Not everyone has support from their organisation” (C2 27/11/02), which led to ANCs asking “How do we enable others in the group to gain the support they need?” (C2 27/11/02).

The journey from the dark to the light (Participant workshop, June 2003)



Box 4.6 Internal and external factors influencing participants’ experience and participation of the project, derived from reflective reviews

Internal factors (all positive)	Reflective review	External factors (positive and negative)	Reflective review
• Own values and beliefs about commitment.	1, 3	• Support from trust/culture/mentor (positive and negative).	1, 2, 3, 5
• Desire/need to learn more about the role and impact.	4, 5	• Pressure of work/juggling commitments (negative)	1, 2, 3
• Being connected to other struggling folk.	2, 4	• No other NCs in trust or nearby (positive)	4
• Support and commitment of co-researchers and facilitators	2, 5	• Culture – personal development subsumed by other priorities (negative)	2
• Project processes experienced positively.	2	• Lack of cover (negative)	2
• Being part of a national project will move role forward.	1	• National debate on NCs and leadership (positive)	4
• Past experience of group work so could see potential.	3		

Nevertheless, participants’ experiences of the action research were overwhelmingly positive throughout its duration.

“I have been part of the first AR project, which is co-operative and sophisticated in all stages ... Feeling positive for being part of something from beginning to end.” (Workshop 9/12/03)

“Being part of the action research project has helped me to understand others’ perceptions of the role, develop strategies in order to articulate the complex nature of the role and to develop the role further. This has been achieved using 360 degree feedback, structured reflection and in particular being challenged in a safe environment, supported and nurtured by the group. It allowed me to have precious, protected time, away from the workplace to reflect on what I was trying to achieve (and often

discover what a muddle I was in!). It has given me insight into how I perform and helped me identify areas requiring development. I would not have had the skills to operationalise this or have been disciplined enough to do this alone, which is why the support and facilitation from the group has been so invaluable.” (C1 Reflective review).

4.6 Conclusion

This chapter has mapped the journeys of participating ANCs and NCs towards becoming practitioner-researchers, through being an active learner and facilitator of others’ active learning. We conclude that the strategies adopted by the facilitators to help participants have been effective.

Despite the difficulties that participants had to overcome, at both individual and collective levels of practitioner research, the

evidence suggests that facilitation strategies, inspired by the 10 principles set out here, enabled rigorous practitioner research. The participants showed strong commitment to engagement in the action research and project management. However, while participants felt supported and valued by the project, they raised concerns about the project coming to an end, in terms of where support for future practitioner research would come. This is a real concern and one that will have to be addressed if effectiveness of the NC role is to be demonstrated.

5

Sailing down the river: moving towards greater effectiveness in multiple roles

Pulling together as we head towards the sea (Participant workshop, June 2003)



5.1 Introduction

Early work confirmed the NCs were working within several roles as described in Manley's research (1997; 2001; 2002). This research had informed the UK DH's concept for NCs (see Chapter 1). The key focus for participating NCs was being an NC, whereas for the ANCs it was on becoming an NC. However, while NCs were in theory clear about their complex and interacting roles, their colleagues and their organisations were not. Moreover, developing and balancing their multiple roles and demonstrating their effectiveness within their organisations were underdeveloped. The starting point for the ANCs was how to become an NC in the NHS, which had no career development pathway in place for NCs.

This chapter charts the NCs' and ANCs' journeys from these starting points, presents their strategies for achieving greater effectiveness in multiple roles and for getting an NC post, and shows their points of arrival. We conclude that the NCs' strategies were successful in increasing their

personal effectiveness in clarifying roles and performing across multiple functions, while the ANCs' strategies resulted in setting principles for career development.

5.2 Starting points

At the outset, the NCs experienced difficulty putting the role into operation and in managing a lack of clarity about its expectations. Therefore, they wished to find out how to best help others to understand their roles. They were concerned with balancing the different aspects of the role and maintaining credibility. In contrast, as the ANCs were not yet sure what an NC did, or how best to become one, they wanted to explore the components of the role.

5.2.1 What am I supposed to be doing? Role ambiguity

Derived from a values clarification exercise involving all participants at the first workshop, the group believed that the ultimate purpose of the NC role was to improve patient care and the patient's experience, through:

- clinical nursing expertise and research
- practice development and enabling others
- clinical and professional leadership.

(Workshop 5/7/02).

Although there was clarity in the beliefs about the role supported by many of the NCs and ANCs, this did not translate into their early practice experiences of being an NC/midwife. ANCs raised concerns such as:

- “I’m not sure what I am doing and where I am going.” (C2 16/8/02)
- “What do nurse consultants actually do?” (C2 16/8/02).

NCs, however, were concerned about:

- “How do we as a group raise the profile of the nurse consultant role to other key stakeholders?” (C2 11/9/02)
- “How are we going to make clear our role to the university?” (C1 20/11/02)
- “How do we distinguish nurse consultant posts from medical consultant posts?” (C2 27/11/02)

Role ambiguity was a frequent feature of the incidents shared during action learning during the first five months of the project:

- “Some organisations are not sure what they want from nurse consultants.” (Workshop 5/7/02)
- “A patient said to me, ‘Oh you’ve become a doctor at last’.” (C3 1/8/02)
- “What is the perception of the director of nursing – do they understand the role of the nurse consultant?” (C2 16/8/02).

Story 5.1 shows how this was experienced by one NC who took up a post located, she thought, in critical care.

Story 5.1 ‘What am I supposed to be doing in this role?’

“Haven’t thought about it before taking it up. Might have been a knee jerk reaction from me. Offered post. New trust, didn’t know anyone, culture, history etc. Interviewers didn’t know what I was supposed to be doing there. Having been there I think today they still don’t know. What the hell am I doing? ...”

“... Felt lots of things I’ve fought for are not for critical care but for the post-office, admin etc. Felt post was running away as there was nowhere to put me. Should the trust have asked for a generic nurse consultant? Involved with projects with weak links to critical care. Fighting not to work in isolation ...”

Intervention: What do you do?¹⁴

“The things taking up lots of time: (1) Chair of nurse specialist forum (100 of them). Initially thought it was a good way to get to know everyone. Expanded in terms of work generated in the year. (2) Conference – all new speakers, hadn’t spoken before. (3) Looking at mattresses. Have to save £5 million so have to look. I’ve asked for admin. This is now about writing a protocol. Halfway through I thought is this critical care? They expanded the coordination of project. I thought I would be in ITU and that would be it. Out of ITU, there are problems in the wards in terms of outreach. The more people you get to know the more you get grabbed. Two people I manage have no idea of the educational process. Needed huge amount of support – comes from me, Higher Education Institute couldn’t offer that. In relation to moving forward I have been unable to do anything ... Looking back over the first year it was very reactive – responding to problems.”

(Cohort 3 1/10/02)

This NC felt bombarded with things to do and worked in an organisation that was unclear about the role and focus of the NC. Participants’ initial concerns and issues about NC accountability at the beginning of the project centred on a lack of clarity about whom NCs were responsible to, thus endorsing a lack of understanding about the role from those involved in appointing posts.

¹⁴ All interventions were made within action learning sets by the facilitator and set members.

5.2.2 Becoming more effective in multiple roles

Four inter-related areas emerged as significant in terms of multiple roles:

- clinical and professional leadership
- political and strategic leadership
- research, evaluation and demonstrating effectiveness
- balancing multiple roles.

5.2.2.1 Clinical and professional leadership

The leadership role constituted a major focus of the incidents presented during action learning. For the NCs, the focus was on achieving professional leadership in practice:

“How can I provide better leadership to the team therefore resulting in a shared vision?” (C1 12/12/02)

“What is my professional leadership role with the H grades?” (C1 23/4/03)

“How do I provide leadership when there are a number of leaders?” (C1 4/9/02).

For one ANC, it was about identifying who provided professional leadership within the trust:

“Is it necessary that I have a professional lead and if so who do I look for to fulfil this role?” (C2 17/12/02).

5.2.2.2 Political and strategic leadership

For both NCs and ANCs, political and strategic leadership in influencing organisations’ strategic agenda was a key feature:

“How do I translate what I do in the trust as trust strategy?” (C3 29/8/03)

“How can I be more involved at strategic

level in developing a role to meet short term needs and then long term needs?” (C2 29/7/03).

Story 5.2 illustrates how one NC was confronted with her lack of influence at strategic level, and her attempts to develop her strategic and influencing role

Story 5.2 How can I get into an appropriate place in the organisation?

“My issue is about how the role is seen in the organisation. I don’t think where it is in the organisation is appropriate.

“When I met the director of nursing (DoN) we had discussed where the NC fitted into the organisation, but there have been events recently where I was not invited, for example, there was a development day for leaders in the organisation ... and a meeting on the direction of the trust and the speciality. This impacts on my role. I sent an email to ask why I had not been invited. I feel like a dog with a bone.

“The organisation is very structured around management hierarchies. The trust has management meetings. I don’t have a management role so I don’t fit into the structure. I have suggested a leadership forum. I was told it was a nice idea, but it doesn’t fit into the structure.”

How do you get information to people?

“Badly. I don’t fit into lines of communication. For example, the trust produced a document called 20/10. Went to a meeting with someone else- found the document. Went to my line manager- concerned that I hadn’t received this document and she assumed I’d get it from the DoN. So I get it from neither. I’ve been saying for two years that I don’t get documentation. They’ve not got their acts together re the nurse consultant and what they want them to do.”

How can you influence that?

“One of the other nurse consultants has been in post for a year- we meet to try and support each other. We will both read 20/10 and come up with how our roles can carry the strategy forward. Try and take it into our own hands. We’ve been waiting to be asked. We’ll give it to people on a plate. Associate director talks to the DoN – as to what their roles will be and then it’s clearer to me about my role with leadership.”

Can you influence that?

“We can say what we think. What I want from them is what their role is. The two things are interlinked.

In the trust where does strategic development take place?”

“Trust board is the most powerful group and in sub groups. I have no links to either. Nursing has very few links to any of them. Nursing is being sidelined in our organisation.” (C1 20/11/02)

Another NC tried hard to influence strategy of both the university and trust, but her dilemma concerned helping other NCs in her trust recognise that this was their responsibility too:

“Dilemma is I have differing opinions to my colleagues. I feel they work in a specialist role. I try influencing the university, strategic influencing with the nursing and midwifery committee. They didn’t want to influence strategically. How do I work with them to articulate and demonstrate what it is as NCs we’re trying to achieve?” (C1 and C3 22/7/03).

5.2.2.3 Research, evaluation and demonstrating effectiveness

The research and evaluation role was one area where the research team needed to give the greatest time and support for NCs (see Chapter 4). Story 5.3 describes a critical incident that focuses on one NC’s actions after she recognised that she needed to complete a PhD in order to fulfil this role.

Story 5.3 How can I get the educational support I need?

Description of experience

“I’m responsible to a clinician – been in a black hole – am I ever going to do/achieve anything?”

“Decided to do a PhD – no planning in trust about my role in terms of educational development.

“I have clinical support and professional support as long as it doesn’t include money.

“I am the only NC in the trust – I have been told that my PhD is a low priority.

“Key issues

1. How do I make a case for the value of my education?
2. I know what I want but I don’t know if I am being reasonable in what I want?
3. Have I pursued every avenue?
4. How can I sell it to the trust? (identified as most significant by the NC)
5. How do I convince my organisation that it’s important to them as well as me?
6. How do I obtain funding?
7. Can I do it all?

“Action points

1. To explore all the options including R&D mechanisms as a support mechanism
2. Explore corporate strategy to see how PhD could link in what they want to achieve – had looked divisionally but not corporately.” (C1 13/5/03).

More broadly, the researcher role challenged NCs and ANCs in evaluating different initiatives or innovations in everyday practice, and how to demonstrate the effectiveness of their own role. NCs felt pressured to demonstrate their effectiveness to their organisations, underpinned by urgency and fear:

- “The organisation is asking you to prove your effectiveness when you’re only just starting your job.” (Workshop 5/7/02)
- “Nurse consultants will be downgraded if they are shown to be ineffective.” (Workshop 5/7/02)
- “How do we persuade management that effectiveness takes time to demonstrate?” (Workshop 5/7/02)
- “How is action learning going to help provide evidence for the organisation of my impact?” (C1 20/11/02)
- “How do I develop a framework that allows me to demonstrate the impact of nurse consultants?” (C1 4/9/02).

5.2.2.4 Lack of balance of multiple roles

A predominant feature of the critical incidents brought to action learning concerned the multiple roles that NCs fulfil. The leadership role and how this differed from management, and the research and evaluation role, featured strongly in critical incidents described by NCs.

The EPP was the focus of the ANCs. Developing the consultancy role was a lesser focus. They linked the educational role strongly to the processes associated with facilitating learning and effectiveness in practice.

Both NCs and ANCs recognised that the post involved multiple roles, but the NCs initially struggled with finding time, support and resources to develop roles over and above their expert practice function:

“The nurse consultant role is more about evidence based practice, practice development and leadership ... I am overwhelmed by the workload. It’s very unpredictable.” (C1 and C3 22/7/03).

5.2.3 Becoming a nurse consultant

The ANCs focused on finding out how to progress their career development towards being an NC:

“Will we have an action plan to help us become an NC?” (C2 16/8/02)

“How do I get academic credit for the work?” (C2 16/8/02).

The following story demonstrates one ANC’s early reflection about how she could do this (Story 5.4).

Story 5.4 How can I equip myself to be a nurse consultant?

Q: Tell us about your experience

ANC: Mine is a question

Q: What would you like to ask?

ANC: Is there a minimum standard of education? Any skills, specific courses?

Q: What are the key issues for you in asking that question?

ANC: What gaps do I have in the knowledge and skills and how can they be filled?

Q: Do you want to expand on that?

ANC: It’s not a specific area. I’m sure there are certain things. I’m not educated to masters’ level so there’s a gap. I do have skills, but I’m not sure they’re advanced.

Q: Would it be useful to clarify what you see as knowledge and skills for the nurse consultant?

ANC: Not sure.

- What frameworks can I use to assess myself?
- What is a nurse consultant in terms of knowledge and skills?
- What frameworks are there to assess where I’m at?
- What frameworks are available so I can assess myself?

(C2 11/9/02)

5.3 Strategies for achieving greater effectiveness in multiple roles

A number of strategies emerged within action learning for preparation and achievement of greater effectiveness in the diverse roles of the NC.

5.3.1. Developing and negotiating role clarity

Strategies to develop role clarity are outlined in Box 5.1.

Box 5.1 Strategies to address the lack of understanding by others of the NC role

- Using values clarification/other approaches to develop a common vision with key stakeholders about role or purpose (C1 23/4/03; C1 and C3 22/7/03; C1 5/5/03; C2 27/11/02; C1 and C3 22/7/03; C3 1/10/02; C3 4/11/02).
- Engaging senior stakeholders in discussion (C3 4/11/02; C3 23/9/03; C3 23/11/03; C3 4/11/02).
- Using facilitative approaches and working collaboratively with clinical director and service managers/maintaining open dialogue (C3 1/10/02).
- Using concerns, claims and issues with stakeholders so as to surface what these are (C3 4/11/02; C3 1/10/02).
- Identifying and checking out assumptions by self and others (C3 4/11/02; C3 1/10/02).
- Self review, role analysis and negotiations (C3 4/11/02).
- Qualitative 360 degree analysis (C1 23/4/03).
- Using evidence-based arguments to support strategic role and need for common vision (C2 11/9/02; C3 23/11/03).
- Obtaining support/critical companionship for self (C1 and C3 22/7/03; C3 1/10/02; C3 4/11/02).
- Negotiating role within strategic planning processes (C1 23/4/03; C3 3/11/03).

A powerful strategy emerged that helped the NCs to map out their starting points, desired end points and strategies that would enable them to move between the two (see Box 5.2).

Box 5.2 Example of a nurse consultant map

Strategic role of NC

Start point	Strategy	End point
Role is not recognised by directorate or trust.	Discussed with DoN and NC colleagues. Formed a group of NCs to develop a unified trust-wide front. Discussed with Directorate manager contribution of role to achieving strategic analysis.	Strategic contribution of NC is recognised.

5.3.2 Clinical and professional leadership

Strategies to increase effectiveness are shown in Box 5.3. These emerged from the analysis of critical incidents in practice by participants, to help them become more effective in their clinical and professional leadership roles, particularly in developing a common vision about various aspects of work.

Box 5.3 Strategies re: clinical and professional leadership

- Developing a common vision about the service and ways of working with key stakeholders (C1 12/12/02).
- Using an external facilitator so as to enable NC to contribute her own vision rather than lose this opportunity by being the facilitator (C1 12/12/02).
- Use values clarification exercise to develop a common vision about teamwork and roles (C1 12/12/02; C1 23/4/03).
- Use 'how can I support them as well as how they can support me' approach (C1 23/4/03).

