



# **A Descriptive Interpretive Exploration of the Nurse Consultant Role and its Influence on the Research Agenda**

**Susan Taylor**

**2016**

A thesis submitted in partial fulfillment for the degree of Doctor of  
Nursing (DNurs)

## SUMMARY

**Aim:** To focus on an exploration of the NC role and its engagement with and influence on the research agenda for nursing,

### **Background**

NC posts have only been established in the United Kingdom since 1999. The role is intended to incorporate four domains: expert practice, leadership and consultancy, education and training, service development and research. Although there has been professional literature regarding the role development in general, there is little written regarding the development of the research aspect and how this influences the research agenda for nursing.

### **Design**

A qualitative exploration of the research component of the NC role was undertaken using semi-structured audio-recorded telephone interviews with 13 NCs across England. Data were analysed using McCormack's (2000a) multiple lens approach, a framework that facilitated thematic analysis. The study was informed by the theoretical frameworks of Professional Socialisation and Benner's (1984) Stages of Clinical Competence, which allowed critical analysis of the data.

### **Findings**

In relation to the development of the research component of the NC role, the data suggest that NCs were poorly supported in clinical practice, and that, although most held Masters Degrees, this educational level did not provide NCs with adequate preparation for the role or for delivery of the research component of their role. There was also poor understanding of the research role by the authors of NC job descriptions who comprised of NCs themselves, service managers or Directors of Nursing. Research has both an academic and clinical focus in relation to development, infrastructure support and delivery and therefore I expected that Higher Education Institutes (HEIs) would have been involved in the development of the research aspect of the NC role. However, there was very little or no engagement with HEIs by authors of the job descriptions in most cases. Constraints of the clinical environment around service pressures, competing demands, coupled with a lack of mentorship and the absence of a research culture and inadequate links with HEIs were other factors contributing to the barriers to research development. However, the findings revealed that NCs contribute to the research culture within their organisations through various levels of engagement, but there was little in the way of active involvement in research projects.

### **Implications for Practice/Research**

This research has added to the body of knowledge concerning how, in clinical practice, NCs are socialised into the world of research and what support should be available to ensure NCs deliver on the research aspect of the role. Research and Development activities are considered a major job requirement, where there is an expectation that research will be conducted in a specialist area. This study has concluded that NCs are a group of expert nurses who are visibly making a difference to EBP but not necessarily in the way first envisaged when the roles were developed. This study has highlighted an emerging conceptual framework CFRE (Allen *et al.* 2004) which could be used to

operationalise the research component of the role. The emerging field of implementation science is recommended for the development of the research element of the NC role in order to accelerate the EBP agenda for nursing. Key stakeholders who currently employ NCs should review the infrastructure and support provided to deliver on this.

## **ACKNOWLEDGEMENTS**

To my supervisors Dr Jane Harden, Professor Lesley Lowes and Professor Davina Allen for all their support and guidance with my thesis. I will always be grateful for your time, patience and constructive criticism that helped shape this work. I owe you all an enormous intellectual debt.

To all the Nurse Consultants for taking time out of your incredibly busy work schedules to take part in this study, I am deeply grateful for your honesty and sharing your professional world with me.

To my husband Kevin for his unwavering support and encouragement and my mum for always saying the right things and raising my spirits to keep going.

To my beloved children Michael and Sophie for inspiring me to complete this thesis, despite missing precious time with them.

To my line manager Dr Stephen Falk, Clinical Director and Dr Mary Perkins, Chief Operating Officer of the Clinical Research Network (CRN) West of England, for allowing dedicated time to conduct the research and write up the thesis. Thank you so much for all your professional support.

To all my professional colleagues who offered me so much assistance and technical support when I needed it, I am deeply grateful.

To my wonderful sister Tracey, for encouraging me to complete when my dad was so ill.

Last but not least, I dedicate this thesis to my late dad, who was so proud of me for my determination to complete, but never got to see the final version. Thank you dad I hope I did you proud.

## Contents

CHAPTER ONE: Introduction to The Study.....	8
1.1 Epistemological and ontological position.....	8
1.2 The research questions .....	12
1.2.1 Research aims and objectives .....	13
1.2.2 Rationale and justification .....	13
1.2.3 Scope of the project .....	14
1.3 Framing the topic in the policy context.....	14
1.3.1 Scope for Professional Practice. ....	16
1.3.2 Overseas Initiatives.....	17
1.3.3 Heathrow Debate .....	17
1.3.4 Waiting Time Initiative: a personal perspective .....	18
1.3.4 Evidence-based practice.....	21
1.4 Nurse Consultant Job Descriptions .....	24
1.5 Summary .....	27
CHAPTER TWO: Literature Review .....	28
2.1.2 National Context .....	29
2.2 The Search Strategy .....	31
2.3 Nurse Consultant Profile.....	33
2.3.1 England .....	34
2.3.2 Scotland.....	34
2.3.3 Northern Ireland.....	34
2.3.4 Wales.....	37
2.4 Empirical Literature Review.....	39
2.3.1 Research Component of the Role .....	39
2.3.2 Role Development .....	40

.....	40
2.3.3 Role Clarity .....	42
2.3.2 Academic attainment .....	46
2.4 Narrative opinion papers.....	48
2.5 Discussion .....	50
CHAPTER THREE: Conceptualising Research Engagement.....	52
3.1 Research Literacy and Awareness .....	54
3.2 Cardiff Framework for Research Engagement CFRE .....	55
3.2.1 Research Utilisation .....	56
3.2.3 Research Producer .....	58
3.2.4 Research Implementer .....	59
3.2.5 Research Teacher .....	59
3.2.6 Research Supervisor.....	60
3.2.6 Research Manager.....	60
3.2.7 Research Influencer .....	61
3.2.8 Research Leader.....	61
CHAPTER FOUR: Theoretical Considerations .....	63
4.1 Benner's (1984) Stages of Clinical Competence .....	63
4.1.3 Knowledge .....	70
4.2 Professional Socialisation: .....	71
4.2.2 Historical Context of Socialisation of the Nursing Profession .....	71
4.2.3 Magic, the Science of Witches.....	72
4.2.4 Caring for the Sick 18 <sup>th</sup> and 19 <sup>th</sup> Century .....	73
4.2.5 Florence Nightingale's Reforms .....	74
4.2.5 Raise the Roof Campaign .....	77
4.2.6 Project 2000 .....	78
4.3 Theories of Socialisation.....	82

4.3.1 Socialisation.....	83
4.3.2 Role learning theory.....	84
4.3.3 Symbolic Interactionism Theory.....	84
4.3.4 Psychoanalytical Theory.....	85
4.4 Professional Socialisation .....	85
4.5 Conclusion .....	87
CHAPTER FIVE: Research Design .....	88
5.1. Interpretive Description .....	88
5.2 Consideration of Data Collection Methods.....	92
5.2.1 Focus Groups .....	92
5.2.2 Qualitative Interviews.....	93
5.2.3 Telephone Interview .....	95
5.3 Negotiating Access .....	96
5.3.2 Ethical Approval .....	97
5.3.3 Ethical Consideration.....	97
5.4 Sample and Recruitment.....	98
5.4.1 Sample Characteristics.....	100
5.4.2 Data Collection: Interviews .....	100
5.4.3 Challenge of telephone interviews.....	101
5.5 Data Analysis.....	102
5.5.1 McCormack’s Thematic Analysis.....	103
CHAPTER SIX: Findings.....	108
6.1 Examples of Analysis of Narrative Data using McCormack’s Lenses: A Comparison of Experiences (Bethan & Carl).....	108
6.1.1 Interview with Bethan.....	109
6.1.2 Interview with Carl .....	110
6.2. Role Development .....	112

6.2.1 Influence of the Development of the Job Descriptions.....	112
6.2.2 Influence of Higher Degree. ....	117
6.2.3 Socialisation of NCs into the Research Aspect of their Role, from Education through to Service Setting.....	120
6.3 Role Clarity.....	127
6.3.1 The Structural Constraints of Negotiating the Role in Practice.....	127
6.3.2 The nature of research expertise .....	131
CHAPTER SEVEN: Discussion.....	140
7.1 Role development .....	140
7.1.1 Influence of job descriptions.....	140
7.1.2 Influence of a higher degree .....	142
7.1.3 The socialisation of NCs.....	144
7.2 Role Clarity.....	147
7.2.1 Structural constraints of negotiating the role in practice. ....	147
7.3 Operationalising the Expert Practitioner in relation to the Research Component of the NC role.....	152
7.4 Thesis Findings .....	153
CHAPTER EIGHT: Conclusion.....	154
8.1 Implications for Research Practice for NCs.....	158
8.1.1 Recommendations:.....	158
8.1.2 CFRE (Allen <i>et al.</i> 2004).....	162
8.2 Suggestions for further research and further collaboration with academia. ....	163
8.2.1 Limitations of the Study.....	164
8.2.2 Summary.....	165
References.....	168
Appendices .....	182

## **CHAPTER ONE: Introduction to The Study**

Pressures on the National Health Service (NHS) have effected major changes to the nursing workforce and the role of all healthcare professionals over the last 20 years. Financial constraints on an overstretched health service have been the main drivers for these changes which have been made in order to ensure a sustainable workforce and an increased responsiveness to patients (Srivatava *et al.* 2008). One of the nursing roles developed as a result of these changes is the Nurse Consultant (NC) with a work focus comprising of four main domains, expert practice, leadership, research and teaching. The explicit research component is what sets aside the NC role from other Advanced Nurse Practitioner (ANP) roles, but little is known about how this has developed or how it has contributed to, or has been influenced by, the evidence based practice (EBP) movement in health care (OCD 2010). This thesis explores the role of the NC and its influence on the research agenda for nursing in the United Kingdom.

In this chapter I will introduce the topic under investigation from a macro/meso/micro perspective by juxtapositioning the evolving policy dimension with my own continuing professional development. Specifically, by locating my own career within a political context I hope to show how the research question emerged and so provide a rationale for the study.

### **1.1 Epistemological and ontological position**

It would, perhaps, be pertinent at this early stage in the thesis for me to clarify my beliefs and position concerning the research topic. In 1982 I qualified as an Enrolled Nurse (EN) where my two year nurse education took place within a school of nursing based within a district general hospital. The terms ‘research’ or ‘evidence based practice’ did not feature within this training which was based, predominantly, on the development of practical skills combined with elements of theoretical attainment. In 1987, Project 2000 (UKCC 1987) was proposed to



reform nursing structure, practice and pre-registration training and accepted by the government in 1988 (Allen 2001). Pre-registration education was now at diploma level and relocated to higher educational institutions. All non-degree nurses were to follow a three year programme with the first eighteen months comprising of a common foundation followed by another eighteen months branch programme in a selected area either adult, child, mental health or learning disability. Unlike my EN training, students were to be supernumerary for 80% of the three years and have 20% rostered contribution to service, receiving student bursaries rather than salaries (Doherty 2009). As a result of these radical changes the enrolled nurse training was abolished and ENs were provided with an opportunity to undertake a conversion course leading to Registered Nurse (RN) status, which I achieved in 1994. Reflecting on the RN education at this point, I cannot recall research being part of the training or relevant to continued professional development courses thereafter. I do however recollect numerous discussions with my nursing colleagues as to what the terms "New Nursing" and "Graduate Nurses" were and how they could make a difference for patient care. Project 2000 was viewed as an attempt to professionalise nursing by aligning nurse theory with practice through the pursuit of professional autonomy, where nurses were seen as 'knowledgeable doers', who delivered research based practice combined with sound rationale for care (UKCC 1986, White 1988; Jolley 1989; Allen 2001). However, there were criticisms that nursing, as an autonomous profession, bore little resemblance to the daily practices of most nurses and therefore the concept of aligning service and education was potentially flawed (Porter 1992; Allen 2001).

In 1994 the implications of the Clothier Report (1994) were being realised following the conviction for murder of Beverley Allitt, of sick children in her care in hospital in 1993. All areas where children were being nursed as a result of this, were required to have a qualified children's nurse on duty (Clothier 1994). The day surgery unit (DSU), where I was employed combined both adult and children's services but had no qualified Registered Sick Children's Nurse (RSCN) appointed. Accelerated RSCN courses were available at Diploma level undertaken over a nine month period and following completion, I qualified as an RSCN in 1997 in order to meet the requirements of Clothier report (1994). In 2001, I completed my

BSc (Hons) Children's Nursing, which was driven by my desire to educate myself to the same level as the "New Nursing" cohorts and to develop my educational requirements to meet the demands for this new vision for nursing.

It was only at this point in my training that my awareness of research within nursing and evidence based practice became apparent. As part of my nursing degree I learned some research skills and on completion could critique nursing research papers and developed a tentative understanding of research methodologies. This research training was developed further when I was awarded a research fellowship with Health Inspectorate Wales in 2004, which I felt was the next research training step to support my professional development in a NHS R&D Management role. The fellowship provided me with the links and professorial supervision within a University which resulted in a publication outlining some of the challenges facing evidence based practice in nursing. The research fellowship also provided me with an opportunity to develop my conceptual thinking regarding nursing research and the challenges associated with it. In the latter part of this chapter I describe how my research education was also linked to my clinical practice and shaped by policy initiatives during this period.

My most recent clinical appointment is to the National Institute for Health Research (NIHR) in England which was created in April 2006. Underpinning the development of the NIHR was the Government's strategy *Best research for best health* (DoH 2006). Prior to this, in the UK in 1991, the publication of *Research for Health: A research and development strategy for the NHS* (DOH 1991) underlined the need to ensure that health care delivery was based on high quality research aimed at improving the health of the nation. Evidence based practice became the focus of subsequent strategies to review and improve the standards of scientific research. The development of this research arm of the NHS was driven by criticisms regarding the way research was conducted within the NHS in particular by the industry sector and predominantly for the following reasons;

- money for R&D in the NHS was not focused where it was needed but was locked into historical allocations to Trust
- The NHS R&D programme did not have sufficient capacity or flexibility to generate all the evidence that is crucial to deliver high-quality health services
- Research was being eroded from health professionals' contracts, and researchers were struggling with the increasing burden of regulation and bureaucracy
- The NHS was not exploiting its full potential as a research platform to support the country's international competitiveness.

<http://www.nihr.ac.uk/about/history-of-the-nihr.htm> [accessed 12th August 2015])

I was first appointed to the clinical delivery arm of the National Institute for Health Research Clinical Research Network (NIHR CRN) in 2009 in a Senior Research Management role. In 2014, driven by a network initiative, the CRNs were reconfigured in order to streamline network business, increase consistency of funding allocation and improve responsiveness of the research workforce to change. The geographical footprint of the CRNs were mapped onto that of the newly developed academic health science networks (AHSNs) in 2014 with a total of fifteen CRNs transitioning from the existing 102 research networks and 'rebranded' as the NIHR Clinical Research Networks (CRN). In May 2014, I was appointed to the role NC for research delivery for the CRN: West of England. This post involves working with the research community across the West of England to provide research leadership and develop research engagement in NIHR portfolio adopted studies. I work with nine secondary care partner NHS organisations and twelve other affiliated organisations, such as Clinical Commissioning Groups (CCGs) and social enterprises within my area covering a geographical area from Gloucestershire to Wiltshire. I also work closely with senior leaders from the local Clinical Research Network groups (CRN: South West Peninsula and CRN: Wessex) to lead research delivery teams within the CRN to deliver their goals as well as actively contributing to national activities as part of a national network of Clinical Research.

Research is now embedded in the NHS Constitution in England and with an expectation that it is every patient's right to be informed of, and take part in, research, with the primary aim of improving patient outcomes. (Department of Health 2012). *Developing the role of the clinical academic researcher in nursing, midwifery and allied health professionals* (Department of Health 2012) outlined the Government's commitment to securing national research training for non-medical professionals hosted through the NIHR. Within this strategy, the Government also outlined a commitment to a national mentorship programme to overcome some of the challenges to establishing and supporting these roles in clinical practice. More recently *The five year forward view* (Department of Health 2014) sets out how the health service needs to change in order to provide high quality care. Research is referred to as vital resource, providing the evidence needed to transform services and improve outcomes.

It seems a little ironic to have recently been appointed to a NC post during the latter period of doctoral study focusing on the same group of nurses. Nevertheless, I feel that my education and career journey driven by policy initiatives over thirty four years in nursing has influenced the development and direction of travel of my research question long before the appointment to this post. Appointment to a Nurse Consultant post has only reinforced the importance of this research which sets out to explore the research component of the NC role.

## 1.2 The research questions

My own professional experience which led me to problematise this fundamental aspect of nursing practice led to the development of two inter-related research question:

- 1) What is the level of engagement and influence with the research agenda in nursing and healthcare by Nurse Consultants? and
- 2) What are the facilitators and barriers to this engagement and influence?

### **1.2.1 Research aims and objectives**

To focus on an exploration of the NC role and its engagement with and influence on the research agenda for nursing, the thesis aims to:

- Explore the development of the research component of the NC role
- Identify and define the challenges and achievements in relation to the research component of the NC role
- Investigate the influence of the NC role on the research and evidence-based practice agenda for nursing

The thesis' objectives are to:

- Examine the policy and historical development of nursing as a 'research based profession'
- Conduct a literature review of current research to locate this study within the wider field
- Collect and analyse qualitative data in order to better understand the influence of NCs

### **1.2.2 Rationale and justification**

NC posts have only been established in the United Kingdom since 1999. The role is intended to incorporate four domains: (i) expert practice, (ii) leadership and consultancy, (iii) education and training and (iv) service development and research. Although there has been professional literature regarding the development of the role, (see chapter two) there is little written regarding the development of the research aspect and how this has influenced the research and evidence based practice agenda for nursing

### 1.2.3 Scope of the project

A qualitative exploration of the research component of the NC role will be undertaken using semi-structured audio-recorded telephone interviews with 20 NCs across England. Data will be analysed using McCormack's (2000a) multiple lens approach, a framework that will facilitate thematic analysis. The study will be informed by a conceptual framework, namely the Cardiff Framework for Research Engagement (CFRE) and two broad theoretical frameworks; expert practice and professional socialisation. It is hoped that this will allow critical analysis of the data within a contemporary practice context. The theoretical framework will be discussed in more depth in chapter three and four of the thesis.

## 1.3 Framing the topic in the policy context

Research is considered a core part of the National Health Service (NHS) as it enables the NHS to improve the current and future health outcomes of the people it serves (Department of Health 2012). However, in nursing research arguably remains an emergent field and is involved in a game of "catch up" with other more established disciplines in the field. When I started nursing in the 1980s, training was based on the apprenticeship scheme and did not prepare you for the world of nursing research. By the early 1990s, I was becoming more aware of research as a concept, propelled by major reforms within health care during that period. This section of the thesis will explore the policy background which led to the creation of the Nurse Consultant role.

It was the Conservative Government, which had been in power since 1979, that introduced major health reforms in the NHS in the early 1990s. *The National Health Service Community Care Act* (1990) was the proposed solution by reforming both management and patient care through the introduction of the internal market. The central aims of the changes were to deliver a more efficient and cost effective NHS. The medical profession were a fundamental target of these reforms and the State began exercising increased control of their practice and use of resources. However, these reforms were also drivers for radical changes in the shape of

nursing work (Allen 2001). Two policy initiatives were of particular importance to the government; these were the junior doctors' hours and waiting list initiatives. *The Junior Doctors: the New Deal* (NHSME 1991) set limits on doctors contracted hours and the reduction of these hours became a major driver for the development of new ways of working for nursing and medicine. *The European Working Time Directive* (EWTD) was implemented in the UK in 2004, where all grades of doctors were limited to working a week of not more than 58 hours, with daily and weekly rest breaks. Throughout the NHS the traditional boundaries between professional groups were changing in response to this issue. A new Medical Care Practitioner role was introduced by the Department of Health (DoH) (2005). This role was built on a model from the United States (US) of a physician's assistant who could deliver care under the supervision of a doctor (Srivastava *et al.* 2008). For nursing in parallel with changes within the medical profession, the Department of Health released a government strategy setting out what was to be regarded as the biggest change for nursing and midwifery since the inception of the NHS (Department of Health 2000). *The NHS Plan* (Department of Health 2000) highlighted the need to introduce new nursing roles and ways of working with the aim of empowering nurses and midwives to help improve services and drive up the quality of patient care.

England's Chief Nursing Officer (CNO) listed ten key roles for nursing that were intended to break down the hierarchical role boundaries between doctors and nurses (DoH 2000, Doherty 2009). Health service managers were charged with the task of making the change happen to work smarter to maximise the talents of the workforce. *Agenda for Change* (Department of Health 2003b) was also introduced and offered career progression pathways, linked to professional development setting out a new pay and grading structure for the NHS. Finally, *Modernising Nursing Careers* (2006a) was published and built on *Agenda for Change* to establish a competency based system for workforce planning. As a result of this initiative, in 2006, I was seconded to work for the Welsh Assembly Government to undertake a scoping exercise to explore where all nurses were working in South East Wales, including primary care and the private sector. This project was called the 'South East Wales workforce

modernisation project for nursing' and the aim of the project was to ensure workforce planning in nursing was better informed.

### 1.3.1 Scope for Professional Practice.

Following a lengthy period of debate in the early 1990s within the nursing profession and in response to the earlier policy initiatives, the United Kingdom Central Council for Nursing (UKCC) recommended that nursing needed to be able to evolve to these changing circumstances and nurses' education needed to keep pace in both pre- and post-registration areas. The Chief Nurses in the United Kingdom (UK) within the DoH, recommended that for extended roles all nurses should act in accordance with simultaneously issued documentation: the *Scope for Professional Practice* (UKCC 1992) and the *Code of Professional Conduct* (DoH 1992b; Read *et al.* 1992). The *Scope for Professional Practice* brought an end to the requirement for nurses to undertake medically sanctioned extended role certificates not covered in basic training and shifted the responsibility for managing the boundaries of nursing to individual practitioners themselves (Allen 2001). In 1993 the United Kingdom Central Council for Nursing (UKCC) described three levels of post registration practice:

- Primary
- Specialist
- Advanced Nursing Practice.

The Council recommended that specialist practitioners should be educated to degree level and considered experts for their specialty remaining in a clinical area (UKCC 1994). Referring to advanced practice the Council suggested that one of the benefits of this level of practice was that advanced practice should lead to an increase in nursing research and research based nursing practice (UKCC 1995). In 2002 in its document *Higher Level Practice and Pilot Project* (UKCC 2002) the Council acknowledged that there was an expectation that NCs were to be educated to Masters or Doctoral level but was unwilling to define standards for



advanced nurse care leading to confusion regarding various role definitions of ANP role. (Lankshear *et al.* 2005)

In the UK, the Greenhalgh Report (1994) was published which also recommended that certain activities traditionally performed by junior doctors could be performed by suitably trained nurses. It was thought that this would not only enhance the role of the nurses, but reduce the workload of junior doctors. This report had been commissioned by the DoH and when published, recommended that nurses and doctors should work together to share these tasks (Read *et al.* 1992, Greenhalgh *et al.* 1994).

### **1.3.2 Overseas Initiatives**

During that time a number of health management initiatives originating from the USA and Canada were imported to the United Kingdom. These initiatives promoted case management which was regarded as a way of controlling quality and cost containment in a hospital. Case management was recommended as being best led by a nurse with the aim of delivering patient centred care. The medical/nursing interface was acknowledged as overlapping more than originally considered and recommendations were made that nurses could take on a case management role by relinquishing some of their administration and housekeeping duties (Read *et al.* 1992, Petrysten 1994). Advanced Nurse Practitioner roles were also evolving in other countries and these are described in more detail in chapter two.

### **1.3.3 Heathrow Debate**

The DoH also published the challenges for nursing and midwifery in the 21st century based on the questions raised during the “Heathrow debate” (DoH 1994). This was an event where senior nurse leaders came together in a venue near Heathrow airport in West London to deliberate over these, with particular reference and discussions around the changing roles within nursing. Nursing roles were evolving and Read *et al.* (1992) likened the innovation and development of professional nursing roles as being pushed and pulled through government policies and changes in NHS organisation. The policy drivers and response from

the nursing profession resulted in the further development of roles such as the Clinical Nurse Specialist (CNS)(Wilson-Barnett and Beech 1994), the Nurse Practitioner ( NP) (Read *et al.* 1992; Touche Ross 1994; Dowling and Barrett 1995) and the Nurse Consultant (DH1999b)

#### **1.3.4 Waiting Time Initiative: a personal perspective**

In the 1990s there were growing public criticisms concerning the changes in health care which government opponents suggested were undermining the principles of the health service. These criticisms prompted the Conservative government to introduce measures to reduce waiting lists, in order to improve efficiency. Day surgery units were introduced and NHS Trusts were provided financial incentives to reduce waiting times for surgery. Skill mix in theatres was also reviewed so that nurses could become more involved in surgery and new roles in outpatients for nursing were developed to release Consultants' time in outpatients to work additional hours in theatre (Read *et al.* 1999).

During that time I worked as a staff nurse on a busy, newly developed surgical day unit. Day surgery involved children being admitted to hospital on the morning of their operation and staying for an average of four hours post operatively. In particular, the NHS Plan (Department of Health 2000) had a set target of 75% of elective surgery to be performed as day cases and, in paediatrics, the European Charter of Children's Rights, stated that "Children should be admitted to hospital only if the care they require cannot be equally well provided at home or on a day basis" (Alderson 1993, pp13-15).

More invasive procedures were being performed and new anaesthetic techniques, agents and analgesics were becoming available. Children were often discharged four hours following surgery for treatments for hernias and circumcisions that would previously have warranted a two day inpatient stay. However, readmission rates were high and initial national audit results regarding day surgery suggested emergency admissions were common place and were the result of poor analgesic management. During that time, there was an anaesthetist who was

becoming research active on the unit. I was impressed by his interest in exploring this new way of delivering patient care through research. However, I did not feel confident enough to approach him about helping me to develop my research idea, which had developed out of the initial audit data and confirmed by my own audit where I raised concerns regarding poor analgesic control following day surgery in children. I decided to undertake research exploring this issue as there was little or no literature available at that point relating to post-operative care in children following day surgery.

I looked to my senior nursing colleagues to help me develop the research protocol. Unfortunately, the research capability of senior nurses was a major barrier to starting the research. I was working at a district general hospital with tentative links with a University, and with no local support and available knowledge to develop this work, the research idea failed at the initial stages. Many of the leaders in clinical nursing within the hospital had no preparation for research during their nurse education and believed that if your interests were in research, a career in academia was the next professional step. The service was their driver and 'getting the job done' a priority. This became a negative influence on my ability to professionally develop in relation to nursing research. I wanted to provide evidence to the medical staff in order to improve post-operative care. However, the profession I belonged to did not place any value on research as a driver for change nor had the skills to support me in doing so.

I started my own research interest group to try and increase what appeared to be a gap in research capability in nursing. I soon realised that without developing my own research knowledge, I would be unable to support other nurses. I was also concerned that nurses were missing opportunities to explore patient care and that nursing practice was not always based on the best evidence. Certainly in surgery, nursing was mainly driven by a medical model. While this was not necessarily a problem, I felt that the nursing aspect of post-operative care was overlooked; for example I wanted to explore post-operative care for children following day surgery. My preconceptions were that if children and their families were supported by the children's community nursing teams following discharge, readmissions would be reduced. I also questioned how nurses could lead changes in nursing without being able to challenge current practice. I viewed research evidence as the tool in the challenge to change clinical

practice as I continued to use research evidence to challenge outmoded and ritualistic practices in acute surgery with medical teams with the sole aim of improving the quality of care for children and their families. The medical model continued to dominate the clinical area and despite some progress where we worked together with the medical team to use best evidence to inform practice (such as allowing parents in the anaesthetic room, reduction in nil by mouth times) ultimately, pre- and post-operative care planning continued to be driven by medicine. Nevertheless, there was some progress and, during the next 10 years, the day surgery paediatric team I led was recognised internally by the Trust for the advances made within children's day surgery and we were awarded four patient care awards. I was also asked to present nationally and internationally on the improvements I had implemented with the day surgery team. Nevertheless, eventually I became frustrated with the lack of support available to move forward with my research idea and looked for other posts that I felt would support my research development in nursing. The agenda for change proposals and bandings were also being discussed internally and I was soon to realise that for the band my post was being considered, research would not have a role and this made me look for other posts where the research component was embedded with the skills I had developed at that time.

By the time there had been a change in government in 1997, New Labour rhetoric meant the health service was once again undergoing reform. The internal market had been abolished and the health service was poised to enjoy a period of investment (DH 2000a, Allen 2001). With the EWTD (2004) in force ways of managing workload would have to be considered and once again nursing had entered into the equation (DH 1999c, Allen 2001). In 1999, the DoH published its strategy for nursing (DH 1999c) where there was promise of new career structures that included NCs. It was also the case at that time that evidence based health care was politically required to become mainstream through the introduction of quality and governance initiatives within the NHS such as clinical governance into the NHS (Department of Health 1998), the National Institute for Clinical Excellence (NICE) and the National Service Frameworks (NSFs). However, EBP as a concept provided its own challenges for nursing and medicine and it is important to describe and understand these in order to

contextualise EBP further on in the thesis in relation to the NC role and the influence on both the research and evidence based practice agendas for nursing.