5.3.3 Political and strategic leadership skills

Strategies for developing political and strategic leadership skills were created through action learning (see Box 5.4).

Box 5.4 Strategies regarding political leadership/influencing strategic agendas/managing hidden agendas

- Meeting formally with key stakeholders to discuss contribution of NCs to strategic analysis (C1 20/11/02; C1 19/8/03; C2 25/3/03).
- Being visible/Being opportunistic in doing work that enables others to recognise value (C2 25/3/03; C3 5/9/02).
- Being tenacious/more assertive during committee/other meetings (C2 25/3/03; C2 29/7/03).
- Seeking advice from external agencies (C2 25/3/03).
- Find out trust board agenda and have pre-meetings (C1 20/11/02).
- Find out trust board membership and identify who has lead for specialism C1 (20/11/02).
- Submit written documents so as to receive a written response (C2 25/3/03).

- Challenge the absence of an audit trail (C2 25/3/03).
- Think in advance the questions to ask so as to receive a meaningful response (C2 25/3/03; C113/5/03).
- Form a trust-wide group of NCs to provide a unified front (C1 19/8/03).
- Rotate chair of NC group on trust Executive Council (C1 19/8/03).
- Link new initiatives to policy agenda (C1 23/4/03).
- Meet with chief executive (C1 20/11/02).
- Mentorship and shadowing with key local political leaders (C1 20/11/02).
- Identify key problems and weaknesses of department and how a NC role could contribute to improvements. (C2 29/7/03).

5.3.4 Research, evaluation and demonstrating effectiveness

Strategies to help participants demonstrate effectiveness through practitioner research are presented in Chapter 4. We also helped participants identify strategies for getting the educational support they needed to conduct research and evaluations in their workplaces.

A number of participants used a qualitative approach to 360 degree feedback to obtain feedback and perceptions from others. More of them would have liked to have used this approach, but issues with achieving MCRE approval prevented them within the project time-frame. Critical incidents, however, were very effective in showing how NCs integrated and used a complex array of evidence, including research, at executive and strategic levels, to benefit patient care.

5.4 Strategies for getting an NC post

The use of tools was important in enabling ANCs to assess their learning and development needs. Exploration in action learning also highlighted key issues that required attention – for example, the impact of organisational culture on achieving an NC

post's full potential (see Story 5.8 below).

Box 5.5 outlines the strategies for enabling career progression towards becoming an NC, as well as career development within the role.

Box 5.5 Strategies for enabling career progression

- Self assessment against tools available.
- Developing a common vision.
- Facilitating and supervising others.
- Obtaining a mentor from within/outside the organisation (C2 27/11/02; C2 17/12/02).
- Using qualitative 360 degree feedback to obtain feedback on role and areas for development (C2 20/5/03).

In the next section, we set out how useful these strategies were in promoting individual effectiveness.

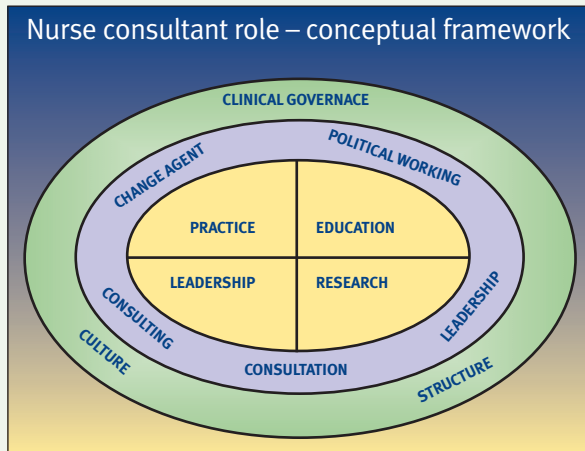
5.5 The individual effectiveness journey and point of arrival

Thick mists uplifting.
Amazing what's in my head
Fishing my stuff out

(C3 21/10/03)

Participants demonstrated through their practitioner research that they were able to achieve role clarity in their organisations, to show greater effectiveness as clinical and professional leaders, political and strategic leaders, educators and facilitators of work-based learning and as researchers. For example, through concept analysis, participants developed a conceptual framework for the role (Box 5.6).

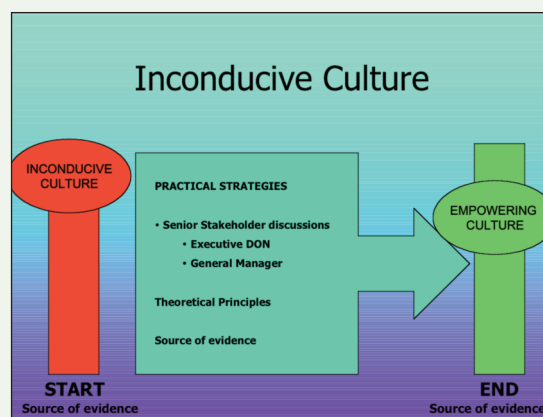
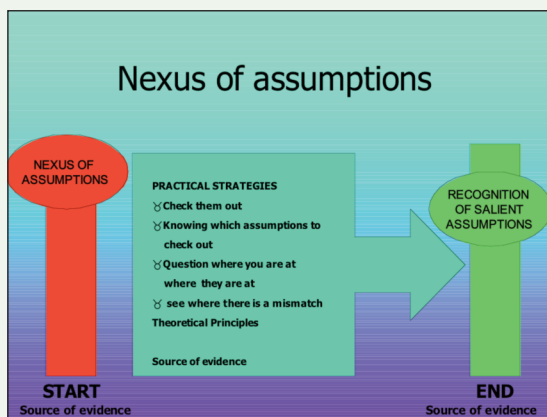
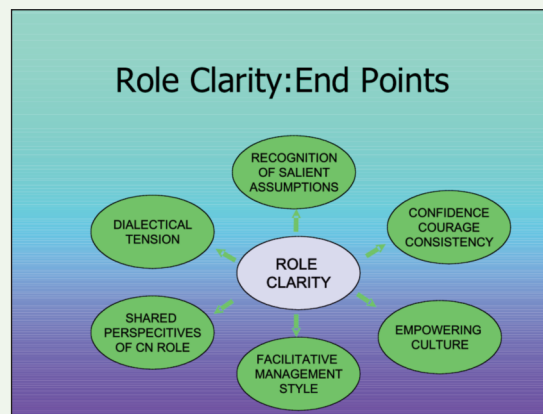
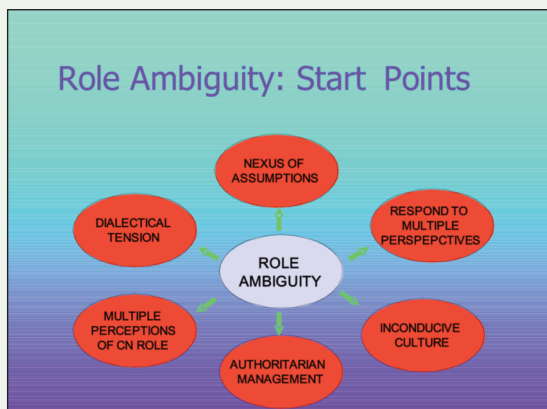
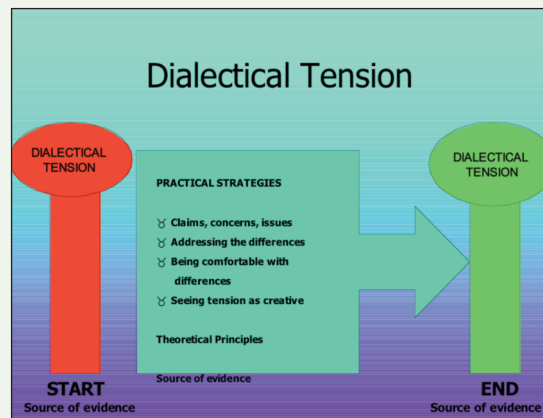
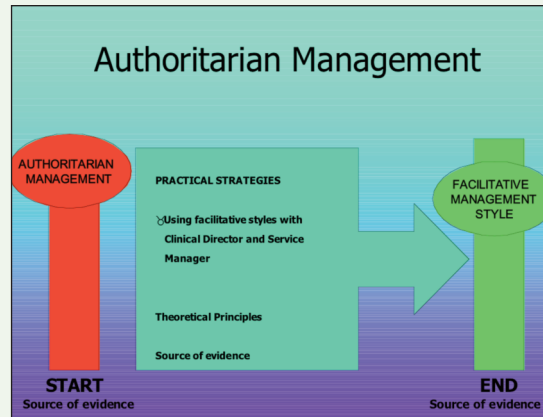
Box 5.6 Conceptual framework

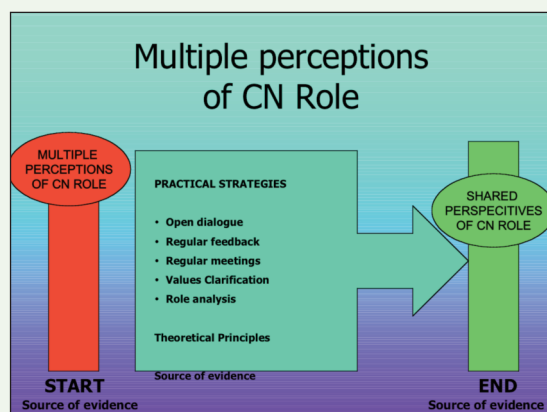


5.5.1 Role clarity

The NCs created maps in action learning to establish their starting points and desired end points. These helped them to develop strategies to help achieve their desired end points. The slides in Box 5.7 below were presented by NCs at a national conference to establish the potential transferability to other settings.

Box 5.7 Role analysis





The power of working in this way, deconstructing and reconstructing critical incidents together, is shown in this reflective review:

“Being part of the action research project has helped me to understand others’ perceptions of the role, develop strategies in order to articulate the complex nature of the role and to develop the role further. This has been achieved using 360 degree feedback, structured reflection and in particular being challenged in a safe environment, supported and nurtured by the group.”

(C1 Reflective review 1)

5.5.2 Greater effectiveness as a clinical and professional leader

Exploration of the clinical and professional leadership role led to a shared realisation of the need to develop a common vision with key stakeholders, illustrated in the learning in Story 5.5.

Story 5.5 Learning and action points arising from exploring leadership role with team

Intervention: What have you learnt?

NC: It’s my vision, I want them to adopt it – I call it a shared vision but it isn’t, it’s mine.

If we don’t have a proper shared vision then they won’t change anything – they will just continue as they are. I have to do some work on developing a shared vision

Action points:

1. Need to bring in an external facilitator (Linked to earlier discussion about enabling the NC to also contribute her vision – if she facilitates this then she loses the opportunity to contribute her vision).
2. Construct a values clarification exercise which also includes what constitutes an effective team for awayday.
3. Include medics in the discussion.

(C1 12/12/02)

Over time, greater effectiveness as a clinical and professional leader was apparent:

“My involvement in the project has provided the opportunity to identify the key attributes of a patient centred, evidence-based culture. To develop this culture within our own team I have met both individually and collectively with the team to identify their learning needs and how they can be addressed. Within the nursing team we now have two nurses undertaking their MSc in X nursing [specialism removed to protect anonymity] and four nurses undertaking degree level specialist X modules. These nurses are now challenging certain aspects of practice and using the evidence to develop a more patient orientated service eg patients administering their own injections of X, devising information leaflets on aspects of self management. A forum has developed where the nursing team can meet and share ideas and concerns, this ensures that the team has a shared vision and engages in collective decision-making to

improve the services for the patients as well as supporting the needs of team members.” (C3 Reflective review 5)

Greater effectiveness as a political and strategic leader

NCs worked hard, successfully in their view, to influence strategically eg the universities they were associated with, their trust boards (see Chapter 4, Box 4.3), directors of nursing, and nursing and midwifery committees:

“I was pivotal in changing nursing strategy in the trust. Also supporting junior nurses in decision making in the new councils. This has been part of getting other people involved in what I am doing.” (C3 18/2/03)

Developing political and strategic leadership was also shown in participants’ concern to raise the project profile:

“How will project findings be fed into the national agenda?” (C2 16/8/02)

“RCN Congress presentation an achievement – raised profile of the project.” (C1 13/5/03)

“How will we share the project’s findings and raise its profile?” (Workshop 10/6/03)

“Management unaware of the project’s aims and objectives – difficult to sell it in a climate of competing priorities.” (Workshop 10/6/03)

The awakening of ANCs’ strategic and political skills is shown below in 5.7, entitled ‘I wasn’t being proactive’.

5.5.4 Greater effectiveness as an educator/facilitator of WBL

Being involved in action learning enabled participants to become more effective as

educators and facilitators of others’ active learning in the workplace:

“I have implemented actions from action learning and reflected on the issues I brought and the management of them. This has resulted in a number of positive outcomes, for example: regular review of supervision sessions with the result of colleagues wanting to continue to be supervised by me, a new member of staff approaching me to commence supervision and enabling colleagues to focus on the action points of their supervision.” (C1 Reflective review 3)

5.5.5 Demonstrating effectiveness through practitioner research

While Chapter 4 shows how participants arrived at being able to demonstrate their effectiveness through practitioner research, Story 5.6 reveals how one ANC – an advanced practitioner – tried to demonstrate effectiveness in a nurse-led round

Story 5.6 How can I demonstrate the effectiveness of my role?

NC: I have only recently looked at ways of developing the role. One thing was to involve myself in nurse-led rounds – developing practice, facilitating.

Monday morning in paediatric ICU – busy doing my round from 9.30am to 12pm. I had to get round all the patients. It was chaotic. My attention was drawn to a junior nurse not long come out of supernumary status. She appeared flustered, not making eye contact with anyone. I made my way over.

“Hello Kate, how are things?” She said the saturations were a bit unstable and she couldn’t put her finger on why. I asked how she was finding things and she replied that it was nerve wracking – didn’t know where to start. I said I would give John an examination and asked if she would like to watch, “that would be good” she said. During the examination I asked Kate about John’s condition. He had a hypoplastic left heart and was undergoing the first stage of a surgical correction. During the assessment his saturations dropped quite rapidly and picked up. They were 74 per cent on air which was

good. I asked Kate if she knew why this was happening. She thought it was due to his heart condition, but was a bit rusty on physiology. As we continued, she began to build up a picture of John by asking questions. We looked at his blood gases over the previous 12 hours. She began to see why things were happening.

What was I trying to achieve? On one level helping her develop her practice.

Intervention from group: What are you asking yourself?

To be able to identify what, as an advanced practitioner, I was contributing by undertaking the nursing round both in terms of the individual and the unit.

Intervention: Is that one issue? You said the nurse round. In staying, you diverted from the nurse round. Are you concerned with the nurse round or the staff member?

From reflection, another question was “Should I feel guilty that because I wasn’t able to do a full ward round, I wasn’t able to achieve my goal?” I wanted to do the nurse-led round.

Intervention: What was your goal of the nurse-led round?

An issue relating to recruitment and retention – I was developing an environment which was supportive and challenging in order for nurses to be involved in the unit.

On a practical level – how can I use my time more effectively? What are my colleagues’ perceptions of the nurse-led round? It’s not just about me feeling good about that round – it’s to enable other nurses to feel empowered and supported. So how am I going to establish and identify my colleagues’ understanding and perception of the nurse-led round?

One of the products of the research, identified by participants at the June 2003 workshop, was a range of frameworks for demonstrating their effectiveness (see Chapter 4). However, time to gather evidence to show effectiveness was difficult due to increasing workloads, pressure of work and juggling commitments. Participants found it hard to focus, prioritise time and source the right evidence. The wait for approval from the MREC to use 360 degree feedback and the passage of the proposal through LRECs compounded the problem. Moreover, once participants had managed to gather evidence, time to make

sense of it was a huge issue. Nevertheless, the participants were successful in demonstrating outcomes of their effectiveness (see Chapter 6).