#### **1.3.4 Evidence-based practice**

Within medicine, EBP originated as a professional initiative that developed through subsequent backing from the Cochrane collection that supported the practice and dissemination of systematic reviews (Thomas *et al.* 2010). For policy makers, EBP was also attractive as a mechanism for gaining control over health care spending by rationalising care on the grounds of effectiveness and also controlling the practice of professionals through standardisation. On the one hand, this placed a moral obligation on clinicians to provide effective and efficient interventions (Thomas *et al.* 2010), which for some was seen as a threat to clinical autonomy. On the other hand, standardisation and clinical guidelines were also considered to endorse a profession's jurisdiction with a scientific and empirical base (Timmermans and Berg 2003). This created quite different challenges for medicine and nursing. Medicine had a much stronger research basis than nursing, a high status and powerful profession with an established evidence base rooted in the biomedical paradigm. The challenge for medicine was getting evidence into practice in the face of a strong professional culture of autonomous clinical practice. Whereas for nursing, a lower status occupation with a stronger history of protocol based care but a low evidence base, the issues were different. Nursing had a comparatively limited understanding of research and was undergoing a professionalization process in which it was trying to emulate medicine based on claims of autonomous practice and holistic nursing care. For some, in nursing, EBP helped to strengthen the profession's standing by offering professional legitimacy by providing a scientific basis for practice. For others, it strained the ideals around individualised care (Allen and Lyne 2006). Nursing has also had a different relationship with evidence, where EBP is predicated on a biomedical paradigm with RCT as the gold standard, which while acceptable for nursing when the issue is effectiveness of treatments is less relevant when the issues of concern are practical, moral and subjective. Allen and Lyne (2006) argued that the reality of

using EBP remained a challenge as research findings did not always provide a definite answer to the question asked.

Within nursing, questions have been raised about the implications of defining best evidence so narrowly when clinical practice is culturally, spiritually and socially diverse (Bradshaw 2000). A range of groups including the state, service managers and different segments in the profession also had a stake in promoting EBP and there have been many discussions in the literature about how this has been adopted (Taylor and Allen 2007). There had been a tendency, historically, to talk about research as everybody's business in order to overcome initial accusations of elitism within the profession, but this also had the effect of underestimating what people charged with a research element in their role can realistically achieve and the skills required to do this (Allen and Lyne 2006). In relation to nursing research, its importance appeared to lie in its value in underwriting nursing's claim to professional status. Developing a theoretical body of knowledge and academic credibility was considered the basis of professional credibility. Cullum *et al.* (2007) acknowledged that central to EBP was high quality research which was regarded as the most important source of information along with the specific patient population under consideration. However, Cullum *et al.* (2007) also suggested that while there had been a marked progression in the development of EBP in nursing, there remained quite a way to go to ensure it is central to every nurse's practice.

Allen and Lyne (2006) have argued that, for nursing, EBP was a hybrid concept with the aim of aligning the professional and management agenda. The managerial model expected that nurses would engage in EBP and research findings to inform clinical decision making where care is standardised and guided by EBP guidelines based on a synthesis of currently available evidence. Whereas professional ideologies emphasised autonomous practice, considering a range of evidence placed before them to make a decision on the needs of individual groups (Taylor and Allen 2007). This has required many nurses to develop skills to undertake research, critique research, synthesise research, translate it and apply it the individual case.

All complex and different skill sets and challenging to incorporate into the nursing curricula. There were also concerns that this type of information would not be readily available to nurses in clinical practice and the skills required to undertake an assessment of the evidence will be varied and depend on the level of practice at which the nurse is working. For example, a newly qualified nurse may have the skills to critique research papers but would not possess the skills to perform systematic reviews and meta-analysis to inform policy documents. It is also argued that because of the practical difficulties involved in accessing and evaluating the evidence EBP would be better achieved through the application of care pathways and protocols (Foundation of Nursing Studies 2001).

There have been criticisms of EBP due to the lack of transparency in decision making and suggestions it turns into 'cook book medicine'. Cook book medicine implied that health care providers would merely follow recipes as laid out by others and stop consulting their own intuition and expertise (Timmermans and Berg 2003). In a world where the cost of health care is constantly evaluated, and guidelines and protocols are promoted, there is a real danger that it will be possible to replace the expert practitioner with lower qualified and cheaper workers. Medicine, according to Sackett (1996), appeared to support the professional ideology that EBP involved a conscientious, explicit and judicious use of current best practice in making decisions regarding the care of patients. Typically, a group of experts evaluated the scientific literature according to a set of criteria and then offer recommendations on the evidence provided. Nevertheless, there have been some challenges to Sackett's definition, one being the lack of best quality research for nursing care, and in particular mental health nursing, which remains under resourced (EBNP 2014). Gray (1997) suggested that EBP should be:

an approach to decision making in which the clinician uses  
the best evidence available in consultation with the patient  
to decide on the option that suits the patient best

(<http://www.ebnp.co.uk/What%20%20EBP.htm> [accessed 25 June 2015])

Gray recommended a combination of the patients' preferences, nurses' own professional judgement and expertise, and the best available evidence about the appropriateness of the

intervention as the most appropriate approach to EBP, which was also recommended by Sackett (1996). Christensen and Hewitt-Taylor (2006) suggested that assimilating evidence from a variety of resources, and applying it to individualised patient care, was central to the concept of EBP. Recommendations were made that although EBP involved the use of current best evidence, it also required expertise in practice in order to apply it to individual situations. Gabbay and Le May (2011) proposed that clinicians rarely accessed and used explicit evidence from research and sources directly, but relied on “mindlines” described as collectively reinforced internalised tacit guidelines. These were informed by brief reading, sharing experience with colleagues, interactions with key opinion leaders and patients. Mindlines were described as being negotiated through a range of informal interactions with professional communities of practice resulting in socially constructed knowledge. Gabbay and Le May (2011) proposed that formal and informal networking was a key to convincing evidence to clinicians. One of the challenges of progressing the EBP agenda in nursing has been argued to be the failure to acknowledge the different modes of engagement of research (Taylor and Allen 2007). The rationale for this is varied but it is suggested that in the field of EBP, there is a danger of creating a theory/practice gap where nurses are educated for what the future professional leadership aspires to rather than the realities of practice in which they work (Taylor and Allen 2007). The promotion of EBP has evidently resulted in several dilemmas for health professionals in relation to its implementation and interpretation in practice and I would argue that it remains a challenge both in terms of its interpretation and application in practice.

#### **1.4 Nurse Consultant Job Descriptions**

It was within this political context that, in 2001, I was appointed Research & Development Co-ordinator in a large teaching Trust, with a remit to work with senior nurses to develop research capacity and capability in nursing. It was this focus on nurses ‘doing research’ rather than implementing research findings that lays to at the heart of the issue and what led me to problematise this aspect of NC’s roles. One of my jobs while in post was to review a database outlining all the research studies registered within the Trust. I was surprised to note that many



of the studies registered to nurses were poor in methodological quality and few in number. The research drive within nursing in terms of both capability and capacity was reflected in the nursing strategy, where the priority focused on delivery of nursing care, a situation that I had encountered myself several years before and which continued to be the trend until 2005 when a Lead Research Nurse with a PhD was appointed by the Trust and hosted within the University. This post was developed in the context of a renewed emphasis on research in nursing and links with academia in light of the evidence based health care agenda. Due to the skills of the appointee, there was a marked uptake in more nurses undertaking nursing research. This was evidenced through development of several credible research proposals for an internal Trust small grant scheme, where for the first time several nurses were awarded small grants to take research projects forward. I also observed the benefits of strong leadership from the Lead Nurse, which were an increase in research awareness and use of EBP within clinical areas. I witnessed the Lead Research Nurse raising the profile of nursing research within the Trust and supporting nurses to use research to inform practice. Personally, this reinforced the notion that research evidence can be a powerful tool in the challenge to change practice, within the service segment of nursing.

There was clearly a long way to go for nursing but I believed that a dedicated post leading research in nursing could make a significant difference. Therefore, I began to explore the role of other nurse leaders who would have the potential to develop nursing research. One of the nurse specialist roles with a defined role for research is the NC role, which, as the title suggests, is perceived to be the pinnacle of specialist practice. NC posts were introduced by the DoH in 1999. The aim of their role was to improve the quality of nursing services, strengthen leadership and help to retain expert nurses in clinical practice (Coster *et al.* 2006).

However, a brief review I undertook of available NC job descriptions identified conflicting terminology in terms of the research element of the role. Some of the job descriptions were explicit and expected the NC to:

- Undertake research and academic activities e.g. develop a research portfolio, appraise emerging acute assessment evidence, and advanced practice issues, address gaps in existing knowledge and practice, evaluate the role, networking with NC colleagues and others.

Whereas other job descriptions simply asked for the NC to:

- Lead on the development of nursing skills and interest in research and audit, ensuring this is in line with service requirements.

Whether these examples provide a realistic picture of the disparity of the research component of the role or merely reflect the writing style of the individual preparing the job descriptions open to question. However, questions emerging from this initial analysis were:

- How does this role influence research agenda for nursing and what are the factors that influence this?
- What can the research element of the role realistically expect to achieve when 50% of the role is clinically driven?
- How are NC prepared for and supported into the research component of this role?
- Is it feasible for NCs to lead research studies or are they only practically able to facilitate the process? Will it be dependent on individuals' academic ability or are there clear pathways to facilitate research development?

If in reality, taking the evidence based agenda forward is recognised as being more challenging than first thought (Cullum *et al.* 2000, Mooney 2007), then there is a need to explore how NCs are prepared and supported to engage and deliver on the research aspect of their role, and how they interpret it.

As I began to question the research component of this role, my preconceptions were that NCs may be educationally prepared for the clinical aspect of their role, but the research component was going to vary dependent on academic capability and the particular nature of the clinical speciality of the NC and, more importantly, the local work culture/environment. Nevertheless, these preconceptions required exploration in order to identify within the nursing literature, how NCs developed the research component of their role, how they were prepared for and supported to deliver on this and whether their role has influenced the evidence based agenda for nursing.

## 1.5 Summary

This chapter provided the reader with an introduction to my epistemological and ontological position and the development of my professional journey that ultimately led to the foundation for this thesis. I aimed to demonstrate how my professional journey was also influenced by these policies and the radical changes in nursing education that were happening the early stages of my nursing career but also continue to shape my career to date. The intention of doing so was to share with the reader not only beliefs and position regarding the research topic, but also how I was introduced to the concept of research in nursing which in reality for me and I would suspect other senior clinically focused nurses, only has a fifteen year history. This factor alone demonstrates the newness of nursing research in relation to clinical practice and placing that lack of longevity in the readers mind is important as we move into the next chapter which comprises of a literature review of the development of the NC role and a critical appraisal from the literature of the development of the research component of the role.

## CHAPTER TWO: Literature Review

*A Nurse Practitioner/Advanced Practice Nurse is a registered nurse who has acquired the expert knowledge base. Complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Master's degree is recommended for entry level (ICN, 2008)*

*The Consultant Practitioner is expected to lead research initiatives and/or audit in the clinical area and contribute to the wider research agenda (Health Inspectorate Wales, 2007)*

This chapter will outline the context of the 'advanced practitioner' within nursing from both a global and local perspective before going on to review the relevant literature around the role of the Nurse Consultant in the UK.

### 2.1. International context

Globally, ANP roles have developed rapidly over the last decade driven by the policy drivers outlined in chapter one. (Sheer and Wong 2008, OECD 2010). According to data collected from documentary resources available in the International Nurse Practitioners//Advanced Practice Nurse Network (INP/APNN) of the International Council of Nurses, the development of these roles has been dependant on the ratio of doctors to nurses in individual countries and reliant on the nursing professions desire to advance nurse education at a higher level. (Sheer and Wong 2008, OECD 2010). Following an analysis of data from fourteen countries and three regions from five continents in relation to Advanced Nurse Practice, it has been recognised that even though advance nurse practice differs in each of the nations, similar challenges exist in every nation. These are reported as being;

- Educational Standards
- Regulation of the roles
- Titles
- Scope and Standards of Practice (Sheer and Wong 2008)
- Opposition of the role by other nurses, professionals and the public. (Sheer and Wong 2008)

As this literature review develops it will be interesting to compare if these challenges are relevant to the advanced practice role I am exploring that of the NC.

### 2.1.2 National Context

Historically ANP roles were introduced into the NHS in the early 1970s and mostly in primary care, but it is in the last decade their numbers have proliferated and more recently have been introduced into acute care, emergency medicines and introduced within hospital settings (OECD 2010). The NC role name existed much earlier in the USA and Australia but the actual functions are reported to be different than those developed within the United Kingdom. (Unsworth & Cook 2003, Woodward *et al.* 2005). NC roles were one of the ANP roles introduced in 1999, against a backdrop of practice and service modernisation. The purpose of the role was to achieve better health outcomes for patients and strengthen leadership in nursing (Department of Health [DoH] 1999a). These posts offered the nursing profession an opportunity to develop senior nurses while retaining their clinical links. The NC role focused on four core functions: expert practice, leadership and consultancy, education and training, practice and service development linked to research and evaluation (Department of Health [DoH] 1999a). Original guidance from the DoH stated that the four components were not seen as commanding equal commitments but the DoH mandated that practice must form at least 50% of the role. The weight attributable to each of the other integral parts of the role was to be dependent on the particular needs of the clinical service. Employers were advised by the Department of Health (1999b) that when determining starting pay they should consider a variety of factors concerning the core functions, and for research this was:

the level and complexity of responsibilities for strategic practice and service development, research evaluation (for example responsibility for developing nursing practice with a small team or applying research evidence with leading on extensive service implementation or evaluation strategy or initiating or undertaking original research to generate new knowledge of national or international repute (DoH 1999b p.5)

These ambitious combinations of functions were thought to provide the same status within nursing that were afforded to medical consultants. The risk of the NC post becoming just another nursing title, adding to the proliferation of specialist and practitioner roles witnessed in recent years was opposed. Suggestions were made that the rigid recommendations regarding the definition, creation and appointment of the positions reduced the risk of this. (Da Costa 2003, Manley (1997).

Enhancing the quality of care for patients was at the heart of the reforms and the NC posts were viewed as a new career opportunity to enable easier movement between posts in practice, education and research (Department of Health 1999b). This was a major development within clinical nursing, because this was the first time research had been included as a key component of service-based senior nursing posts. Early discussions concerning the research element of their role suggested that research should be integral to NC practice (Manley 1997). It was anticipated that NCs would be engaged in research through a number of activities, ranging from establishing a research culture through to developing collaborative research (Department of Health 1999b). The Department of Health stated that they expected NCs to have experience of undertaking research and a record of academic achievements at appointment, which should include publication as part of the norm. Therefore, it could be assumed that, sixteen years on, NCs would be at the forefront of delivering on the research aspect of their role whether that is applying research evidence to inform service delivery or extensive service implementation or initiating and undertaking national and international research. However, variation within the JDs (see chapter one) may have had implications for how the research component has progressed within the NC role.

My initial preconceptions were that this disparity could be addressed by introducing a generic JD for specific elements of the role such as the research component. However, there have been suggestions that NCs' roles were so diverse that it would be extremely challenging to achieve this (Hourihane *et al.* (2012). Despite being underpinned by a set of national guidelines, the NC roles were not uniformly translated into practice and were suggested as being shaped to match the needs of their local population. The literature implies that any JD should be based on a combination of professional guidance and Government policy to suit the individual's context and service demands (Harker 2001, Coady 2003, Hayes and Harrison 2004, Hourihane *et al.* 2012).

## 2.2 The Search Strategy

The search strategy for this review was an inclusive and iterative approach and was undertaken in two distinct stages; firstly I gathered data from the four countries within the UK regarding the role development; secondly I undertook a 'traditional' search of databases to find published papers in journals. Online searches were combined with attempts to find unpublished literature in a number of databases. The search methodology is offered below while a critical analysis of the included literature provided in appendix 1. This process of searching continued throughout writing this review until new literature did not raise new issues or concepts. Following the search a total of 23 papers were retrieved; 18 of which were empirical and the remaining five were narrative or opinion papers.

**Table 1.**

Electronic data bases accessed	EMBASE. Cumulative Index and Allied Literature (CINAHL) Databases of the National Library of Medicine (MEDLINE) British Nursing Index BNI)
Key words used	Nurse Consultants Research Service development Evidence based nursing practice Nursing Practice, Evidence Based

Boolean Operators Truncations	<p>CINAHL  “nurse* consultan* 852 results  Research* 245168 results  “service development” 607 results  Exp Nursing Practice, Evidence Based, 9182 results  CINAHL: 2 or 3 or 4or 5: 254136 results  EMBASE, MEDLINE, BNI, CINAHL;  “nurs* consultan* 2412 results  Research* 2475111  “service development” 3086 results  “evidence based practice” 20754 results  exp Nursing Practice Evidence Based 9182 results  EMBASE, MEDLINE, BNI, CINAHL;  9 or 10 or 11 or 12; 2422701  EMBASE, MEDLINE, BNI, CINAHL;  8 and 13 306 results</p>
Timeframe	1999 – 2014
Inclusion criteria	<p>English language articles only.  Peer reviewed journals.</p>
Exclusion Criteria	<p>Non English language  Low impact Journals</p>
Back chaining	Back chaining of initial articles selected from electronic search allowing manual retrieval of books and articles relevant to the topic
‘Grey’ Literature	<p>OpenSige <a href="http://opensigle.inist.fr/">http://opensigle.inist.fr/</a> was searched for theses and unpublished manuscripts.  Government sources  Professional Websites  Google scholar  NHS Evidence</p>
No of ‘hits’	Before Filters applied 306
No retrieved	Individual review of 306 hits which resulted in the selection of 18 research publications and 5 narrative opinion papers selected for their relevance to the research question.



The following review presents an analysis of the retrieved literature from both phases.

### **2.3 Nurse Consultant Profile**

To explore the pattern and numbers of NCs currently employed across the United Kingdom (UK), the available data were reviewed by undertaking a literature review of Government documents concerning the development of the roles and a search of the internet websites of the Department of Health, Welsh Assembly Government (WAG), Scottish Executive (SE) and the Department of Health, Social Services and Public Safety Northern Ireland (DHSSPSNI). Although data were found concerning the number of NCs in post in England, no statistical data were available for Wales, Scotland and Northern Ireland. Therefore, e-mails were sent to the Chief Nurses in the devolved countries requesting this information, but only the Chief Nurse in Northern Ireland responded.

A RCN/DH (2005) UK wide questionnaire survey including all advanced practice roles (APRs) (758 with a 69% return rate) asked specifically for information around the activities undertaken by nurses in these roles in order to develop an activity based typology. The survey highlighted that the mean age for APRs was 45.1years, with an average of 21 years since qualifying to being appointed to a post. NCs had spent an average of 11.4 years in their chosen speciality as opposed to other advanced practitioners whose average was 8.4 years. It was reported that NCs, although they do a large number of activities overall, view the diagnostic and organisational elements of their job as distinguishing them from other advanced specialists. The research component of the role was reported as being only 8% for all advanced roles and was referred to broadly in the report and poorly defined in the survey analysis. One of the key recommendations regarding the NC role was that employer organisations must consider the support and infrastructure around existing and proposed new NC posts. Typical for all APRs included in the survey, NCs had been heavily involved in setting up their own posts. While this was a useful report in relation to statistical data regarding the NC role, too much of the data was combined to cover all APRs to tease out the relevance to NCs for some of the typology themes.

### 2.3.1 England

Although, during the past decade, there has been a gradual increase in NCs across the UK, growth in England has been most marked. Findings suggest that in 2008, there were 859 NCs employed within England (NHS statistics 2008) with 1091 NCs in post by 2010 (National Health Services (NHS) Information Centre ([www.ic.nhs.uk](http://www.ic.nhs.uk))).

### 2.3.2 Scotland

In Scotland, the literature suggests that the numbers of appointed NCs are considerably less than in England and Wales. Unlike England, NC posts were slow to evolve within the devolved nation of Scotland (Scottish Executive 2000). In 2000, the Scottish Executive approved funding for the first NC posts and Scotland's Health Minister announced 12 centrally funded posts and invited bids from individual Health Boards. A second announcement was made 12 months later as only three appointments had been made. The reason for this has not been described in any detail other than the suggestion that there was a lack of commitment by the NHS to invest in both the role of the NC and to raise the strategic contribution of nursing to the health service (Redwood *et al.* 2006). It is possible too that there was a lack of appropriately qualified nurses available to apply for the NC posts at that time. NCs' job specifications were set nationally and included the requirement for applicants to be educated to Masters or Doctorate level and hold additional speciality-specific professional qualifications (Department of Health 1999a). In 2004, the Royal College of Nursing, concerned by the lack of appointments, recommended that each of Scotland's 12 Health Boards should have at least one NC in post. In 2007, there were reportedly 38 NCs employed.

### 2.3.3 Northern Ireland

In Ireland, a review of the NC role in 2005 acknowledged that the posts had evolved very slowly with only five posts appointed to at that time. The review was undertaken because of requests to do so by relevant stakeholders (although who these were was not stated in the

publication) to the Department of Health Social Services and Public Safety DHSSPS (2005) Nursing and Midwifery advisory group. An independent management centre was commissioned to undertake the review. The methods used to analyse how the posts were being developed and supported and to identify key areas for development were comprehensive. A mixed methodology involving key stakeholders 30 per nurse consultant, nurse consultants, Chief Nurses and patients was used. The review had a particular focus on the four core functions of the NC role.

- Questionnaires were issued to key stakeholders (30 per nurse consultant) with a 35% return rate
- Structured interviews were undertaken with NCs plus NCs were asked to complete a diary analysis of one typical working month
- Two focus groups were held regionally to establish stakeholders views regarding the NC role
- Structured meetings with Chief Nurses were undertaken.

The review confirmed that the roles, although in their infancy, had all made a significant difference in each of their speciality areas. As an overarching summary, DHSSPSNI (2005) reported that numerous service improvements and clinical developments had resulted from the appointment of NCs and their involvement in longer term projects. More relevant to this research study, the review also highlighted stakeholders' and NCs' views on the research component of the NC role. The expert function of the NC role was considered by stakeholders, who suggested that expertise not only relates to the NCs clinical practice, but also their involvement in audit and research which would cascade into improving delivery of care. The research function was noted as involving working in proximity with practitioners, informing them of the most effective ways to deal with patients and informing them about the latest evidence influencing patient care. Advising at Executive level within the NHS in relation to delivery of care based on best evidence was regarded as another key role that elevated the NC to the status of expert practitioner in relation to the research element of the role by those involved in the review. In the findings, reference was made to the debate

amongst NCs about how the research component could be interpreted. There was consensus by the NCs that their role was not to lead all research, as this would be unrealistic and detract from other parts of their role. As this study was based on the views of only five NCs, it will be interesting to compare this finding in particular, with those of the sample group for this study. It was agreed nevertheless by all parties that the NC role was key in identifying appropriate areas for research and to ensure the results of research are implemented and audited in specialist areas.

The NCs had mixed experiences regarding the development of their job plans and objectives when assuming their posts. Some were conversant with the job plans that had been submitted with the original bid to have their post approved from which their job description and objectives were derived in their first year in post. However, others were not familiar with the original job plan, whilst aware that it had been part of the original process in getting their posts approved.

There was widespread agreement amongst the NCs that the target of ‘50% direct contact’, as stated in the original circular, was unrealistic if it was to be interpreted literally as face-to-face contact with patients for 50% of their working week. It was argued that the term ‘direct patient contact’ was ambiguous and could be interpreted in a variety of ways. Unsurprisingly, there was consensus amongst the NCs that 100% of their work had a direct effect upon patient care, and their work was key to service improvement, and therefore of benefit to all patients in their specialist areas of care. This personal analysis was supported by the stakeholders involved in the review and it was hoped that these posts would continue to bring significant improvements in clinical outcomes and improved services to patients. In 2010, I received an email from the Chief Nurse in Ireland confirming that approximately 8 NC posts had been appointed to.

### 2.3.4 Wales

In Wales, NC posts were introduced by the Welsh Assembly in 2000. To ensure a consistent approach to the establishment of NC posts, a centrally-controlled scrutiny process was introduced. This process is currently managed by Healthcare Inspectorate Wales (HIW) and covers a number of other non -medical professional groups. The guidance published on the HIW website (<http://www.hiw.org.uk/page.cfm?orgid=477&pid=29384> ) states that NC posts were established to develop and modernise clinical practice across and beyond traditional and organisational boundaries and were assumed to be well placed to provide the clinical leadership and partnership working to deliver the modernisation agenda identified in Designed for Life (National Assembly for Wales [NAfW] 2005). In terms of relevant reports, HIW (2007) appears to provide the first example where research and development is considered and written with clear objectives based on Designed for Life (NAfW 2005). The NC role in research is defined as meeting specific and strategic objectives. In summary these are cited as:

- Promoting the role of the NC in clinical care, pathways and innovative models
- Evaluating and demonstrating effectiveness of pathways and service models
- Ensuring that all NC posts are linked to R&D strategies
- Developing appropriate focused studies, including MSc and PhD studies in others

This is the first report uncovered as part of the review that clearly defines how the research component of the role could be delivered and developed. An update provided on the same website but dated 2011 suggested that any new applications for NC posts should be undertaken in partnership between a NHS organisation/s and an appropriate education provider/s. It was also recommended that a clear description should also be given of the links between practice, education and research in the post. I undertook a review of the Chief Nursing sites for England and the other devolved nations to try and identify whether there were similar strategies setting clear objectives of the research component of the role. It became clear that there were no other strategies with which to make comparisons. This was expected for Ireland or Scotland as they have not developed the same number of NC posts as

Wales and England. Nevertheless, for England, where most NC posts had been appointed, clear objectives for this role in terms of the research development eleven years post inauguration would have been expected.

On the Welsh NC forum website, there were 31 NCs registered in April 2010. Posts were created to maintain and develop clinical nursing expertise within frontline patient care services. Minimum essential criteria for a NC appointment are outlined by the NAFW (2008) (Appendix 2). Since the first evaluation in 2003 of the nurse/midwifery/health visitor consultant posts by the Chief Nursing Officer for Wales, (this paper is no longer in circulation) there has been acknowledgement that the role of the NC is challenging, particularly in meeting all of the expectations set out in the areas of practice (NAFW 2008). Current recommendations strongly suggest that employer organisations must consider the support infrastructure around existing and proposed new NC posts and in particular consider how the posts could be used to build research capacity in service provider organisations (National Assembly 2008). Extended programmes of research in clinical practice were advocated rather than one off projects. NCs, through their links with HEI and high level strategic role within service provider organisations are felt by the NAFW (2008) to be well placed to facilitate expansion of programmes of research.

Since their introduction, it is reported that NCs have provided leadership and impacted on clinical care and have been at the forefront of consultations for reform (NAFW 2008) However, it is difficult to critique the development of NCs in Wales due to the lack of available literature relating to the earlier evaluations of the role. However, on the Consultant nurse midwife and health professions Cymru website (CNMHP 2014) there are annual plans developed by the forum starting from 2009 until 2012. Within these plans are clear objectives regarding the research and development element of the NC role. These range from the NC evaluating and demonstrating effectiveness of pathways and service models to actively engaging and leading on research and development. However, there was no narrative provided to indicate whether or not these had been achieved.

## 2.4 Empirical Literature Review

The following discussion presents a synthesis of existing research relevant to the understanding of NC's job descriptions and the expectations associated with those descriptors. In reviewing the literature, a thematic analysis of the content was conducted and four main themes emerged inductively from the literature: (a) research component of the role; (b) role development; (c) role clarity; and (d) academic attainment. A synthesis of findings from the empirical studies included in the review is presented below according to these themes.

### 2.3.1 Research Component of the Role

The literature confirms that research component of the role was perceived by NCs as one of the most challenging to achieve, with the role aspiration and the lived reality quite different. (Charters *et al.* 2005, Dawson 2008, McIntosh and Tolson 2009, Hourihane *et al.* 2012, Franks and Howarth 2012, Franks 2014). Lack of professional support and supervision was cited as the reason with the research function the first to be dropped when there were competing priorities (Redwood *et al.* 2007, Abbott 2007, McIntosh and Tolson 2009, Gerrish *et al.* 2011, Franks and Howarth 2012, Franks 2014). However, research was cited within the literature as a way NCs could demonstrate their impact under the theme of organisational significance, through the generation of new knowledge (Gerrish *et al.* (2013). NCs acknowledged the need to contribute to scholarly activity but identified this was extremely challenging because of the service-level responsibilities and the variation of time spent in designated functions. This lack of scholarly activity was viewed as a weakness by them and had precluded the NC ability to demonstrate their impact within their employing organisations (Franks and Howarth 2012, Franks 2014). There was agreement that the majority of NC time was spent on clinical commitments with a higher involvement in practice and service development than the other components (RCN/DH 2005, Fairley 2006, Ryan *et al.* 2006, Frank and Howarth 2012). NCs expressed a wish to contribute to policy and research knowledge but felt unsupported by their managers. NCs viewed their role as

important in developing EBP frameworks and guiding their professional peers, and reported their own professional development as equally important. Nevertheless the majority of time was taken with leadership and consultancy and expert practice relating to supervision of practitioners, with research and quality assurance only taking up a small percentage of their time. Indeed, this very aspect was reported by Charters *et al* (2005) in their survey among NCs working in emergency care. Respondents described that aspect of their role which received the least attention was research and the need for protected time for undertaking research was highlighted.