5.5.6 Greater effectiveness in multiple roles

Following an exploration of the multiple roles of NCs and a self-assessment, the ANCs could now see how they could contribute this understanding to their present roles:

“I feel clearer about what my contribution could be to the unit.” (C2 27/11/02)

“I have something to offer on nurse leadership.” (C2 27/11/02)

“I feel positive that I have started to engage staff in what my contribution could be.” (C2 27/11/02)

On the other hand, NCs developed an appreciation and recognition of the complexity of the role in terms of its multiple functions in practice:

“If I look at the document from the Department of Health (*The contribution of nursing to comprehensive critical care*), I am [now] doing most of those things: strategic/organisational development; leading research projects; disseminating practice/educational initiatives; engaging in the political processes at local level; trying to use facilitation processes to develop others.” (Workshop June 2003)

“The role is very challenging and stressful at times. There are competing demands from the four aspects of the role and it is difficult to be as skilled as you need to be in all four areas.” (C1 Reflective review 3)

They also recognised the need to balance the functions and to be comfortable with doing so:

“To be comfortable with diversity of role.” (C3 Reflective review 5)

“To accept that I will spend more time on some of the role components than others and not perceive this as a failure.” (C3 Reflective review 5)

“When not seeing tangible results in one area it’s important to balance this with successes in another.” (C1 Reflective review 3)

The NCs felt they had drawn on their multiple roles to maximise their impact and achieve their purpose:

“Utilising my professional leadership, consultancy and teaching skills to help others have max impact.” (C1 reflective review 3)

“Work strategically for service development locally and nationally.” (C1 reflective review 3)

“Broadened sphere of influence but need to do more.” (C1 reflective review 3)

One NC summarised her learning as:

“Shared understanding and strategic positioning of NC role in organisation is essential if role is to have maximum impact on patient care. I have identified how the NC role could be used more effectively clinically and strategically.” (C1 Reflective review 3)

However, dilemmas remained, not so much in managing the multiple roles in practice, but at what level they should focus their efforts; clinical or strategic:

“Although I have started to make some links about how working strategically at

a broader level impacts on improving patient care, in some instances I am not fully convinced of this and thus at times it is easier to see the impact by spending my time in direct contact with the young people and with colleagues who also see the young people.” (C1 Reflective review 3)

5.6 Getting the job: achieving NC posts

ANCs’ experience of undertaking a self-assessment against available frameworks led them all to becoming more discriminating in their applications and career plans, as well as questioning whether they wanted to be a nurse consultant. Story 5.7 is one such example.

Story 5.7 ‘I wasn’t being proactive’

“A position [in my organisation] is coming up in September, an advanced nurse practitioner in paediatric high dependency unit, which could be further developed to a nurse consultant role later. My main concern was I was not in a position to be actively involved in developing the role. I wasn’t being proactive in how to achieve it. Some problems of my own doing. So I went to see head of nursing for paed. Said I was interested in high dependency and had heard this role was developing. Keen to be involved in developing the role. Wouldn’t have dreamed of doing it a few months ago. I also felt no one had been in overall charge of how the service could be developed. Keen to find out from head of nursing services how the role would develop. They weren’t clear. Alarm bells rang – my present role indicates there is no strategic direction, so the role would be a non-role. I want to look at how I can become more actively involved strategically to help develop the role which will address the short term and then long term issues.

“Key question: how can I be more actively involved at a strategic level re the new H grade?” (C2 29/7/03)

Analysing critical incidents enabled the ANCs to make decisions about the organisations they wanted to work in – see Story 5.8.

Story 5.8 Checking out the culture of the workplace for a nurse consultant post

“I applied for a nurse consultant post. I worked in a hospital for three years, two years ago put a proposal together and did the ground work. Then I became pregnant and went on maternity leave and moved house. Post was advertised during this time. I made a decision not to apply for the post. In September a job came up near my house and I thought of applying. Went to the hospital twice. Didn't get the job – disappointed.

“What else could I have done to assess the environment? How do I assess trusts to see how supportive they are?

“I spoke to the medical director, and other nurse consultants. Spoke to the senior nurse and directorate manager. Director of nursing was on annual leave – spoke on phone. The role reported to the directorate manager. The questions were very low key. I didn't get the right vibes.”

What indicators would you look for in an organisation?”

“A practice development team. Specialist nurses. I would also look for gaps. Things that were lacking in this trust were: gaps in the nursing leadership, support for senior nurses was not good (70 specialist nurses who didn't meet regularly), weak link to a higher education institution, reporting mechanisms – not to a director of nursing – so no strategic influence, structures and strategies that are not operationalised.”

(NC 21/10/02)

NCs, on the other hand, reflected on how they had got their own jobs, and were wondering where their next career move would be, and the succession planning required (who, when and how).

During the project, three ANCs applied for NC posts and two had been involved with developing an NC post at their own hospital. One achieved an NC post at the

end of the project and another a similar post in Australia.

5.7 Conclusion

In this chapter, we have looked at the journeys undertaken by the ANCs towards greater effectiveness in preparing for an NC role and by NCs in working in multiple roles. The starting point for the ANCs was how to become an NC when career development pathways had not yet been explored. Through developing strategies for assessing themselves for the NC role, finding themselves a mentor and/or gathering qualitative 360 degree feedback on the role and areas for development, the ANCs moved successfully towards developing new NC posts in their organisations or achieving positions in others.

The NCs' first step was to recognise that understanding the multiple roles and their interplay required more development and balancing before they could truly demonstrate the effectiveness of the role in their organisations. Acting on this recognition, they addressed role ambiguity at service and strategic levels. Participants clarified the nature of this ambiguity by undertaking sophisticated analyses, which enabled them to clarify the role and negotiate its exact form at strategic level in their organisations. Their attention turned then to developing the knowledge, skills and capacities to show how effective their multiple roles were and to gathering evidence, using a variety of tools, to demonstrate their achievements to their organisations.

For some, this was an arduous journey because their research skills were underdeveloped. Those who already had higher degrees were better able to demonstrate their effectiveness within the timescale of the project. In addition, the research, evaluation and effectiveness role was the most problematic to demonstrate

due to resource and ethical committee constraints. While the power of the interaction of multiple roles in relation to strategically influencing patient care has been shown, dilemmas remain about the level of focus at which NCs should direct their energy.

6

Wiring them in: the impact on others, the organisation and service

“To wire them in is to engage them with a connection so there is enthusiasm for the process. They’re engaging in it even if they don’t agree. Wiring is an interesting image. Wires can get crossed so you have to check they are wired in.”

6.1 Introduction

One of the aims of this research study was to help NCs demonstrate their impact. Manley’s doctoral study (Manley 2001, 2004) found that the attributes of NCs, combined with a supportive context and use of a specific set of processes, achieved change. They created a transformational culture, characterised by empowered staff, practice development and a conducive workplace that provided effective patient centred services (see Chapter 1).

We have seen how NCs can develop their effectiveness to achieve outcomes which improve patient care and services. We have also looked at how, by using the study’s research approach, they became self-sufficient and active in their own learning and inquiry, and at the journey they took to become practitioner-researchers.

This chapter describes the impact and tangible changes achieved by the NCs, namely:

- developing the effectiveness of others
 - through enabling individuals and teams to be effective
- improving the organisation’s ability to draw on what the NC has to offer
 - through making explicit its potential, achieving support and credibility and embedding it in the organisation

- improving services to patients
 - through changing the workplace culture and influencing the strategic agenda.

These three strands are summarised in Box 6.1. They are described within the context of the NC’s journey, identifying their starting points, the strategies they used and the end points achieved.

This framework provides the structure for this chapter, and the evidence of each strand is described in sections 6.2, 6.3 and 6.4 respectively. The chapter uses research data to illustrate different aspects of the journey. Much of the data is drawn from one practitioner researcher’s experience, which we have used as a paradigm case (C3). It encapsulates the MC experience and a wide range of insights and understandings about the development and negotiation of the NC role.

Box 6.1 A framework for describing the outcomes of the project with regard to the NC role

Strands of the journey	Starting points	Strategies	End points
<ul style="list-style-type: none"> Enabling others to be effective. 	Knowing that enabling others is an important aspect of the role. Not knowing how to enable others.	Strategies identified, tried and tested for enabling others.	<ul style="list-style-type: none"> Skills developed in enabling others. Others become more effective. Greater team effectiveness.
<ul style="list-style-type: none"> Enabling others to draw on what the NC had to offer so that the role becomes embedded in, and supported by the organisation to achieve its potential. 	A context that didn't know how to: <ul style="list-style-type: none"> use NCs or seem to value them embed NCs in the culture support and develop NCs. 	Strategies identified, tried and tested for NCs to become embedded and fulfil their potential.	<ul style="list-style-type: none"> Credibility earned from others who began to recognise what NC has to offer. Contribution NC is making is valued. NC influences strategic agenda. NC support mechanisms improved.
<ul style="list-style-type: none"> Knowing what an effective culture is and developing this in the workplace for patient care. 	Recognising ineffective cultures.	Knowing what an effective culture is. Developing effective cultures.	<ul style="list-style-type: none"> Greater person-centred focus. Achievement of best practice. Practice and patients' experience influences strategic direction.

6.2 Developing the effectiveness of others through enabling individuals and teams to be effective

By the end of the project NCs possessed the necessary skills and were in a position to use them to enable others – as individuals and teams – to become more effective and to sustain this improvement.

At the project start, NCs and ANCs asked:

“How do I introduce and evaluate action learning in my department?” “Am I going to be able to deliver? Am I going to have the expertise to do it?”

(C2 20/5/03).

By project end, NCs could build on the self-confidence they had gained from developing

the necessary skills, and being clear about their role and its contribution. Chapters 4 and 5 show how the NCs and ANCs learned to become effective learners and practitioner-researchers, which are pre-requisites for sustaining on going effectiveness in the workplace.

Learning to be personally effective provides the basis to help others with their work. So, facilitation, clinical supervision, critical companionship and other helping processes featured strongly in the work cohort groups wanted to examine and in NC's personal priorities.

Helping others with their work in the context of this study is associated with work-based learning, rather than a more traditional educational perspective. It uses the workplace and everyday practice and experience as the main resource for learning for individuals and with others (Manley et al., 2009).

NCs were confident in using the processes they learnt during the project. They moved from a position of working with their own assumptions and behaviours to challenging those of others (see Story 6.1). They concluded that:

“The strategy is to ask the unanswerable question.” (C3 21/10/03)

Story 6.1 Which assumptions do I challenge?

“How do you enable others? This is the thing, trying to facilitate critical behaviour in others and being critical all the time is hugely debatable. I work with people who have more challenge of assumptions than I do. A lot of what comes out is assumptions and it’s trying to facilitate critical behaviour in others which is a massive challenge. It’s extraordinarily time consuming. I have this one particular person – she’s a wonderful woman but her claims are based on a whole series of assumptions – mixed messages come out. You can fall into the assumption trap. Thinking about communicating with people – you don’t know what their claims are.

There is an issue of expertise – it’s about saliency. It’s about which assumptions to challenge. If we don’t make assumptions in our life and our work we probably do, so we have to know which assumptions do we need to check out.”

(C3 29/8/03)

Through reflecting on and analysing their own practice, NCs identified and refined other strategies directed at helping both individuals and teams to become more effective. Many of these strategies were already described in the literature, for example:

- helping people to ask specific questions in relation to situations. This is termed “problemising” (C3 29/8/03) (Friere, 1972)
- providing opportunities for critical questioning and critical dialogue and role modelling (C3 29/8/03) (Titchen, 2000)
- paying attention to what is noticed and doing something about it (C3 29/8/03)

- using role clarification to help people understand expectations (C1&3 22/7/03) (Binnie and Titchen, 1999; Manley, 2001)
- working with senior staff, shadowing them (C3 29/8/03)
- using critical companionship (C3 29/8/03) (Titchen, 2000)
- modelling and establishing critical self review and evaluation, setting up formal peer challenge and support mechanisms (C3 29/8/03; C1 and 3 22/7/03) (Titchen, 2000; Manley, 2001)
- making facilitation visible clinically as well as strategically (C3 29/8/03).

Integral to achieving effectiveness is to ensure participants feel ownership of a project, and to keep people on track if they are to meet agreed goals and objectives. One NC provides a sophisticated yet simple explanation of this process:

“To wire them in is to engage them with a connection so there is enthusiasm for the process. They’re engaging in it even if they don’t agree. Wiring is an interesting image. Wires can get crossed so you have to check they are wired in.” (C3 21/10/03)

Developing a common approach to day-to-day work is a recognised pre-requisite to developing and achieving effective teams and workplace cultures (Manley, 2001).

Role-modelling was another powerful strategy for challenging others’ expectations. Story 6.2 illustrates the staying power of one NC, and the impact she had on others’ behaviour by being a role model to them.

Story 6.2 Role modelling: paying attention to what you notice, noticing something and doing something about it

“I had been to a meeting about MRSA. There is a perception that ICU is dirty as MRSA goes out to the wards. I had to go out of the unit and as I went back I followed a consultant surgeon and three junior doctors in. I watched them. The entourage didn't wash their hands and went straight into the unit. The nurses were looking at me. So I asked the doctors to wash their hands and remove their white coats. The consultant thrust his hand into my face and asked me to smell his hands. I pointed out the policy. He said he had washed his hands on another ward. The three junior doctors were laughing. Before I said anything he walked out of the unit saying he'd never put patients in there again.

“Later on there was a phone call from the unit manager who wanted to know what was happening. He had discussed it with the clinical director and wanted to take the issue of doctors not washing their hands further.

“In the unit the nurses said they needed to discuss what had happened. I explained why I had done it. I think it's part of everyone's role. It was an opportunity for them to see a nurse consultant. We talked on leadership and role modelling.

“A physiotherapist came up to me a few days later and said the junior nurses had asked her to wash her hands.”

(CNP3 04/11/04)

Role-modelling meant that NCs earned credibility and respect. One NC received this feedback from a clinical colleague:

“We don't see senior nurses doing nursing, but we see you.”
(C3 05/09/02)

In their hopes and expectations for the project, NCs frequently mentioned the need to enable learning and develop new skills in helping others. Chapters 4 and 5 outlined facilitation processes useful in helping to transform practice. These include fostering critical behaviour in others and challenging assumptions. Implementing action learning and being a role model are further strategies.

The NCs and ANCs recognised that using enabling and facilitation could help improve the effectiveness of colleagues and develop a culture where ongoing supervision and critique of practice could become the norm. NCs could develop the skills and opportunities necessary to support and supervise staff so that they moved towards a working culture where everyone is continually striving for effectiveness:

“I manage a small team of clinical staff and have been able to reflect on my performance and thought of new ways of improving their performance.”

(C1 Reflective review 1)

NCs also realised the importance of developing, and working with, a shared vision for practice. NCs and ANCs recognised that such a vision could be a starting point for developing and achieving clear goals and team effectiveness, and for succession planning (C1 28/10/02).

These enabling processes were a strong feature of the project itself, and were modelled by the research team as part of the project's methods (Chapter 3). Research has shown that using the workplace for learning during, and from, practice, supported by facilitators and an enabling learning culture, are influential in transforming practice (Manley, 2001; Manley et al., 2009; Binnie and Titchen, 1999; Titchen, 2000). Facilitating improved practice in others is a core aspect of the NC role. So the NC is in a particularly privileged position, both to develop expertise in these skills and to use them in everyday practice (Manley 2001, 2002). They demonstrated in our research that they had the skills and strategies to achieve this.

6.3 Improving the organisation's ability to draw on what the nurse consultant has to offer and embedding it in the organisation

A second aspect of NCs' ability to enable greater effectiveness is the effect that they can have on the wider organisation and its purpose in providing health care.

First, however, the NCs had to overcome some challenges present in many organisations before their full potential could be accessed by employers. These challenges are described in some detail and, as identified in Manley's framework (2001, 2002), the context in which NCs work, is a major factor in determining whether outcomes can be achieved.

The NCs learnt that their role would be valued and drawn on, and its potential to improve patient care developed and recognised, if a shared understanding of the role and appropriate positioning/status was achieved. This is reflected in one NCs review at the end of the project:

"A shared understanding and the strategic positioning of the nurse consultant role in the organisation is essential of the role is to have maximum impact on improving patient care." (C1 Reflective review 3)

During the project, the NCs achieved a number of outcomes which showed their role had become valued, more embedded and supported, and the expertise of the NCs was now being drawn on to benefit patients.

6.3.1 The organisational context at the beginning

At the beginning of the study, NCs and ANCs recognised that their workplaces presented challenges which would prevent their

organisations capitalising on what they as NCs had to offer.

Generally, organisations did not:

- know how to use NCs and did not value them
- embed NCs within the organisational structure and culture, so as to benefit the organisation
- know how to support and develop either NCs, nurses and nursing generally
- accord them the same status as, for example, medical consultants.

NCs and ANCs initially were working in a context where organisations and their leaders were unsure of what they wanted from NCs, or what they had to offer. Employers seldom appeared to value them, according to NCs' early comments:

- "Employer doesn't know I'm here." (Workshop 5/7/02)
- "Person I report to doesn't see the value." (C3 1/8/02)
- "Management doesn't see the value of nurse consultants." (Workshop 5/7/02)
- "Our role is undervalued and not understood by others in the organisation." (C1 28/10/02)
- "Organisation is unsure what they want from NC role. Chaos in practice with no strategic direction." (Workshop 5/7/02)
- "Feel a single voice – climate not receptive." (Workshop 5/7/02).

This perception was strengthened by a commonly held NC view that they seemed to have been appointed with little thought about how they would contribute to the organisation:

"I'm a knee jerk reaction. They didn't think seriously about this before putting the bid in." (C3 5/9/02)

The lack of understanding about how to use NCs also meant the role was not initially embedded into organisational culture. NCs felt that they could not influence the culture, when they were not a part of it themselves:

- “Who covers the NC on their absence such as sickness, maternity leave?” (C1 28/10/02)
- “Nothing moves forward in our absence.” (C1 28/10/02)

NCs experienced competition for resources from others, such as medical consultants (Workshop 5/7/02), and also felt that later policy initiatives, such as the introduction of modern matrons, were overtaking them (C1 28/10/02).