### **2.3.2 Role Development**

There are criticisms by the NCs themselves regarding the way the roles were set up and suggestions were made that the establishment of the roles was poorly implemented and handled and there needed to be greater thought and commitment to planning the support required for the NC role (Guest *et al.* 2004, Charters *et al.* 2005, Dawson 2005, Dawson 2008). Inconsistent job descriptions were cited as only adding to the challenges of the role development where the four domains were not uniformly defined and the research domain within this, underspecified (McIntosh and Tolson 2009). Organisational culture was also cited as influencing the development of the NC role with mentorship and support being crucial to the success of the role. Organisational expectations and expectations of professional colleagues were varied and, at times, unrealistic when they were expected to be experts and know everything about their speciality (McIntosh and Tolson 2009). Since 2001, it is recommended that new applications for a NC role should be undertaken in partnership between an NHS organisation and appropriate education provider to ensure support for clinical and academic elements of the role is provided from the outset (Charters *et al.* 2005, Graham and Wallace 2005, Woodward *et al.* 2005, Hoskins 2008, HIW 2011, Manley and Titchen 2012). Personal characteristics of the NC were viewed as equally important as having the relevant knowledge and skills in relation to delivering the key components of the NC role (Woodward *et al.* 2005). NCs also viewed their role as important in developing EBP frameworks and guiding their professional peers, and reported their own professional



development as equally important. Nevertheless, role aspiration and the lived reality were quite different, with the research component again perceived as one of the most challenging to achieve (Charters *et al.* 2005, Dawson 2008).

A number of issues have been identified that may have impacted on the development of the roles. These have been acknowledged as; the way the roles were set up causing role ambiguity (Guest *et al.* 2004, Woodward *et al.* 2006, Abbott 2007, McSherry 2007, Franks and Howarth 2012), the organisational support for all four components of the role once they were established, an understanding by the organisation and peers of the role, (Aitkenhead 2003, Mckenna *et al.* 2006, Abbott 2007, Graham 2007, Guest *et al.* 2004, Charters *et al.* 2005, Dawson 2005, McSherry *et al.* 2007, Dawson 2008, Franks and Howarth 2012, Franks 2014), the influence of academic attainment (Charters 2005, Woodward *et al.* 2005, Gerrish 2011, Hourihane *et al.* 2012) and the characteristics and interpersonal skills of the post holder, where the delivery on all components of the role was dependant on the experience and expertise combined with a clear vision of the role objectives for the four components of the role. The ability of the NC to undertake and access professional supervision was also viewed as important to ensure the professional development in all four domains. (Guest *et al.* 2004, Woodward *et al.* 2005, Manley and Titchen 2012, Hourihane *et al.* 2012, Franks and Howarth 2012). Indeed, McSherry *et al.* (2007: p2075) point to a ‘potential organic evolutionary process to aid with the implementation and evaluation’ of nurse consultant roles. They suggest that, by involving stakeholders in the development of a nurse consultant post from conception and throughout implementation, ‘many of the practical and organisational issues could be addressed from the outset’ (p2078). This statement is in agreement with the earlier studies by Manley (2000) and Guest *et al.* (2004), but McSherry *et al.* go on to emphasise the issue of the lack of pre-existing capacity in NHS organisations for ‘new’ roles. This reflects Allen’s (2001) argument that there needs to be some prior understanding of *where* [my emphasis] a particular role will actually sit within an organisation and that a negotiation between post-holder and other stakeholders needs to take place.

### 2.3.3 Role Clarity

The review clearly highlights that role clarity is a key facilitator of role development for all four components of the role. It also highlights that as all NC roles are so different and that the multi-faceted nature of the NC role makes it inherently difficult to capture the benefits of this new role (Gerrish *et al.* 2007, Hourihane *et al.* 2012). It is recommended that individual NCs need to have a better understanding of all four components of their role so that they can articulate and demonstrate the benefits of these to their relevant organisations (Hourihane *et al.* 2012, Manley and Titchen 2012). There is agreement that the majority of NC time is spent on clinical commitments with a higher involvement in practice and service development than the other components (RCN/DH 2005, Farley 2006, Ryan *et al.* 2006). However, there remains a lack of clarity regarding the leadership and research function of the role. It was acknowledged that research was the most difficult component to achieve but reasons for this were not explicit in the literature,

only that this component was the first to be dropped when there were competing priorities (Redwood *et al.* 2006, Abbott 2007, Gerrish *et al.* 2007, McIntosh and Tolson (2009). Mclean *et al.* (2007) nevertheless suggest that strong links with HEIs facilitated the development of the research component of the role. Leadership appeared to be a key component of the role and it was suggested that good leadership could instigate a change in culture. McIntosh and Tolson (2009) acknowledged that integral to leadership was developing EBP frameworks and guiding practitioners in their implementation. This, arguable, is one of the possible interpretations of what the research function may be but it has not been explicitly articulated.

Clearly, the existing literature confirmed that the establishment of the roles was poorly implemented and handled and greater thought and commitment to planning the support required for the NC role was required (Aitkenhead (2003), Abbott 2007, Guest *et al.* 2004, Charters *et al.* 2005, Dawson 2005, McSherry *et al.* (2007), Dawson 2008). Role clarity was a key facilitator of role development for all four components of the role, but the multi-faceted nature of the NC role made it inherently difficult to capture the benefits of this new role due

to its diversity and variation between specialty and across the four countries within the UK. (Guest *et al.* (2004, Hourihane *et al.*2012, Gerrish *et al.* 2013).

Guest *et al.*'s.2004 mixed method study was one of the largest in terms of sample size and the researchers' identified four main functions for the NCs.

86% were heavily engaged in leadership activities, 48% in practice and service development, research and evaluation, 43% in education, training and staff development and 33% in expert practice. 15% reported that they were heavily engaged in all four functions while 11% said they were heavily engaged in none of them (Guest *et al.* 2004 p8).

One of the challenges of analysing the data in relation to informing this literature review is that the function for research and evaluation was combined with practice and service development and there is no indication of what percentage of the 48% was purely on research within the findings. Assessing the impact of NCs on patient care directly was thought to be problematic by the researchers because, firstly, post holders tended to work through others to improve processes and systems and, secondly, because no two posts were the same. In the same study, one of the strongest criticisms made by NCs related to the way in which the roles were set up. Indeed, 80% agreed the establishment of the role was poorly implemented and handled. According to Dawson and McEwen (2005) the survey did not explicitly capture organisational culture as influencing the NC role but it was implied by the results of the survey. The report concluded that there was still scope to give greater thought and commitment to the planning and of the support for the development of the NC roles. Several forms of role conflict were reported between achieving the four elements of the formal role, with the research element the first to be relinquished when clinical pressures dictated prioritisation was necessary. However, it was not explicit within the findings what that research component entailed and what it might deliver.

Charters *et al* (2005), in their survey also found the lack of clarity as described by NCs a major finding and one which was echoed by Manley and Titchen some seven years later, suggesting a lack of movement within the NC field of employment. A small qualitative study undertaken by Macintosh and Tolson's (2009) drawing on 31 semi-structured interviews with four NCs who were interviewed twice over four to six months and 23 other stakeholders with whom they worked. Despite this being a small sample group, the data were collated using a multi-method approach that was adopted to address the evaluation objectives and provide insight into the extent to which NCs fulfilled each of the four core functions. This study's findings concentrated on evaluation of the leadership aspect of the role and revealed that leadership, as described in their individual JDs, was inconsistent. Out of the four NCs, only one job specification indicated that education, audit and research were integral parts of the leadership role. NCs also reported that they found it difficult to balance the different functions of the role and that, as previously reported, the research and education function was the least well developed. McIntosh and Tolson (2009) suggest that this disparity in core component development only adds to the complexity of articulating the different dimensions of the NC roles. Despite NCs reporting this, however, there was an acknowledgement with all the NCs that, integral to leadership, was developing evidence-based practice (EBP) frameworks and guiding practitioners in their implementation. Their own professional development was also viewed as important, and preconceptions were that further down the line a career development programme would be available which would include the development of the four functions of the post. NCs described how leadership involved providing direction and working in partnership with people rather than dictating the way forward. A top down approach was reported as not always the best way to lead change and, if adopted, often provoked resistance from clinical nurses.

There was a clear view by NCs that their role involved developing nursing practice through evidence based frameworks. Although, NCs did report an underestimation of the level of input required for successful practice and service development. They also reported unrealistic expectations by other professionals that NCs' practice was in some way superior and they were expected to be experts in every area of their specialty. However, NCs did acknowledge

that, as their confidence grew, they were able to educate peers about having a more realistic expectation regarding expert practice. Peer support was reported as being the most valuable official support for NCs with the preferred option being a variety of mentors and specific individuals for different aspects of the research role. There was also agreement that there were fundamental differences between the NC role and the clinical specialist nurse role. These were reported to be wider leadership responsibilities, the level of cross boundary and multi-agency working and the requirement for NCs to have a much more strategic element to their role both locally and nationally.

Recommendations were made that individual NCs needed to have a better understanding of all components of their role so they can articulate and demonstrate the benefits of these to their relevant organisations (Graham and Wallace 2005, Hourihane *et al.* 2012, Manley and Titchen 2012, Franks 2014). The inconsistency in role clarity was compounded further by the JDs where the four domains were not uniformly defined and the research domain within this underspecified (McIntosh and Tolson 2009). Findings from Manley and Titchen's (2012) action research study revealed the key areas that nurse consultants struggle within their day-to-day practice. These were: a) role ambiguity; b) the need to develop skills in strategic, political and clinical leadership; c) the need to develop the role of researcher (both in practice and consultancy roles) and; d) working with the contextual factors that inhibit optimising care (although how could be achieved was not part of the study's findings). However, recommendations were that NCs be supported through: a) providing mentorship and support; enabling role optimisation; c) the development of necessary skill sets to support clinical teams; and d) the development of a culture of challenge and support and one where clinical supervision was central.

Mitchell *et al.* (2010) suggested that the NCs involvement in writing the JDs added to longevity of the posts however, there was no rationale provided to support this statement. Graham and Wallace (2005) suggested that the role uncertainty could be resolved by the NC and the organisation having agreed parameters for the role. McSherry *et al.* (2007) supported

these findings by illustrating that the continued success of the NC role was the development of a more structured approach to the implementation and evaluation within organisations and this should begin prior to drawing up a business case or personal specification plan. McSherry *et al.* (2007) recommended raising awareness of the NC role and clarifying expectations by engaging and informing staff in order to facilitate the acceptance of the role. Recommendations were made that new applications for a NC role should be undertaken in partnership between an NHS organisation and appropriate education provider to ensure support for clinical and academic elements of the role is provided from the outset (Charters *et al.* 2005, Graham and Wallace 2005, Woodward *et al.* 2005, Hoskins 2008, HIW 2011, Manley and Titchen 2012). Leadership appeared to be a key component of the role and it was suggested that good leadership could instigate a change in culture. McIntosh and Tolson (2009) acknowledged that integral to developing leadership was developing EBP frameworks and guiding practitioners in their implementation. This could be one of the first interpretations within the literature of what the research function may look like.

### **2.3.2 Academic attainment**

Academic attainment of the NC was also suggested as influencing the ability to deliver on the four components of the role (Charters *et al.* 2005, Graham and Wallace 2005, Woodward *et al.* 2005, Hoskins 2008, Jolin 2009, Mitchell *et al.* 2010, HIW 2011, Gerrish *et al.* 2011 Hourihane *et al.* 2012, Manley and Titchen 2012). Educational preparation for the role was reported as crucial and was recommended at Masters level and above and to include postgraduate programmes depending on specialty (Hoskins 2008). The rationale for this level of academic preparation was that clinical capability and critical thinking of nurses was enhanced enabling NCs to work independently and to stretch the boundaries of traditional nursing roles. (Hoskins 2008, Gerrish *et al.* 2011). Gerrish *et al.* (2011) highlighted the variation in advanced practitioners ability to contribute to the EBP agenda with few considering themselves to be experts. Those with Masters qualifications perceived themselves to be more skilled to promote EBP than those without, but still reported a requirement for support in order to do so. Graham and Wallace (2005) believed that fundamental to the

success of the role was the development of a well- educated clinically competent workforce who could lead and create new systems of working, supporting other views within the literature regarding the need for strong links with education (Mclean *et.al* 2007, Franks and Howarth 2012). In contrast, Redwood *et al.* (2007) suggested that educational attainment was not intrinsically linked to achieving the core components of the role.

In the study by Hoskins (2008) the level of preparation that ‘aspirational’ emergency care NCs felt was required to prepare them for the role was investigated. The rationale for this study being that there was little guidance available as to the appropriate preparation for such a new and innovative role. The study achieved a high response rate of 86%, which was viewed as a positive return by the researcher but the researcher also acknowledged that this was in fact a small scale study representing just over 2% of all NCs (n=18). Data were analysed using a process of coded data, and while the results cannot be generalised to the whole NC population, they can be generalised to represent the views of the NCs working in the field emergency care as the sample represents 55% of this particular population. 94% of the respondents recommended a medical model of educational preparation. Hoskins (2008) suggested that the respondents were simply seeking a practical solution to an issue of appropriate level of study for this professional group and their specialty and that some of the respondents had expressed concerns that their role may be seen as medicalisation of a nursing role. Hoskins (2008) suggests that the participants in this study agreed with the findings from Gerrish *et al.* (2003), suggesting that in completing a clinical Master’s education, the clinical capability of the nurse/practitioner was enhanced enabling nurses to work independently and to stretch the boundaries of the traditional nursing role. In this study, Master’s level education was seen to entail both a deepening of existing knowledge and a broadening of the participants’ knowledge base. Conclusions were made that more work needs to be undertaken in relation to joint and collaborative working with medical staff as well as developing national programmes for preparation for the role of the NC in emergency care.

Woodward *et al.* (2005) reports one aspect of a larger study of nursing research strategies in one English region, focusing particularly on NCs' characteristics and achievements in the role. Ten NCs working in a variety of settings and specialties participated in in-depth, tape-recorded interviews. Of interest is that not all had the recommended minimum of Master's degree level preparation and most had limited research experience. In comparison to Redwood *et al.* (2006), these background characteristics seemed to influence the extent to which they were able to achieve the four domains of the role, with those with lower qualifications and from a mental health background appearing to struggle most. Conclusions were made that new appointments to these roles should only be made when candidates possess the recommended levels of educational preparation and professional experience of change management. It was also suggested that it was important that there is clarity about the scope of the role, which should not include management responsibilities. Conclusions were made that on-going research is essential to evaluate how the roles develop for post holders, the extent to which they fulfil policymakers' expectations and what difference they make to patient care from a patient perspective. Woodward *et al.* (2005) concluded that holders of such posts need to have appropriate previous knowledge, skills and personal characteristics, as these seem to influence their ability to integrate the four domains of the role and thus achieve the requirements of the post.

## **2.4 Narrative opinion papers**

I also explored the anecdotal literature because of the paucity of available research publications. Almost all the anecdotal literature was focused on role development as narrated by NCs in specific posts. I chose the specific examples included here as one of them referred to the research component of their role and was therefore relevant to this research and the others because they supported or provided a link between the findings of the aforementioned research/audit papers described in the main body in the literature review. These papers supported the findings of the main body of this literature review which identified how links with Higher Education Institutes, mentorship, a development programme and educational qualification supported the development of the research component of the role. All anecdotal



papers focused on the role of the NC and how this had changed since inception in 1999. The NCs' specialities were paediatric pain (n=1), cardiology (n=3), cardiology (community) (n=1) gerontological care (n=1), with a final paper representing six NCs from; critical care (n=1), outreach (n=1), gynaecology (n=1), oncology (n=1), trauma orthopaedics (n=1) and vascular surgery (n=1)

Supporting the findings of Charters *et al.* (2005), Aitkenhead (2003), a NC specialising in paediatric pain illustrated how a training-needs analysis undertaken at the start of her appointment was invaluable in terms of her own professional development. However, Aitkenhead suggested that it could be challenging to balance the wide ranging non-clinical activities of research, education and service development within the NC role. Mclean *et al.* (2007) described the role of NCs within the same speciality cardiology but within three totally different settings in Scotland. The first, a major tertiary cardiology centre, the second, a small acute hospital service that also provided community based services and finally a busy district general teaching hospital. The two busier organisations indicated that NCs were more involved with research than the smaller acute hospital, which may have been due to the strong links to HEIs. The NCs in these two areas also stated that the clinical area had given rise to several research interests in acute cardiology. Kirk (Jolin 2009) describes her role as a NC in the community as a post that allows her to challenge the status quo. The fundamental difference to this role analysis was that Kirk was an honorary lecturer on a Master's course and saw research as integral to her role as a NC. Kirk (Jolin 2009) reflected that a Master's level qualification makes individuals view things critically and recommended that all NCs should be educated to this level as well as having a strong clinical background.

Mitchell *et al.* (2010) provided an analysis on six NCs professional accounts in one NHS Trust in order to demonstrate their extraordinariness in practice and the difference between their role and that of other advanced practice roles. This was followed by subsequent concept mapping. Mitchell *et al.* (2010), described how the terms "expert, advanced and specialist" were often used to describe similar nursing roles and suggested that NCs that the difference in

the NC role was they demonstrated a higher degree of autonomy not apparent in other advanced practice roles. Mitchell *et al.* (2010) also suggested that there was an expectation that NCs would contribute to the research agenda through a record of scholarship and publication. For Clinical Nurse Specialists and ANPs the difference was that that they would base their care and treatment on best available evidence rather than produce and publish. Out of the six NCs, 2 nurses who contributed to the research agenda one was qualified to PhD level with the other NCs qualification unspecified. All those NCs had contributed to their JDs which were cited by the NCs as adding to the longevity of the posts but the literature does not provide an explanation as to why.

## 2.5 Discussion

This review is notably short and limited in its findings. I anticipated that it may be a challenge to identify relevant literature in terms of the research component of the role, but what I did not envisage was that the literature would be so limited and only focus on the inception of the role and how this role had developed since 1999. However, given the NC post has only been part of the nursing culture since 1999, it may be reasonable to expect the focus of the literature to be on role development and its impact. Nevertheless, the review does highlight three key areas that have influenced the four core components of the NC role: role development, role clarity and academic attainment. The review also acknowledges that one of the most challenging of the core functions is the research component but there is little evidence provided in the literature as to why, or what the research component should 'look like' or how NC contribute to the EBP agenda for nursing. The only evidence provided is a lack of professional supervision and time to develop the research component. Research is viewed as key to determining the value of the NC role through the NCs contribution to new knowledge and policy development within an organisation. However, the challenges associated with the development of this aspect of their role are viewed as a risk to the longevity of the posts by this professional group.

In summary, this review highlights a need to further explore the development of the research component of the role, what that actually means on a daily basis for NCs and whether the role has had an influence on the research or evidence based practice agenda for nursing. It is important for this study to identify and define the challenges and achievements in relation to the research component of the NC role in order to establish the support structures needed for this component of the role to succeed, in order to enable NCs to demonstrate their value and significance to their employing organisation. In chapter three, the concept of evidence based practice (EBP) is explored in order to understand locate it within the historical context from which it has evolved and how this has influence its development within the NC role.

## CHAPTER THREE: Conceptualising Research Engagement

The next two chapters will introduce the reader to the concepts and theories that support and inform my research study. This chapter will focus on the model for research engagement that aids in the conceptualisation of the problem and the following chapter (chapter four) will discuss the wider theoretical implications which are seen as impacting upon nurse consultants' roles.

According to (Miles & Huberman (1994), a conceptual framework is primarily a conception or model of what is 'out there' that you plan to study, and of what is going on with these things and why. The particular conceptual framework that I felt best 'fit' my research question was that of Allen and Lyne's *Cardiff Framework for Research Engagement* (2006). This was for two reasons; firstly, it allowed for a tentative theory of the phenomena that I was investigating; and secondly, I was involved with its initial inception and felt invested in its findings.

The word 'research' according to English Dictionary (2004) derives from the old French word *rechercher* to seek, to search again. It is also referred to as "the systematic investigation to establish facts or principles or to collect information on a subject" (p1309). As discussed in the previous chapter, the Department of Health (DoH 1999b) had the vision that the research component of the NC role would generate new knowledge of national and international repute and, furthermore, that the NC would translate and implement research evidence through leadership and role-modelling. Therefore, in its purest form my preconception initially was that the NC will act almost as a 'Chief Investigator', exploring a subject developed from clinical practice where there is lack of evidence regarding the intervention required for, or service provided to, a patient. In doing so, the NC would produce the evidence required to improve health outcomes for that individual or for a group of patients with similar health issues and therefore contribute to the evidence based practice agenda for nursing.

It could be argued that this is a very naive view of what the research component of the NC role could achieve, given the challenges of delivering on all four components as cited within the available literature. (Franks and Howarth 2012, Franks 2014). Nevertheless, it cannot be disputed that nursing research literacy has developed over the last decade with Masters and Doctoral level study increasing for nurses and for most students this involves undertaking a major piece of research at a high standard. The UK Clinical Research Collaborative (UKCRC 2007) made recommendations for preparing and supporting clinical academic nurses and proposed a more flexible career structure, so that nurses could pursue and combine their clinical and academic work. Several research training schemes have developed as a result of this with the expectation that those nurses with research training would be more likely to lead research teams and projects (Butterworth *et al.* 2005, NHS Education Scotland 2011, DH 2012). However, locally within the CRN: West of England there appears to have been little impact or increase in nurses leading research studies or nurses applying for grant applications. A comparison of local CRN research delivery databases recording Chief Investigator and Principal Investigator activity revealed that less than one percent out of 613 researchers recorded were nurses. This also reflects the national academic picture where it is estimated that only 0.1 percent of the nursing workforce in England are professors, an indication of inadequate numbers to lead the research agenda in nursing (Association of UK University Hospitals (AUKUH) 2015).

So, it would appear from this evidence that nursing research has made huge strides forward in terms of research awareness, but still has a long way to go before the impact of its research evidence is realised within the clinical area. One of the reasons could be that historically the development of nursing research has been complicated by the lack of clarity within the nursing profession as to what this should 'look like'. Academic departments of nursing have always lagged behind more established disciplines such as medicine in relation to nursing research funding with criticisms over the disparity between the research required to do well for the Research Assessment Exercise (RAE, now known as the Research Excellence Framework) and the applied research to enhance professional practice (Allen and Lyne 2006). Tensions exist between the research agendas of the health service and higher education and

the barriers to the development of research in nursing has been well documented with the structure of nurse education central to this (Allen and Lyne 2006, Taylor and Allen 2007). Nursing has only recently become an all graduate profession and pre-registration nurse education training is fundamentally a preparation for clinical practice. The focus of the training has been on large numbers to meet the service demands without investment in career structures and post registration development. There is also the reality that the research experiences required for leading and developing a study through competitive funding from major sources needed clinical research leadership, mentorship and academic support and therefore quite challenging to achieve as a lone champion in clinical practice (Taylor and Allen 2007). From a practice perspective, it is argued that the value of research is that it aims to provide answers to a clinical question. This is in opposition to the academic focus where the value of multiple research projects have aimed at stimulating nurse reflection and questioning attitudes by extending the ways nurses thought about what they do and how they care for patients (Allen and Lyne 2006).

### **3.1 Research Literacy and Awareness**

As early as 1993 the *Report of the Task Group on the Strategy for Nursing, Midwifery and Health Visiting* (DoH 1993) recommended that rather than all nurses becoming research active it was more feasible for them to be ‘research literate’ and, for most nurses today, there is evidence that overall this may have been achieved through critical appraisal of research literature during nurse undergraduate training. This has facilitated nursing students to write essays using research evidence but not necessarily supported them to translate that evidence into clinical practice. McSherry and Warr (2008) use the term ‘research awareness’ to describe the knowledge and skills required to understand the research process which involves an understanding of patient participation, what is meant by research and why we need research in nursing. Research awareness has also been reported as understanding the various elements that interact with each other and how organisational cultures and work environments could impact on that (McSheery and Warr (2010). Allen and Lyne (2006) argue that research literacy/awareness does not prepare individuals for the realities of using evidence to inform

practice and argued that the reality of using EBP remained a challenge (see chapter 1) where research findings do not always provide a definite answer to the question asked (Allen and Lyne 2006).

Suggestions have been made that nurses do value research, but do not necessarily base individual decisions on particular research findings and research was not necessarily considered the most important form of evidence (Heaslip *et al.* 2012). Other factors such as patient preferences and experiences formed an important part of evidence based practice. There are also limited resources within clinical practice that enable nurses to find, appraise and make decisions about using research. Conclusions have been made that in order for research utilisation to increase, time, resources, role models and supportive environments were required. It is also emphasised that research should not eclipse other forms of nursing knowledge such as patient views and experiences and professional expertise in the promotion of EBP (Heaslip *et al.* (2012).

### **3.2 Cardiff Framework for Research Engagement CFRE**

In 2004, I took part in a working group led by School of Nursing and Midwifery, Cardiff University where clarity was sought about the type and level of engagement of research required by individual nursing roles. Allen *et.al* (2006) suggested that there was lack of clarity regarding the function of research in diverse nursing roles and the skills required to perform research at any level. The working group discussed how this had arisen from the unresolved issues between the professional and managerial versions of EBP and their expectations regarding research. It was also acknowledged that the question of research engagement was so poorly articulated in nursing, and there was recognition of a local need to think systematically about professional development. As a result, the Cardiff group was developed to unravel some of these issues consisting of academic and clinical nursing colleagues who sought to develop a framework describing the different modes of research engagement, with the overall aim of supporting research capacity in the school. A focus

group was organised where modes of engagement including different levels were developed. Within the group it was recognised that different roles, whether they were in academia or practice, would be based on a different constellation of modes and different skill requirements.

This work influenced the development of a strategy for Nursing, Midwifery and Health Visiting in Wales (WAG 2004). Initially workshops formed the focal part of the discussions which produced the stimulus for thinking and the development of the Cardiff Framework for Research Engagement (Allen *et al.* 2004). Nine modes of engagement were identified with the aim of supporting professional development of research for nurses. These were: Research Utilisation; Research Evaluator; research Producer; Research Implementer; Research Teacher; Research Supervisor; Research Manager; Research Influencer and Research Leader. For each mode there were different levels of engagement and that different roles had different expectations for practitioners. The framework has since been tested further by the authors undertaking research which resulted in modifications to the original version. The Cardiff Group analysed the complexity of what was meant by research engagement and the following summaries of each individual mode presents a broad overview of the findings.

### **3.2.1 Research Utilisation**

*“One who makes use of primary or secondary research directly or indirectly”* (Allen and Lyne 2006 p.54)

The Cardiff Group identified research utilisation as a continuum of research engagement, dependent on the different levels, experience and expertise of the individual concerned or within the utiliser community. Allen and Lyne (2006) described how a research utiliser should not be thought of in the context of a researcher undertaking a single activity, but should be considered as comprising many facets with two distinct differences between research as an activity and the products of that activity (findings, results etc.). Allen and Lyne



(2006) proposed that, in their opinion a failure to recognise these differences had hindered the development of nursing research. Indeed, this observation was to feature strongly in this study's findings and will be discussed in detail in chapter seven. In relation to the continuum of skills and relevant expertise associated with this mode of research engagement, Allen and Lyne (2006) provided the following examples to illustrate the point and to describe some of the challenges associated with these. They proposed that at the start of the continuum was the new practitioner, guided by evidence based protocols, making use of existing research. However, as they gained clinical experience, they were required to apply problem solving skills to inform professional decisions. However, Allen and Lyne (2006) maintained that with only diploma or degree level education, of which research was a minor element, it was quite a challenge given the fact that these nurses had not been prepared to undertake these skills. At the other end of the continuum, Allen and Lyne (2006) described the challenges facing the NC role, of which research forms one of the key components. They described the NC role as being expected to act as a bridge spanning research and practice. Nevertheless despite this, the authors suggested that even if the NC is educated to doctoral level, it is unlikely that the NC will have had the opportunity to have gained the experience or the preparation to deal with the actual demands of synthesising research -based evidence with information from a range of resources, given the necessity to gain high level competency in the other core components of the role. In conclusion it is suggested that at both ends of the spectrum there had been a mismatch between preparation and experience required and the expectation by others in relation to the research aspect of individual roles. Also discussed is the use of research findings for the production of guidance and policy. Allen and Lyne described how at this senior level, the skill of interpreting research and the synthesising evidence were an essential combination with the managerial capacity to create conditions where individual practitioners can be confident that their practice is informed by best evidence. Reflecting on the influence of organisations and how they had the potential to affect research utilisation, two examples were provided for the reader. The first example was where the responsibility for preparing individuals for the research element of the clinical role was placed on the individuals themselves by the organisation without appropriate support to achieve this, thus almost setting individuals up to fail. The second was the opposite of this, where EBP was considered to be the responsibility of the organisation and recommended through the

development and application of care pathways, guidelines and protocols within organisations (FoNS 2001). In summary, it is (2006) suggested that the vision of research engagement where a nurse produces, disseminates and implements research and the preparation required to do so has been largely overlooked in debates about research education.

### **3.2.2 Research Evaluator**

*“One who has the skills to make and communicate judgements about the quality of the research and the strengths of the evidence that arises from it”* (Allen and Lyne 2006 p.58)

Allen and Lyne (2006) proposed that there was considerable difference with research engagement in the research evaluator mode, specifically between the skills and the level of engagement review research for professional purposes. As with the research utiliser, arguments are made that there needed to be clarity regarding the skills and educational preparation required to undertake this role and the level of expertise expected, depending on the nature of the role.