There was a strong desire for more support and opportunities for development. The following comment captures the lack of development time some NCs experienced:

“I like the toilet – time out opportunity for clarification of strategies/ reflection. I don’t have any other avenue for this kind of discussion.” (C3 29/8/03)

This perceived lack of support was reflected in the high level of interest the RCN received from NCs and ANCs wanting to participate in the project. Participants expressed marked relief when they first met, reflected in comments such as: “The first day of project provided a support mechanism.” (C1 7/8/02).

Many of the practitioner-researchers had echoed the need for support and development at the inception of the project, as Box 6.2 shows.

Box 6.2 Need for support and development articulated at the beginning of the project

- “Like to see clear support mechanisms for nurse consultants and aspiring nurse consultants.” (Workshop 5/7/02)
- “Finding support is an issue.” (Workshop 5/7/02)
- “Not everyone has support from their organisation.” (C2 27/11/02)
- “How do we enable others in the group to gain the support they need?” (C2 27/11/02)
- “Supporting NC’s to make a difference.” (Workshop 5/7/02)
- “Some nurse leaders not supportive.” (Workshop 5/7/02)
- “No process to develop NC role.” (Workshop 5/7/02)
- “Need central and local support mechanisms.” (C12 16/8/02)
- “NC initiative dependent on support from medics.” (Workshop 5/7/02)

The following quote captures the frustration experienced by one NC who, a year into the project, identified the sort of support she required, but concluded that staff who should be able to support her did not have the skills required:

“I seek support on an issue and I find myself unable to think clearly but they either haven’t got the ability to enable me to do my work, to sort the issue out, to bang ideas off them and get a sense that this person is supporting me and not vaguely nodding their head. I have ideas that are inspirational and ground breaking and I’m asked what am I going to do about it, but I often need something a bit more concrete. I come away thinking I’ve taught them about management of theory. Or I have been doing a leadership role. People who should be able to support me in my role don’t have the capacity or capability.” (C3 21/10/03)

Most of the participating NCs and ANCs experienced this lack of support. However, there were one or two exceptions:

“I have employer support and they value what I am doing.” (C2 27/11/02)

“My clinical mentor was keen that I could access an appropriate forum for personal development and support.” (C3 Reflective review 5)

“However I did feel supported by the trust in terms of time and support. The culture of the trust supports this project.” (C1 Reflective review 1)

ANCs realised the importance of working in a supportive culture, if they were to go on to develop and deliver on their potential and tap that of others. It became key to them to assess any NC post for which they might apply for its formal provision of support. This influenced the development of assessment tools that could help aspiring NCs judge whether a new workplace would be supportive and ready to embrace what a NC post could offer. Chapter 5 gave a number of observations on this.

Participating NCs and ANCs recognised that many of their organisations seemed unsupportive not only to NCs but to staff in general:

“Lack of understanding and support from management and colleagues. Working within an organisation where the culture for ‘personal development opportunities’ to be subsumed by other priorities.” (C1 Reflective review 2)

Participants felt that this lack of support was often because organisations did not know how to provide support for professional development and continuing effectiveness, or how to develop a culture that sustains these. To improve the situation, the NCs and ANCs had first, through the project, to experience a high level of support and a culture favouring development themselves. They could then see how to begin to implement these approaches to benefit their teams and wider workplaces.

6.3.2 Embedding the NC role within the organisation

To work towards embedding the NC role in their organisations, NCs had first to address these barriers. During action learning, participants began by identifying action-orientated questions to examine their workplace experience. This established a starting point for the journey. Examples of the questions they asked were:

- “How could we engage more people in our role how to get others to use us?” (C1 28/10/02)
- “How do I get others to value my role?” (C1 Reflective review 1)
- “How do we influence organisational culture?” (C1 28/10/02)
- “I’m interested in developing the skills to sort out the infrastructure – how do I develop practice development?” (C3 1/8/02)
- “What to do if your values/beliefs are different to the key people?” (C1 28/10/02)

Once they had asked these questions, the NCs and ANCs could then through action learning identify strategies to influence and develop the culture in which they worked.

Story 6.3 illustrates one NC’s experience of trying to make sense of a myriad of issues concerning her workplace culture. This process challenged her to think about:

- where she fitted in
- how she fulfilled her strategic role
- what her key relationships should be
- how she could position herself so as to influence and work with the director of nursing and key governance committees.

Story 6.3 Finding a way through the maze to be able to influence

“When I was first in post I looked locally, negotiating with stakeholders locally. I had questioned the rationale of reporting to the nurse manager in the directorate. Post was accountable to director of nursing (DoN) wanted to find out the reason. I was trying too to find out the culture of the department and the trust. There was a feeling my questions weren’t being answered. No openness or honesty. I should have had dialogue with the DoN earlier but I was not enabled to do that then. I had made assumptions that the nurse manager would feed info into the DoN.

“I realised I had to engage more with the DoN, be open and honest, try to clarify perceptions of what the role was. At that stage there was no hint of having nurse consultants on the nursing and midwifery strategy committee. I didn’t know there was a misunderstanding of the role in the trust or because of reporting lines there was no discussion with the DoN, yet I was expected to feedback how the department was being led and managed.

“When I saw the general manager – there was a lack of clarity of the role and issues in the department. I went up the hierarchy for quite a while before engaging the DoN. I have learned it’s essential for any new post holder to explore the relationship they have with the DoN. What is it a DoN has to do and what does a nurse consultant do – what are the lines of accountability? This was an issue for our nurse consultant meeting in terms of enabling the nurse consultant function, and in terms of behaviour.

“When I look back it was about an individual coming into post and making a judgement about components of the role. I would have been clearer about the diagnosis of where the organisation was and where it needs to go.

“I had to get people ready for the strategic nurse consultant role through the nursing and midwifery committee. It was through direct dialogue with the DoN that the issue came about - reporting to DoN about the strategy. No information was being passed to me so I had to ask the nurse manager for minutes of the nursing and midwifery committee. These did not provide enough information so I went back to DoN and asked what if I don’t agree with some of this. She then facilitated a discussion at the nurse consultant meeting around the strategic work of the nurse consultant. This had been my idea – she then called the nurse consultants together for a meeting. I didn’t feel the other two nurse consultants were on board. They just requested minutes I had to say: what if I don’t agree? That’s when it was discussed at

the nursing and midwifery committee and agreed it was of benefit. DoN asked us for a succinct view as to why we should be at the nursing and midwifery committee. I highlighted the importance. Put in material from references so it was evidence based. Also sent this evidence to the general manager and others. I argued that I didn’t have organisational authority – I drew on Manley. I explained that we didn’t have a common vision for the department. We are not working in a democratic way. Previously reporting lines disabled me as I couldn’t make any changes. Gaining organisational authority was difficult.

“The new acting head of department – didn’t have any issues with lines of reporting. Their management style was facilitative, they facilitated staff in an enabling and empowering way. She was clear in what she needed to do and how to facilitate. Everything was done in partnership. Manager adopting this style naturally. Our communication is three to four times per week. She was a G grade sister who had worked with me developing outreach. Showed leadership qualities in enabling development. She’s facilitating staff to manage their workload. She has always been like this. She’s a transformational leader. She challenges me on outreach. I find that therapeutic.”

(C3 23/9/03)

This story typifies the sort of working context many of the NCs experienced. These required NCs to be persistent in challenging ways of working, so they could establish themselves as clinical leaders and embed their role in the culture – then they could begin to change it. Two reflections capture the NCs’ learning about how to get their role understood and embedded:

“I realised I had to engage more with the DNS – be open and honest, try to clarify perceptions of what role was.” (C3 23/9/03)

“I drew on how we didn’t have a common vision for the department. Not working in a democratic way. Reporting lines disabled me as I couldn’t make changes.” (C3 23/9/03).

This kind of understanding emerged repeatedly within action learning over the span of the project. The learning informed strategies to address the lack of understanding of the role by others and to embed it in the organisation:

- using values clarification/other approaches to develop a common vision with key stakeholders about the role and purpose (C1 23/4/03; C1 and C3 22/7/03; C1 5/5/03; C2 27/11/02; C1 and C3 22/7/03; C3 1/10/02; C3 4/11/02)
- engaging senior stakeholders in discussion about their perceptions (C3 4/11/02; C3 23/9/03; C3 23/11/03; C3 4/11/02).

The NCs integrated these strategies, and marketed what they did locally and at senior nurse level, then sought feedback about it. Outcomes were positive, such as:

“The G grade was working with me and she said: “I didn’t realise all this went on – what influence you had.” (C3 29/8/03)

“Colleagues/team: increased their understanding of the role as I would feedback the conceptual framework that was evolving. Actively involved in sharing their views on the effectiveness of the role in qualitative interviews.” (C3 Reflective review 5)

The study led to the identification of a number of strategies that NCs and ANs used for supporting others wishing to become NCs, and for embedding the post within the organisation. These are outlined in Table 6.1

Table 6.1 Strategies for providing future support for NCs and ANCs through embedding the role into the organisation (June residential, 2003)

• Raising the profile of NCs.
• Being political in whom we target.
• Written publications about being involved in the project and project processes.
• Sharing what makes a good NC bid with others?
• Using project processes to support succession planning.
• Working towards regional and national networks.
• Looking at the organisational factors including commitment towards enabling NC to achieve potential.
• Having explicit, transparent selection criteria for NC posts.
• Clarifying accountability and responsibility mechanisms.
• Clarifying good practice in succession planning.

Embedding NCs in their organisations' cultures meant addressing a perceived lower status compared with medical consultants:

- “Nursing versus medicine (comparatively low status when compared with medicine).” (Workshop 10/06/03)
- “Nursing is low status.” (Workshop 10/06/03)
- “Have to now share office with nurse consultant as medical consultant back from maternity leave and has to have nursing consultant's office.” (Workshop 10/06/03)
- “How do we influence terms/conditions/salary – it appears this is how NC is valued/placed within organisation?” (C1 28/10/02).

The evidence showed interplay between the organisational culture and the authority bestowed on NCs. Participants questioned their own place in decision-making, their own perceived personal power and credibility, but some went on to really establish a presence and make a difference.

One NC felt her credibility was challenged on a nurse-led initiative that was “taken over” by a consultant anaesthetist while she was on holiday (C1 4/9/02). She recognised that she needed to address the issue, although in the past she might have let it go. A number of personal principles emerged from exploring this critical incident, and informed her action learning set's development of strategies for maintaining credibility (Box 6.3).

Box 6.3 Maintaining credibility: general principles (C1 4/9/02)

1. Being a role model.
2. Being proactive by addressing issues.
3. Involving all key stakeholders.
4. Have let issues like this go before- now we have to address them.
5. Reflect on values being considered.
6. Weighing up the benefits and risks of no action.
7. Need to be a leader.
8. Awareness of political agenda/ local agenda.
9. To have an explicit understanding of what it means to be collaborative.

A further strategy for developing credibility was identified in another action learning set:

10. Taking on things that expose you to others so that they become aware of your capability.

Another NC shared her strategy for asserting her presence:

“You have presence and you do this through your physically being there, through humour, irony and mischievousness.” (NCP3 21/10/03)

She goes on to elaborate how she used this presence in situations where she did not feel respected or felt trivialised by others, or where others were behaving in a disrespectful way to patients (see Story 6.4).

Story 6.4

“Getting them by the balls and squeezing them – where the person power becomes coercive power. Sometimes you use power strategies to subdue others. Sometimes you're in situations where you're with a collection of men. I think I don't push them unless I have evidence to back it up. So after we've re-presented the patient and they're still failing to recognise the question – that makes me cross. I think that goes to the realms of disrespect. I don't see why I should put up with that. So I draw myself up to my full height and fix my pitch.

“It is a strategy to demonstrate that I am not prepared to be disrespected, and neither am I prepared to see the patients disrespected. There's

no denying the stuff, by the time it's got to this stage it's very serious, and to deny that would be to disrespect the patient. People who are dying and not being looked after properly. I think it is very important to be clear that I'm not prepared to be trivialised or intimidated."

Assertion: "To demonstrate that I am not going to go away on this issue – that the evidence is irrefutable. I got chucked out of the professional mortality review twice by the clerk."

(C3 21/10/03)

From this critical incident emerged a number of personal strategies the NC used to achieve personal influence in situations where others would not listen, were resistant, or trivialised her contribution (Box 6.4).

Box 6.4 Strategies to influence

- Wiring in – engage in the process – so as to connect, energisation:
 - requires re-checking to make sure the information delivered is wired in to engage the audience.
- Resistance – how to deal with it? Stop telling people things and start asking what they think – ask what their experience, evidence, perceptions are. They won't listen to what you say, so ask them what they think:
 - with people who are resisting – need to achieve a connection through agreeing that the question is significant and salient, even if unanswerable, therefore the agreement that the question is an important one and 'exists' is important.
 - this overcomes the minimisation, trivialisation that some resisters employ to do down my argument/case
 - to overcome resistance – increase the voltage – use a power surge.
- The importance of asking the unanswerable question – just because it can't be answered doesn't mean it shouldn't be asked. Links with saliency.
- Having confidence – the use of rigorous assertion to demonstrate I am not going to go away and the evidence is irrefutable.

One participant wrote this following Haiku poem building on the metaphor of 'wiring them in', following deliberations during action learning to capture these strategies:

Increasing the voltage
Overcoming the resistance
Give them a power surge

Pursuing these strategies and using enabling skills achieved change: NC roles eventually became valued, more embedded and supported, and the NCs' expertise was being tapped to benefit patients:

"I feel that being part of this group has enabled me to look at the nurse consultant post in the primary care setting and bring it forward for the debate." (C2 25/3/03)

"The nurse consultant project has been included in the trust R&D report." (C2 20/5/03)

"I have employer support and they value what I am doing." (C2 27/11/02)

"I have managed to secure an extra G grade for clinical practice education by lobbying, as nurses are not feeling supported." (C1 and C3 22/7/03)

"I now feel accepted as an expert. Medics are looking to me for support and answers and I feel confident in my response." (Workshop 10/6/03).

Through their experiences and the challenges they addressed, our participants also achieved clarity about the role of the NC and how it could contribute to organisations. By the end of the project all practitioner-researchers were very clear about the role, and in particular its strategic contribution to patient care, as evidenced in reflective reviews. They were also able to communicate this to stakeholders:

"I should not be acting in the capacity as an expensive bank nurse. It's about

strategic intent. What is the purpose of my work? To develop others, it's a design and development role, not a super-specialist role. I am making progress in this respect, for example, strategic handling of meetings – requires preparation.” (C3 Reflective review 4)

“I recognise and can articulate the value of this role in clinical practice and the direct benefit this has on patient care.” (C1 Reflective review 1).

This second strand (embedding the NC in organisations' cultures), is related to the first (enabling others), in that the strategies for enabling others also endorse the need for a common vision, making explicit assumptions and having clear expectations. The second strand also works with elements of the third strand, improving services to patients. Story 6.4 illustrates this, where embedding the NC role in the culture provided a means for changing that culture, to achieve positive benefits for patients. Section 6.4 makes this impact on patients and services more explicit.

6.4 Improving services to patients through changing the workplace culture and influencing the strategic agenda

This last strand focuses on how enabling others and embedding the NC role in organisations fed into improving services for patients. Project participants were able to influence services so that they became more person-centred, evidence-based and reflected the changing health care needs of society.

Participants recognised that the workplace context needed to change. For example, one NC commented about the emphasis on management over clinical leadership in her organisation:

“Clinical leadership is not embraced, dominance of management leadership in organisation's culture.” (C3 Reflective review 3)

Another NC felt the key issues and opportunities to influence came through informal contact:

“Why do corridor conversations come up as pervading and not others? You find out more down corridors than in offices. People tell you when they see you. A lot of things are senior doctors talking about juniors. You can't say these things in an open forum. You get the combination of 'It's just happened'. You see them in the corridor. People discuss the real salient issues in corridors. Making appointments for meetings – the moment is gone.” (NCP3 05/09/02)

By the later stages of the project, participants could see that an effective culture is one that is person-centred and evidence-based:

“My involvement in the project has provided the opportunity to identify the key attributes of a patient-centred, evidence-based culture.” (C3 Reflective review 5)

Story 6.5 draws together the three journeys (starting points, strategies and end points) to illustrate how they led to a more person-centred service. The NC established that in her acute trust, there was no common vision. Disparate parties across the trust and day hospital, were using different referral mechanisms in intermediate care. She identified that the culture needed to change to one that focused on team-working, putting the patient at the centre of care, as opposed to one where the emphasis was on different teams keeping their beds full.