### **3.2.3 Research Producer**

*“One who conducts primary or secondary research”* (Allen and Lyne 2006 p.59)

For this mode of research engagement, the authors referred to a lack of understanding generally regarding the realities and demands of undertaking research in practice. Suggestions are made that current nurse education training only provided a basic understanding of the research process and was clearly out of touch with what could be achieved with a basic understanding of research and the true expertise required for research production where the experienced researcher designed projects, co-ordinated teams, secured funding opportunities etc. Allen and Lyne (2006) proposed that nursing appeared to have expected that this process could be accelerated from an artificially raised baseline, which was unrealistic.

### 3.2.4 Research Implementer

*Spans individuals who implement research findings in their own practice through to those who implement research-based decisions in the development of policies and protocols at national level. In between and of crucial importance, are those who implement research findings as they institute and manage change at organisational level (Allen and Lyne 2006, p 60)*

Allen and Lyne (2006) referred to the leadership and change management skills required to deliver on this mode of research engagement, where once in place, the level of engagement in research was raised from individual practice to the development of protocols and national policies. In relation to the NC role, it is proposed that possessing change agent skills was far more important to the success of this mode of research engagement than the current practice of focusing on the development of skills in the evaluation and conduct of research.

### 3.2.5 Research Teacher

*“One who has expertise in certain types of research or aspects of the activity and transfers this to others, (Allen and Lyne 2006, p61)*

Allen and Lyne (2006) questioned the level of preparation required to produce effective research teachers. Reference is made to Ashworth *et al.* (2001) who proposed that discourse existed within nurse education and particularly a tension between academic orientation and practical utility of research. The authors discussed how the diversity of nursing research and provision of high quality research education is more challenging than for other disciplines given the limited history of nursing research and the continuing debate about what constitutes the discipline of nursing. It is suggested that these are clouded further by the dilemma of how to teach the research component of professional practice. Also discussed is the lack of clarity surrounding the skills required by those who engaged in research in a teaching role. These factors combined with a lack of clarity surrounding the different modes of research engagement required by a research teacher emphasised the challenge for individuals who acted in the teaching role.

### 3.2.6 Research Supervisor

*“A person who acts in a supervisory capacity to less experienced researcher producers”*, (Allen and Lyne 2006 p.64)

A research supervisor is described as an individual whose work ranged from supervising diploma level literature reviews, through to PhD level study to supervising major research programmes. Allen and Lyne (2006) referred to the fact that historically possession of an academic qualification gave an individual right of passage to undertake this role, however this has since changed with the personal and intellectual attributes required for this role being prescribed by HEIs. The implications of this change were cited as academic supervision in nursing facing the same challenges as supervision in any other discipline where the student may be an expert in a particular field but becomes a novice when it relates to research and where the volume of supervision outweighs supervisory capacity. Recommendations are made by Allen and Lyne (2006) for investment in appropriate research supervision for today's nursing workforce so that the full nursing research potential could be realised.

### 3.2.6 Research Manager

*Encompasses a spectrum of activity ranging from self-management by the research producer at any level, through to management of international programmes and the commissioning of research at the highest levels. It encompasses both managing research and managing researchers* (Allen and Lyne 2006, p66)

Allen and Lyne (2006) described some of the challenges for research managers which were defined as enabling research producers to conduct high quality work while meeting the requirements of the organisation. They suggest that managers needed to be aware of the different modes of research engagement to enable them to identify who is best employed in each mode. Allen and Lyne compared managing the implementation of research to managing research producers and suggested they present different challenges. In one example they described, at a senior management level, how the manager was responsible for having a wide familiarity with the research field and the researchers, comprehensive understanding of the world of any health professionals involved in the research and the knowledge of the workings of government departments, who in this instance was the organisation involved. They also

cite one of the barriers to research utilisation as a lack of understanding by managers of the nature of research.

### **3.2.7 Research Influencer**

*“One who contributes to the focus of the research activity”* (Allen and Lyne 2006, p 69)

Allen and Lyne (2006) suggested that any nurse who takes part in discussions around research priorities engage in research in this mode. Nevertheless, they propose that articulating the research question or the precise nature of the topic to decision makers required a particular skill. If undertaken badly it is acknowledged that broad research strategies are developed that are not easily translated into practice. It is recommended that the nursing curriculum paid more attention to the analysis and description of research topics/questions so that they are embedded in every nurse’s skill set. Also endorsed is the provision of research mentorship and support as a key element to the research influencer role.

### **3.2.8 Research Leader**

*“One who has a vision for research communicates it to others and develops a strategy for achieving it”* (Allen and Lyne 2006, p69)

The research leader is described as an individual who encompasses all the modes of research engagement, becoming more engaged with more of the components as the leadership level increases. In addition to generic leadership skills such as delegation, motivation, the research leader engages with research as producer, utiliser, evaluator, manager and influencer in addition to the clinical skills required in some programmes of research. Allen and Lyne (2006) described these requirements as being demanded of research leaders at middle levels in the leadership continuum, the NC role was being categorised within this group.

The aim of this chapter was to introduce the reader to the conceptual framework which has informed this study and to illustrate the complexities associated with 'research engagement'. By using the CFRE (Allen & Lyne 2006) the various modes of engagement of research activity have been articulated. It also highlights some of the challenges associated with these modes and the different levels engagement and preparation required in order to achieve success. Allen and Lyne (2006) conclude that these modes do not map precisely onto nursing roles, as individuals often engage with research in more ways than one throughout their career trajectory, but the framework is, nevertheless, a helpful tool. A table can be found in appendix three which gives the reader a comprehensive overview of the framework. The next chapter will further develop the theoretical underpinnings which have informed my conceptualisation of the research problem by offering an examination of the theories of professional socialisation and expert practice.

## CHAPTER FOUR: Theoretical Considerations

Given the themes to emerge from the initial literature review, this study is informed by two broad theoretical considerations; expert practice and professional socialisation. Nurses are appointed because of their clinical expertise and in addition they have a triad of professional activity to demonstrate through practice, research and teaching. It is important therefore to describe the role of the expert practitioner and the skills and attributes that an ‘expert’ possesses. These can then be compared with expertise of NCs in relation to the research element of their role. Benner’s (1984) Stages of Clinical Competence was chosen as an analytical framework to facilitate understanding of the NC role. Theories of socialisation were also selected because the literature suggested that development of the NC role and how it was set up has been poorly handled and that there was greater thought and commitment needed to planning the socialisation of the NC role (Aitkenhead 2003, Guest *et al.* 2004, Charters *et al.* 2005, Dawson 2005, Mckenna *et al.* 2006, Woodward *et al.* 2006, Abbott 2007, McSherry 2007, Graham 2007, Dawson 2008, Gerrish 2011, Franks and Howarth 2012, Hourihane *et al.* 2012, Franks 2014).

### 4.1 Benner’s (1984) Stages of Clinical Competence

Nurse Consultants are senior practitioners and considered experts in their field who carry out their role under the umbrella of the four domains of (i) expert practice, (ii) leadership and consultancy, (iii) education and training and (iv) service development and research. However, there are two key, arguable competing factors which can influence the role: the assumption that practitioners have been socialised into this world throughout their education training and experience in clinical practice (Fairley 2006). NCs are expected to deliver on leadership and consultancy, education and training, practice and service development linked to research and evaluation. They are also considered to be experts within their disease specialty in nursing (Department of Health [DoH] 1999a)

The study of expert nursing practice received its recognition and incentive from three major studies by Patricia Benner and colleagues. The first was from *Novice to Expert: Excellence and Power in Clinical Nursing* (Benner 1984); the second, *Expertise in Nursing Practice: Caring Clinical Judgement and Ethics* (Benner, Tanner & Chesla 2009) expanded the sample of nurses who were studied and included implications for nursing entry level education. The third, *Clinical Wisdom and Interventions in Critical Care: A Thinking in Action Approach* (Benner, Hooper-Kyriakidid & Stannard 1999) added advanced nurses to their study.

Benner's (1984) theory of expert practitioner changed the profession's understanding of what it means to be an expert by placing emphasis on the acquisition of skills of the nurse rather than on remuneration or seniority. Benner (1984) suggested that there were certain qualities and levels of skills that define an expert practitioner and influenced the thinking around practice which she recommended should inform theory. An important feature of the expert practitioner was the ability to draw on and rapidly retrieve information from long term memory. The ability of expert nurses to use 'intuitive' knowledge to make decisions is what Benner referred to as setting them apart from other practitioners. Benner implied that there were radical differences in the problem solving skills of an expert practitioner than that of a beginner or competent nurse. These differences are attributed to 'know how' acquired through nurse experience, rather than 'know that' acquired in a classroom. Tacit or experiential knowledge enables the expert nurse to problem solve by viewing the situation as a whole, drawing on this knowledge to make clinical decisions in a short space of time.

Benner described how experiential learning in high risk environments requires the development of a sense of moral agency and responsibility. The expert does not stop at vague hunches over a change in a patient's condition but neither do they ignore them when they could lead to early identification of a problem,

Benner's theory draws heavily on the work of Dreyfus and Dreyfus (1980) who suggested a five stage model of the mental activities involved in the direct skill acquisition. During the process of acquiring a skill, practitioners pass through five developmental stages and as they become skilled, they depend less on abstract principles and more on concrete experiences.



**Table 2. Benner's Stages of Clinical Competence (Benner 1984 pp13-34)**

Stage 1. Novice	The novice or beginner has no experience in the situations in which they are expected to perform. The novice lacks confidence to demonstrate safe practice and requires continual verbal and physical cues. Practice is within a prolonged time period and he/she is unable to use discretionary judgement.
Stage 2. Advanced Beginner	Advanced Beginners demonstrate marginally acceptable performance because the nurse has had prior experience in actual situations. He/she is efficient and skilful in parts of the practice area, requiring supportive cues. May not be within a delayed time period. Knowledge is developing.
Stage 3. Competent.	Competence is demonstrated by the nurse who has been on the job in the same or familiar situations for two to three years. The nurse is able to demonstrate efficiency, is co-ordinated and has confidence in her actions. The conscious deliberate planning that is characteristic of this skill level helps achieve efficiency and organisation. Care is completed within a suitable time frame without supporting cues.
Stage 4. Proficient	The proficient nurse perceives situations as a whole rather than in terms of chopped up parts or aspects. Proficient nurses understand a situation as a whole because they perceive the meaning in terms of long term goals. The proficient nurse learns from experience what typical events to expect in any given situation and how plans need to be modified in response to these events. The holistic understanding improves the proficient nurse's decision making. It becomes less laboured because the nurse now has a perspective on which of the many existing attributes and aspects on the present situation are the important ones.
Stage 5. The Expert	The expert nurse has an intuitive grasp of each situation and zeroes in on the accurate region of the problem, without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions. The expert operates from a deep understanding of the total situation. His/her performance becomes fluid and flexible and highly proficient. Highly skilled analytical ability is necessary for these situations

According to Benner, nurses at the novice stage are still in nursing school. Nurses at the advanced beginner stage use learned procedures and rules to determine what actions are required for a given situation. Competent nurses are task orientated and deliberately structure their work in terms of plans for goal achievement, competent nurses can respond to many clinical situations but lack the ability to recognise situations of an overall picture. Proficient nurses perceive situations as a whole and have more ability to recognise and respond to changing circumstances. Expert nurses recognise unexpected clinical responses and can alert others to potential problems as they occur. Experts have an intuitive grasp of whole situations and are able to accurately diagnose and respond without wasteful consideration of ineffective possibilities (Benner 1984). Benner *et al.* (1999) also suggest that expert practice is not confined to a particular role and can be found in the practice of experienced staff nurse clinicians as well as nurses in advanced roles. Later works by Benner *et al.* (1999) also suggest that that there are four key aspects of expert nursing practice.

- i. Clinical grasp and the ability to respond quickly, which occurs when the nurse is fully engaged and knows the patient.
- ii. The nurse is able to perform technical skills and judge when to use them.
- iii. The nurse recognises the anticipated trajectory and not just the immediate clinical situation
- iv. The nurse learns to work with and act through positive relationships with others

These four characteristics would appear to link with the two of the domains of the NC role where they are considered experts in their clinical area and are also responsible for leading change with a number of key stakeholders in order to deliver the required service.

Benner (1984) suggested that, historically, nurses have been poor at documenting nursing practice and, as a result, the theory of nursing knowledge has inadequately developed. Narrative reflection of knowledge is recommended as equally important to clinical skills in the development of nursing knowledge, because new questions concerning patient care can derive from this data source. Benner implied that this experiential knowledge and tacit knowledge is embedded in the practice of the expert nurse suggesting that, historically,

nurses have been poor at documenting nursing practice and, as a result, the theory of nursing knowledge has inadequately developed. Narrative reflection of knowledge is recommended as equally important to clinical skills in the development of nursing knowledge, because new questions concerning patient care can derive from this data source. However, this knowledge cannot be expanded or developed if it is not systematically recorded and as Benner stated this was the challenge for expert practice, in that expert practice may not capture the usual criteria Benner's concept of nursing expertise is consistent with other theories of expertise (see Dreyfus and Dreyfus 1980, Darbyshire 1984, Rolfe 1997, Christensen *et al.* 2006). Christensen *et.al* suggested that in Benner's view, the mark of an expert practitioner is an individual who performs holistically rather than conducting a series of tasks proficiently. The DoH (2000) also advocate the provision of holistic care, but recommend it is used alongside standardised care, protocols, guidelines and EBP. However, while there is a place for guidelines and protocols, Benner argues that these would be used during the transitional stage in nurses' decision making process. Pearson (2013) however, suggests that intuition can be used in conjunction with EBP to achieve good outcomes and should be acknowledged in clinical practice. Fundamental to this discussion however, is the lack of consensus as what, exactly, 'intuition' is and where (and how) it can utilised alongside protocol and evidenced based care.

#### **4.1.1 Art versus Science.**

While nursing has been historically linked to medicine and its positivist philosophy, it has more recently tried to move away from that approach (Christensen *et.al* 2006). Benner's definition of expert sits in the naturalistic paradigm. In Benner's view, the value of the expensive expert practitioner in a quantifiable format can be challenging, due to the naturalistic methods that have been used to articulate nursing. Christensen *et.al* (2006) also support this view and suggest that the term *expert* is incompatible with positivist thinking, depending on the power hold of those making decisions. Despite changing demographics where medicine is now represented by a more equal distribution of male to females,

medicine's ideology continues to be an arguably male gendered profession (Allen 2005). Regardless of the fact that nurses form the largest part of the healthcare workforce, they have failed to gain an equal footing with other professional disciplines, particularly medicine. This could be seen as a potential barrier to the acceptance of nursing expertise, where medicine is located in the positivist tradition and often dominates multi-professional decision making (Burnard 1989, Mead and Mosley 2000). Crucially, it can also act as a major obstacle to nurses becoming the principal investigators in the competitive field of grant application and funding. Particularly so where the funding lies within the NIHR programmes of research as the criteria for application positively discriminates against nurses in practice settings.

#### 4.1.2 Intuition

One of the key components that sets experts apart is cited as intuition (Dreyfus and Dreyfus 1980, Benner 1984). Intuition is a decision making process that is used unconsciously by experienced practitioners, but is inaccessible to the novice (Benner 1984, Greenhalgh 2002). One of the challenges outlined by Benner (1984) was the difficulty in articulating how experts use intuition, a view also shared by Payley (1996).

English (1993), who critically analysed Benner's work, raised several questions regarding the notion of expert nurse. English posed the question; how, in reality, do individuals identify an expert nurse? Once recognised, do only experts make use of intuitive judgement? In his view Benner does not provide a clear description of the expert nurse and suggests this may force nursing back into precise definitions and descriptions of patient care. English (1993) believes that the explanation of intuition has links with telepathy and mysticism and questions at what point nurses become experts, and asks why some nurses who have worked in the same specialty for several years are not considered experts in their field? English suggests that intuition is subjective as it has not been empirically validated and therefore has limited applicability to nursing. He argues that if the expert practitioner tried to vocalise the decision making processes based on intuition, it would be incomprehensible to the novice and only intelligible to other experts. However, it could be argued that intuition is precisely about this concept and that only another expert would be able to recognise intuitive thinking. Benner

describes intuition as understanding without rationale and that intuitive judgement is what distinguishes expert human judgements from the decisions or reckonings that might be made by a beginner or a machine. Nevertheless, intuition, provides huge tensions for the expert practitioner such as the NC whose role is to follow guidelines and policies but their expert practice is based upon the use of intuition to legitimate their practice, something that is not taught.

Supporters of Benner accuse English of subscribing to a traditional notion of subjective science and misinterpreting Benner's work completely. Christensen *et. al.* (2006) imply that the definition of expertise appears to contrast with the conception of intuition, defined by the Oxford dictionary as 'unthinking and unanalytical'. Nevertheless, the counter argument to this concerns the involvement of analysis as an unconscious process, rather than a step by step analysis (Christensen *et. al.* 2006). In my view, this definition of intuition is flawed as it implies that it is a concept that is not taught. The binary opposite definition of intuition is "tuition", and how we learn from not being taught through pattern recognition, repeated experiences and stories that are shared with colleagues and would reflect Benner's intuitive thinking. Indeed, it must be seen as important as formal academic courses and Darbyshire (1994) revokes the view of English (1993) and suggests that intuition requires both formalised and decontextualized knowledge and should be accorded the respect of empirical knowledge. Payley (1996) refers to Benner's model stating that experts are identified by peer assessment or performance criteria, but also possess mental capabilities unavailable to non-experts. Payley (1996) suggests that the main question should be who is the relevant community to identifies the expert nurse? Darbyshire (1994) takes the professional stance and suggests that peers identify the expert nurse whereas English (1993) implies that this may be the health service management community. However, according to Payley (1996), the patient community also has a stake in identifying nursing expertise. These communities reflect different needs, visions, priorities and perspectives, which may clash. Thus, expert practice for one may not be valued by another and suggests a lack of consensus on the definition of the expert practitioner. However, while nursing appears to struggle with the concept of intuition medicine have used the term mindlines to legitimise their practice which supports Benner's concept of intuitive thinking. Mindlines are acknowledged as something that is not

taught but learnt through seeing the repeated experiences during practice, stories that are passed down through colleagues (Gabby and Le May 2011).

### 4.1.3 Knowledge

Benner (1984) acknowledged that nursing practice has been structured from a sociological perspective and, as a result, the profession has learned a lot about role relationship socialisation in nursing practice. Socialisation is a fact of life and its existence is essential for the profession. NCs are at the forefront of the socialisation process as a relatively new role where NCs try to develop a sense of purpose within an organisation. However, the profession has learned less about the knowledge embedded in nursing practice and has gone uncharted because of the difference between practical and theoretical knowledge (Benner 1984). Most writers agree that expertise in nursing requires more than technical proficiency and the ability to follow prescribed care guidelines and protocols (Benner 1984, Hewitt-Taylor and Melling 2004, Christensen *et.al* 2006). However, one of the challenges of applying theory to practice is that theory can never fully explain what is happening in practice and theory needs to develop from practice for the theory gap to close. Benner (1984) recognized that nursing was poorly served by the paradigm that called for all nursing theory to be developed by researchers and scholars, but rather introduced the revolutionary notion that practice itself could and should inform theory. She further suggests that merely encountering patient conditions and situations is not experience, rather experience involves nurses reflecting on nursing practice or the moment encountered with a patient to help develop and refine decision making so eventually intuitive decisions are made.

Benner (1984) argued that years of nursing experience may provide fluidity and flexibility but not the complex reflexive thinking that has been hypothesized to be an important component of clinical expertise. Benner proposed a strong link of education influencing expertise by providing a theoretical knowledge and practical base to nursing and suggested this was best developed through mentorship within the classroom and in clinical practice. Without background knowledge, nurses risk using poor judgement and lack the tools necessary to learn through experience. The context in which nursing practice was undertaken was also key

to the development of nursing practice. In order to retain nurse expertise in organisations, Benner (1984) noted that most clinical nursing performance should be attained in a supportive environment where clinical learning with colleagues from all levels of expertise takes place.

The journey from novice to expert has been documented in some detail; expertise is regarded as the pinnacle of professional practice, with the knowledge base of expert practice based on intuitive knowledge combined with a comprehensive theoretical knowledge and practical grounding. Simply being experienced in a particular speciality does not automatically make you an expert nurse. It is also necessary to understand the social context that people (and professions) operate in.

## **4.2 Professional Socialisation:**

This next section of this chapter, sets out my epistemological position reflecting my understanding of the changing modes of professionalism for nursing and examines the fundamental issue of professional identity and socialisation of nursing into a profession. Secondly, it will provide a broad overview of socialisation theories and introduce professional socialisation to the reader. Finally, professional socialisation and its implications for nursing will be discussed. The purpose of this section is to assist the reader to gain an understanding of the theories of professional socialisation and to demonstrate how it fits within the historical context of nursing and how this in turn influences the current professional agenda..

### **4.2.2 Historical Context of Socialisation of the Nursing Profession**

The meaning of professions and professionalism has changed over time as the shape and our understanding of society has evolved. One of the criteria of professionalism has been defined as autonomous practice, based on a specific body of scientific and theoretical knowledge particular to the group concerned, usually associated with expertise requiring extensive specialised training (Abbott and Wallace 1990, Hennessy and Spurgeon 2000, Collins 2015). The historical context of socialisation of the nursing profession has been well documented

where gender ideologies have played a key role in shaping the development of nursing as a profession. (Roberts 1995, Davies 1995, Holliday and Parker 1997, Hennessy and Spurgeon 2000). Gender structures and processes exist beyond the individual level and it is important therefore to reflect on women's role in society and the effect it has had on nursing. Suggestions have been made that these tensions have been exacerbated by the fact that science and research are instilled with masculine connotations. (Hennessy and Spurgeon 2000). Nursing with its female associations and its emphasis on practicality, care and intuition is considered to be incompatible with the masculine tradition of medicine, which is grounded on scientific training and holds a position in health care which grants it autonomy and professionalism. Gendered thinking has been and continues to be a major barrier to nursing's claim to professionalism and to professionalise nursing is viewed by some as replacing the values of caring with those of science (Waerness, 1992, Hennessy and Spurgeon 2000).

#### **4.2.3 Magic, the Science of Witches**

The suppression of women as healers became virulent during the witch hunting period between the 14<sup>th</sup> and 17<sup>th</sup> Century. Witch hunts were organised campaigns initiated and funded by both the Church and State and was a campaign directed primarily at the female peasant population. One of the 'crimes' witches were accused of was their ability to heal the sick, a skill they had learned through what could be regarded today as scientific practice, developed through trial and outcome and cause and effect of treatment of the sick with herbal medicines. Received wisdom was that healing was only acceptable when delivered by men to the wealthy elite. Medical practice at that time was based on superstition and the will of God, both of which were completely unscientific notions when compared to the folk knowledge of the witch healer. In contrast the witch healers practice appeared to be based on empirical study. The Church and the State felt overwhelmingly threatened by the witch healers' ability to heal the sick and declared they had to be eradicated citing their evil work as a threat to the church. As a result, women were executed for their ability to heal and for being female. Despite the fact that witch healers became more skilled at healing than their male counterparts, exclusion of women from independent healing roles was to become a theme in



history. Medical schools appeared from the 13<sup>th</sup> century onward but women once again were excluded and licensing laws were developed to prohibit all but university doctors from tending to the sick. However, who they tended to was very exclusive and doctors had little contact with the patient and most of the care continued to be built on superstition. Non-professional healing was now almost denounced as heresy and by the 17<sup>th</sup> and 18<sup>th</sup> century women healers had been so thoroughly discredited that women lost their foothold as independent practitioners. The last push to abolish independent healing or care practices by women was in the 18<sup>th</sup> century where men claimed technical superiority over the untrained midwife by the introduction of the use of forceps. Doctors now claimed the legal monopoly over midwifery which meant for poor or working class people no obstetric care being provided by expert lay practitioners as medicine provided obstetric care for the middle and upper classes who were able to pay (Ehrenreich and English 1972).

#### **4.2.4 Caring for the Sick 18<sup>th</sup> and 19<sup>th</sup> Century**

The Industrial Revolution of the 18<sup>th</sup> and 19<sup>th</sup> centuries saw massive movements of people from the country and villages to the city attracted by new factories and the opportunities for work. People lived in overcrowded conditions with poor sanitation and dirty drinking water which inevitably led to high mortality rates for diseases such as cholera, tuberculosis, measles and pneumonia. Nursing the sick was haphazard and was reliant on women where several vices were attributed to their role and where hospital authorities would often pay them with gin. As the economy boomed the voluntary philanthropic work in the 19<sup>th</sup> century increased and parishes began building voluntary hospitals from public subscription. This transformed them from places of refuge to places of curing rather than caring for the sick and poor. The new hospitals were aimed at reducing distress and restoring the afflicted individuals to respectable and independent living (Harden 1999, Abbott and Wallace 1990). However the Poor Law Amendment Act (1834) effectively ended outdoor relief and workhouses numbers increased dramatically based on the principle that the poor were responsible for their situation. Workhouses soon filled up with the sick and infirm and early nursing in the workhouses was provided by female inmates who were often poorly educated or skilled.

Independent nurses and midwives continued to practice but were condemned by leading social reformers such as Florence Nightingale as being inexpert, unprofessional, drunken dishonest and disreputable (Davies 1976, Abbott and Wallace 1990, Holliday and Parker 1997). Physical decay was linked to moral decay and women (mothers) in particular were held responsible for the health of other family members.

#### **4.2.5 Florence Nightingale's Reforms**

In 1837, Nightingale felt that God was calling her to do work and this work was developed through an interest in nursing for which she trained in Germany. In 1854, these nursing skills were put to the test when Nightingale led an expedition of thirty eight women to take over the management of the Selimiye barrack hospital in Scutari where she observed and radically changed the disastrous sanitary conditions. Military officials and medical officers/doctors objected to her views on sanitary reforms and viewed these as an attack on their professionalism and made her and the accompanying nurses unwelcome (Abbott and Wallace 1990). Nightingale used her connections with the Times Newspaper to make the public aware of the soldier's plight and it was only then that she was allowed to improve the sanitation and conditions for the sick. Nightingale also introduced a number of patient services that still stand today; healthy diets for patients, laundry services and recreational services to stimulate patients' intellectually.

Nursing was emerging as a profession supplementary to medicine heavily influenced by the hygiene discourse at that time. (Gamarnikow 1978). Nightingale recognised the need for trained nurses but scorned the medical ideology (male) of nurses being dedicated and obedient to medicine. Nightingale advocated that what nursing needed was scientific training so it could become the skilled servant of medicine, surgery and hygiene and not the servant of physicians, doctors and health officers, which were radical statements given Victorian values regarding gendered thinking at that time (Holliday and Parker 1997).

Nevertheless, the event most frequently symbolising professionalisation is state registration for doctors, which became publicly recognised in 1858 by the General Medical Council. Victorian society at that time regarded men as superior to women, mentally and physically and therefore education was regarded as being wasted on women as it may make them ill. (Holliday and Parker 1997). As doctors began to develop new ways of practicing medicine new type of assistants were needed to monitor patients. During that time the relationship of the doctor and the nurse resembled that of the Victorian husband and his wife where the nurse was responsible for the physical environment, while the doctor made the important decisions regarding the patients treatment (Abbot and Wallace 1990). This subservience was given scientific legitimacy due to the lack of theoretical knowledge associated with nurses' work with the rationality being that nursing tasks were developed out of sanitary ideas. The only role left for nurses to develop was to train other nurses and manage untrained helpers (Davies 1976, Abbott and Wallace 1990).

In order to legitimise nursing reform Nightingale and her nurses employed ideologies of the caring nurturing female. They claimed women's work at home was identical to nursing and encouraged women to enrol on uniquely feminine basis (Holliday and Parker 1996, Harden 1999). Ironically, it has been argued that these reformers employed feminine ideologies in an enabling manner by providing women with a career that empowered women with economic independence, and has been argued as playing Florence Nightingale as one of the founders of modern feminism (Gamarnikow 1991).

The Nightingale Training school for nurses at St Thomas' in London, 1860, trained nurses and then sent the Matrons to voluntary hospitals all over Britain to train other nurses. Nightingale viewed nursing as a vocation consisting of cleanliness, governed by a sense of moral duty to the patient than the self-interest of the nurse. Training schools were developed at most voluntary hospitals with new regimes and regulations to facilitate the professional image of sobriety and chastity where marriage meant the end of a career and in complete contrast to the vision of the drunken unskilled lay carer (Harden 1999).