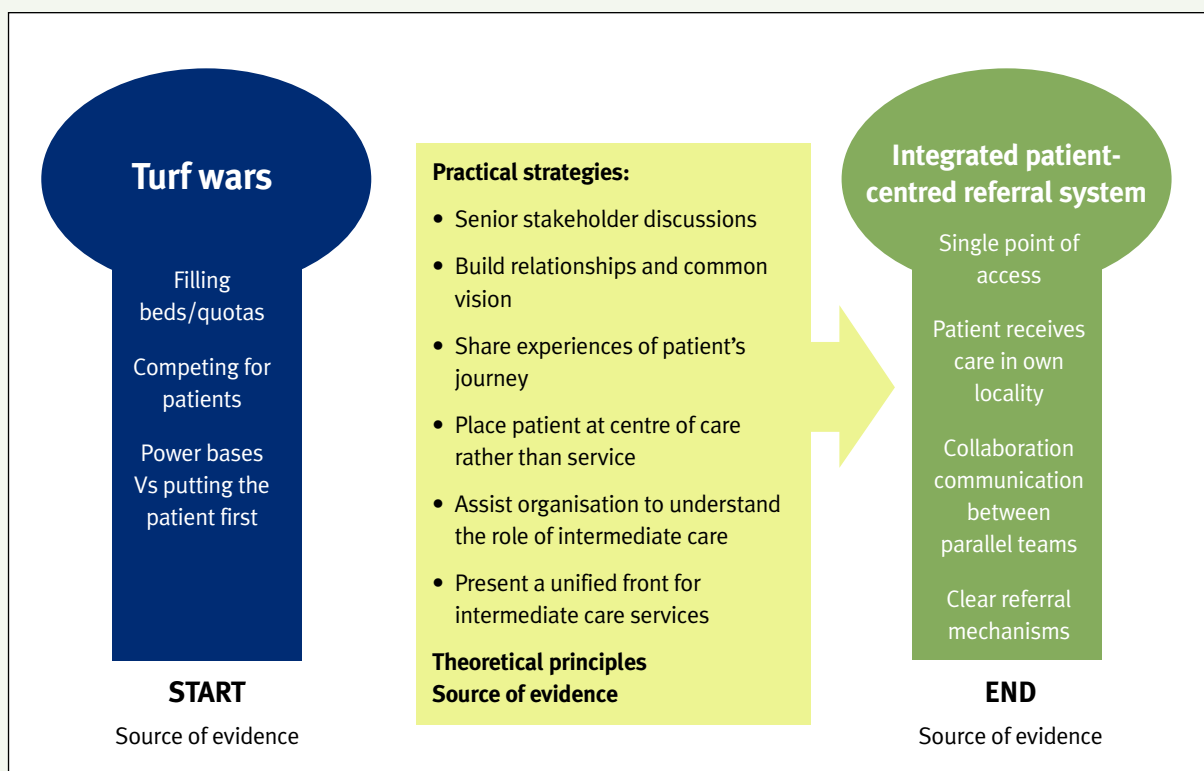
Story 6.5 Turf wars

“I work in intermediate care in an acute trust. Within the trust there is an intermediate care team that works with nursing homes. I have 24 beds in the trust which are my responsibility. The issue is how we all pull together to set a common goal. It was OK at first and then the primary care group became a primary care trust. Everything is up in the air. It has left services aware of each other but not developing as a team. There is an issue as a sister manages the intermediate care team. Her patients are taken from the community and not the trust. However she comes into the trust to find patients to fill her beds. Now there is confusion as to how patients are referred to her and how to contact her, she decides where they go.

“My main concern at the moment is that operational issues need sorting first. We’ve built all these services up. Patients aren’t in the centre. It’s all about getting your beds full.

“I have raised this with the director of rehabilitation, who was unaware of the issue. The sister has upset consultants as well because she is dictating who goes into her beds and who goes into mine. I think small core multidisciplinary team should be rekindled.”

Figure 6.1 Turf wars



Ten months later, after further analysis during action learning and implementing a number of strategies for change, the NC could describe the triggers to this issue, the strategies implemented, and the outcomes achieved. To do this she used the theorising template refined during the project for helping practitioner-researchers to theorise from practice (see Figure 6.1). The concept of turf wars captured the culture associated with a number of aspects the NC experienced.

The template demonstrates where evidence from practice can be collected to demonstrate the triggers, strategies and impact. It also shows the place of theoretical principles in informing the practical strategies as well those as being refined following their use in practice.

Many of the issues emerging in this strand characterise non-effective cultures in terms of how people work together and how things are done. But they also show that changes were linked to concepts of authority, personal power, influence and credibility. By the end of the project, each NC felt they had developed credibility and influence in their organisation, and that these outcomes had been achieved through persistence and hard work.

The NC role in Story 6.5 is an example of how NCs can have a positive impact on patient care and the potential to improve on wider patient services. This potential became widely accepted by the practitioner-researchers:

“The NC role has the potential to enable delivery of person-centred evidence-based healthcare delivery.”
(Workshop 9/12/03)

“My role – the capacity to influence and develop services, to provide better outcomes for users is immense. In fact the potential is frightening at times!”(C1 Reflective review 2)

“[The project] helped me to identify areas of the service that I needed to be actively involved in to be most effective in my role.” (C3 Reflective review 5)

NCs also felt they had achieved recognition from others that the culture of the workplace needed to change:

“My recognition of the negative culture has now been acknowledged by unit managers.” (C1 and C3 22/7/03)

“I feel I have more people on board with what I am doing. There’s a vision materialising.” (C3 23/9/03)

“I feel I have influenced the culture of staff development within the directorate I work.” (C1 Reflective review 1)

“My involvement in the project has provided the opportunity to identify the key attributes of a patient centred, evidence-based culture.” (C3 Reflective review 5)

NCs knew, for example, that it was imperative to ensure that patient care was on the radar of the executive board, if they were to achieve change (see Box 6.5).

Box 6.5 Influencing the executive team

“As the nurse member on a professional executive committee a lot of time is taken up with other agendas. Not enough time is being spent taking practice forward. Nursing issues around patient group directives needed discussion around professional accountability. I need a sponsor’s directive for strategic roles for midwives and got no reply. I wrote to the chief executive as this was not on the agenda, however it was on the agenda. I’m trying to work out how not to be deflected again.”
(CNPo2 25/03/03)

Story 6.6 demonstrates the lengths that one NC went to achieve executive sign-up.

Story 6.6 Achieving executive sign-up

“It is essential to put over to senior managers, executives what health care might be about because some of them don’t have any idea about what it takes to look after people. People need to be looked after and they’re not being. I see it as my job to tell them what the state of play is. There’s something about my status within the institution that means they have to listen.

“I’m throwing together the very grounded experience that patients and staff have with the strategic direction of the trust, research base, what’s going on in other places, the national picture, training issues, recruitment issues. Connecting up the person who sits on Ward 3 and their family with all this other stuff. There’s the patient and family, then there’s the strategic direction, recruitment and retention issues, the critical care agenda, the research base we can bring in, things to do with the transient workforce, issues with language, the creation of cultures in care.

“There’s a political drive in terms of targets and numbers but little attention to quality. If they sat down and talked to patients I think they have no idea of the implications of those things. So that’s my claim.”

Do you have any sense of why they don’t have a clue?

“I think it’s because health care is such a private activity. What goes on behind the curtains is such a private thing. The implications of not paying attention to detail – they can’t see that. If someone’s bleeding to death then that’s relatively obvious and they have an idea about that. But if someone’s dying and they haven’t been given a drug for a couple of hours and they’re not being fed, they’re not being turned, their family doesn’t know what’s going on and neither do they and they’re upset and depressed. We are putting our arms round the patient and giving them a squeeze, because no one has got any time and are they interested anyway. And are they clean and do they feel comfortable? That kind of stuff is not on the agenda. These issues haven’t changed. To me it’s women’s work, it’s dirty work, it’s not technical, it’s personal, it’s upsetting, it’s done behind closed doors or curtains. And people don’t want to know about that stuff. It’s not that they’re not interested – it’s just that they cannot get a grip on it because they have limited experience of it.

“This is why the director of finance was trying to work out with me what the trust can avoid paying in clinical errors. He came round with me to see a dying

man and various other people. He was asking some very sensitive questions. It’s not that they can’t – it’s just for most of their lives they don’t deal with that, whereas I do. I’m with people most of the time who do. I know as a researcher I’ve walked into an intensive care unit and I think I know what’s going on but I’ve become disassociated from that work. I know at one level, but in terms of doing it, organising it, knowing at the end of the day I’ve done the job properly – there’s no way I can contact them about that stuff. I don’t see how the chief executive/director of finance haven’t got a clue.”

And they haven’t any research to articulate this?

“No – their jobs revolve around making sure the books balance, that not too many people leave, making sure we don’t get done on the Equal Opportunities Act. Possibly some of them aren’t interested – I wouldn’t like to make that sweeping statement. I know some of them are interested – the finance woman is. I hope the director of nursing is interested – and he does have a thorough grip and hence the significance of the report into his role at executive level. Unless you’ve got articulate people that can put across those kind of cases they are never going to have any idea at all. Because that’s technical stuff, that’s the agenda, it’s too upsetting. All the high tech sexy stuff – that’s comfortable isn’t it?

“And it needs articulating at executive level. The chairman said, because I did this yesterday;”It’s very nice to sit here and talk about patients.” That meant a lot. And I knew the director of finance was supporting me. The chief exec knew nothing about what I was talking about. And I started talking about skill mix, consequence of error. We didn’t finish till 6pm. I don’t know what they thought – I’ll have to get feedback on that.”

Should we be saying we haven’t got the cash so we shouldn’t do it? We just have to keep saying it’s not alright.

“The true context is reality. Is the person in the NHS. I think they are all doing their best and I think that’s a great thing that the lists are coming down otherwise these people have another 18 months in agony. A lot of people have benefited from these things, but it doesn’t mean it’s OK. It’s the being CRITICAL – this is where we’re at, this is what is good but we need to be aware that we’re not meeting these kinds of needs.”

CNP3 21/10/03

Comments from the participants show the influence they had on the strategic agenda:

“Participation in the project has increased my ability to influence the strategic direction of services – I have been active in mapping services and developing strategies to address identified shortfalls, thereby ensuring that the trust is in a position to deliver quality services to children, which reflect DH requirements.” (C1 Reflective review)

“I feel I am able to demonstrate/evaluate my impact as a consultant midwife by being credible, raising the profile of the role within the trust both locally and regionally.” (Workshop 10/11 June 2003)

“I have developed an excellent service for the users and contributed to other services that affect the care/support the users receive. I feel I have also fulfilled the criteria for being a nurse consultant that is, expert practice, leadership skills, education/training and consultancy etc.” (Workshop 10/11 June 2003)

“I can demonstrate I have effected change by identifying issues within clinical practice and putting systems/solutions in place to improve practice/outcomes. Clinicians, especially medics, have moved from disliking a nurse in the position of expert/strategist to seeking guidance and support on clinical issues. This change has taken two and a half years and still has some time to develop.” (Workshop 10/11 June 2003)

6.5 Outcomes

To achieve positive outcomes for patients and services as well as for themselves, NCs and ANCs needed to:

1. develop facilitation skills as active learners and become integral inquirers into their own practice, focusing on developing their own work effectiveness
2. further develop their skills to enable others to become more effective
3. earn credibility from others, who began to recognise what they had to offer
4. be valued for the contribution they made to services.

The impact the NCs and ANCs had on workplace culture and services led to:

- a greater person-centred focus
- achievement of best practice
- a strategic influence from practice.

The research data on the experience of one nurse consultant (C3) has been presented in this chapter to show the salient characteristics of the NC’s journey and the subsequent impact this had on both colleagues and patients, on the culture and on the service.

7

Discussion, conclusion and recommendations

7.1 Introduction

In the early context of the then Government's support for establishing NC posts (DH, 1999a), this study set out to help NCs and ANCs to develop their effectiveness and demonstrate impact as they put the new role into practice, or worked towards becoming a NC.

The participatory research approach and methods we used were chosen because we believed they were consistent with helping practitioners to both learn from and research their own practice, at the same time as transforming their workplaces. Explicit propositions underpinning the study were:

- to develop expertise in practice-based research approaches, to enable NCs and ANCs to build the necessary skills to be active in their own learning and inquiry and to demonstrate personal and professional effectiveness
- support NCs to acquire the necessary skills for maintaining personal and professional effectiveness and to enable others to develop their effectiveness
- the presence of these skills, combined with personal attributes and expertise within the multiple roles of the NC, would enable a workplace culture to develop providing effective, patient-centred services.

These propositions were derived from the findings of an earlier action research study into putting the NC role into operation (Manley 1997, 2001, 2002). Other studies with senior clinical leaders has also demonstrated the propositions, for example with senior ward sisters, team leaders and specialist nurses (Binnie and Titchen, 1999; Titchen, 2000; Manley et al., 2005).

The research processes used in this study parallel those the research team believed were useful in the workplace. By becoming part of the project, NCs and ANCs experienced a culture of support, challenge and enablement, working collaboratively to achieve the project outcomes. As co-researchers, participants individually and collectively within a research community collected, analysed and interpreted data. They implemented their findings in everyday practice, and created theory from practice en route.

In this discussion of the study's findings, we also reflect on our chosen research approach and the study's limitations. The findings of the study are discussed in relation to pre-existing research on NCs and to subsequent research undertaken in parallel to this study or completed later.

7.2 Key project findings and discussion

The discussion focuses on the findings presented in Chapters 4, 5 and 6:

- moving towards being a practitioner researcher
- moving towards greater effectiveness in multiple roles
- the impact on others, the organisation and service.

7.2.1 Moving towards being a practitioner researcher

In Chapter 4, we mapped the journeys of NCs and ANCs as they moved towards becoming practitioner-researchers, active learners and facilitators of others' active learning. As they set out, the participants were uncertain about how to integrate learning and inquiry, how to work collaboratively and how to demonstrate the development of new knowledge by critiquing and researching their own practice. Their praxis skills were underdeveloped. On the other hand, they had a strong commitment to taking responsibility for project management as co-researchers.

We concluded that the strategies used by the project facilitators to help participants along these journeys were effective: as a result of taking part in the project, participants began to apply the strategies they had learnt to their everyday work. They transformed their practice and becoming practitioner-researchers through:

- becoming active learners and facilitators of active learning. For example, they developed and used strategies recognised as mindful, intentional actions, blending different types of evidence and knowing; they used reflexive ways of knowing, thus increasing their self-awareness and their awareness of the impact of their actions on others

- using resources appropriately. For example, they used tools to assist the ANCs in self-assessment, and tools to assist NCs with role development
- developing dimensions of professional artistry, for example by creating new theory from the experience of practice.

The facilitation strategies are described and illustrated with project data in Chapter 4. They were framed by the 10 principles drawn by Manley et al (2009) from using work-based learning to develop a culture of learning and inquiry, integrating McCormack's (2009) practitioner-research processes associated with transformation of the workplace.

There is a dearth of studies about NCs or other clinical leaders that explore the use of similar approaches to enabling research practitioners to inquire into, and actively learn, from their practice while at the same time transforming patient care.

Notable exceptions include the work of:

- Webster (2009), an NC in older people's nursing
- McGinley (2009), a specialist incontinence nurse
- Henderson (with McKillop, 2008), a lead cancer nurse.

All three examples describe personal journeys using principles derived from emancipatory or transformational practice development (Manley and McCormack, 2003) as well as assisting others in the workplace, transforming services through achieving a culture where individuals and teams can flourish (McCormack and Titchen, 2006; McCormack, 2009). In 2009, McCormack proposed that practitioner researcher opportunities can increase human potential and linked this to ideas of human flourishing.

In their early evaluation of NCs in Scotland, McIntosh and Tolson (2008) demonstrate

the need for expertise in cognition to complement expertise in practice. They conclude that NCs need to include critical thinking and helping others to achieve this as part of transformational leadership, as well as being able to synthesise material from diverse sources.

Despite the difficulties that participants had to overcome during our study, both individually and collectively, the evidence suggests that the facilitation strategies used enabled rigorous practitioner research. This culminated in:

- learning in and from practice
- change in practice, as well as
- theorisation from practice.

Participants felt supported and valued by the project, and showed strong commitment to action research and project management. They were concerned about where support for future practitioner research would come from once the project ended. This is a very real concern and will have to be addressed if the effectiveness of the NC role is to be demonstrated further.

Developing expertise in the skills described by the 10 principles suggests that there is a relationship between the following concepts:

- developing expertise in the ten principles of work-based learning and practitioner inquiry are necessary for increasing and sustaining one's own effectiveness
- using the 10 principles of work-based learning and practitioner inquiry in one's work develops and sustains the effectiveness of others
- embedding the principles of work-based learning and practitioner inquiry in everyday work enables the:
 - transformation of practice and the workplace
 - development of evidence in and from practice.

These relationships appear to be further endorsed by the findings from the other two chapters.

7.2.2 Moving towards greater effectiveness in multiple roles

Chapter 5 described the journeys made by NCs as they became more effective at working in multiple roles and by ANCs as they prepared for an NC role.