Even though Nightingale fought for autonomy for nursing from the medical profession, in her writings she described her despair at the inefficiency and lack of mental power she met amongst women of that era. Despite Nightingale being seen as a woman who disclaimed women, her theoretical base appears to be a hybrid of her duty to do good, (the subservience) and the promotion of the rights of women as nurses to a vocation of their own, administered and controlled independently (Roberts 1995). Nightingale wrote in her *Notes on Nursing* published in 1859, that gender should not be central to the identity and work of any person, and that while nursing was the skilled servant of medicine, it was not the servant of physicians. Historical perspectives of Nightingale have reported that while she did not engage in feminist analysis, she was a staunch advocate of the importance of women's emancipation and educating women of all classes in their approach to health care and the one of her memorable achievements was the act of autonomous control of nursing from doctors. (Smith 1981, Roberts 1994, Roberts 1995). The interplay between nursing and medicine's interpretation of "nursing as women's work" lies at the heart of the occupational formation of nursing, making the gendering of nursing complex and problematic (Harden 1999)

Nurse training at that time consisted of two elements, theoretical instruction through lectures by doctors on medical subjects and later on sister tutors combined with practical ward work. This theoretical training by medicine gave doctors the monopoly to control the nursing curriculum and hence nursing practice (Harden 1999)

Standards of schools varied enormously and the more militant nurses wanted to draw a line between those nurses who were fit to practice and those who were not (Davies 1995). In 1887, the Royal British Nurses Association (RBNA) was founded and was the first professional association for nurses in the world. Mrs Bedford Fenwick who founded the association fought for the registration of nurses and pressed for the introduction of a minimum standard of three years nurse training. There was major opposition to this notably by the powerful influence of Florence Nightingale and her advocates of the vocational nature of nursing saying that to professionalise nursing would destroy its vocational spirit (Abbot and Wallace 1990). Nightingale set great store in the personal qualities required by nurses rather than training which could be obtained through individual hospital assessments. Thirty years and five select committees later, following the death of Florence Nightingale, the

Nurses Act was passed in parliament in December 23<sup>rd</sup> 1919. This was a major change in nursing and as nursing entered the 20th Century nurses it was reported that overall nurses felt less subservient to doctors but registration did not give nursing the monopoly of practice that the Medical Act did in 1852 for doctors (Abbott and Wallace 1990).

From 1943, men were allowed into the profession and moved far more quickly into the ranks of the managerial elite than their female counterparts. The Salmon report in 1966, introduced a career structure through management for the nursing elite. Dirty duties were allocated to lower grade staff such as State Enrolled Nurses and auxiliary staff and it could be argued that the development of the managerial structure into nursing downgraded the need for a professional nurse as an autonomous practitioner, as nursing duties were controlled by management with nursing care allocated to the least trained staff (Abbott and Wallace 1990). Nurses at this point in history were being socialised differently into nursing depending on their gender, and registration status which feels like a step back given the historical *Notes on Nursing* written by Florence where gender was advocated as not being the defining component of an individual's identity. The nursing process was also advocated as the basis for autonomous practice enabling managers to monitor and evaluate qualified nurses' work.

1946 saw the introduction of the Health Service and in the same year the Government set up the Wood committee, a working party who reported on the recruitment and training of nurses. A detailed report was produced recommending student nurses supernumerary status placing them under the control of the training institution rather than the hospital. It also recommended suitably qualified trained teaching staff. In 1948 the GNC agreed with the findings but they were never legislated for. It was against this, somewhat ignominious background that the nursing profession had to press its case and break free from its historical shackle of gendered subservience.

#### **4.2.5 Raise the Roof Campaign**

In the 1970s a large pay dispute referred to as the Royal College of Nursing (RCN) 'raise the roof campaign', put in an ambitious call for wages to be increased and a move away from the

vocational thinking around the nursing role. In 1972, the Briggs enquiry was set up against this background of unrest to review the role of nursing and midwifery to ensure the best use of manpower to meet the needs of an integrated health service. Recommendations were made and accepted that nurse training was inadequate and proposals were made for a two tier training course leading to two grades of nurse. The concept of vocation was viewed by the profession as a barrier hindering the development of nursing (Bradshaw 2010). Historically the Briggs Report (1972) is considered a major driver in reshaping nursing and the first to suggest that nursing should be a research based profession. Briggs also recommended a framework for a central council for registration, professional standards and discipline, with education boards in all four countries. The Briggs Committee also recommended far reaching changes accepted by the government and implemented over the following decades as Project 2000 (Bradshaw 2010).

#### **4.2.6 Project 2000**

The introduction of Project 2000 has been the most radical change in nurse education forging and inextricable link between nurse training and the higher education sector (Hennessey and Spurgeon 2000). The aim of these changes was to raise nursing's professional status by allowing its students to be supernumerary and have nursing qualifications validated by an institute of higher education (Hennessey and Spurgeon 2000). Nursing at that time was perceived to be striving for equality to medicine as a profession by recommending a move to a theory based profession (Davies and Rosser 1986, Cross 1987). Project 2000 also allowed the government to make efficiency savings by developing a new category of unqualified support worker the health care assistant. Critics of this change suggested that the new Project 2000 training would not necessarily make doctors or patients view nurses as equal or afford the professional status for nursing because of two major objectives. The first was that nursing was not a profession as it was constrained by medicines professional dominance (Melosh 1989). The second was that in broader terms nursing by definition could not be a profession as the majority were women where the gendered discourses played a huge influence. Gendered discourse as a concept is something nursing had struggled with since its inception and it has been questioned that if nursing skills were perceived as natural attributes questions

why did it need such an investment in training (Garmarnikow 1978, Needleman and Nelson 1988, Melosh 1989).

One of the workforce criticisms of Project 2000 was there was no national decision on who provided the care, qualified or unqualified and as this was never addressed it resulted in the decision being left for local interpretation (Davies 1995, Allen 2012). There were also suggestions that Project 2000 was more about a struggle for survival for nursing rather than a push for professionalism through a new occupational model (Salvage 1988). Nevertheless, the change from a vocational apprenticeship to a merger with academic institution was to have a major influence in the way nurses were socialised into the nursing profession both from an academic and service perspective. Melia (1984), who is regarded as one of the most influential writers of occupational socialisation of nursing, suggested that the structure of nursing and nurse training was an historical compromise between service (occupational agenda) and education (professional agenda). The education segment through which nursing promotes the professional version of nursing is most credible when it does not have to contend with the realities of the clinical setting and is often seen as disconnected with service. Second is the service segment, which portrays a very different version of nursing where nurses are socialised into the occupational tasks of getting the job done and the two ideologies do not align causing confusion and disintegrated learning context where opposing values of learning exist. Clinical expectations are often at odds with those of academic nurses and continue to contribute to the theory practice gap.

In 2000, Hennessey and Spurgeon raised concerns of the reduction in collective professional strength that had resulted from the expenditure on Project 2000, the reduction in service contributions through supernumerary status and the expansion of health care assistants. They reported that this initiative may have generated sufficient threat to reduce care practices to their mechanistic origins. Ten years later it was reported that nursing had moved too far away from its basic principles of caring and was ill equipped to deliver quality care which could not be taught but was a value nurses should have. (Francis Enquiry 2010). The Francis Enquiry, highlighted the appalling suffering of many patients which was reported as happening in a culture of secrecy and defensiveness. Francis claimed that the most striking feature of the stories told by patients related to the lack of basic care by nurses. Among the 209

recommendations included in the report Francis proposed that fundamental care standards should be established and all of these were policed by the Care Quality Commission (Allen 2012). Frances also highlighted the inadequate staffing levels on the wards a recommendation which was initially ignored by the government. Following this enquiry a number of reviews were commissioned by the government, Professor Sir Bruce Keogh's, review on the quality of care and treatment provided by 14 NHS hospital Trusts with persistently high mortality rates. The Keogh Review reported on 16th July 2013. Professor Don Berwick's review of patient safety in the NHS. Professor Berwick reported on 6th August 2013. Camilla Cavendish's review of how the training and support of healthcare and care assistants could be improved so that patients receive compassionate care in both NHS and social settings. Camilla Cavendish published her report on 10th July 2013. The Clwyd-Hart report 2013, reviewed the handling of NHS complaints. Anne Clwyd spoke of the coldness, resentment and indifference and contempt of some of the nurses who were supposed to have cared for her dying husband. The review of how the Liverpool Care Pathway was being used in practice for people at the end of their lives. The Review, chaired by the crossbench peer Baroness Julia Neuberger, reported on 15th July 2013 and recommended that when someone has a concern the first step should be to discuss the matter with the practitioners concerned, such as doctors, allied health professionals, nurses, or paramedics. At this level problems can be resolved quickly and immediate appropriate action can help avoid.

As I reflected on the literature of the reviews following Frances, I read an article published in 2007, describing an example of the appalling nursing care of the author's mother, where the cleanliness of the wards was unacceptable and where they felt they had witnessed the collapse of the ethic of caring. The lack of caring was blamed on nursing's move towards professionalism compounded by taking nursing away from the wards and training nurses in universities. The author argued that these changes have moved nursing away from its basic principles of nursing as founded in Nightingale's teachings which placed the basic needs of the patient first (Daily Mail Columnist 2007). I could relate to this reflection on care as personally I had also witnessed varying standards of nursing care through the hospitalisation of a close family member. I also blamed the qualified nurses as the individuals responsible for this when the care was substandard in my view. It was interesting that I did not blame



management, the organisation or the medical profession or the political drivers that have shaped the nurses ability to care. On reflection, I acknowledge, as did Davies in (1995), that vilifying the nurses reflected my perception that nurses are women and therefore should be care givers who are nurturing, comforting and concerned whatever the circumstances they are delivering that care in. It would appear nursing has come full circle and the public perception of what nursing should look would appear to welcome the return of the old values of the vocation rather than the ambitious values of the profession.

Davies (1995) also wrote about how nurse education and service were intertwined to the detriment of both, that the nursing workforce was stretched beyond its limits and management and leadership were out of touch. The Frances Inquiry (2007) and the reviews that followed appears to reflect Davies's rhetoric and nursing appears to have lost the 'good will' of the public and, in doing so, has given a political free hand for more policy changes built on negative press and driven by the current Government's austerity programme. Allen (2012) argues that central to the debates regarding the quality of care arising from Frances and subsequent inquiries is the ongoing tensions between nursing's aspirations for its practice and the challenges of delivering these in within the service segment of nursing. As early as 1995, Davies reported the resentment of the academic development of nursing by those who were not associated with it. Nevertheless, despite these criticisms one of the positives of nursing education embedding its provision within a University is the development of research in nursing and the opportunity for advanced study and leadership

In contrast to the engendered thinking, the British Prime Minister David Cameron is reported to have stated that nurses should be remunerated for compassion suggesting that caring is not necessarily a 'natural attribute' and is something individuals have to be trained for (Allen 2012). However, it has been argued that in the post-Frances period, the focus has been on the attributes of individuals and wider regulatory arrangements when the focus should actually be on the social organisation of care work. More recently, the Nursing & Midwifery Council (NMC) has introduced revalidation, a new process by which nurses and midwives will need

to engage with to demonstrate that they practise safely and effectively throughout their career and which will replace the previous PREPP Initiative. Final proposals for revalidation will be announced by October 2015 but will mean nurses have to demonstrate every three years that they have met the requirements to stay on the register.

As I move on to describe broad socialisation theories it is important to be mindful of the NC role and how this has been shaped by the historical development of nursing from a vocational occupation to that of professional status. It is also important to establish if there is any difference between the socialisation of NCs to the socialisation of other nurses.

### **4.3 Theories of Socialisation**

In the pursuit to becoming professional there is also the issue of developing a sense of purpose within an organisation and this is referred to as professional socialisation. The introduction of nurse consultants took the profession by surprise and as highlighted in chapter two, the nursing profession appeared to be ill prepared to deliver on all four domains of the NC role. In order to explore if the socialisation of NCs has had implications for the professional development of the research component of the NC role, I thought it relevant to remind the reader of the broad concepts of socialisation and to then describe the tensions for socialisation within nursing.

Social context consists of two important sociological concepts, society and culture. Society is one of the fundamental tenets of sociology as people live in societies that typically identify the general group to which they belong. Sensitivity to culture is an important part of sociological thinking as it is how societies relate to each other in meaningful ways. The culture is what binds people together as a collective society and is important as it helps individuals to distinguish between the social and natural aspects of human life (Bauman and May 2001, Walsh 2004). The linking of individuals' social behaviours and experiences to a

broader social context is one of the distinguishing features of sociological thinking (Walsh 2004). Sociological approaches to the human world also see society as being structured and organised through institutions with health care being one of them, where organised patterns of social behaviour are a feature of the social world beyond the level of the individual (Bauman and May 2001, Walsh 2004).

#### **4.3.1 Socialisation**

Socialisation is the means by which social and cultural continuity is attained (Walsh 2004, Carlson 2005). Sociologists and other professionals such as psychologists and educationalists indicate that socialisation provides an individual with the skills and habits necessary for participating in their own society, and that society is formed through a number of shared norms, attitudes, values, social roles and languages. In order to understand the process of socialisation into the nursing profession, it would seem relevant to provide a broad overview historically of the development of theories of socialisation which emerged in the 18<sup>th</sup> and 19<sup>th</sup> Century. Sociologically I also need to remain mindful of how the nursing profession has been shaped as a consequence of history and culture when relating to the socialisation process to nursing. Three major sociology theories dominate the landscape of socialisation processes and complement, rather than compete with each other regarding the development of these theories. These are reported as: role learning theory; symbolic interactionism theory; and psychoanalytical theory (Fulcher and Scott 2011). These theories explain how people become socialised in society where they acquire their culture, specific skills and abilities and the knowledge of what type of people they are. There are two key timelines associated with the socialisation process, the first acquired during childhood and regarded as primary socialisation and the latter teenage years onwards until the end of a life regarded as secondary socialisation.

### **4.3.2 Role learning theory**

Role learning theory has been developed mainly by the writers of structural functionalist theories such as George Mead (1863-1931). The principle of the theory is that when children are born they have the potential for social action but these have to have developed through socialisation into normal expectations that define their social roles. Social roles are treated as social facts and they are seen as institutionalised social relationships that are matters of constraint not choice (Fulcher and Scott 2011). Individuals are not free to negotiate their roles e.g. what it is to be a nurse, they must accept the way these have come to be defined in a culture. Social roles are blueprints or templates for action and individuals are required to follow specific requirements and obligations to define the role. Socialisation is how individuals learn how to perform a social role (Fulcher and Scott 2011).

### **4.3.3 Symbolic Interactionism Theory**

This perspective relies on the symbolic meaning that people develop and rely upon in the process of social action. George Mead an American philosopher and Erving Goffman (1922-1982) who worked in the University of Chicago were key figures in the development of this theory although its origins can be traced back to Max Weber's assertions that individuals' actions are based on their interpretation of the world. Mead suggested that sociological analysis must always start out from the meanings that objects have for individuals. The meanings are suggested as being socially constructed through interpretation e.g. race, gender and the process depends on communication of meanings negotiation between and within social groups. Definitions that individuals use are formed from the symbols (names and labels from objects) that are available within a culture and provide meaning to situations in which people find themselves. Mead argued that the creation of meanings can only happen when individuals consciously monitor their own actions. An individual's self is constructed through socialisation. Mead also argues that social self is a social emergent and there are three activities where self is developed through language, play and games. Self is formed of two aspects 'I' and 'me'. Me represents expectations and attitudes of others that the individual assumes. I represent the response to me or persons individually. Mead argues that me is the

major construct of social control for its mechanisms by which the community exercises control over the conduct of its member. Mead's concept of the generalised other is also essential to the theory which he defines as an organised and general attitude of the group. The group defines a person's behaviour with reference to the generalised attitude of the social group they occupy. Critics of the theory state that this theory may miss the larger influences in society such as social forces and institutions on individual reactions.

#### **4.3.4 Psychoanalytical Theory**

A key figure in the psychoanalytical theory was Sigmund Freud (1856-1939) which focussed on a child's development and was further advanced through his clinical work with mental health patients. He developed a theory based on a description of psychosexual stages and if conflict occurred during these stages this could have major influence on behaviour. Another sociologist inspired by Freud was Eric Erickson (1959) who described eight stage theory of psychosocial development where Erikson assumes that a crisis occurs at each stage of development and are psychosocial in nature e.g. psycho social needs of the individual conflicting with the needs of society. According to Erickson, successful completion of each stage results in a healthy personality and the acquisition of basic virtues which are characteristics of strength that the ego can use to resolve subsequent crises. Nevertheless, a failure to successfully complete a stage results in a reduced ability to complete further stages, and therefore create a more unhealthy personality or sense of self-worth. (Fulcher and Scott 2011).

#### **4.4 Professional Socialisation**

The most current definition of professional socialisation in nursing is by Dinmohammadi *et al.* (2013) who undertook a concept analysis and defined the process as starting from the entry into nurse education and continuing through entry into the workforce. Dinmohammadi *et al.* (2013) describe professional socialisation as have four defining attributes; learning interaction, development and adaptation. The precedents of these attributes are described as

comprehensive orientation and educational programs, competent role models and adequate field experience. Dinmohammadi *et al.* (2013) describes socialisation as an integrated function of educational processes and workplace experiences and when done well, leads to a positive experience for the individual in relation to the acquisition of professional identity, ability to cope with professional roles and professional and organisational commitment. Undesired outcomes are usually formed from an improper management of socialisation experience leading to poor motivation, demoralisation and continuation of ritualistic practice. Prior to Dinmohammadi *et al.*'s. (2013) concept analysis, the impact and prevalence of professional socialisation and occupational socialisation in nursing has also been written about extensively (see Olesen and Whittaker 1968, Dingwell 1977, Melia 1984, Macleod-Clark *et al.* 1997, Jackson 2005, Gerrish 2000) and most agree that in order to be socialised into nursing individuals have to internalise the values and norms of the profession and its own behaviour and learn the concepts that are unique to the profession. Every nurse that enters the nursing profession has a fixed view on entry on what nursing will look like from a lay person's perspective, based on lay images and experiences. The lay perception is soon replaced by a more professional understanding within nursing schools and students' pre-set values are replaced with those of the profession. Individuals have to form a self-view as a member of nursing, shaped by their experience of being socialised from education into service. This socialisation is the result of interaction with a number of professionals who should facilitate effective communication and professional development for individual nurses (Lai and Lim 2012).

However, because the improvised construction of roles occurs not only in the world of education but in the world of employment, for nursing its historical development continues to cause tension in the role of socialisation between the two organisations. Conflict remains between socialisation into the profession through nurse education and socialisation into service within the clinical area, where values, beliefs and behaviours are reported as being in conflict with each other and this is often referenced as a 'theory practice gap' (Melia 1984, Macleod-Clark *et al.* 1997, Jackson 2005, Gerrish 2000, Allen 2001). It has been suggested that nursing reforms have reshaped the cultural tensions of the role making them even less

certain than before and nursing continue to be shaped by its origins. As a result, the meaning of the role has to be negotiated on a daily basis and it will be interesting therefore to explore how the forces of professional socialisation are inscribed onto the NC role and whether these create a tension between their clinical expertise and delivery of research (Allen 2001)

## **4.5 Conclusion**

This chapter firstly described the role of the expert practitioner and then provided a historical perspective of some of the challenges that nursing has faced with regards its socialisation from a vocation to a profession, the gender issues that have influenced its development and its internal struggle between academia and service and the impact of those discourses on the profession which remain relevant today. A broad overview of the theories of socialisation provided a broad brush view of the concept of socialisation from its inception. The professional concept of socialisation has been acknowledged as having a process and an outcome but is also complex and diverse for nursing where the structural constraints of the organisation are irreconcilable with the values of the nurse education. This chapter describes how the theory practice gap has the potential to inhibit whether research actually takes place, where roles may be negotiated and changed to suit the needs service rather than support the delivery of the research component of the NC role.

In the next chapter, I will describe how the research design for the study developed and provide an audit trail to the final version of the research proposal.

## CHAPTER FIVE: Research Design

This chapter will present the design aspects of the study starting with the methodology utilised before going on to discuss issues of method such as data collection and analysis, sampling strategy, access, research governance and ethics. Since the aim of my research question was to explore the experiences of NCs in relation to the development of the research component of their role and because of this, it seemed appropriate to understand their experiences through an interpretive research approach. As a novice researcher myself I sometimes struggled with the theoretical and philosophical aspects of the interpretive method, particularly when reading around the three main approaches of ethnography, phenomenology and grounded theory. Because of the sometimes incomprehensible epistemologies attached to these three approaches it was decided to take a more pragmatic position. As a candidate undertaking a Professional Doctorate it is important that my research has relevance to practice and has an outcome that will actually help NCs negotiate their role more effectively. The difference between a Professional Doctorate and a more traditional PhD route is that the outcome needs to feed back into the candidate's field of work and, hopefully, make tangible improvements, albeit in fairly localised terms. After discussions with my supervisor, a 'generic' interpretive methodology was chosen, that of Interpretive Description as proposed by Thorne *et al.* (1997).

### 5.1. Interpretive Description

Thorne *et al.* (1997) proposed interpretive description as an approach applied to qualitative inquiry into human health and illness experience, for the purpose of developing nursing knowledge. Interpretive Description, often referred to under the umbrella term 'generic research', was derived specifically for nursing research and was articulated by qualitative nursing scholars as a methodological approach relevant to applied health researchers questions. This approach has been used as a credible alternative to other philosophical tenants such as ethnography, phenomenology and grounded theory, all of which have their



origins in other fields. Ethnography with its roots set in cultural anthropology, phenomenology which is based on the 20<sup>th</sup> century philosophical traditions of both Edmund Husserl (descriptive) and Martin Heidegger (interpretive), where the researcher is interested in how the respondents give meaning to their experience and, in particular, how they perceive the world is based in the psychological domain. Grounded theory, where hypotheses and theories are generated out of or grounded in data, and has its origins set in sociology. It is because of this reliance on other philosophical approaches that Thorne and her colleagues advocated an alternative approach in order to address the challenge for qualitative nurse researchers, where they had to fit the objectives and methodological rules of other approaches to applied health and clinical problems. Thorne *et al.* (1997) were able to offer through the development of interpretive description, a pragmatic approach which would draw on evidence from clinical practice which was then translated back into the clinical setting in a way that a clinician would find sense of them (Kahlke 2014).

As qualitative inquiry has evolved there has been an increase in its refinement and application across health and social sciences and it has been argued that this methodology should stand alone and not have a definite allegiance to a specific philosophical stance (Patton 2002, Kahlke 2004, Smith and Becker 2008). However, increases in generic approaches in qualitative research have fuelled academic debate on its merits, where traditionalists argue there is no place for qualitative research that is not driven by a theoretical approach a view that has been both supported and challenged (Caelli *et al.* 2003, Kahlke 2014, Smith and Becker 2008, Reeves *et al.* 2008). Suggestions have been made that generic approaches are not specific methodologies but are simply methods of undertaking analysis (Braun and Clark 2006). These views seem persuasive at first but what the traditionalists fail to consider is the core skills required of a qualitative researcher, which is the process of grouping data into themes, a widely used analytic method in qualitative research. Thematic analysis and discussion form the foundation of the majority of theoretical approaches within interpretive research such as grounded theory and phenomenology. Interpretive description will also include thematic analysis as a process of generating meaning within the data and therefore in my view and others weakness the argument of the traditionalists (Holloway and Tordes 2003, Caelli *et al.* 2003, Kahlke 2004). Kahlke (2014) acknowledged the validity of concerns

raised within the literature regarding congruence in research design but also proposed that advocates of generic research had clearly demonstrated how creative thinking around methodologies to fit the researcher, the discipline and the question far outweighs the difficulties of conducting generic research. Another criticism levied at generic research is the belief that there is a lack of relevant literature describing how to do a generic qualitative research study well. However, two researchers Caelli *et al.* (2003), Kahlke (2014) offer a solution and guidance to this by proposing rigorous criteria for the design and evaluation of generic research and suggest ways in which the issues raised by critics may be reconciled. Caelli *et al.* (2003) describes the quality criteria of generic research under four headings; the researcher's theoretical positioning, distinguishing method and methodology, making explicit the approach to rigour and identifying the researchers' analytical lens. The first the theoretical positioning of the researcher refers to the researchers' motives, presuppositions and personal history that leads them towards a particular inquiry which does not include bracketing. As I reflect on my own research against this quality criteria, I have set out my theoretical positioning in chapter one where I describe what brought me to the topic of interest and the assumptions, personal and professional nursing history that underpinned my earlier thinking.

Caelli *et al.* (2003) also propose that when engaging in qualitative research, methodology must be clearly distinguished from method. This chapter provides the methodology as the theoretical framework which will guide how the research will proceed. The method for collection of data is described separately within this chapter and is congruent with the epistemological and ontological inferences of my chosen approach. Caelli and her colleagues suggest that for researchers wanting to conduct a generic study, investigators need to ensure rigor by adhering to principles that are congruent with the approach they are using. The analytical lens referred to by Caelli *et al.* (2003) relates to how the researcher engages with her/his data. Caelli and her colleagues proposed that the researcher's own assumptions must be clear as well as ensuring that the methods they choose are congruent with those assumptions. They recommend in thematic analysis that the researcher should show what meaning lies behind the themes and it is those meanings that need to be embedded into the theoretical and historical context of the research and the topic researched. These

recommendations are made clear within my research and analysis and findings within the next two chapters. Kahlke (2014) supports the concerns for rigorous and effective use of generic approaches by focusing on the researchers' ability to be reflexive in particular, defining the boundaries of the study. Recommendations are made that researchers should provide an audit trail so that editors and other researchers seeking to build on a particular research framework, have a clear picture of that framework and the decision making process of the researcher. Kahlke challenges Morse's (1989) view which was later supported by Thorne *et al.* (2004), that working outside of established methodologies is not safe for neophyte researchers. A counter argument to this claim is that novice researchers would be challenged by their supervisors to consider and debate different methodological approaches through discussion and wide reading (Kahlke 2014). I can relate to this view as within my own study I have researched and debated with my supervisor my thinking on the different methodological approaches and the scholarly conversations have facilitated my thinking around the methodological approach. The collaboration and conversation that happens during this process Kahlke argues are time honoured tools for developing rigorous research.

In summary, I have chosen interpretive description as my study aims to explore the experiences of the NCs in relation to the development of the research component of their role. The strengths of the interpretive descriptive approach in relation to my research question is its ability to capture themes and patterns through interviews with NCs on how the research component of their role has developed and to identify the barriers and facilitators that relate to the clinical area that are embedded within organisations. This will generate an interpretive description formed through an analytic inductive approach creating a better understanding of the phenomena and could have the potential to make recommendations for change. This information will inform clinical understanding of the research component of the role which would have value to nursing both clinically and nationally (Kahlke 2014).

## 5.2 Consideration of Data Collection Methods

When considering data collection method/s for the study, two qualitative approaches were explored: focus groups, and interviews. The thought processes that informed decisions about the selection of the most appropriate data collection methods are now discussed.

### 5.2.1 Focus Groups

Morgan (1997) suggests that focus groups enable the collection of data through group interaction on a topic determined by the researcher. Focus groups can serve as the primary means of collecting qualitative data. In a multi- method approach, focus groups typically add to data collection alongside other qualitative methods such as participant observation and individual interviews (Morgan 1997). Kitzinger (1994) acknowledged that the group is 'focused' in the sense that it involves some kind of collective activity - such as viewing a film, examining a single health message or simply debating a particular set of questions. The researcher has to make choices concerning the number and size of focus groups, and each focus group would involve the distinct role of a moderator responsible for facilitating effective inclusive interaction between participants and maintaining the topic focus. The advantages and disadvantages of focus groups were compared by Morgan (1997), who stated that the comparative advantage of focus groups was the researcher's ability to observe interaction around the topic area. Group discussions provide observational evidence of the participant's opinions and interactions. The downside of such group dynamics is that the group may stifle any deviation from group standards - inhibiting people from talking about certain things.

Differences between individuals within the group are equally important and, in any case, rarely disappear from view. Regardless of how they are selected, the research participants in any one group are never entirely homogenous. Participants do not just agree with each other, they also misunderstand one another, question one another, try to persuade each other of the justice of their own point of view and sometimes they vehemently disagree. During the course of the group the facilitator can explore such differences of opinion and encourage the participants to theorise about why such diversity exists (Kitzinger (1994 p 113).

This data collection method would have provided the opportunity to explore the diversity of the NC role with participants and develop a discussion around this. However, had I chosen this method for my data collection, there would be challenging practical inhibitors, such as geographical spread of participants, gathering together individuals at the pinnacle of their careers and committed to clinical duties. Thus, although relevant data may have been collected using focus groups, I took account of the feasibility issues and the analysis by Morgan (1997), and decided that focus groups were not appropriate for this study. Consequently, having discounted ethnography and focus groups, I explored qualitative interviews as a potential method of data collection.

### 5.2.2 Qualitative Interviews

Kvale (1983) defines the qualitative research interview as:

an interview, whose purpose is to gather descriptions of the life-world of the interviewee with respect to interpretation of the meaning of the described phenomena (p.174).

These descriptions can be collected in several ways (face to face interviews, focus groups, telephone interviews) with face-to-face interviews being the most common. In face-to-face interviews, the interviewer and interviewee directly react to what the other says resulting in spontaneous responses to questions asked (Opdenakker 2006). Body language and social cues also provide very important information sources. There are three main types of interview, structured, semi-structured and in depth. According to Ritchie and Lewis (2003), whichever type of interview type chosen, the interviewer requires:

- A clear logical mind
- An ability to listen
- A good memory
- Curiosity
- An ability to establish a good rapport and to empathise.

Structured interviews, as the term suggests, comprise the introduction of structured questions, with interviewers trained to ask questions in a standardised manner. Semi-structured interviews have a looser structure and comprise open ended questions that address the topic to be explored. In depth interviews are used when little is known about the topic and are, therefore, more exploratory in nature, often using questions such as ‘what is it like to...?’ They may cover only one or two issues but in much greater detail. Semi structured in depth interviews should be personal and in depth encounters in which open questions are used to stimulate in depth narratives (Dicocco–Bloom and Crabtree 2006)

One advantage of interviews is the potential depth of data collected. Morgan (1997) believes that individual interviews offer the opportunity for detailed insight due to the development of a close relationship between interviewer and participants. Interviews also allow the researcher to check that the respondent understands the questions being asked, initiate clarification if a response is not immediately clear and follow up/probe particular topics for further data of interest.

However, as with any other method, there are disadvantages that must be considered. Some individuals can feel more vulnerable providing answers to someone they might see as judging them, particularly in this instance where the researcher will be questioning NCs on the delivery of a certain aspect of their JD. Also, once again, the practicalities of this method are that it can be costly travelling to interviews if they are spread over a large geographical area.

Qualitative interviews appear to be the most effective method of acquiring in depth data regarding NCs and their role in relation to research in nursing. Qualitative interviews aim to go below the surface of the topic being discussed exploring the narrative and uncovering new areas and ideas not anticipated at the outset of the research. Although the sample would be potentially smaller using interviews rather than a questionnaire survey, the data obtained have the potential to be comparably more comprehensive. The qualitative nature of this data collection method would concentrate on individuals’ perceptions, experiences, personal insight and beliefs and, as the interviews would be semi-structured, more useful data would be generated regarding the research component of the role. I selected semi-structured rather than unstructured interviews as I wanted to follow a guide for asking questions that were

linked directly to the themes arising from the literature review which were role development, academic attainment and role clarity. I also wanted to allow for topical trajectories in the conversation that may stray from the guide as appropriate.

### 5.2.3 Telephone Interview

Like face-to-face interviews, telephone interviews allow some personal contact between the interviewer and the respondent. Relative benefits of telephone interviews have been cited by Shuy (2001) as greater cost efficiency and fast results and the convenience of the research in comparison with face to face interviews. Telephone interviews reduce the need to travel and offer more flexibility to interviewees than face-to-face interviews, usually taking place at a time agreed beforehand with the interviewee (Greenfield *et al.* 2000, Shuy 2001). The telephone interview is cited by Shuy as reducing the interviewer effect. However, it is also argued that it is difficult to assess the appropriateness of telephone interviews versus face to face interviewing in all potential contexts. The primary concern when comparing telephone and face-to-face interview modes is in the quality of the data collected. Relatively little has been written about using the telephone with qualitative interviewing. Creswell (1998) notes that use of a telephone does not allow the researcher to see the respondents' informal, nonverbal communication, but believes this method is appropriate when the researcher does not otherwise have access to the respondent.

Sturges (2004) described the results of a comparison of face-to-face interviewing with telephone interviewing in a qualitative study designed to explore visitors' and correctional officers' perceptions of visiting inmates in county jail. The original study design called for all the interviews to be face-to-face but the contingencies of fieldwork required an adaptation, and, consequently, half of the interviews were conducted by telephone. Comparison of interview transcripts by Sturges (2004) and other researchers (Greenfield *et al.* 2000) revealed no significant differences in responses from face-to-face and telephone interviews, and there was a general consensus that telephone interviews can be used productively in qualitative

research. Despite the limited evidence concerning the validity of this data collection method, telephone interviews have been cited as a credible interview technique that can capture views from participants difficult to attain due to geographical challenges (Shuy 2001).

Therefore, I concluded that telephone interviews would be the method used to collect data for this study, as it would provide access to NCs across a wide geographical area across the UK. The interviews would be transcribed and audio-taped, with participants' consent, to ensure none of the data would be missed during the interview process.

### **5.3 Negotiating Access**

To access an adequate sample of NCs by contacting their individual NHS Trusts, I would need to seek permission from an unmanageable amount of NHS Trust Research and Development Offices (R&D Offices) across the UK, as accessing nurses on site or through NHS email accounts for interviews would require NHS R&D approval and possible associated costs. With this in mind, it was decided that the research governance requirements could be overcome by accessing the NCs through a professional network, the Royal College of Nursing (RCN) NC forum website. This would eliminate the requirement for approval by NHS organisations but also ensure that Good Clinical Research Practice Guidelines had been adhered to (Clinical Research Training 2014). Other relevant professional websites across the UK would also be used to access the contact details of individual NCs e.g. NC forum in Wales. A lead individual on the RCN website NC forum was e-mailed to request permission and assistance in accessing this professional group, which elicited a positive response. Nationally, other lead NCs were approached in a similar way and asked to approach potential participants.



### **5.3.2 Ethical Approval**

The School of Nursing and Midwifery Studies (SONMS, now the School of Healthcare Sciences) Research Review and Ethics Screening Committee (RRESC) was approached for scientific review which was approved. Once reviewed by RRESC, as health service participants across the UK were to be approached, approval was sought from a multi research ethics committee (MREC). The South East Wales MREC was contacted by letter providing a copy of the protocol and other relevant documentation. Confirmation was required concerning whether ethical approval was necessary for this study, as previous experience suggests there was a varied response regarding studies that involved interviews with professional NHS staff and the need to obtain approval. Governance arrangements for research ethics committee guidance (GAFREC 2001) clearly states that if interviews were specific to exploring individual roles in their professional capacity, there was a requirement for ethical approval. The first enquiry elicited a request to reduce the size of the information provided from a full proposal to three A4 sides. The second submission submitted to SE Wales MREC confirmed that ethical approval for this study would not be required, as this proposal was regarded as a survey and therefore the study could proceed (appendix four).

### **5.3.3 Ethical Consideration**

A key methodological consideration of this research concerned the researcher being a nurse and researching other nurses. One advantage of my background/experience was that I had a grounded and comprehensive understanding of medical terminology and an understanding of what it was really like to develop a new role in a clinical area. This could have been perceived by participants as a positive factor and allow them to open up to a colleague who knows how challenging it could be to develop the research element within a nursing role. On the other hand, NCs could have felt threatened – feeling that the value of their role was being questioned and that information they gave may be used in a negative way. To address this, I reassured the NCs that they would not be judged on the development and impact on others regarding the research function of their role. The research component would be reviewed in the context of the overarching research question and not on individual achievements.

A disadvantage of internal knowledge of the role development is that I could have been too familiar with the potential challenges of developing the research component of this role. This could have clouded my ability to identify new themes evolving from the data and result in the analysis focusing only on the historic barriers to research saturating nursing literature. I ensured that the scribed notes and taped conversations were reviewed by another experienced colleague to ensure no themes were missed due to insider knowledge. This also lessened the impact of insider knowledge clouding the final data analysis by a nurse whose clinical links are limited. I have also acknowledged and reflected in chapter 1 my own preconceptions regarding the study.

The research was supervised by two academics in Cardiff University. All participants were required to give their written, informed consent before the study commenced. All data were anonymised to ensure confidentiality and privacy, and assurance was given that individuals would not be identifiable in any subsequent publications. Any possible disadvantages of participating in the study were fully explained. Participants received written information about the study and were informed that they were able to withdraw from the study at any time without giving a reason. There were no anticipated risks to participants or researchers. Data were stored safely and will be retained and, subsequently, correctly disposed of within University guidelines after completion of the study.

#### **5.4 Sample and Recruitment**

It was initially anticipated that data collected from interviewing 20 participants would provide a manageable amount of data and cover the range in sufficient depth within the resource constraints of the study. However I acknowledged that to achieve saturation of data, i.e. when no new information is being elicited, more participants may need to be recruited. My initial thoughts were that participants could be accessed through the Royal College of Nursing NC Forum (RCNCNF). Due to uncertainty concerning how NCs were appointed in the NHS, this was felt to be a sensible starting point. Once NCs were identified, I sent a flyer to their individual e-mail addresses outlining the proposed research with my contact details and inviting their participation. They were asked to make contact if they were interested in

participating, and to complete a consent form with their contact details. Due to the potential geographical spread of participants, the interviews were offered as telephone interviews at a time convenient to themselves. The RCNCF website was searched and the lead contact for the group identified and subsequently e-mailed to ask whether he could assist in recruitment for the study when that stage was reached. A positive response was received with an invitation to contact RCNCF when their assistance was required. However, when I approached the individual again a few months later, I discovered that he was no longer in post and there was no current contact for this group. I undertook another web search and identified an excellent web site established for NCs in Wales with all the NC contacts available on line. Unfortunately, there was no similar site available for the rest of the UK possibly because there were far less NCs in the other two devolved countries and too many in England.

Due to my unfamiliarity of the process of appointing NCs (e.g. whether they were appointed in secondary or primary care), I was initially unsure how to recruit my sample group. As part of my personal development, I met monthly with a professional doctorate student, who was also an R&D Manager and a nurse, within her place of work. I asked her how I could access NCs. I subsequently made contact with a NC locally who informed me that NCs were registered with Strategic Health Authorities (SHAs) and that the contact details of the SHAs could be accessed via the internet. I spent three days e-mailing relevant nurse leads, and telephoning them asking for support with the study. This was followed up with the nurse leads being sent copies of the invitation to take part in the study, my contact details and a consent form who all agreed to pass on the research details and invitation to take part to NCs. I e-mailed the 30 NCs in Wales via the web site. I also e-mailed the Chief Nurses in Scotland and Ireland to establish how they could make contact with NCs but received no response despite two follow up e-mails requesting the same information. I received 20 responses in total from NCs in England and Wales and arranged interviews with 13 of them in the first instance. All participants had been qualified/in post for at least one year, which was relevant in relation to the experience of the NCs involved as it has been suggested that that, during the first six months of practice, nurses are focused on learning their roles and the policies and procedures of the practice setting, rather than working autonomously (Benner 1984).

Out of 20 interviewees, 13 were selected using purposive sampling, a method involving recruitment of members of a pertinent group to ensure the broad range of experiences and characteristics inherent in these roles were captured in the research. Characteristics of the purposive sample were:

- NCs employed in primary or secondary NHS care
- Both male and female NCs
- No restriction on specialty group, but their specialty would not be revealed due to confidentiality issues.

#### 5.4.1 Table 3: Sample Characteristics.

<b>NC in order interviewed Pseudonyms are used to protect identity of participants</b>	<b>Gender</b>	<b>Highest Academic Qualifications</b>	<b>1 year+ post</b>	<b>in Publishe d</b>
<b>Alice</b>	<b>Female</b>	<b>MSc</b>	<b>1 year</b>	<b>Yes</b>
<b>Bethan</b>	<b>Female</b>	<b>MSc</b>	<b>Yes</b>	<b>Yes</b>
<b>Carl</b>	<b>Male</b>	<b>MSc</b>	<b>Yes</b>	<b>No</b>
<b>Dawn</b>	<b>Female</b>	<b>MSc</b>	<b>Yes</b>	<b>No</b>
<b>Elsa</b>	<b>Female</b>	<b>MSc</b>	<b>Yes</b>	<b>No</b>
<b>Frank</b>	<b>Male</b>	<b>MSc</b>	<b>Yes</b>	<b>No</b>
<b>Gabrielle</b>	<b>Female</b>	<b>MSc</b>	<b>Yes</b>	<b>No</b>
<b>Helen</b>	<b>Female</b>	<b>PhD</b>	<b>Yes</b>	<b>yes</b>
<b>Irene</b>	<b>Female</b>	<b>PhD (in progress)</b>	<b>Yes</b>	<b>No</b>
<b>Jacqui</b>	<b>Female</b>	<b>MSc</b>	<b>Yes</b>	<b>No</b>
<b>Kathleen</b>	<b>Female</b>	<b>PhD</b>	<b>Yes</b>	<b>No</b>
<b>Lauren</b>	<b>Female</b>	<b>MSc (in progress)</b>	<b>Yes</b>	<b>No</b>
<b>Melanie</b>	<b>Female</b>	<b>MSc</b>	<b>Yes</b>	<b>Yes</b>

#### 5.4.2 Data Collection: Interviews

A pilot interview was undertaken with a nursing colleague to ensure the quality of my interviewing techniques and to ensure that I was giving participants adequate time to think and respond to questions and that I was not asking leading questions. These interviewing

skills were different that my 'usual' communication skills I used as a clinical nurse, but there was familiarity with the importance of listening and I drew upon my existing skills to ensure the data arose from participants' accounts of their experience. The interview schedule was developed from the key findings of the literature review which were role development, academic attainment and role clarity regarding the research component of their role (appendix five).

The interviews were undertaken between October 2010 and January 2011 and lasted approximately one hour with each participant. I asked the participants if they had any objections to the interviews being tape recorded for accuracy purposes, all participants agreed to this. I also took detailed notes during the interview process which reduced the chance of losing important information. I took comprehensive notes during the interviews in addition to audio recording due to my fear of equipment failure. One initial disadvantage of taking notes while interviewing was that I occasionally felt distracted and not fully engaged in the narrative data provided by participants. However, my skills swiftly improved. At the end of each interview, I summarised the main themes of the interview with the participant and all agreed with and approved the data. I also presented data interpretations to the first three participants to verify the appropriateness of the findings, following the first three interviews. These were sent by e-mail as a word document as an integrated data set. I considered data saturation to have been achieved following the thirteenth interview.

#### **5.4.3 Challenge of telephone interviews.**

A challenge of using telephone interviews as a data collection method concerned technical difficulties that arose during the process. During one interview, the tape recorder failed to record and I only had my comprehensive notes to analyse. I also reflected that as I was conducting the interviews in a room sometimes used by others, it was important to ensure the room was booked out to me with a sign placed on the door to avoid unnecessary interruptions. However, on one occasion, the room was double-booked and after starting the interview, I had to stop when I was challenged about the room booking by an individual who entered the room. Within two minutes, I had clarified the booking. Although I apologised to the

participant for the interruption, I felt this interruption could have been perceived by the participant as unprofessional. I also had to purchase a headset (to use the telephone with the audio tape recorder), which allowed me to take notes and conduct the interview simultaneously. It took me a while to master these skills, particularly when adapting the equipment for use with different telephone styles and configurations. The weather during December 2010 (mid –way in the interview process) also influenced the recruitment process where the UK experienced heavy snow that caused one interview to be cancelled once by me and once by the participant. I tried to re-establish contact two weeks later by e-mailing and leaving telephone messages, but received no response. After three attempts, I felt it would be unethical to continue to try and make contact as it could have been perceived as harassing the participant.

## 5.5 Data Analysis

Data analysis was on-going from the time of the first interview. The data were examined by listening to the audio tape and revisiting the comprehensive notes collected by myself during the interview to ensure neither were lost in translation. I successfully applied to the Western Comprehensive Local Research Network (WCLRN) for funding to employ a transcriber to write up the audio taped interviews, a research officer who signed a confidentiality agreement. On receiving the transcribed data from the research officer, I listened to the audio taped interviews while reading the transcripts to ensure accuracy of content. This was a slow process, but necessary, as there were several misinterpretations of the data due to a lack of medical knowledge and understanding of regional accents by the research officer.

I did not feel that having someone else transcribe the data inhibited my immersion in the data due to the many hours I spent re-visiting the tapes and analysing data on the transcripts. I struggled at first with the analysis process and started to undertake a literature search to explore possible analysis methods. Transcripts were originally going to be themed for content and extensively coded, with a code assigned to emerging concepts if needed. A computer aided package e.g. NUDIST, was to be used to facilitate thematic analysis of the text, and allow the researcher to earmark segments of the text, apply tags or descriptive labels to the

segments and build up categories and themes of analysis. However, while acquiring knowledge from the literature on qualitative data analysis, I read an article by McCormack (2000a, 2000b) describing thematic analysis of data using a multiple lenses framework. This approach really interested me and seemed wholly appropriate for analysis of my data and identification of themes.

### 5.5.1 McCormack's Thematic Analysis

McCormack (2000a;2000b) developed a framework to facilitate researchers to understand what they do and where to begin after they have transcribed their interview tapes and described the process as looking at interview tapes through multiple lenses. These lenses were designated as active listening, narrative processes, language, context and moments. The researcher would then use the views highlighted by these lenses to write interpretative stories. McCormack defined these lenses as the dimensions people used to construct and reconstruct their identity and give meaning to their lives, therefore highlighting both the individuality and complexity of life. Dibley (2011) suggests that analysing data using McCormack's lenses aligns well with a phenomenological approach as it enables the researcher to make accessible to the reader the lived experiences of the research participants. Dibley (2011) also advocates that it supports the role of the researcher as an integral part of the research process and therefore provides transparency and as a result increases confidence in the findings.

McCormack (2000a and 2000b) acknowledged that the process described was not presented as a recipe whose steps are to be followed meticulously and in sequence rather, it is one approach researchers may wish to consider as they approach their transcripts. With that flexibility in mind, I used the research framework broadly to analyse transcribed data to identify themes. McCormack suggested that the traditional method of coding for themes in transcripts and studying those themes separated people's words from their spoken and heard context lost the individual's experience and the context of that experience. McCormack suggests that viewing the transcript through multiple lenses involves the following:

- Immersing oneself in the process through *active listening*;

- Identifying the *narrative processes* used by storyteller;
- Paying attention to the *language* of the text;
- Identifying *moments* in the text where something unexpected had happened;
- 

### ***Active Listening***

According to McCormack active listening involved the researcher listening to the tape several times asking themselves a number of questions. Those relevant to my data analysis included:

- What are the main events? Where/When do they occur?
- As a researcher, how am I positioned in this conversation?
- How am I responding emotionally and intellectually to this participant?

This was important according to McCormack as many months may have passed since the interview conversation occurred. Active listening enables the researcher to connect with the story, the storyteller and his or her reactions to these. I found this process incredibly invaluable in terms of reconnecting with the interview participants where some of the interviews had been undertaken three months previous.

### ***Narrative Processes***

McCormack (2000a and 2000b) described how during an interview process individuals or storytellers may become reflective or attempt to theorise their experience. Often the story teller will add information to the stories already told such as people, places or things in detail. McCormack argues that while these descriptions read alone offer little in the way of interpretation they do inform the listener by building a picture of the particular meanings the storyteller wishes to convey. The researcher then identifies those aspects of each story that constitutes the basis for interpretation mainly the abstract which summarises the point, the evaluation (highlighting the point and the orientation (who, what where and where). Next the researcher identifies the descriptions, argumentations, augmentations and theorising and asks is the participant reflecting, giving an opinion or trying to work out something (theorising) and what does this add to the story. Narrative processes are also described as relating to the



ways in which people use and structure words to tell stories, a hesitant and disjointed use of words will provide a different meaning and context to a story than free flowing conversation.

### ***Language***

McCormack (2000a, 2000b) suggests that central to the analysis of an interview script is language which is more than a method of communication but a tool for constructing reality.

McCormack states that:

As a social process, language functions to construct individual identity and social relationships between systems of knowledge and beliefs. Language helps the researcher see how the storyteller speaks about himself or herself, about the relationships in his or her life and about the environments in which his or her life has been lived (p287)

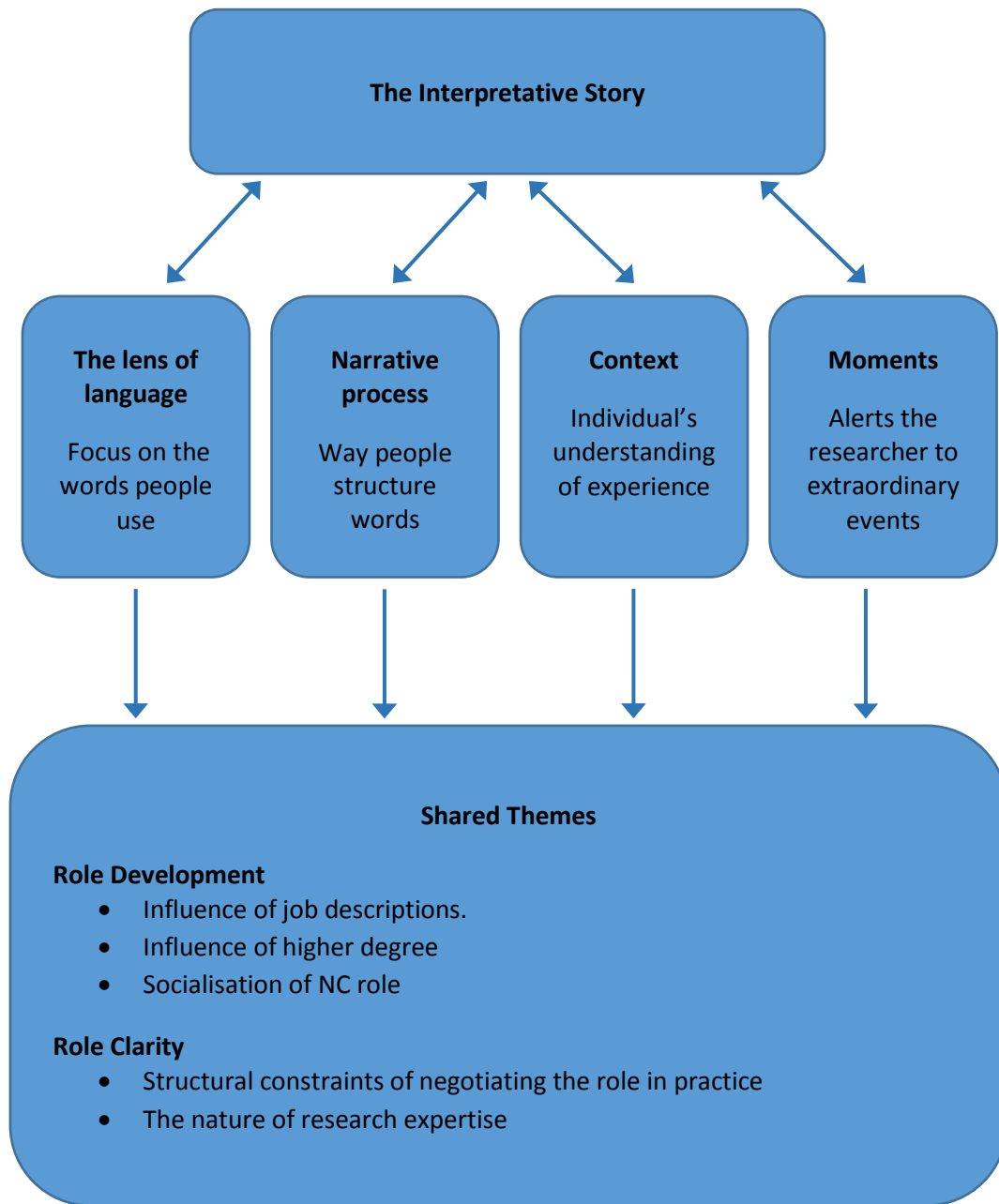
McCormack argues that this process allows the researcher to see how the storyteller speaks of themselves. The researcher should consider three language features, what is said, how it is said and what remains unsaid.

### ***Context***

McCormack (2000a and 2000b) suggests that stories are very rarely told in a vacuum and are simultaneously situated in a particular context and a wider cultural context. An individual's understanding of an experience is influenced by the context in which research takes place. In research the context is the interview and both the interviewer and interviewee and involves the autobiographical context each person brings to the interview or to put it more succinctly the personal context. McCormack also refers to the context of culture the social, political, cultural, historical and structural conditions of the wider society in which stories have been told. McCormack summarises by stating that using the multiple lenses the researcher can view more of life as constructed by each individual and reduce the distance between an individual's understanding of his or her life and the researchers' interpretations. McCormack suggests that one of the questions the researcher needs to ask is: What can I learn about our interaction from what is not said in the text? For example, does the participant ask me a

question without giving me time to respond? Where do I pause before asking a question or responding to a query? Are there places where I feel I could have responded but didn't?

Therefore, I analysed each individual interview applying all four lenses to each NCs data, which enabled me to review the experience as told by the story teller and as understood by myself as the researcher. McCormack's (2000a) multiple lens approach, focus for analysis, facilitated an understanding of the interview and storytelling process, and resulted in identification of themes.



In the next chapter I describe the themes that arose from the NCs stories as a result of my analysis and interpretation of the data.

## CHAPTER SIX: Findings

In this chapter I aim to demonstrate the way I used McCormack's Lens approach to analyse narrative data arising from the semi structured interviews with the NCs. In the first instance I provide the reader with two contrasting examples of how the data arose from the interview process. I also use tables to demonstrate how the two themes and five subordinate themes developed, showing different meanings in the interview stories and how they are interconnected. The two main themes were role development and role clarity with the five subordinate themes as described below.

### 1. Role Development

- a) The influence of the development of the job descriptions
- b) The influence of a higher degree
- c) The socialisation of NCs into the research role, from education through to the service setting

### 2. Role Clarity

- a) The structural constraints of negotiating the role in practice.
- b) The nature of research expertise "being research savvy".

In considering how to present my findings I decided the most appropriate method was to amalgamate the data and ongoing discussion, presenting the analysis both as an interpretive description and in a table format. This avoided any necessary repetition within the discussion.

### 6.1 Examples of Analysis of Narrative Data using McCormack's Lenses: A Comparison of Experiences (Bethan & Carl)

The following two extracts provide examples of how I used multiple lenses to identify the shared themes from two NCs data interviews. The two interviews are completely contrasting and aim to provide the reader with examples of interpretative stories and an alternative mode of analysing interview transcripts in order to identify shared themes. They also share with the reader my reflections and feelings on the journey during the interview process as a researcher.

McCormack suggests that it is important that the storytellers' voices also need to be heard and this is best achieved by presenting excerpts and using the researcher's voice as the narrator to explain what has been revealed.

Viewing interview transcripts through multiple lenses according to McCormack (2000a; 2000b), reveals both the individual nature of an individual's experience at a point *in* time and *over* time. Developing an interpretative story involves looking at those views through each of the lenses, writing up a story and reflecting this back to the participants. To ensure confirmability, I e-mailed the first two participants their full transcripts for accuracy and to ensure objectivity, that is that the interview transcripts reflected the experiences and ideas of the informants rather than my thoughts and preferences. As the interviews were semi-structured I felt that confirming the data collection method with two participants provided the confirmation of objectiveness of the interview process. I did not feel it necessary to repeat the process with all participants by e-mail but for all interviews on closing, I verbally summarised the interview responses and asked the participants to confirm they were correct in order to ensure reliability.

### 6.1.1 Interview with Bethan

For all the interviews I was very conscious that I was a nurse who had a strategic role in developing nursing research and employing research nurses. I had to be very aware that my thoughts and feelings did not influence the direction of the interview. For Bethan this was even more implicit, as I knew of this individual and their work but only had a limited preconception of how Bethan had achieved or developed that role. In narrating the story of how the role evolved, the language used by Bethan portrayed a **passionate commitment for the research** element of the role and this came across quite strongly throughout the interview. The language was **free flowing with little hesitation**. Bethan described how she **legitimised** the research component role through **the job description** and saw **the job description as an entitlement to develop research**. The **context** in which this happened was driven partly by the NC **commitment and passion for the specialty** and improving health outcomes for patients. **Language** was used that reflected the **commitment** and Bethan taken the **research**

**element of the role “very very seriously”** and it had resulted in conducting two research studies. Her passion for the specialty was **driven by an appointment in the clinical area and post registration courses and MSc degree**. Bethan was **socialised** into the research component of the role through a **“really good supervisor”** and the **context in which the research was facilitated** was also viewed as equally important by her. Bethan recognised that **research could not be undertaken in isolation** and the **role of the University** and funding for research enabled the research to reach fruition. The **language used by Bethan was very different** from many of the other nurses I interviewed where they regarded **the strategic direction of the research element of the role was not as important as the clinical strategy**. I explored the impact of the research aspect of the role and asked Bethan how she felt it had impacted on the consultant nurse service and other health professionals. Bethan stated that it had **impacted clinically, both locally and nationally** and **the importance of the leadership element of the role**. Negative language was only used to when alluding to the impact of the current **financial crisis affecting the NHS** and its potential impact on research development for nurses.

I then repeated the main themes of the interview for audit purposes and thanked Bethan for taking part. Bethan was also sent an e-mail copy of the interview for reliability purposes which was confirmed by her as being a correct and accurate account of the interview.

### **6.1.2 Interview with Carl**

The overall structure and delivery of language used during the interview with Carl was **hesitant and portrayed a negative picture** of the research development of the role. The **flow of the interview was also disjointed** and as a researcher I was finding it difficult to get Carl to engage and expand on the questions asked and therefore this was one of the shorter in time length interviews I had undertaken. When I asked Carl to describe **the research element of the job description** Carl appeared to view the job description as **pulling him many different ways** and described how in their **original job plan** they envisaged spending half a day a week doing research and education but it turned out to be much less than that one of them being **clinical practice takes precedence**. I had to be extremely careful as the researcher **not to**

**share my opinion at this point** where I felt half a day for both was unrealistic. Carl stated that the **NC role had become very strategic** which did not give them any time to commit to research, which **he appeared to apologise for**. Carl referred to the **strategic clinical demands of the role** and how they have **taken precedence** over the research element. In describing the context of how the research role has developed Carl recognised **failings in terms on their part of educational experience in research** which has inevitably affected personal interest. Carl **had not been socialised** into the research through nurse education and therefore the **lack of experience in research** was provided as a rationale as why it was not his driver for developing the research component. The **financial climate** was also described as a key factor to Carl's inability to commit to research where there was **lack of funding available within the University**. More importantly, **Carl's own motivation is also perceived as major factor** in terms of the research element of the role not developing. The research component of role was described as having **an active formal link to the University** where Carl was an honorary research assistant. However, **Carl viewed the role as less researcher** as this part of the role has graduated towards **curriculum planning** and described how that part of the role tended to generate ideas than undertaking primary research. Carl appeared to have a **moment of uncertainty and reflection** regarding the lack of delivery of this aspect of his role, he stated that he had gravitated **towards things he felt more comfortable with** when in fact it **he could have challenged himself and the people of XX University** to have more input into that process. There were **trailed off responses to my question about future development of the research** component of the NC role with silent spaces. **Negative language was used repeatedly** to describe how the **research component** of the role had worked out and could work out for the future due to public sector working and **lack of time** but also recognised lack of progression was also **partially due to lack of drive**.