The starting point for the ANCs was how to become an NC in an NHS where career development pathways for NCs had not yet been explored. They developed strategies for assessing themselves in preparation for an NC role, found mentors for themselves, and/or gathered qualitative 360 degree feedback from colleagues, to look at how ready they were for the role and areas for development. Through these processes, the ANCs moved successfully towards developing new NC posts in their organisations or achieving positions in others.

The first step for NCs was to recognise and understand the multiple roles required of them and how these interplayed. They examined how to develop and balance these multiple roles. Once they had achieved a full understanding of the role, they could demonstrate its potential to their organisations. They recognised that there was a great deal of ambiguity about the role at both service and strategic levels, and explored this using sophisticated analyses. As a result, they were able to clarify the nature of the role and strategically negotiate its position within their organisations.

Their attention turned to developing the knowledge, skills and capacity to allow them to demonstrate the effectiveness of their multiple roles and to gather evidence using a variety of tools to show their achievements. For some, this was harder because their research skills were

underdeveloped. The research, evaluation and effectiveness aspect of the NC role was the most difficult to demonstrate within the timescale, because of a lack of resources and the need to obtain ethical committee approval for research carried out in the workplace. While NCs were able to demonstrate the power in influencing patient care that could come from the interaction of their multiple roles, dilemmas remain about where NCs should direct their energy – the clinical or the strategic.

NCs confirmed through early project work that they were working within several of the multi-faceted roles described in Manley's framework (2001, 2002) drawing on the personal qualities and attributes required for the role, and the knowledge, skills and expertise within integrated sub-roles.

Other researchers concur that the role of the NC is complex and diverse (McIntosh and Tolson, 2008; Jinks and Chalder, 2007), challenging and innovative, and that managers and others do not understand or value the non-clinical domains of the role, which are often considered as secondary rather than integral (Woodward et al., 2006).

Woodward et al., (2005) found that those who were highly experienced in practice, education, leadership, and research were more likely to feel they managed to integrate the four domains more effectively (p.848). Redfern's commentary (2008) on Woodward's research draws on the findings of the Guest et al. (2001, 2004) studies to state that at every level of involvement, NCs performed higher than specialist nurses and concludes that the NC was not a clinical nurse specialist in a new guise. The two evaluation studies involving Redfern (Guest et al.) argued that the outcomes achieved by NCs were linked to those who:

- were engaged in many activities
- regarded themselves as competent
- felt well supported by medical staff

- had been in the job longest.

The findings of Guest et al. endorse those found in our study and have implications for the preparation of ANCs within the career framework, particularly as Woodward (2005) showed that those NCs who struggled with integrating the roles reported they had limitations in several of the role's required characteristics. Preparation and succession planning is therefore important along the career framework.

Research has frequently singled out the leadership role of the NC. Manley (1987; 2000b) originally highlighted the transformational leadership role as one of three sets of processes, the others being emancipatory processes (linked to the facilitation role) and practising expertly as a practitioner, researcher, educator, consultant and practice developer in practice. A final framework developed from a three-year action research study (Manley; 2001, 2002) also showed that strategic and political leadership complemented the NC's transformational leadership role.

Guest et al's evaluation (2001, 2004) recognised leadership as the mechanism through which NCs achieved their positive impact on service delivery. However, the McIntosh and Tolson (2008) evaluation of Scottish NCs concluded that the actual nature of leadership exceeded that identified in much of the literature. They also highlight: the need for persistence and determination to underpin skilful interactions with followers; the integration of technical expertise with cognitive and interpersonal skills and an ability to take risks; and the ability to justify proposals, defend cases and stay abreast of policy and professional issues.

The clinical leadership role of the NC is an under-researched area, particularly in relation to how NCs spend their clinical time and how they work with colleagues, when

and how, they intervene in care provided by other nurses. A co-operative inquiry by four NCs working in the specialism of older people's nursing identified a number of strategies for achieving clinical leadership in the workplace from an analysis of their clinical stories (Manley et al., 2008). Most of the interventions were linked to complex, clinical patient scenarios and cross-boundary interfaces during the patient journey.

The other role singled out by researchers is the researcher role, which studies find is under-developed in many NCs (Gamble et al., 2008). This finding is also reflected in the results of our study. To enable NCs to bridge the academic and clinical communities, and fulfil their potential, they need support in developing skills in researching and evaluating practice, if what is envisaged nationally is to be achieved locally (Redwood, 2007).

In this study, we examined the facilitation skills developed in becoming practitioner-researchers, and the principles used to support practitioners in learning in and from practice, inquiring into their practice and theorising from it. We found that strong facilitation skills were an effective method for honing NCs' inquiry and critical skills and would therefore be useful in contributing to developing their potential.

This understanding needs to be linked to the three types of knowing required in nursing practice to develop and use knowledge for development and to transform the workplace (Manley and McCormack, 2003).

Our study demonstrated that NCs and ANCs can be supported when developing their effectiveness in multiple roles. Through their ability to theorise from their own practice, the NCs and ANCs identified strategies to assist them in gaining clear understanding of their role from colleagues, in clinical and professional leadership, political and

strategic leadership, and in career progression.

Participants demonstrated through their practitioner research that they had achieved clarity of role clarity in their organisations, and shown greater effectiveness as clinical and professional leaders, political and strategic leaders, educators and facilitators of work-based learning, and as researchers. Increasingly through the project, practitioner-researchers examined critical incidents, using a complex array of evidence including research at executive and strategic level, to benefit patient care.

7.2.3 The impact on others, the organisation and the service

Chapter 6 showed that after they had built on the new skills acquired as practitioner-researchers, becoming active in their own learning and inquiry, and combined these with a mastery of the multiple roles and strategies required of the NC, the impact of working with NCs began to show in teams, services and the wider organisations. NCs created demonstrable change through:

- developing the effectiveness of others
- improving their organisation's ability to draw on what NCs had to offer through making explicit their potential, achieving support and embedding the role within the organisation
- improving the service to patients through changing the workplace culture and influencing the strategic agenda.

As we showed in Chapter 5, developing effectiveness in others was associated with the facilitation skills NCs were developing. Their ability to enable individuals and teams to become effective was built on developing their own expertise. That expertise was encouraged by the project facilitators' use of the 10 principles to help practitioner-researchers move forward as active learners and inquirers. The

participants in turn then used these principles with others or modelled them in everyday work. Redfern's commentary on Humphries' meta-analysis of the literature argues that it is through the indirect impact of others' work that NCs achieve their major purpose of improving patient care.

Other NC studies or reviews recognise the role of the NC in enabling others to become empowered through providing support (Woodward et al., 2006; Humphreys et al., 2007). However, they do not focus on how this support is achieved, other than making an implicit link to transformational leadership.

Researchers do not generally detail the processes that NCs use to facilitate learning and inquiry in the workplace, nor do they propose an explanation for how NCs may achieve their impact or outcomes, other than through transformational leadership. The educator role of the NC in other studies is often perceived in a more traditional light – such as teaching directly or indirectly, or through links with higher education – rather than role modelling, providing clinical supervision or articulating a vision of what is possible (Manley, 2000b; 2001).

The NCs in this study used approaches meaning their organisations can now draw on the full potential of their skills. To achieve this, they spelled out their potential, gained much greater support for themselves and others, and embedded their NC role in their organisations. Other researchers generally recognise the potential that NCs have to offer as leaders in their field, but as we do, highlight the need for support systems if this potential to be realised and sustained (Woodward et al., 2006; McIntosh and Tolson, 2008; Lathlean, 2007).

Woodward et al. (2006) found that support systems and NHS influences were highly influential on role achievement, identifying types of support that included internal trust

networks, NC forums and links with higher education institutions. Graham (2007) showed that NCs' need for personal growth and development could benefit by using techniques of internalising mental models through a case study. Our study demonstrates both the skills and the type of support required to help NCs and ANCs to become effective. It also identifies the need for ongoing support if effectiveness is to be sustained, something echoed by McIntosh and Tolson (2008).

Organisations will therefore need to provide support and commitment if they are to maximise the benefits of NCs. Strategic positioning is also vital. Manley's framework (2001, 2002) identified the single most important contextual pre-requisite to achieving positive outcomes from using NCs was according organisational authority to the post. Woodward (2006) suggested that this is achieved by not being part of the management tier but by reporting directly to the executive nurse. McIntosh and Tolson (2008) recognised the challenges of not having a position of power, but instead of identifying management structures, focused on the skills they considered essential for transformational leadership; the influencing skills to manage upwards; and the courage needed to defend a position counter to current practice.

Story 6.6 illustrated how NCs need to engage the executive board in understanding the challenges of practice so that they would become committed to improving care. Other NCs in critical care recognise that achieving greater strategic engagement within NHS trusts is now more pivotal to the NC role (Dawson and Coombs, 2008).

Improving patient services through changing workplace culture and influencing the strategic agenda were outcomes that could be achieved once the NC role had been embedded within an organisation.

Participants achieved these through changing ways of working, working towards shared visions, and focusing on delivering person-centred services. Manley (2001, 2002) labelled such a culture as transformational, because of its ability to positively adapt to the changing needs of patients. Such a culture is likely to be in place when three attributes are present: staff empowerment; practice development with its focus on achieving patient-centred and quality services; and a workplace that has the embedded systems required for sustaining quality services.

Woodward et al. (2006) found that the cultures and structure of the NHS were powerful influences, and participants had to select strategies carefully to deal with cultures dominated by the medical profession. This is similarly demonstrated in Chapter 6 shows that our participants also had to adopt such strategies to achieve a transformational culture. Our illustration in Chapter 5 showed how culture was changed from one of turf wars over patient referrals and filling beds, to one where there was a single point of entry and an integrated, patient-centred referral system.

Redwood's study (2007) shows the development of services achieved by NCs two to three years into post, showing the role's impact across organisations and the breaking down of barriers. Avery and Butler (2008) showed, in a study of NCs working with patients with diabetes, that top performance fell into three areas: developing and encouraging interdisciplinary collaboration at all levels; promoting and disseminating new ways of working across agencies; and facilitating and supporting the monitoring and evaluation of service delivery.

In the context of innovation, Woodward et al. (2006) warn that a great deal of nursing innovation involves taking on work done by doctors, rather than developing the nursing

role. They also show that new nursing roles are not easily accepted in multidisciplinary settings. Examples in Chapter 6 illustrate similar points, but show that challenges can be positive, particularly where role-holders possess the appropriate knowledge, skills and personal characteristics to negotiate their way past organisational influencers.

This idea is well illustrated in the research of Crocker (2009), an NC in critical care who showed how she was able to develop and research actual practice and improve service provision while implementing changes along the way. Through an ethnographic study, Crocker describes in detail the culture of her unit and the role of the NC in weaning patients from a ventilator. By researching in and on practice Crocker changed the way she worked, developed expertise in others, used research to explicate expertise and demonstrated how she transformed ritualised care into patient-centred and negotiated interventions.

Other person-centred outcomes linked to changing culture are illustrated by Ryan (Ryan et al., 2006; Ryan 2009), a NC working in rheumatology. Ryan was able to demonstrate improvements in patient care by enabling patients to take ownership of their symptoms and by increasing access. Ryan led change and had the organisational authority to implement a new model of care. This involved changing the culture, remaining visible, and demonstrating clinical expertise. Colleagues recognised and verified these strategies, as Ryan demonstrated using a qualitative 360 degree feedback process.

Two evaluation studies undertaken by Guest et al. (2001; 2004) showed that improved patient care was related to: improving standards of care, improving follow-up and access to services, and streamlining discharge of patients. Their analysis showed that NHS trust managers who sponsored NC roles were more outspoken about positive

outcomes (such as shorter waiting times in minor injuries, decreased morbidity and mortality from outpatient emergencies, reduction in admission and readmission rates to acute wards, improved crisis intervention and intermediate services, and reduction in medical obstetric interventions). However, Redfern (2006) identifies the need to triangulate data outcomes to include independent measures over and above the perceptions of participants and sponsors.

7.3 Reflection on project methodology, processes, methods and limitations

Reflecting on this study – its aims, approach, processes and methods – we identified a number of insights. The study took place during the early days of NC research. Since then, a number of other research and evaluation studies have been completed, and we have used these to make sense of or challenge our findings.

While there is much in common between the outcomes of this study and others, the one major difference has been the use of a research approach that facilitates NCs in developing their effectiveness. Participants learned in and from practice, became practitioner-researchers, and used the facilitation processes learnt to increase effectiveness in others and transform practice. We believe we have identified and shown how NCs can improve patient services ie through developing facilitation skills to enable others to become effective and practice to be transformed.

We know that these facilitation skills need to be combined with the right personal qualities in the post-holder, with expertise in multiple roles, and with a role that has been accorded high enough authority in an organisation. Other researchers emphasise the achievement of NC outcomes through

transformational leadership interlinked with strategic and political leadership. We concur with this, but in addition put forward the importance of the facilitation skills used in our study. These 10 principles are required to create a culture that develops and sustains effective, patient-centred services.

Our research approach set out to build on the RCN's EPP, which had provided each participant researcher with a critical companion. The EPP also expected that all participants would be involved in qualitative 360 degree feedback, including drawing on patient perspectives, and would developing a portfolio of evidence drawn from multiple sources. The limitation in the EPP study was that participants were only involved in analysing their own stories and incidents; they were not collectively involved in the whole research cycle, undertaking the meta analysis, interpreting findings, and theorising from practice.

The project research team used critical companionship principles, but this time we did not provide each participant with a critical companion. We felt this would have limited the amount participants could achieve between their attendance of action learning sets. Although we included the potential for developing a portfolio of evidence, and an option for undertaking a qualitative 360 degree feedback analysis, this was not fully achieved. The participants were very interested in using these tools, but the systems were not in place in workplaces to enable them to be incorporated early enough to be useful. Only a small number did complete a 360 degree analysis. We experienced major problems in helping LRECs (as opposed to MRCEs) to recognise these processes as research rather than audit.

These issues limited the project outcomes. If we had been able to plan in these methods more formally, the project could have achieved a wider range of evidence from

different sources. Guest et al. (2004) identified the need for evaluation that includes more than the judgements of participants and sponsors, and qualitative 360 degree feedback has the potential for achieving this if it includes patients, users and other members of the multi-disciplinary team in the process. A number of NC research studies have used 360 degree feedback (for example Avery and Butler, 2008; McSherry et al., 2007) but these have not drawn on the views of patients. Those that do (for example, Ryan et al.) offer better triangulated evidence of impact, as was demonstrated in *Revealing nursing expertise through practitioner inquiry* (Hardy et al., 2009). The value of qualitative 360 degree feedback is that it can be used both for evaluating the role of the NC, and the role of others. It also enables the giving and receiving of feedback to be embedded in every-day work, which is an important characteristic of an effective workplace culture.

ANCs in particular could have benefited from developing a portfolio of evidence to demonstrate their readiness to be considered for an NC post. Participants in action-learning and needs-led workshops spent time helping ANCs develop the qualities required to identify, analyse, interpret and synthesise evidence, which are attributes expected of a skilled facilitator. Professional accreditation systems could have accorded ANCs greater public recognition for their achievements if ANCs had completed a portfolio. The use of a portfolio, as demonstrated in the earlier EPP, is also useful in preparing ANCs for the multiple roles they will be required to undertake as an NC. The ANCs became empowered from participating in the NC study, and by the end they were very clear about whether they wanted to become an NC. Some were able to establish well thought through posts in their own workplaces; others were successful in achieving an NC post. The research led to

the ANCs' clarity in understanding the NC role, the skills required, and the outcomes that could be achieved in a supportive culture.

We achieved our aim to include participants in all stages of the analysis (except for one final level of analysis by the research team), interpreting the data and theorising from practice. The framework for theorising from practice was developed during the project, enabling links to be made between the incidents and triggers that challenged NCs and ANCs in their everyday work, the strategies they were trying out in practice to address the triggers, and the outcomes achieved. Each of the components of the theorising framework could be verified by multiple sources of evidence. The framework led participants to identify strategies that NCs could use in their practice. These strategies were generalised from particular incidents involving different NCs, who found similar triggers in different contexts and achieved similar outcomes. These strategies can be shared with others to help them with their roles. New insights were achieved in this study about how to enable participants to contribute to theoretical development at the collective and community level.

A second methodological insight arose from developing a clearer connection between EAR and fourth generation evaluation. Specifically, we established how a CCI tool can guide the starting point for action research cycles. This tool either identified concerns or issues that needed to be addressed (as in the trigger incidents arising from action learning) or uncovered claims that needed to be tested and explored through action research cycles (Titchen and Manley, 2006).

Redfern (2006) identified the need for research to disentangle the difficulties of evaluating the effect of the NC role on patient outcomes. Lathlean (2007) identified a similar need for innovative methods for

examining the impact of roles such as NCs. We propose that through using the insights achieved from this study, together with the theorising framework that emerged, we have identified one such innovative approach – one that is suited to researching the complex social world of nursing practice.

By comparing our study with the EPP, we conclude that critical companionship in this type of inquiry would greatly enhance the rigor of a study. In the EPP, critical companionship was central to rigorous practitioner inquiry, as evidenced by the support critical companions provided to complete a portfolio of evidence (Hardy et al., 2009) – something that did not happen in this nurse consultant research.

7.4 Implications of project findings

Career framework

It is vital to draw out the project's findings concerning a career framework in nursing which puts the NC at the pinnacle of the clinical career ladder. As Guest et al. (2001; 2004) showed, in this study and others an NC operates at higher level than specialist nurses in every function. This is not to denigrate the contribution of specialist nurses, which is substantial, but to recognise that specialist nurses and all nurses working at an advanced level require the support and additional skills needed to build on their expertise in their specialism. The skills necessary to complement specialist expertise include: facilitating others in their learning and inquiry and therefore their effectiveness, developing their expertise in multiple sub-roles; and developing their transformational, strategic and political leadership. It is the NC's expertise in these areas that will sustain the level of service development to an organisational level beyond the individual (Manley, 2009).

Employers

The project's implications for employers relate primarily to the support that is required to help NCs and ANCs develop the skills required to be effective and successful in their role.

However, for organisations to really embed the NC role so that patient services can benefit, it is imperative that employers:

- understand the full concept and value of NC posts
- accord the post with the organisational authority required
- recognise the skills required when developing others for these posts and how outcomes are dependent on the skills and experience post-holders possess
- provide ongoing support to develop the full range of skills and roles required in the job.

Recent policy directives emphasise that service provision needs to be of a high quality and also productive (NHS Improvement, 2010). They place increased focus on indicators and measures that demonstrate both the contribution of nursing, its impact, and improvement activities. NCs have a major role in enabling health care teams both to deliver on quality as well as to evaluate the contribution of nursing and innovation.

Higher education

The implications for higher education include:

- the need to include the development of facilitation skills and the skills associated with the multiple roles and leadership within post graduate courses
- valuing the achievement of these skills reflected in practice outcomes to the same level as academic outcomes

- working with providers to increase the number of work-based learning opportunities provided and helping to develop the skills necessary to facilitate this in the workplace.

Policy makers and commissioners

For policy makers, departments of health, and commissioners, it is important to note McIntosh and Tolsen's (2008) conclusion that it would be regrettable if the important contribution to leadership in nursing that NCs provide was in any way diminished (p.227). NCs should not be overshadowed by a focus on modern matrons, advanced practice and specialist nurses. All these levels and roles are required, but if services are to achieve current policy aspirations of safer and effective services with increased productivity, then it is important to build in funding for more NCs. These nurses will be a powerful force for change and for sustaining that change at the patient-provider interface.

From the perspective of the new Research Excellence Framework (HEFCE, 2010), this research approach and the resulting framework for theorising from practice will be able to contribute new insights into social impact through illustrating the inter-relationship between inputs, actions, outputs, outcomes and impact in practice.

7.5 Conclusion and recommendations

This study endeavoured to support NCs and ANCs as they grappled with new roles, using a research approach which combines EAR and fourth generation evaluation. This approach enables participants to become practitioner-researchers. In this way, the research team set out to help NCs and ANCs develop the facilitation skills necessary to develop and demonstrate their own effectiveness, foster the effectiveness of others and at the same time to transform practice and create a culture that sustains effective, patient-centred services.

Participants in the study demonstrated that as they moved towards being practitioner-researchers, they achieved greater effectiveness in their multiple roles and through these processes demonstrated their impact on others, their organisation and services. The study concludes that the facilitations skills based on 10 principles derived from a concept analysis of work-based learning (Manley et al., 2009) are key to achieving transformation in practice. These skills, when combined with other multiple roles and leadership, results in change that is transformational, strategic and political.

The authors again acknowledge the delay between the data collection and its concurrent analysis, and the overall final analysis and compiling this report, but the findings of this project are just as relevant today: the contribution that NCs can make in the current health service is more important than ever before.

Current government reforms and strategies (DH, 2010; QIS, 2010) continue to raise the importance of person-centred, safe and effective care in tandem with increasing productivity and innovation. Yet the full potential of the NC role is still to be recognised and unlocked. NCs have expertise in developing workplace cultures of effectiveness that will sustain person-centred, safe and effective care right along patient pathways.

More than any other role, NCs possess the full range of integrated expertise necessary to achieve the current government agenda in practice. Through bridging expert nursing practice with learning, evaluation and measurement in practice, and clinical and political leadership, NCs have the skills and expertise to build a culture where quality practice and services are both developed and maintained. However, critical to achieving this potential is the need to:

- recruit NCs with the full skill-set required

or the provision of focused support to develop the full skill-set quickly

- help executive teams understand and recognise the value and contribution that NCs can provide.

7.5.1 Recommendations

We make the following recommendations for different key stakeholders:

Policymakers, governments and commissioners:

- Promote and endorse the NC role as the pinnacle of the clinical career ladder in nursing: one that bridges practice, education and research.
- Increase the funding for appointing NCs within career modernisation.
- Recognise the role of facilitation skills in achieving quality, productivity and patient centred services.
- Commission programmes that develop these skills in senior clinical leaders and higher education.

Employers:

- Appoint more NCs with the full range of skills required to transform practice and services.
- Support those NCs without the full range of skills required to develop these promptly.
- Ensure that NCs have the strategic authority necessary and ongoing support to achieve their full potential.
- Actively plan for succession for aspiring NCs, so that they can develop the full range of skills required to become an NC.

Universities:

- Build in opportunities for developing facilitation skills in post graduate courses in nursing and midwifery to support the career progression of ANCs.

- Provide opportunities to health care providers to use and develop expertise in work-based learning through academic and practice partnerships.
- Continue to provide opportunities for NCs to develop their research and evaluation expertise.

Researchers:

- That EAR is integrated with the fourth generation evaluation approach and the insights developed into initiating action research cycles, and that theorising from practice is further tested and refined.
- When planning to use qualitative 360 degree feedback, that sufficient advance planning time is integrated to enable the full ethical approval for using 360 degree feedback with patients and users as part of the evaluation.
- That the 10 principles of facilitation are tested with other clinical leaders, and also within different research designs that compare the impact the principles have against other approaches to transforming workplace culture.
- A portfolio and qualitative 360 degree feedback is integrated with programmes designed to help ANCs prepare for a NC role.
- The framework for theorising from practice is used to demonstrate the links between input, output, outcomes and the impact of research in practice.

8

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Appendix 1

Speciality and geographical location of participants

Cohort 1 (Nottingham cohort of CNs) Facilitator: Kim Manley

Speciality	Number from speciality	Geographical location	Attendance
Child and adolescent psychiatry	One	Mid Trent	
Critical care	Two	Mid Trent	
Child protection	One	Mid Trent	
Intermediate care	Two	Mid Trent	
Midwifery	One	Mid Trent	
Stroke care	One	Mid Trent	Withdrew because of serious illness half way through project.
Colo-rectal	One	Mid Trent	Withdrew after six months.
Colo-rectal	One	Mid Trent	Never attended.
Intermediate care	One	Mid Trent	Attended only two sessions.
Total	10 recruited but one never attended. Therefore nine commenced project.		<ul style="list-style-type: none"> • One attended only two sessions. • Two withdrew at six months and 12 months respectively. • Six attended between 8 and 17 sessions. Two of these were on maternity leave during the project.

Cohort 2 (ACNs) Facilitator: Kim Manley

Speciality	Number from speciality	Geographical location	Attendance
A&E	Two	a) East Anglia b) London	
Cardiothoracic	Two	a) Wolverhampton b) Chester	a) Moved to Middle East one-third through project. b) Late starter but prescribing courses coincided with CN dates so withdrew after two sessions.
Critical care	Two	a) London b) Glasgow	b) Attended only one session.
Community	One	Bristol	
Midwifery	One	Bath	
Public health	One	Manchester	
Paediatric critical care	One	London	
Orthopaedics/trauma	One	North Tees	Attended only one session.
Addictive behaviour	One	London	Never attended.
Intermediate care	One	Cannock Chase	Never attended.
Total	11 recruited, two did not attend, but both replaced by late starters.		<ul style="list-style-type: none"> • Two attended one session and then did not participate. • Two withdrew: one late starter after two sessions, and one after six months. • Seven attended between 9 and 16 sessions, one of whom was on maternity leave during the project.

Cohort 3 (CNs UK-wide) Facilitator: Angie Titchen

Speciality	Number from speciality	Geographical location	Attendance
A&E	One	North Yorkshire	Attended one session only.
Critical care	Two	a) East Anglia b) Surrey	
Coronary care	One	Cardiff	
Diabetes care	One	London	Late starter to replace non-starter but withdrew by six months due to PhD commitments and illness.
Health protection	Two	a) Accrington b) Manchester	a) Attended first action learning set then withdrew. b) Withdrew after four sessions.
Mental health	One	Southampton	Attended one session only.
Health protection	One	Manchester	Unfortunately passed away.
Rheumatology	One	Staffordshire	
Total	10 recruited but two never started and replaced by one late starter. Therefore nine commenced project and four participated in most of the sessions.		

Appendix 2

Critical incident analysis for action learning

In total 40 critical incidents were presented in action learning 23 from NCs and 17 from ANCs. The focuses of these critical incidents are presented below linked to emerging themes.

Theme	Sub themes	Negotiated focus of critical incident shared in action learning
Role	Role ambiguity/clarity	<ul style="list-style-type: none"> • Role clarity/strategic thinking/facilitation C3 October 02/2. • Role clarity/what am I meant to be doing/how develop a common vision and infrastructure C3 October 02/3. • Role clarity/succession planning C3 October 02/4. • Lack of clarity about consultant midwife role/manager's negative attitude C1 May 03/11. • Link with: Enabling an open culture/accountability/facilitation C3 September 03/9.
	Multiple roles	<ul style="list-style-type: none"> • Rationalising what you do so as to undertake the other consultant nurse roles C1 and C3 July 03/13.
	Role processes	<ul style="list-style-type: none"> • Developing a common vision for consultant nurses/receiving peer support C1 and 3 July 03/12. • How do I transfer the processes from project into practice/challenging assumptions/facilitating critical behaviour C3 August 03/6. • Using critical dialogue with senior staff C3 August 03/7. • Using critical dialogue on ward round/marketing role/promoting and role modelling evidence-based nursing practice C3 August 03/8.
	Demonstrating role effectiveness (link with research role)	<ul style="list-style-type: none"> • How can I demonstrate the effectiveness of my role/role clarity – what am I achieving on a nurse-led round/expertise – demonstrating saliency and helping a junior nurse to identify saliency in her practice C2 November 02/4. • Collecting evidence to evaluate role C3 December 02/5. • How can I use 360 degree feedback tool to integrate with my other academic work/selecting appropriate measurement tool fit for purpose C2 May 03/11.
Leadership (linked to multiple roles)	Professional leadership	<ul style="list-style-type: none"> • Clarifying and achieving professional leadership/developed a shared vision for outreach nurses enabling succession planning C1 December 02/7. • Clarifying and achieving professional leadership/ C1 April 03/9. • Saliency in corridor conversations/accessibility/knowing what's important/going on C3 September 02.
	Political leadership	<ul style="list-style-type: none"> • Influencing strategic agenda/the strategic role is not recognised by directorate or trust C1 November 02/6. • Influencing strategic agenda C2 July 03/13.
Research and evaluation (linked to multiple roles and also role effectiveness)		<ul style="list-style-type: none"> • Clarifying my current research role C2 September 02/2. • Developing my research agenda C1 May 03/10. • Research mindedness (linked to patient centred care C3 October 03/11. • Introducing and evaluating action learning to the department C2 May 03/12.

Theme	Sub themes	Negotiated focus of critical incident shared in action learning
Career	Interview	<ul style="list-style-type: none"> Reflecting on NC interview C2 February 03/7.
	Strategies to help me become an NC	<ul style="list-style-type: none"> Getting a mentor towards becoming an NC C2 November 02/5. Identifying a professional lead to help me become an NC/influence of a professional leader C2 December 02/6. How can I equip myself to be an NC? C2 September 02/1.
Context and culture	Culture	<ul style="list-style-type: none"> Creating a common vision from disparate positions/turf wars/unclear referral mechanisms – linked with: a) working with others, and b) person-centredness C1 October 02/4. Enabling an open culture/accountability/facilitation C3 September 03/9.
	Organisational authority, personal power and credibility	<ul style="list-style-type: none"> Lack of value of NC role C1 November 02/5/CR. Maintaining credibility in nurse-led initiatives/assertiveness (linked to working with others' agendas) C1 September 02/1.
	Working with others' agendas	<ul style="list-style-type: none"> Managing hidden agendas C2 March 03/10. Managing being compromised C1 April 03/8. Relationship with medical staff C1 August 02/1. How do I develop a framework that allows me to demonstrate the impact of consultant nurses/managing others' agendas/feeling disempowered/assertiveness, credibility C1 September 02/3.
	Support	<ul style="list-style-type: none"> Obtaining support C3 October 03/10. Feeling unsupported as a secondee/held back from achieving potential by organisational culture C2 February 03/9. Assessing sustenance and support for an NC in the workplace C2 September 02/3.
Person centredness		<ul style="list-style-type: none"> Re-presenting patient care/patient centred care/patient-centred care/research mindedness/use of personal knowledge C3 October 03/11.
Innovation		<ul style="list-style-type: none"> Introducing innovation in practice C2 February 03/8. Introducing and evaluating action learning to the department C2 May 03/12.

(C1-C3 = cohort 1-3)

Appendix 3

Themes arising from claims across the project period

Themes	Categories arising from claims
NC outcomes	<ul style="list-style-type: none"> • NC outcomes
Aspirations and hopes of NCs and ANCs	<ul style="list-style-type: none"> • aspirations for NCs' career pathway • aspirations for support • aspirations for success • aspiration for RCN • hopes project could produce standards.
Career choices	<ul style="list-style-type: none"> • aspiring NCs questioning the career choice • aspiring NCs selective in NC applications • clarifying career direction • succession planning (from January residential analysis).
Project processes	<p>Contextual needs early on in project</p> <ul style="list-style-type: none"> • request to look at project literature • where we are with the project • would like national breakdown on NCs • request for big picture. <p>Action learning</p> <p>Learning</p> <ul style="list-style-type: none"> • action learning gives me tools to help others • action learning helps me • action learning outcomes better than individual reflection • group helps me prioritise. <p>Attendance</p> <ul style="list-style-type: none"> • more people attending • welcoming back colleagues. <p>Comfort</p> <ul style="list-style-type: none"> • feel more comfortable in group. <p>Positive time out</p> <ul style="list-style-type: none"> • legitimate development time • positive time out. <p>Theory development and impact</p> <ul style="list-style-type: none"> • universality through sharing. <p>Residentials</p> <ul style="list-style-type: none"> • all cohorts coming together positive • progress with residential. <p>Evidence gathering</p> <ul style="list-style-type: none"> • request to thematicise cohort days • excited catching-up with evidence • progress with 360 degree • collecting evidence. <p>Portfolio</p> <ul style="list-style-type: none"> • one portfolio for multiple accreditation • suggested structure for portfolio • evidence can be weighted against a clinical doctorate (cross reference to career progression).

Themes	Categories arising from claims
Project processes (cont)	<p>Project journey</p> <ul style="list-style-type: none"> • half-way through. <p>How to achieve project outcomes</p> <ul style="list-style-type: none"> • activities have to be multi-purpose • saliency is key • finished faculty of emergency nursing programme and can focus on NC (having more time). <p>Lived experience of project</p> <ul style="list-style-type: none"> • lived experience of project • positive experience of project methodology.
Raised project profile	<ul style="list-style-type: none"> • Congress presentation raised profile of project • project included in trust R&D report • abstract submitted (and accepted) at research conference.
Support	<p>Support hoped for from project</p> <ul style="list-style-type: none"> • support mechanisms required • request for other cohorts as a resource. <p>Supported by project</p> <ul style="list-style-type: none"> • project provides support • feeling supported through project • feeling valued by project • project coming to an end (where are we going to get our support?) • fear the project is coming to an end (how are we going to get everything done?) • near the end.
Outcomes	<p>Personal outcomes: I'm developing and learning</p> <ul style="list-style-type: none"> • I can see my improvements over two years • learning to be imaginative with evidence • I'm developing • personal outcomes • new thinking through critique • new strategies • there are tools to help me • internal motivation • now positive about the role • ANC becomes NC • personal focus • seeing the benefits of the project already. <p>Realisation of expertise</p> <ul style="list-style-type: none"> • my practice is innovative (in the context of expertise). <p>Contextual outcomes</p> <ul style="list-style-type: none"> • employer values what I am doing • gained an extra post • negative culture now identified by others • a vision is materialising in the workplace • others acknowledged my role is too broad. <p>Role clarity</p> <ul style="list-style-type: none"> • I'm clearer about what I have to offer • role clarity • making progress with facilitation • vice chair of research and quality for region • development of NC skills • positive potential of NC role. <p>Raised profile</p> <ul style="list-style-type: none"> • project has enabled me to raise profile of NC.