I then repeated the main themes of the interview for audit purposes and thanked Carl for taking part.

The following findings are presented and discussed with the subordinate themes used as headings. Data extracts are used to support the reported findings, with the pseudonyms assigned to each of the NCs to provide anonymity and confidentiality of participants. Individual tables for each sub theme can be found in appendix six.

## 6.2. Role Development

### 6.2.1 Influence of the Development of the Job Descriptions.

The NCs in my research sample are professionals with legitimate research time written into their job descriptions but despite this, some reported that they felt research was the most challenging to develop. There appeared to be a link between the development of their job descriptions and the development of the research component of their role. The NCs whose job descriptions had been written and scrutinised independently appeared to be far more successful in developing the research element of their post than the NCs who were involved in writing their own Job descriptions, despite varying levels of clarity concerning the research element for most of the posts. This outcome seems linked to the fact that the former were appointed to posts where they met the criteria whereas the latter had Job descriptions crafted to fit their existing skills, which perhaps were not an exact fit with the formal requirements of the NC role. This links with earlier observations regarding the challenges with recruitment to NC posts across the UK due to a lack of nurses with the appropriate skills to deliver on all four components of the role (chapter2).

An example of where a job description was written independently was provided by Bethan. The research component of her role was written clearly and along a continuum of engagement. Since coming into post, Bethan had developed her research skills from novice researcher to Chief Investigator.

*“And then at that time consultant nurse posts were becoming available and a higher priority and the organisation put together a post and got sent off for scrutiny and the scrutiny panel accepted the post and it was advertised nationally and locally...there was a section specific to research...active participation in research from all angles really, not just involved in implementing research and EBP evaluating but actively involved in research as I remember rightly”* Bethan

Bethan relates to the importance of the job description and its scrutiny, which appeared to influence the legitimacy for Bethan taking time to develop and conduct research.

*“...research is a legitimate part of the role and the job description entitles nurse consultants to have dedicated time to do it, this makes it easier”* Bethan.



The following analysis provides examples of the relationship of the development of the job descriptions and the socialisation of NCs to the research component of their role. Data from the NCs suggest that all their job descriptions had been written without input from HEIs, with the exception of Frank who was affiliated to a University and played a major part in the development of the job description. However, despite the University access, Frank was also unsuccessful in conducting research. Due to a lack of research experience, Frank reverted to what felt comfortable, which was teaching at the University rather than trying to develop the research component of his role.

*“ I was put into a University as an Honorary Principal Lecturer, was not only to do academic teaching, but to have the access to the facilities around research...but then with different workloads and doing other processes, I haven't actually conducted research but have been active in conducting case studies” Frank.*

Most of the job descriptions had been developed by the NCs themselves or by service managers or Directors of Nursing.

*“Yeah I wrote the job description...I consulted with other nurse consultants. I had been looking for a couple of years to do this role, they might not have been so clear at the time but you had to have a Master's degree and the previous post holder didn't have a Master's degree...it was obviously a risk strategy to put that change in the role and then it went back to two or three national adverts although I had to write it...the XX obviously had to approve the post” Frank.*

*“I was fortunate to be able to be involved in what was writing what became my own job description...The guidance was a kind of blanket...this is what a consultant nurse/midwife role would look like...yeah, there were personalised bits to this really and what we did a lot of work on identifying what the focus of the role would be, but there was a board remit...it should say management in there somewhere, it was basically what the guidance said, quite a few nurse consultants were in that position at the time, and that was about the second wave of consultants,.... the tail-end of 2001” Elsa.*

*“it was written by a service manager at that time ...as I said, it was developed with me in mind...when my post was developed, I was in the 2<sup>nd</sup> wave and then went through approval with the disciplinary panel within the strategic health authority...the job description had a research component in it and the expectation was that you would be engaging or participating in research. I think at the time you could get away with just participating in research. But it might have been some project someone else was leading.....As long as you were engaged in research in some way then that would have ticked all the boxes” Gabrielle.*

*“At the time, the general manager with the head of nursing wrote the job description...well it was divided into four components of consultant nurse role...a huge component of audit, service evaluation and research...it said academic preparation, at least a MSc preferably working towards a PhD...The interpretation of this part of the role is probably the hardest component to fulfil”* Helen.

Most of the NCs felt that the research component of the role was either too vague or detailed with no preconceptions how management wanted them to deliver on it. The vagueness of the research component of the role may be linked to the organisation’s desire to appoint reactively to the posts to fit individuals, rather than to fit the national criteria for the NC role.

*“I was really unhappy with that. We all wrote the job description to almost fit the person, which I was very unhappy with, even though I was part of the interview process...the job description talks about research but it does not talk about how much...they had no preconceived ideas about what they wanted. They wanted a nurse consultant but they didn’t know anything else.. I am not saying that these individuals are not good at their job but they did not meet the requirements for the post at the time”* Irene.

*“X Director wrote the job description, not many posts for this specialty when I started here. I know they had approval by the XXX but a battle ensued by the director of nursing that they did not think that the role had enough clinical focus...University not involved in JD...the research element was not clear it was pretty weak”* Lauren.

*“Service design became the priority within the core functions. NHS re-designing, getting basics right within the role responsibility for staff...it also stated lead and develop research...I’ve only done bits of research for my Master’s”* Dawn.

It could be argued that if the individuals writing the job descriptions were not experienced in research, it would be challenging for them to describe the research component of the NC posts. They would also have little insight about what they could realistically expect in terms of research delivery/development from a post holder.

This was acknowledged by Allen and Lyne (2006):

*We would argue that in nursing we have a sphere of “proto-research” in which understanding the nature of activity, its demands and its deliverables is slightly distorted (p71)*

Those responsible for the development of the job descriptions disappeared to write job descriptions to fit the candidates so that the posts could be filled and the research component written with limited knowledge of the time necessary to deliver on all the criteria stipulated in the job description. With little or no input from HEIs, there was a lack of expert knowledge

and little understanding (if any) of what is deliverable in relation to the research component of the role. For example, Kathleen was asked to write the job description for a post she was subsequently encouraged to apply for. At that time Kathleen had not undertaken a PhD and only had limited experience of research development and delivery, so understanding the realities of research in practice and the skills required to deliver on this aspect of the role would have been limited.

*”Having worked with a lot of consultants, the medical consultants at the infirmary for quite a long time, people were encouraging me to apply for the post...I was interviewed by five people...interviewer from XX University, HR there was the Nurse Exec and there was a medical consultant and there was a Chief Executive from the organisation. And what I said at the time was that although I had done a small piece of research as part of my dissertation for my Master’s degree, I haven’t been involved with other team investigators, I was willing to do it...as part of an academic process” Kathleen.*

Despite this, Kathleen exemplifies how NCs have the potential to take a service challenge within their clinical specialty and develop this into a research question.

*“I think initially, it would have said research and audit, but there wasn’t a specific section around practice and service development, and I think when we got together as a group of consultants, we looked at what we were actually doing, to describe it, and actually what we were describing was this whole practice and service development and research and evaluation...it’s almost an action research thing, isn’t it really? You try and...you start with service development based around ideas. You take the inspiration, you take the lead and you help people to move the service forward...look at how it’s doing, and continually look at how it’s doing, and you can say that is audit, or you can say actually, well that’s, on a small scale, not necessarily contributing always to the wider debate, but it is...a research function as well. It is not called that though...I think some of the things that we do that might not be part of the research function are not necessarily identified as that.” Kathleen.*

Another example of unrealistic expectations of the research component of the NC role regarding the development of the job description was provided by Jacqui and Melanie.

*“It was the Head Nurse...the managing director...the directorate manager who wrote the JD...In the job summary it said “to have a leading role in the development of multi-professional research, provide educational research nationally and internationally by lecturing and through journal publication...to utilise and develop and evaluate the systematic approach for data collection” Jacqui.*

*“My Director of Nursing developed it and it was a very specific job description which I think said needed some research done....Ah it says taking the role in the development of multi-professional research....lead in the development and preparation of relevant research*

*proposals to attract both internal and external grants....to shape and evaluate systematic approach for data collection.....need and initiate R&D programmes that have an impact on Trust R&D objectives” Melanie.*

It is probable that the research components of the job descriptions described by Jacqui and Melanie would warrant a full time research post by individuals with vast experience in research and, therefore, these extracts from their job summaries appear a little ambitious. Jacqui did not say whether she thought the research component was ambitious or not but it was clear that she felt unable to deliver on all of the research role outlines but, conflictingly, referred to wanting a bigger research component, although this could have related to wanting more time to undertake research.

*“I’m obviously up-to-date with any clinical research that’s relevant to practice...I mentor quite a lot of nurses within the directorate who are doing degrees or degree level modules or masters and helping them understand about research and give them answers.....just that sort of thing...I am interested in research and if I had a bigger component and more direction, probably as to what was wanted of me, I would probably do more” Jacqui*

It is probable that, in this case, the Head Nurse/Directorate Manager needed to present the NC role as more than a specialist nurse role by demonstrating criteria in keeping with the higher level working of an expert practitioner. Unrealistic expectations of the research component of the role could inhibit any attempt by the job holder to start fulfilling the criteria – the challenge could seem immense, and without knowledge and experience of the research process, would be difficult to break down into more manageable chunks. Melanie talked about the split in delivering on the four components of the role and questioned whether, for her, the research component was the least developed.

*“Then 25% teaching and 25% research... I have held a leadership role within all components...I would say is research the one that is the least fulfilled?.... I do always have some research on the go, but I do not get funding for that, I am just part of a research team.. I do not take a lead in that”. Melanie*

Dawn stated that her job description was altered due to Agenda for Change. The word *research* altered to ‘*practice and service development*’, which were referred to as outcome indicators of the research component of the role. This is interesting as it leaves a whole range of options about how these are achieved, through implementing research, action research,

service improvement etc. This may be ambiguous perhaps, but from another perspective an opportunity to develop the role flexibly.

### 6.2.2 Influence of Higher Degree.

Most of the NCs had been educated to Master's level but although this educational level had prepared them to develop research skills, it had not prepared the majority of them to lead or produce their own research. Three NCs had been working towards doctorate level education, which they commenced after taking up their NC posts. Despite this, there was an expectation by authors of the job descriptions that NCs would be able to deliver the research component of the role in practice. There appeared to be a theory practice gap where expectation of the service did not align with the realities of the demands of the research process. The NCs suggested that, while an MSc may have made them more aware of the research process, research implementation was facilitated by mentors within clinical practice and practical research experience with researchers. This highlighted the importance to NCs of learning the research process from clinical practice, which seemed an important concept to the NCs.

*“having said that it is still very daunting nothing really prepares you, you just have to get hands on...it is only from actually conducting research that I have learnt on the job and also from other good mentors and experienced researchers” Bethan.*

*““Masters wasn't particularly clinical, it was more around ethics, critical thinking, except it did have a research module within it and I did do a dissertation...I felt I had a research module which was good in my Masters, but I think I got all my education through research working with the team in XXX Health and Related Research Unit” Melanie.*

Carl believed that the MSc facilitated a better understanding of the process but did not prepare them for the mechanics of actually doing research. The challenge of exploring funding opportunities or linking in with HEIs was cited as a barrier to their development of their research role and was too daunting to take forward without experienced help.

*“Partially some elements of the MSc helped towards it... but these courses do not prepare you for the mechanics of the process or trying to develop funding links with HEIs, these have only been partially developed” Carl.*

NCs who felt they were successful at developing the research element of their role had a research component to their MSc but they were also supported to develop research through strong research leadership in clinical practice, once again developing their skills from practice.

*“The previous places I worked in, we were involved in two studies....there was an onsite nurse consultant within the Trust and I worked closely with her as I was the onsite principal investigator” Alice.*

*“When I did my master’s degree, research was a core component of the course, there was a very robust module in the MSc that I did which helped me a lot plus I had a really good supervisor....”Bethan*

The interview data suggested that some of the Master’s programmes completed by the NCs were very clinically based, chosen due to the nature of their role, and the research element was undertaken through a dissertation and not by undertaking primary research.

*“A lot of them are doing extended literature reviews. I know that’s research sorry, don’t get me wrong...But what I can gather, up and down the country, they do not go off and do some research themselves. So my worry is that when they go off and do a PhD, they have never done a piece of research” Irene.*

Concerns were raised by the same NCs regarding the development of more literature based Master’s degrees for nurses, stating that these were not going to prepare or develop nurses to understand research in the future.

*“I think the difficulty largely, is that you know, whilst people are doing Masters, it is much more of a usual kind of thing now for people to do Masters...primary research isn’t really demanded any more at Master’s level. You know, you can get your Masters and go through your dissertation without even talking to a patient...whilst you’re required to learn about research, certainly locally and in other areas actually, then, you know, we are not necessarily requiring that people do primary research” Elsa.*

Kathleen, one of the NCs who had completed a PhD while newly appointed to the role, noted that being awarded a PhD does not result in being expert in research particularly, if the research skills acquired are not constantly used.

*“I think what’s challenging, if you undertake an element of research training, unless you are doing it all the time you are not an expert. So I don’t feel like an expert in research but I have some good grounding in it in order to make recommendations, but I certainly wouldn’t say that I am an expert in the process of research. I think it is like anything else you*

*know, when I was doing my PhD you learn what you need to learn to do the PhD and then unless you are doing it after that, you still have those basic skills but you have not developed them into an expert” Kathleen.*

Kathleen also stated that linking research to an academic process facilitated the development of research within their NC role:

*“although I had done a small piece of research as part of a dissertation for my MSc, I hadn’t actually been involved with other team investigators, I was willing to do it and if I was going to take part in research, I would want to do it as part of an academic process and therefore would probably want to do it as part of a PhD, as I have done” Kathleen.*

In comparison, Elsa suggested that an expert in research would be regarded as someone who had completed a PhD and being educated to post graduate level, which would enable NCs to strengthen the research component of their role.

*“It is quite clear that the research component role would be strengthened if we had PhDs. you know, it can be a desirable role, and...that is where the PhD comes in...I think it would, I think it would strengthen the research component of the role, but at the end of the day, it is a critical role. Whilst a nurse consultant with an academic background can support and facilitate research, I think that is probably about as much as you can expect for somebody who has got such a massive workload. Unfortunately, there isn’t protected time. One of the great things about not having done my PhD in the last, best part of 10 years, is that I have time to concentrate on my clinical work...although a lot of that work is about service development.” Elsa.*

Interestingly, Elsa also stated that *“unfortunately there isn’t protected time”* despite the research component being one of the key components of the job description. Only two nurses stated that the influence of higher education had helped because their masters were based on research programmes. Nevertheless one of the NCs stated that they did not enjoy the scrutiny of the MSc.

*“It was the MSc that prepared me most to embark on actually conducting research” Bethan.*

*“...my Masters did...I done it in a year, and it was a research project...then I went and did a research project, which was a qualitative piece, as part of my work for a Masters I quite like research but when I did my Masters I didn’t particularly like the scrutiny of it” Gabrielle.*

However, half of the NCs felt that nurse education and Masters degrees did not prepare them for the research component of their role. Regarded as experts in their clinical field, these NCs were aware that they were relative novices in relation to research.

*“Partially some elements of the Masters helped towards it. I don’t know in terms of developing primary research whether I have actually achieved this” Carl.*

*“I think I could manage to write a research proposal etc., but you don’t know until you are faced with it” Dawn.*

*“People doing research around me the language has changed quite a bit you know, it is quite likely that I do need to push on and do a PhD, I’ll need to go and do some research training” Elsa*

To summarise, the interview data suggest that these NCs were involved in research at some level in relation to their specific specialities. For example, Kathleen chaired a research and development committee providing peer review and governance assurance for studies, and Irene advised on research development, undertaking and initiating studies, establishing a research culture within her unit and developing the knowledge and practice of health care professionals to generate new solutions to best meet the needs of patients and clients. It was perhaps surprising, though, that NCs who had attained PhDs did not undertake research at the time of interview, suggesting that, just because NCs were educated to doctorate level, this did not necessarily mean that they were actively leading research studies. However, from the description of research engagement they were clearly playing a major part in leading research at quite senior levels along the research continuum (CFRE Allen and Lyne 2006). Of those NCs who completed a Master's degree, there were mixed views on whether this had supported and prepared them for the research component of the role. This appeared to be linked to whether the Masters was research based or not. The two NCs who were primary researchers acknowledged a link with the Masters but cited mentorship and practical experience as the facilitators.

### **6.2.3 Socialisation of NCs into the Research Aspect of their Role, from Education through to Service Setting.**

Irene was the only NC who alluded to the fact that there were now nurses coming through nurse training who were much more research aware as the training was now at degree level.



NC9 was the only NC to undertake pre-registration training at degree level. All the other NCs had trained within the hospital based schools of nursing. Irene stated:

*“One of the problems I had until I qualified was that we were degree nurses and at that time we were few and far between. Part of our training we were charged to go and challenge practice and we did use research to help. And some of the staff on the ward at that time really did not know what to do with us. They struggled with us. But now all of the nurses in training are much more aware of this practice. So whether the big change in training nurses has made a difference...it’s hard to tell if this has made a difference” Irene.*

Training pre 1990s was undertaken in hospital based schools of nursing, managed by Directors of Nurse Education who were accountable to the local authority. Training was practice-based and by means of a national examination, which had no academic currency (Allen and Lyne 2006). While I agree contemporary nurse training is more theory and policy based, the literature review suggests that the tension between the management and professional agendas remains endemic and far from aligned with each other, resulting in the professional/occupational divide as outlined in chapter 3.

Nevertheless, creating and developing an evidence based culture appears to be valued by all NCs in this study but more challenging in practice to deliver.

The four NCs in this study, who had actually managed to lead on research, taking part as a Principal Investigator (PI) or had published, had been nurtured and supported by Universities linked directly to their NHS Trusts. They also had strong research leaders within clinical practice or within the Universities to facilitate their success in relation to the development and implementation of the research component of their role. The experiences of this sample group suggest that NCs who are supported are more likely to undertake research than those who are left to “*get on with it*”. The following extracts are from those four NCs.

Alice was provided with an opportunity to develop her research skills and her enthusiasm to continue with research, by working alongside an influential leader in nursing research within Alice’s specialty. The influential nurse leader was leading as a PI on an academic study,

*“So I worked alongside XX for a period of time in London and she is the chair NC on XX forum...who is a nurse leader in this subject. Um, she’s very big, high “falooting” side of things”. Yeah. I think that was what probably inspired me more than anything, um to continue down that course of action. I then moved Trusts and quickly established links with*

*the University of XX and managed to get authorisation for the latest trial...it is multi-site, there are lots of different hospitals and communities, PCTs involved with the trial” Alice.*

The overall language used by NCs who had been involved in research and had published was positive and enthusiastic in comparison to the majority of NCs who had not. Alice’s narrative provided a good example of this where they spoke of funding invested by the Department of Health and it was this funding that had helped to develop research in their specialties. Narrative such as *“loved that completely”* was used by Alice to describe her involvement in research. This experience also enabled district nurses who worked with Alice to become socialised into the research process as the main recruiters, so also developing their research experience. The driver for Alice’s enthusiasm for research was the inspiring leadership qualities of another professional colleague who was regarded as a research champion in the NCs specialty in nursing.

*“It was new money that was available to promote XXX services keeping patient costs down and providing the most appropriate care close to home. So I worked alongside XXX for that period of time and xxxx is the National Chair on the xxxx forum and also a nurse leader in this area...I think that was what probably inspired me more than anything to continue” down that course of action (referring to research)” Alice*

Alice had managed to publish papers as a result of working with them, and it was this individual’s strong leadership that inspired Alice to continue to develop the research aspect of her NC post.

Bethan concluded that it was an experienced researcher who acted like a mentor that taught her skills in relation to research:

*“yes you cannot do research single handed and you cannot do research without funding or money so each time I applied for a grant and was successful with money I was able to recruit a research team with me, so on the first study I recruited a researcher with a very legitimate role - experienced researcher in xxx who was well published and very well known in the area of work with me, which was absolutely fantastic as she has been like a mentor to me in relation to research and has really taught me a lot. Then I also recruited two or three lecturers from xx to help us with the study. And then on the second study, the researcher I had worked with on the first study had moved to University of xxx as a reader in nursing, and because we had such a good relationship, we carried through and her and I worked together on the second study” Bethan.*

Bethan had not completed a PhD but appeared to succeed in the research aspect of the NC role, because she considered research to be a legitimate part of the role and took full advantage of the time allocated to do so, demonstrating that for some NCs with a positive drive, lack of educational preparation did not need to hold them back. This extract provides an example of how NCs view research as part of a continuum, which includes evaluating and auditing, and not as something only undertaken by academics:

*“Driver for it is that I am interested in this area of practice. I have been involved in developing all aspects of my service over the years and evaluating and auditing it but I had not really developed this area of service xxx and I had not really looked at it closely. If you like, it was one of the gaps I wanted to fill - that was my clinical and service driver for it. Research is a legitimate part of the role and the job description entitles NCs to have dedicated time to do it. I feel that I can balance my diary and my work to enable me to do research. As a NC, we have the facility to do it, it makes it easier- it is a legitimate part of our role and we can have some dedicated time to do it- it makes it easier”* Bethan.

Bethan spoke enthusiastically about how the research element of the role had changed practice:

*“The research that I have done has really changed practice by listening to the patient and their experiences of the service provided to them, I have been able to put together a list of recommendations of what is needed to happen.... I wrote a new protocol for XXX so that people who are taught XXX are only taught by a specialist nurse or a nurse who may not hold the title but had been trained and experienced in XXX....We have a much more robust follow up systems in place for patients”* Bethan

Irene described how they hand-picked the research champion to provide the support needed for them to develop the research development of the role

*“It was probably in the first two years the organisation didn’t really know where I fitted in. I was the first nurse consultant in the organisation and actually only up until this year we now have a consultant midwife...so the organisation didn’t know where I fitted in because I didn’t fit the management structure. The nurses on XXXX did not know what to do with me and thought I was some type of manager. A lot of time I would have to prove to people that I wasn’t out to performance manage or discipline them. So it took a long time just trying to get them to see me not as a threat but as an aid to produce. There were very good consultant anaesthetists and we had two new ones started...younger and more enthusiastic.....so you actually pick the research champions don’t you?”* Irene.

### **“Felt Much Better”**

Irene was undertaking a PhD at the time of her involvement in this research. She appeared to use the interview as an opportunity to vent frustrations about having to manage a clinical

workload, undertake a PhD and the reality of this fitting in with family. Irene explained that these commitments were juggled on a weekly basis as she had no job plan, something she had been asked to look at. Irene stated that she found it quite challenging to work on certain mornings on certain things because they all slip from one thing into another. The clinical element could take priority at any time and the research element was just slotted in. Irene acknowledged that this has moved on. Interestingly, she believed that research is not really welcomed by nurses, and a lot of time initially was spent trying to get other nurses to see her role not as a threat but an aid to produce.

*“Because you know, I had quite a rough ride earlier on. You know, I mean, lots of people with research that are not really welcomed by nurses particularly, you know you get the “Who does she think she is” kind of scenario going on...which I experienced...it seems, yeah, quite extreme importance to be honest and not really welcome by the colleagues either because they can’t quite make sense of it, you know, nurses that do it, you know, I will ask the nurse to call around. You don’t want a nurses around who are going to say, “Well, maybe that, you know, in my clinical opinion, I don’t really know what I’m going to do, I think we should be doing this instead... and all that sort of stuff.” Irene.*

Irene had nearly completed her PhD and stated initially that she would never want to be involved in research ever again, which could be expected perhaps after a long period of studying. Nevertheless, on further reflection, when asked how the research aspect of her role continuing to develop, she stated that after the PhD, she would continue to undertake work based research because she could see that it can make a difference. At the end of the interview, Irene conceded that she felt so much better airing her frustrations and feelings of guilt about not having the ability to provide the time she wanted to the research element of the role. She also stated that it re-enforced to her that she had actually succeeded, by nearly completing a PhD, changing a working environment to engage with research, supporting Masters’ students to publish and engaging clinical champions of research for her clinical specialty. Reflecting on the frustrations raised by Irene, it may be that being involved in this study encouraged Irene to reflect on the role, identifying what they had done well and where more effort and motivation was required. This may have been the first time Irene had reflected on, or tried to measure the impact of the role in some way. It also raises questions about the appraisal process for NCs if, as is likely, they are appraised by individuals (e.g. managers) who know nothing about the research component of the role. I, on the other hand

was someone who did and maybe Irene saw me as an individual who understood the realities of research in clinical practice and therefore used the opportunity to share her feelings regarding this.

Helen suggested that educational attainments and nursing experience were not the only skills required to deliver on this aspect of their role, and believed that NCs had to make their own opportunities.

*“I suppose it is more about me making sure I am in the right place at the right time, so it’s actually keeping control of that and looking for opportunities, you have to make opportunities for yourself, it’s more for things just to fall into your lap, so you have to put yourself forward for committees and that national work, and I am going to try and publish in the year...push and engage...but also look for opportunities locally undertaking some small pieces of research and making sure you keep up to date, look at things like the UK research network and just engage with researchers in academic institutes as well”* Helen.

*“I suppose the interpretation is that it is probably the hardest component to fulfil. Personally one I have been able to do through national work around research, award committees and advisory panels. I know it’s been quite difficult but it’s a question of having to push forward and engage with national pieces of work...and engage with researchers in academia. Its time isn’t it particularly the last few years, in XXXXX services, there are huge challenges from the national strategy to deliver on service elements and a lot of us tend to focus on that which tends to put research into the background...you have to work extra hard to make sure research doesn’t fall off the agenda completely”* Helen.

The context in which research was supported in practice was viewed as equally important, and these NCs recognised that research cannot be undertaken in isolation. With the aid of supportive mentors and strong leadership, some nurses were able to move along the continuum of research engagement, from advanced beginner on the first study to expert researcher by the latter. The socialisation literature for nursing tends to focus on the student population, but for these NCs, the key challenges as outlined in chapter X appears to have equal application to nurses entering a new domain of nursing such as research. The role of University funding and supervision has been the enabler for some research to develop. Nevertheless there was also a determination to succeed embedded in the language used by the four NCs who had been successful in developing a research role.

Melanie acknowledged that the main introduction to research was working alongside a team who were research active led by an enthusiastic medic. There were also two Professors who had contracts with the XX Centre for Health and Related Research.

*“I felt that I had a research module which was good in my masters, but I think I have got all my education through research and working with the team in XX. I think the link with the university was an essential component of the nurse consultant role. Um, two ways really, one is you are able to seek other research and look at the evidence you practice and also, the other part of it is taking the service and practice through research that you do. While my research is not within the A&E department, the results of the research have an impact on the way I work”* Melanie.

One of the NCs (Elsa) spoke positively of her experience of being involved in research that had facilitated critical thinking and empowered her to “*hold my own*” with other research active clinicians. The socialisation was described in the context of a team approach and related to evidence-based practice and contributing to the research agenda at national level.

*“We worked together as a team, Because of the national contacts that I have, I am currently president of the British Association of Nurses in XXX. We are looking at how to generate the nursing research agenda and we have a network of consultant XX nurses who are, you know, very easily able to contribute to the debate....It is quite liberating having those kind of opportunities um, to openly debate and discuss what people are doing and what’s going on elsewhere and use that and use other people’s experience as well as contributing our own to developing the service. And that impacts, not just at local level, but quite widely”* Elsa.

Despite not producing primary research, Elsa’s experience of research engagement enabled her to contribute to discussions on developing the service through EBP. Elsa also stated that undertaking research but retaining clinical links was the key to the connection to the real world of academia and clinical development and referred to it as a powerful combination of use. Interestingly reference was also made to the fact that, historically, nurses have not tended to undertake research because this had certainly been left to the “*professionals*”.

However, other NCs talked about making the time and creating opportunities. When asked how the research aspect of their role had directly impacted on the NC service or with other health professionals most NCs acknowledged different ways they had impacted with teams etc.

*“...it has shaped the way that the service has been developed within our area. We have also influenced the development for the services for example the faults of the service. We have also developed links between the services so they are more joined up now..I think you can influence other staff to make them more research aware so going to look at the evidence based on what they are doing”.* Melanie.

## 6.3 Role Clarity

### 6.3.1 The Structural Constraints of Negotiating the Role in Practice.

The professional mandate for the NC role claims that research will be a key component of the NC role. The reality is that the structural constraints of the work place and prioritising clinical practice have inhibited the development of the research component of the NC role.

The nature of some of the NC specialities meant the demands for their clinical work, which was originally only envisaged to be 50% of their role, was in reality nearer 75%. This meant that, although NCs talked positively about EBP and how they kept up to date through professional journals, other senior clinicians and national changes, the sheer volume of their clinical work and lack of research leadership through an experienced mentor hindered their ability to do more. Some NCs talked about the challenges they have in working out how research can be integrated into the clinical/service role without somehow biasing service demands. This is in contrast with other NCs within this sample who talked about research audit etc. as more blended within the role. Most of the NCs appeared to be struggling to find ways to integrate research, as they interpreted it from the job description, into the NC role.