Appendix 4

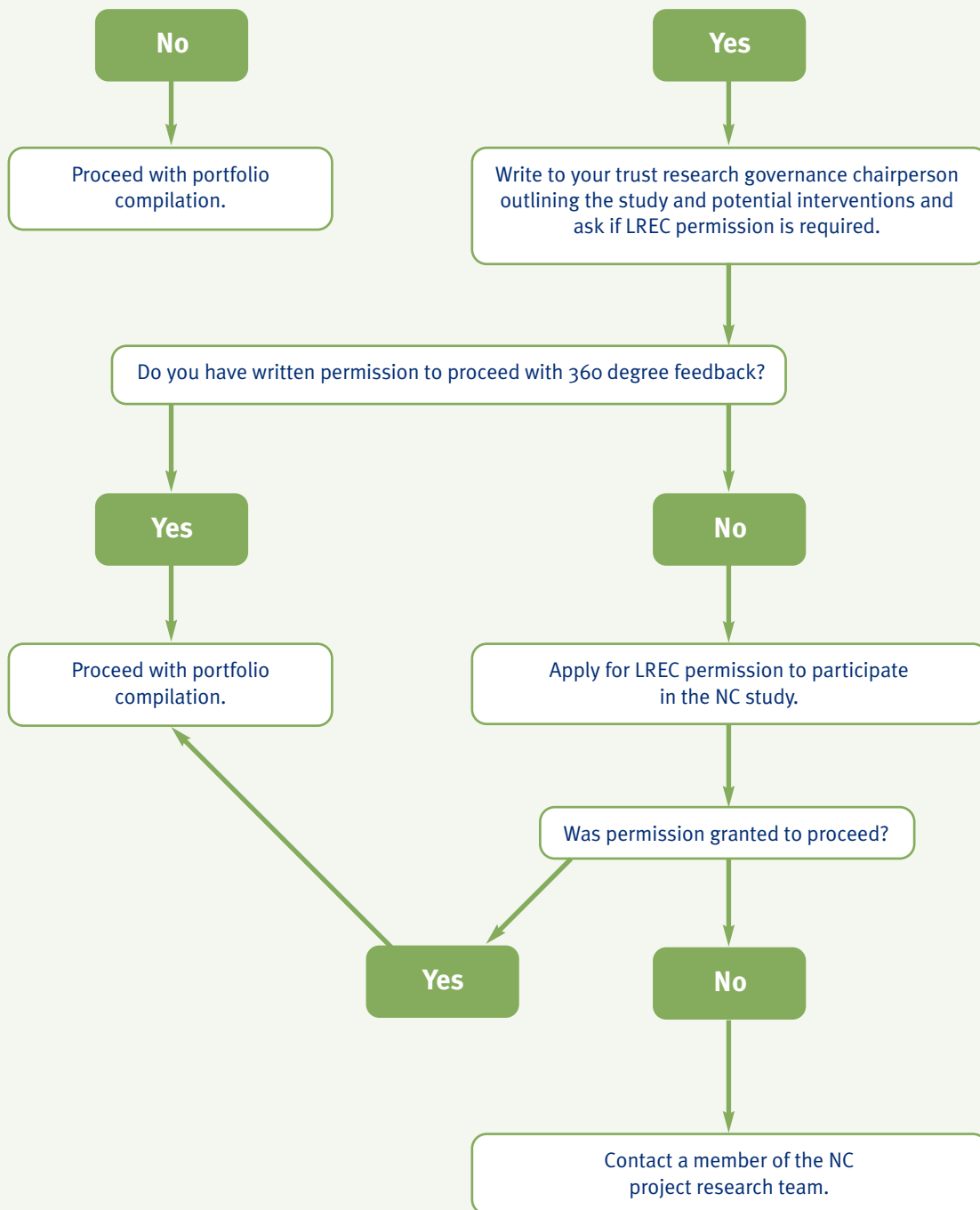
Themes arising from concerns, and issues across the project period

Themes	Categories arising from concerns and issues
NC role	<ul style="list-style-type: none"> nursing vs medicine value of NC role not valued inconsistency promotion and marketing maintaining credibility inconsistency vs diversity lack of clarity diluting NC concept DoN's understanding clinical input lack of concern with process NC role leadership role developing political skills cover for NC enabling others to use NC role a threat facilitating others in strategic agenda.
Context	<ul style="list-style-type: none"> work context political agenda support developing infrastructure enabling collectivity long term funding strategy hidden agendas manager's influence sustaining change workplace culture links with university link with organisational objectives miscellaneous – no public health links.
Career	<ul style="list-style-type: none"> recruitment and selection career direction.
Accountability	<ul style="list-style-type: none"> lines of accountability.
Project practicalities	<ul style="list-style-type: none"> project practicalities collecting evidence evidence 360 degree feedback.
Project processes	<ul style="list-style-type: none"> project processes and experience portfolio development attendance project purpose project influence project context factors influencing participation in the project timescales project's profile working with project data.
Demonstrating effectiveness	<ul style="list-style-type: none"> demonstrating effectiveness.
Ethics	<ul style="list-style-type: none"> ethics.
Outcomes	<ul style="list-style-type: none"> project outcomes what are the products?

Appendix 5

Ethics guidance around 360 degree feedback

Do you intend to use 360 degree feedback from patients, carers and colleagues in your portfolio for the NC project?



Appendix 6

Reflective review analysis

(Numbers 1-5 designate each of the reflective reviews analysed)

AL: action learning

AR: action research

Theme	Sub-theme	Negotiated focus of critical incident shared in action learning
Project hopes		<ul style="list-style-type: none"> learning from others about role 1, 2, 3, 4, 5 to be challenged, identify strengths and weaknesses and be supported 1, 3, 4 learn about AL and AR 1, 3, 4 learn new skills 1 influence role in trust 1 to be a role model 1 to be involved in national research that would raise profile of NC 2 to capitalise on research skills 4.
Project fears		<ul style="list-style-type: none"> lack of theoretical understanding 1, 2, 3 workload and commitment 1, 2, 3 may not really be performing role 5 only nurse in my speciality 3.
Project expectations		<ul style="list-style-type: none"> help me fulfil role, critique role so as to shape it 1, 3, 4 demonstrate my effectiveness/review my role 1, 3, 5 skills and professional development 1, 3, 4 think about how to operationalise strategic plan 4 share experiences/issues with others/networking 1.
Consequences	Self	<ul style="list-style-type: none"> support, challenge, safety 3, 5 skills in reflection, facilitation, AL 1, 2, 3, 5 time out to think/reflect 2, 4 increased confidence 1 how to evaluate practice/framework to collect both outcome and process evidence 1, 4, 5 professional development 1, 3, 5 learnt about AR 1, 2, 3, 4 more targeted and focused/feedback on how I perform 2 stressful – juggling priorities 2 time management and prioritisation 4.
	Others: teams and colleagues	<ul style="list-style-type: none"> supervision/AL skills with colleagues and in meetings 3, 4, 5 how to improve performance of team helped others understand and prepare for role 1, 3, 4, 5 actively involved colleagues and patients in exploring effectiveness/more inclusive/colleagues more empowered 2, 5 regular requests for consultancy from others 3 identified areas for service development 2, 5 team have had to provide cover while I am away 2 put essential care at top of agenda 4 mechanisms for evaluating NC processes 4
	Others: patients	<ul style="list-style-type: none"> more analytical as a team and look for supporting evidence 2 team benefited because I have become clearer and more effective in role 2 changes in way services delivered led to improved access 2.
	Dilemmas	<ul style="list-style-type: none"> time and prioritisation in role vs time in NC project 1, 2, 3 working strategically vs working clinically 1, 3.

Theme	Sub-theme	Negotiated focus of critical incident shared in action learning
Internal factors (personal attributes)		<ul style="list-style-type: none"> • values and beliefs about commitment 1, 3 • past experience of group work so could see potential 3 • desire/need to learn more about role and impact/motivation 4, 5 • being connected to other struggling folk 2, 4 • being part of national project will move role forward 1 • support and commitment of co-researchers and facilitators 2, 5 • project processes experienced positively 2.
External factors/context		<ul style="list-style-type: none"> • support from trust/culture/mentor – positive and negative 1, 2, 3, 5 • no other NCs in trust/nearby 4 • national debate on CNs and leadership 4 • pressure of work/juggling commitments 1, 2, 3 • culture – personal development subsumed by other work priorities 2 • lack of cover 2.
Key work themes arising through project AL	Working with role and role functions	<ul style="list-style-type: none"> • role ambiguity/role confusion 2, 3 • clinical and professional leadership 3 • developing consultancy role from clinical to organisational 1, 5 • being an expert practitioner 5 • being an expert educator 5 • developing research skills 5 • multi-agency working 2 • influencing change 2.
	Helping others	<ul style="list-style-type: none"> • critical companionship 5.
	Working strategically and influencing	<ul style="list-style-type: none"> • influencing culture 5 • establishing role within the trust 1 • measuring sphere of influence 1 • working strategically/influencing change 1, 2 • grounding experiences/communication in patient care issues so irrefutable 4.
	Visibility and accessibility	<ul style="list-style-type: none"> • importance of visibility and accessibility 4.
	Developing specialism	<ul style="list-style-type: none"> • developing specialism at local/national level 1, 5.
Learning	Increased effectiveness	<ul style="list-style-type: none"> • strategies to increase own effectiveness 1, 5.
	Role clarity and complexity	<ul style="list-style-type: none"> • understanding of role by others is lacking 3 • shared understanding and strategic positioning of role 3 • developed understanding of role through AR project 1, 4 • role is complex, multi-faceted and diverse 1, 3, 5 • competing demands for different roles – managing the balance 3, 5 • it's a design and development role with strategic intent, not an expensive bank nurse or super-specialist 4 • the capacity through my role to influence and develop services 2.

Theme	Sub-theme	Negotiated focus of critical incident shared in action learning
Learning (cont)	Strategies helpful in my learning	<ul style="list-style-type: none"> • AL useful for reflecting on practice, asking clarifying questions, focusing ourselves 2, 3, 5 • the need to recognise and clarify assumptions 4 • to challenge the power structures 4 • the need to trust the process 4 • the emotional investment in our role confusion/overload 4.
	Self	<ul style="list-style-type: none"> • need instant feedback 4 • I know more about some things than others 4 • problem identification is key 4 • getting crossover in terms of tasks meeting multiple agendas 4 • I needed to acquire new skills, be clearer in articulating needs and be more assertive 2.
	Strategies in helping others	<ul style="list-style-type: none"> • role-modelling not enough – need to explicate actions and strategic thinking to others so they can learn themselves 4 • importance of practice with feedback 4 • being explicit about prioritisation and giving rationale about not taking on some tasks 4.
	Teamwork and change	<ul style="list-style-type: none"> • importance of therapeutic teams and social processes are the key to change 4.
Areas for future action		<ul style="list-style-type: none"> • clinical work and developments 1, 3 • visibility, accessibility and fulfilling strategic agenda 4 • grounding communication in patient care issues 4 • publishing 3 • role developments in practice 1 • research skills/measurement of outcomes 2, 5 • clinical leadership 2, 5 • trust-wide consultancy 1 • facilitation skills/challenge existing practice/change the culture to one that values children 2 • influence local and national policy 2.
Paragraph for manager	Outcomes: personal and professional skills	<ul style="list-style-type: none"> • I have clarified my role, how it benefits patients and how to develop it clinically and strategically 3 • developed facilitation skills and how to support and challenge others 1 • I question my work more deeply 1 • I have learnt skills and tools for evaluation 1.
	Outcomes: service development and patient care	<ul style="list-style-type: none"> • purpose of my role is to improve patient care – project has helped me to do this 1, 2, 3 • I am working on how to develop and deliver services for most impact 3 • I am using my skills to help others to have impact 1, 3 • I have broadened my level of influence locally and nationally and am being strategic 3 • actively involved in research agenda to ensure clinical significance 3.
	Outcomes: culture	<ul style="list-style-type: none"> • I have influenced the team/directorate/trust culture with regard to staff development, actions and involvement of stakeholders 1, 5 • I can identify the attributes of an effective culture 5 • trust board spending time and refocusing culture to patient-centred issues 4.

Appendix 7

Synthesis of all data analysis into key themes

Overarching theme	Themes from analysis of concerns and issues	Themes arising from analysis of action learning	Themes arising from analysis of claims	Themes arising from reflective reviews
1. Role of NC and becoming an NC	CN role accountability Demonstrating effectiveness	Role <ul style="list-style-type: none"> • role ambiguity/clarity • role effectiveness • multiple roles. • role processes (including facilitation). Leadership <ul style="list-style-type: none"> • professional • political. Research and evaluation <ul style="list-style-type: none"> • practitioner research • using research to influence strategy • research mindedness • evaluation. 	(Linked to NC outcomes)	<ul style="list-style-type: none"> • visibility and accessibility • working with role and role functions • role clarity and complexity • developing specialism • areas for future action • dilemmas. • helping others • learning: strategies/helping others. • working strategically and influencing.
	Career development	<ul style="list-style-type: none"> • interview • strategies to help me become a NC • succession planning/developing NC posts. 	<ul style="list-style-type: none"> • career choices • aspirations of NCs and ANCs. 	
2. Context	Context	<ul style="list-style-type: none"> • personal power within context • power linked to context and culture • working with others' agendas • support • organisational authority • culture. 	<ul style="list-style-type: none"> • support needed • contextual outcomes. 	<ul style="list-style-type: none"> • external factors • outcomes: culture.
3. Outcomes	Outcomes	<ul style="list-style-type: none"> • person-centredness 	<ul style="list-style-type: none"> • NC outcomes 	<ul style="list-style-type: none"> • consequences: others. • outcomes: service development and patient care.
		<ul style="list-style-type: none"> • self-awareness/meta-cognition (personal outcomes). 	<ul style="list-style-type: none"> • personal outcomes: I'm developing and learning. 	<ul style="list-style-type: none"> • outcomes: personal and professional skills.
		<ul style="list-style-type: none"> • learning. 	<ul style="list-style-type: none"> • realisation of expertise • role clarity • raised profile. 	<ul style="list-style-type: none"> • learning: about self • learning: increased effectiveness of role • learning: teamwork and change.
		<ul style="list-style-type: none"> • innovation. 		

Overarching theme	Themes from analysis of concerns and issues	Themes arising from analysis of action learning	Themes arising from analysis of claims	Themes arising from reflective reviews
4. Project (to include evaluation analysis)	Project practicalities			
	Project processes		<ul style="list-style-type: none"> • contextual needs early on in project • action learning • theory development and impact • residential • evidence gathering • portfolio • project journey • how to achieve project outcomes • lived experience of project. 	<ul style="list-style-type: none"> • project hopes • project fears • project expectations • internal factors • learning: strategies helpful in my learning.
	Support		<ul style="list-style-type: none"> • support hoped for from project • supported by project. 	<ul style="list-style-type: none"> • consequences: self.

Appendix 8

Components of the nurse consultant

Developmental tools

Starting points		End points	Evidence
Cultural indicators	1-----5		
Caplan's model			
Critical companionship			
Consultant nurse own theorising/consensus			

Critical companionship

Starting points		End points	Evidence
Relationship processes	1-----5		
Rationality- intuitive processes			
Facilitation processes			

Caplan's model

Starting points		End points	Evidence
Client centered consultancy client	1-----5		
Consultee centered consultancy consultee			
Programme-centred administrative consultancy			
Consultee-centred administrative consultancy			

NC role

Starting points		End points	Evidence
Practice	1-----5	Expert practice criteria	
Education	1-----5	Critical companionship work indicators	
Research	1-----5	Practitioner research - audit - qualitative - action research	
Leadership	1-----5	Transformational leadership Online tools	

Processes – facilitation

Starting points	Consciousness raising	Problematisation	Self-reflection	Critique
Role modelling				
Articulation of craft knowledge				
Feedback on performance				
High challenge/high support				
Observing, listening, questioning (O, L, Q)				
Critical dialogue				

Appendix 9

A continuum to understand the researcher role of the nurse consultant

Research activity	New	Proficient	Expert	Consultant
Participating in research.				Leading on programmes of research in practice.
Research supervision.				Supervising individuals, teams and projects. Peer review.
Generating research opportunities.				Strategic bids and collaborative opportunities. Multi stakeholder.
Contributing to the strategic research agenda.				R&D committee/forum membership.
Developing evidence based practice.				Individual, team, service, organisational levels.
Enabling a developmental research culture.				Across team/service/organisation.
Enabling others to access all stages of the research process. Enabling others to do research.				Work-based learning opportunities/frameworks.



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