The NCs mentioned the challenges arising from the national strategy concerning delivery of service elements of the post, with many of the NCs prioritising service delivery over research.

Carl was the least research active of the NCs and the overall structure of language used during the interview was hesitant and portrayed a very negative picture of the research element of the role. The flow of the interview was disjointed and I found it difficult to encourage the participant to engage and expand on the questions asked, and therefore this was one of the shorter interviews. Carl referred to being “*pulled lots of different ways*” and of research not being “my bag”.

*“In my original job plan I envisaged that I would be spending approximately ½ day a week, doing research and education but in fact it has turned out to be much less than that for a range of reasons one being that clinical practice takes precedence. I also have my Lead xxx role this can prove very demanding. The main strand of my role as a nurse consultant has quite a bit of variation in xxx across the board and this part of the role has become a very strategic strand to my job and that takes up quite a lot of time...so you are pulled lots of different ways. The Lead xxx Nurse Role, although it sits well with the nurse consultant role, it doesn't always give you the time you would like to commit to research I am afraid”.*

Carl stated that he was not experienced in research, did not consider himself to be “research savvy”, and that research was not something he was particularly interested in undertaking - He was, therefore, not driven to develop this aspect of his role.

*“And maybe that even though I have a Master's, it may be that I am not that experienced in research and therefore this is not my driver, not my bag. The development of the research component of my role has had the least attention for these reasons. It is also difficult to commit in this current financial climate to anything that doesn't reflect or impact on current practice. HEIs are also struggling...I must say none of these things have come to a full paper yet in fact I am thinking that it is really hard to follow that through completely, fruition of time and the senior lecturers' time. Anybody who works in public service these days are always pushed for time. Another issue is accessing funding and getting the time to write up a research proposal...I suppose I have gravitated towards things I feel more comfortable with when in fact it might be worth me challenging myself and the people of HEIs to have more input into that process. I really don't think this part of the job description has worked out well but this could be partially due to my own drive. I suppose I cannot blame them for that I need a little more motivation to do this. It is always on the second or third list of priorities” Carl.*

For the majority of NCs in this study, the clinical component of the role remained the priority and driver of their work, and the following narrative is used to illustrate different examples of this. Despite positivity regarding research development of the role, Alice felt that time was spread very thinly across multiple service areas, service development, service review and strategic direction and that there had been limited supervision to deliver on the research aspect of the role, which was mostly provided in an ad hoc way and through peer support.

*“it's tricky to match up research with your time spread so thinly in relation to service development and other things you need to do. However, what you can see from some of your evidence-based practice outcomes that research and evidence-based practice is starting to change things” Alice.*

*“My boss is a professor so the essence of what was in a JD was to actively undertake research which is why I said before why I went to a university and was put in as an Honorary principal lecturer, was not only to do academic teaching but to have access to research*



*facilities but then with different clinical workloads...I haven't actually conducted research but actually what I have done is I have been active in doing case studies...in quite a structured way" Frank.*

The following extract from Gabrielle exemplifies the challenges of the clinical demands of the role in practice and a view of research as something quite distinct from practice development and evaluation.

*"I think everybody does something completely differently. There are not many nurse consultants in this organisation...if you are looking at specific research projects rather than service evaluation type...development, ah, then, I would say, that is not something that is...given as much priority as it perhaps could be. We are surrounded at the moment NICE guidance hitting us...and so much of it is an audit function. Ah, and the organisational priorities...to look at the implementation of NICE Guidance and Audit, against the implementation of NICE Guidance...You get to look at service in terms of producing data for auditing against things like NICE Guidance, because that is a service priority, rather than what difference is this making to patients? I am caught up in the day-to-day mess of all those kind of things rather than trying to find specific time for research. One of the things we can do, I guess, is to press on, to get nurse consultants registered for and to doing their PhD to strengthen that component. I do almost feel, that it will be through the pressure of having to be an academic that will take that forward further. Rather like universities, I guess."*  
Gabrielle

In contrast, Elsa sees the connection between research and service development but realises the challenge of undertaking research as part of the role.

*"We know that, XX provides better outcomes for patients, so we can improve patient access to XX by just changing the way we follow up people and the way we contact them, then we may be able to change the long term outcomes for patients. So, you know it involves a lot of working right across the patient pathway and that...from before, when they are admitted to hospital or after they have been discharged from hospital, by working with primary care, pharmacists and so forth that we all have the right protocols in place in terms of how patients are managed. So much of my practice is about service evaluation...how do you find the manpower to randomise people to traditional follow-up or early follow up so you can compare outcomes. There are a hundred questions out there but you know if I could only find time to sit down and write them all down. I have my fingers in so many pies, it's so difficult. It's so difficult. I mean, if you, look at those components of the role, how do you define research as part of the role? You can say, ok, we're going to do a research study and we could turn service evaluation into a research study. But then it becomes, I don't know what really... Does it become more messy, because actually, if I were doing this as a research project, I wouldn't be able to see the patient for myself? so, how do you, use it as a research project, unless you start looking at services across say, the regions, and looking at comparisons between them? While a nurse consultant with an academic background can*

*support and facilitate research, I think this is probably as much as you can expect from somebody who has a massive workload” Elsa.*

Elsa, who had not led their own research study had critically thought about the challenges of delivering on the research aspect of the role. Elsa commented on the potential requirement for research practitioner roles, comparing this to the development of lecturer practitioner posts already in place, and questioned why similar research equivalents had not been developed. It is important to note the implicit reference by Elsa of combining research with all other elements of a clinical role.

*“My feeling is that we should be thinking about more is how we develop, we have lecturer-practitioner roles, why could we not have researcher practitioner roles?...I think that would strengthen it more if we got an identified body that would not be someone with their own caseload” Elsa.*

Elsa was clearly not aware that a new clinical academic career pathway for nurses, midwives and allied health professionals has been introduced in the UK with associated resources. Funding commenced in September 2009 to establish an education structure at four levels to support and sustain research careers in clinical practice (NIHR 2010). National Institute for Health Research (NIHR) Fellowships aim to support outstanding individuals to become the health research leaders of the future by buying out their salary costs, meeting their training and development costs and contributing to the research costs needed to complete an identified research project.

Melanie stated that the educational aspect of the role, e.g. teaching on university modules, had also been time-consuming, and had a detrimental effect on taking the research component forward.

*“the clinical and educational element, pulls so much of my time that I don’t have time to lead research, but that is something that may change in the future. With the demand on my time, I don’t think I am giving as much as I can to research at the moment. I think the next step is to start to look at leading my own research project but at the moment I don’t have time to do that” Melanie*

The descriptions of the NC role being clinically driven and adhering to national drivers, which management were keen to deliver on, inevitably left some of the NCs feeling as though they were unable to deliver on the research component of the role, even when they did have an infrastructure to support that.

*”My job plan is to do clinical work a minimum of 50%...and the reality of that is, I would say that 75% of my job is clinical. I have my own xxx clinics, my own surgeries...so exactly the same as my medical consultants colleagues’ work. And the patients they are referred directly from the GP...If I didn’t work more clinically...I could drive forward with research because we have got links here with an R&D department in the Trust and it is something I am interested in...but I would find it a difficult argument with management against bringing down targets like waiting times and things...so I don’t know the answer to that” Jacqui.*

Unrealistic expectations of aligning the two ideologies were reported as challenging and frustrating yet some of the NCs were clearly doing so.

*“The way I look at it, you have to juggle all the four components of the role on sort of a weekly basis, and I know some people had job plans, my role didn’t come with a job plan which is something I have been asked to look at. And I have actually found that difficult to work with, on certain mornings or afternoons you do certain things because they are all slipped from one part of the day to another part of the day. Also there is the clinical component...I have received the research part with everything else being juggled with everything on a weekly basis. I don’t know if this is right or wrong or I should have a dedicated day for research” Irene.*

Most NCs interviewed as part of this research were only able to evaluate their perceived impact in relation to the evidence based agenda for nursing rather than describing actual measures. Due to wide variation in their roles, there appeared to be little commonality in impacts in relation to the development of the research component of their role or how that is being measured, if at all. Only the NCs leading on primary research were able to articulate their impact.

This raises questions about how we define being a research expert or being research savvy. Does a NC have to be leading on primary research to fulfil this element of their role or does there need to be better definitions of expectations of this, and should one size necessarily fit all given the multifaceted nature of the NC role? (Guest *et al.*2004, Allen and Lyne 2004).

### **6.3.2 The nature of research expertise**

#### **“Being Research Savvy”?**

It seemed appropriate, therefore, to explore what “research savvy” meant in relation to this sample group. Allen and Lyne (2006) suggest that nurses in clinical settings are engaging in

research in different ways according to their particular role and at different levels within that mode, and provide a framework outlining nine modes of engagement required by individual nursing roles (chapter 3) The role of NCs and their engagement in research are evaluated next using the CFRE as a guide.

### Research Utiliser/Influencer

These two modes of engagement have been presented simultaneously because it was a challenge to separate the two in relation to the NC role as these are analytical categories and not role descriptors. These modes of engagement were the most common to the NC role. There were examples where NCs supported others to utilise research to inform practice and in doing so also influenced other professionals' socialisation into research. Allen and Lyne (2006) described the influencer as an individual who contributes to the focus of research experience and the utilizer as an individual who makes use of primary or secondary research directly or indirectly. The NCs' mode of research engagement appeared to combine the two. There was a definite acknowledgement that EBP was starting to change practice and although the NCs found articulating their role in this process challenging, they were definitely the conduits in driving this forward

*"I am still trying to get my head around the nurse consultant role because I have only been in post for a year and that is the period of time I have been implementing research. I am trying to look at service development and service change because I entered a post where there had been very little input in terms of service improvement and service development for my particular area...the research is great as I feel like we are developing capability and capacity for research within the district nursing team in a new and exciting area"* Alice

Frank, although not research active, referred to EBP and incorporating that into lectures

*"I am not actually doing research but I actually do incorporate research into my practice...I have been doing research from publications, from articles to underpin my lectures...the expectations where we have to write serious cases we incorporate research to underpin evidence our thinking. And that has definitely been the latest ones I have done in relation to the overview reports where I tried to bring research findings to support how we undertake practice....I guess trying to look at it in a new light of what does that research mean for practice and you know in relation to outcomes with XXX what are you doing to make a difference"* Frank

Helen and Lauren also describe their contribution to EBP, with Helen taking this a step further by supporting other research active nurses.

*“I always engage with physiotherapists and speech and language therapists, occupational therapists and as many disciplines as possible...If I see anything of interest I would share...we run quarterly multi-professional meetings so we have a spot on there for research we make sure we share papers or anybody who is engaged in research or you know a Masters or degree or undertaking a small research project we would share that and look for opportunities to support people, so...in a wide variety of ways”* Helen.

*“Focus on the latest research with what is proven to work and share information if early signs are that it has made a difference,... who are these patients, what are their experiences, you have to know what the latest research is”* Lauren.

Gabrielle was not actively leading on research but acted as a mentor to other nurses who were undertaking research modules and, therefore, was regarded as an expert by them.

*“I did quite a bit of mentoring, as well around, people, nurses in our organisation, and like I say, it is a big organisation, and my role is now Trust wide, so, I don’t just work in one team all day, community teams, got four in-patient areas and posts for the services we provide and lots of nurses....there are quite a lot of active researchers in our nursing...groups, historically, this has not been the case...nurses don’t tend to do research as certainly this is left for the professional...we have supported quite a lot nurses to go through degree level, including some people who trained some time ago. Our aim is that they will all be degree level educated. And, and we are pretty much there now. So...you know, that involves research modules and things like that. And then we actually encourage them afterwards to use those skills and be there, practice that and use their teams...so, I think that is a lot better than it was”* Gabrielle.

Elsa refers to the confusion over the research terminology but ultimately contributes to the debate about nursing research through her national work:

*“service development is almost like action research role that you look at a problem, you find a solution, you re-visit that problem.....the lines are sort of blurred but it has definitely affected other health professionals. Nursing, medical non -medical because of the way we look at patient pathways... I am a facilitator as opposed to a directive individual when it comes to service development and I work with the teams to offer solutions. I write about what nurses do in clinics, I write about secondary prevention present at national conferences”* Elsa.

Melanie’s role involved the development of an intervention for and facilitating recruitment to a clinical trial:

*“My role within the research team is developing an educational package and then developing that in each of the sites and then going out and working with paramedics delivering education....it is part of the research project and it is almost sort of helping to set up the research before the educational package is received...I am part of the trial team”* Melanie.

At the other end of the scale, Carl, who had previously indicated that research was “*not his bag*” had also impacted on the EBP agenda. Carl suggested that the projects he had been directly or indirectly involved with had helped to develop critical thinking around practice. The educational component of his role had enabled him to encourage other NCs to write for publication without him directly undertaking a lot of this work himself. He had helped other people who had never written before and had found the process extremely useful.

*“I suppose the projects I have been involved with have directly influenced practice.. I have definitely promoted CNSs to write for publication without necessarily doing a whole lot of work myself”* Carl.

Dawn supported this and suggested that she could not deliver or change things without research being engrained in clinical practice. The outcome of the research she had been involved with had informed the evidence based agenda for her specialty, had involved networking to share best practice with others at conferences and changed guidelines regarding clinical care. Other health care professionals had also been encouraged to participate in the process with guidance and support from Dawn and the research team, mostly concerning support to undertake small research projects for Master’s level study.

*“ I was lucky I had a GP specialist who was interested and an expert in service design so I tapped into this expertise which provided me with a focus for this role ...the role is just not about myself I also had to manage a team which is not familiar to other nurse consultants. We use research to underpin practice, looking at different research studies, using evidence-based practice to underpin clinical care...journal clubs and national guidelines. We also do comparison of services and write these up for journals. Couple of the team are undertaking masters so we make sure the services are there to support them”* Dawn.

### **Research Producer/Implementer**

*Research producer, one who conducts primary or secondary research, Research Implementer, implements research findings in their own practice (Allen and Lyne 2006)*

Alice appeared to fit the mode of research producer and implementer. Alice was not only implementing their own research but had also worked towards achieving the research aspect of the role by generating opportunities for research experience through facilitative practical teaching with clinical nurses in research, who had no previous experience of the research

process. The enthusiasm for the research aspect of the role was reflected in the following two examples in which Alice discussed the benefits of the research to the multidisciplinary team:

*“I did quite a bit of major research which looked at XXX pressure of those in fractured neck or femur and looked at protocols in place and looking at managing these patients and looking at whether or not if we implement the protocol the number of XXX pressure would reduce or whether we implement the new protocol, the number of XXX pressure would reduce”*

*“Yeah, yeah. Yeah, I mean things have moved massively within the last year since I have been in post and there have been huge changes and huge improvements in terms of that, so, one of the first things that I actually did when I came into post was to do a swapping audit of with varying chronic wound care which looked at XXX, outcomes of care for patients, patients suffering from XXX, we looked at all of those things when I came into post. Because I guess from my point of view we want to be able to measure that one year down the line and see just how far we come and we are just in the process now of repeating that audit um, to look at where we have come from and to in the last year. So until we get the results of that... but my gut feeling is that we have come a long way.”*

*“Um, we’ve have been working very, very closely with the XXX team since the last year and the relationship with the consultants has strengthened enormously, so, we are now I feel getting far better at care for patients so actually call me in at a consultation to , look at, with the rest of the multi-disciplinary team at the care of that patient and look at significantly that perhaps we can improve the outcome for some of the patients with diabetics and the consultant feels that things have progressed tremendously within this last year since I came into in to post, so, that’s quite, quite a good feeling really. We are developing capability and research within the district nursing team and this is a new and exciting area. Really, things have improved so much, um, but to have to quantify that is difficult that is why I am hoping that the results of this audit which we are just about to repeat, will show that, you know, we have, we have moved on.” Alice.*

Helen also appeared to fit the description of research producer and implementer where her PhD gave her credibility with her professional peers and her publications were directly linked to clinical services.

### Research Leader

*Allen and Lyne (2006) described these requirements as being demanded of research leaders at middle levels in the leadership continuum, the NC role was categorised within this group.*

Bethan was the only NC who seemed to fall into the category of a research leader at the time of interview. Bethan stated that research had impacted clinically, both locally and nationally and was an important component of the leadership element of the role. The domino effect of

the work by Bethan had been extremely positive and was now developing research at international level:

*“I think both locally and nationally it has been really good and it has been quite high profile research in my area of practice in my speciality. It has provided learning opportunities for my nurses who are clinical nurse specialists that I work with as part of my team. In fact on the first study, one of my xxx advisors was involved in interviewing patients, so she was able to gain experience in doing a qualitative research interview so it’s been really useful from that perspective, and also some of the learning I picked up along the way I have been able to share that with my team here and also when I present it and I talk about the Nurse consultant and the leadership element I have been able to demonstrate to nurses in my speciality across the UK that it can be done, it is not that difficult that it is actually doable. I have been able to talk them through the process I went through to enable me to do the research so they learn from the process that I went through. As a result of this research it was submitted for the nurse of the year award and I actually won it so again you know, I was able to present to Nurses on the national basis what I did, how I did it the process I went through in gaining the grant the way I recruited research participants and people at the university to work with me all that learning I have picked up along the way I have tried to share with other nurses as best I can”* Bethan.

Bethan had been able to talk the nursing teams within the specialism about the process that Bethan went through to undertake research to improve patient care and to demonstrate that it is achievable. Bethan was also able to present to nurses on a national basis what they did, the process they went through in gaining a grant, how they recruited participants and the people involved at the University to work with them and all the learning they had picked up on the way. Bethan felt it was extremely important to share the knowledge of their progression and the impact on the service with other nurses to encourage them to do the same.

*“yes the research that I have done has really changed practice by listening to the patient and their experiences of the service that was provided to them I have been able to put together a list of recommendations of what needs to happen”* Bethan.

As a result of her research, Bethan had developed a protocol recommending a complete revision of a service to improve patient care, and she anticipated that her research would continue at an international level.

*“one of the things I really want to do and I will try and fulfil, because I am a member of the international XXX society and other associations, develop a number of validation tools and one thing I wanted to come out of my list is an internationally validated tool so I intend to carry on and bring to fruition if I can and work with others such as XXX University who have*



*contacted me to take part in a study with them in a consultant role and will be recruiting sites around the UK and America and New Zealand so it will be quite a big study” Bethan.*

McCormack’s lenses has facilitated the interpretation of the NCs individual stories and has provided a framework to compare the themes arising across the stories and in my opinion is highly effective at enabling the researcher to preserve the truthfulness of the original story. Below is a table summarising the finding. More detailed summaries for each sub theme can be found in appendix six.

#### 6.4 Table 4. Summary of findings

Main Themes	Subordinate Themes	Findings
Role Development	1. The influence of the job descriptions	<p>Written by organisations to fit the skills of individuals applying rather than written for the research skills needed to deliver the research component of the role.</p> <p>Written without the involvement of a Higher Education Institute and mainly by individuals with limited research experience.</p>
	2. The influence of a higher degree.	<p>Post graduate education had an influence on the preparedness of NCs research knowledge, and for the majority of NCs the only research knowledge they were bringing to posts.</p> <p>Nevertheless, post graduate education did not prepare NCs for research delivery or development within clinical practice</p> <p>Nursing research mentorship in the clinical area or through links with academia were the key driver for success of research component of the role.</p> <p>Articulating their influence on evidence based practice agenda was a challenge for the majority.</p>
	3. The socialisation of NCs into the research role,	Influential leaders in nursing research available in clinical practice were the key drivers for

Main Themes	Subordinate Themes	Findings
	<p>from education to service setting.</p>	<p>success, but were opportunistic rather than structured from the outset of the posts.</p> <p>The research component of the role and the link with academia and clinical practice was regarded as a powerful combination, but unachievable for the majority.</p> <p>Research component not understood organisationally or by peers with the emphasis on clinical delivery, meeting targets was the measure of success for organisations.</p> <p>Demands of clinical practice meant role aspiration and lived reality quite different.</p> <p>No measures to performance manage the research component of the role or what that might look like.</p> <p>Acknowledged by NCs that they should make their own opportunities to develop the research component of the role but very challenging to do so without the infrastructure to support this.</p>
<p>Role Clarity</p>	<p>1. The structural constraints of negotiating the role in practice.</p>	<p>Unrealistic expectations of two different ideologies, theory practice gap between academia and clinical practice</p> <p>Priorities organisationally were for NCs to deliver on the clinical aspect of their role driven by targets, NICE guidance clinical demands of specialty.</p> <p>Support and facilitate research development was as much as can be expected with the huge demands of clinical workloads</p>
	<p>2. The nature of research expertise “ being research savvy” .</p>	<p>Using the CFRE (2004) most NCs in this study were categorised as research influencers with three as producers and one as a leader.</p>

Following on from the identification of the themes and subthemes, the next chapter will explore the themes in relation to the major findings of this study and compare these to the relevant literature and conceptual and theoretical frameworks as presented in previous chapters and discuss in detail the issues arising from them.

## **CHAPTER SEVEN: Discussion**

This chapter will attempt to theorise the research findings within the wider contexts of professional socialisation and expert practice which have underpinned this research study. As stated, there were two main themes within the data; role development and role clarity. Within these themes, there were a further five subordinate themes.

The three subordinate themes within role development and which emerged from the data which impacted on the development of the research aspect of the role were cited as: the influence of the job descriptions; the influence and impact of obtaining a higher degree; and the socialisation of NCs into the research element of the role from education to service setting.

### **7.1 Role development**

#### **7.1.1 Influence of job descriptions**

In chapter 1, I described how one of the advanced nursing roles developed with a specific research component within their job description, was that of the NC, a role that was introduced in 1999 by the Department of Health. The aim of the role was to strengthen nurse leadership while retaining expert practitioners within clinical areas. NCs were expected to not only lead a clinical service within a specific disease/speciality area, but to also use and engage in research to shape the clinical service to ensure better health outcomes for patients. Four components of the role were clearly defined, expert practice, leadership, research and teaching and, unlike other advanced nursing roles, because of these clearly defined domains, there was an expectation at a macro and meso level that this reduced the risk of them becoming just another 'new nursing title' (Manley 1997, Da Costa 2003). Following a brief review of available NCs job descriptions during my role as a Research and Development Co-ordinator, there appeared to be disparity in the requirements of delivering on the research domain and what this needed to look like. A proportion of the job descriptions set high expectations of the NC role, citing leading research at an international level whereas others were less ambitious only asking the NCs to lead on developing nursing skills in nursing

research and audit. The available literature, also described inconsistencies in role clarity compounded by the job descriptions where the four domains were not uniformly defined and in particular the research component unspecified (McIntosh and Tolson 2009).

This study's findings support both my original conclusions in 2001 and the cited literature; that there is a lack of clarity regarding the research component of the role within the job descriptions and how that role should be implemented in practice. This link between the development of the job descriptions and the development of the research component of the role was a key finding for this study. However, these results go a step further in that for some of the NCs the job descriptions appeared to be written by the organisations to fit the skills of the individuals applying rather than the research skills needed to deliver on all components of the role. It can be assumed that in 1999 there would not have been a vast pool of potential NCs who were experienced in delivering research in the way described by the DoH (1999b) given the nurse training at the time. Nationally today the academic picture of the nursing workforce in England is reported as having an inadequate number of nursing research leaders to lead the research agenda in nursing, so while progress has been made, the research agenda continues to remain a challenge. The research component of the job descriptions overall was vague, ambiguous or over ambitious and on reflection in my view were down to the fact that they were written without the input of a HEI. This would be compounded further if the individuals who were writing the job descriptions had very little experience of delivering research themselves which appeared to be the case for some of the participants. For the majority of these NCs this meant that they were totally reliant on making the connections with academia themselves or had to seek out research mentors within the clinical areas of which for some NCs were more successful than others and was reflected in the NCs stories as more opportunist than planned for most.

McSherry *et al.* (2007) suggestions of clarifying expectations at the outset of new NC posts has particular relevance in relation to the findings of this study where if the job description had been clear and the supportive links between clinical and academic links were in place the research component of the role could have had the potential to develop more successfully. Melia's (1984) theory regarding the segmentation of nursing was also relevant to this study as Melia suggested that the idealised professional version of NCs undertaking research, which is

aligned to academia, was organisationally impaired by the ideals of the decision makers within the clinical setting. Protected time for research was reflected by most of the NCs in this study as a challenge despite this being part of their expected duties within their job description. The NCs interpreted the research component of the role differently and without the socialisation to this domain within the clinical area, priorities of the clinical managers regarding delivering of the service became a priority. The development of the research component by nursing service without the input from academia supports Melia's (1987) argument regarding the segmentation of nursing and is evidence of the professional 'silo' which, she argues, shapes the nursing profession.

This study enhances previous literature where one of the critical success factors of the NC role is cited as having clarity around all four components in order that NCs can articulate and demonstrate to their organisations the benefits and added value of the NC role (Hourihane *et al.* 2012, Manley and Titchen 2012) The data demonstrates that lack of clarity and collaboration with academia regarding the development of the research component of the job descriptions links succinctly with the NCs being able to deliver on this component of their role. This is more specific than the broader findings of earlier literature which relates loosely to the four components and also provides a better understanding of why research is the first component to be dropped when there are competing priorities within the clinical area (Redwood *et al.* 2006, Abbott 2007, Gerrish *et al.* 2007, McIntosh and Tolson 2009).

### **7.1.2 Influence of a higher degree**

In chapter 2, I described the historical context of how globally advanced practitioner roles had developed. Following analysis of data from fourteen countries and three regions from five continents in relation to Advanced Nurse Practice, similar challenges existed in every nation and one of these were reported as educational standards. The literature described how the academic attainment of the NC had an influence on their ability to deliver on all four components of their role. (Charters *et al.* 2005, Graham and Wallace 2005, Woodward *et al.* 2005, Hoskins 2008, Jolin 2009, Mitchell *et al.* 2010, HIW 2011, Gerrish *et al.* 2011, Hourihane *et al.* 2012, Manley and Titchen 2012). For one author the educational

preparedness was reported as crucial in order to deliver the NC role and recommended Masters and above to include post graduate programmes dependent on specialty (Hoskins2008). The literature also suggested that those NCs with Masters qualifications perceived themselves to be more skilled to promote EBP than those without. In a chapter 3, I discussed how nursing research literacy has advanced considerably in terms of increasing Masters and Doctoral study (Allen and Lyne 2006, UKCRC 2007). I also described how several research training schemes had developed as a result of this with the expectation that those nurses with research training would more likely lead to research teams and projects.

All the NCs within this study were educated at Master's level or working towards a Master's education. Two had been educated to Doctoral level and one working towards a Doctoral qualification. Additional research training schemes had not been applied for by any of the NCs or indeed mentioned by NCs during the interviews. Nevertheless, in relation to their educational achievements the findings of this study mirror cited literature that NCs themselves felt that post graduate education has had an influence on their preparedness of research knowledge (Charters *et al.* 2005, Graham and Wallace 2005, Woodward *et al.* 2005, Hoskins 2008, Jolin 2009, Mitchell *et al.* 2010, HIW 2011, Gerrish *et al.* 2011, Hourihane *et al.* 2012, Manley and Titchen 2012). In addition to the literature, this study also demonstrates that for the majority of the NCs, post graduate education was the only research experience NCs were bringing to the posts and while research knowledge was viewed as important by the majority of the NCs in relation to understanding the research process, there was an acknowledgement by them all, that Masters Education and Doctoral Education did not prepare them for the mechanics of actually doing research within their clinical specialty.

Regarded as experts in their clinical field, these NCs were aware they were relative novices in relation to research. In comparison to previous literature, educational attainments were not the only influencing factor affecting NCs ability to deliver on the research component of the role. The key enabler for the delivery of research in its purist sense was described by the NCs who had performed a Principal Investigator role or Chief Investigator role as mentorship by research champions/leaders combined with links with HEIs. Education alone did not provide the NCs with the knowledge capability and expertise to deliver a research study in practice. Strong research leadership in clinical practice enabled those NCs who received it to develop

their research capability within the clinical area. This not only meant that research skills and knowledge were developed and embedded within service and supported by academia, but their research practice promoted research awareness in other health professionals within their specialty. For the remainder of the NCs within this study, articulating their influence on the evidence based practice agenda proved quite a challenge and while this study supports the findings of others that being educated to Masters Education was crucial to think critically, it was not the only intrinsic factor to achieving success in research. (Charters *et al.* 2005, Graham and Wallace 2005, Woodward *et al.* 2005, Hoskins 2008, Jolin 2009, Mitchell *et al.* 2010, HIW 2011, Gerrish *et al.* 2011, Hourihane *et al.* 2012, Manley and Titchen 2012).

### **7.1.3 The socialisation of NCs**

The literature suggests that socialisation into the nursing profession involves forming a self-view as a member of nursing, shaped by an individual experience of being socialised from education to service (Olesen and Whittaker 1968, Dingwell 1977, Melia 1984, Macleod-Clark *et al.* 1997, Gerrish 2000, Jackson 2005, Lai and Lim 2012, Dinmohammadi *et al.* 2013). However, the conflict between the socialisation of the profession into academia and socialisation into the clinical area remains so strong that nursing does not appear to have moved forward with the socialisation process. Melia's (1984) theory resonates with the findings of this study, where the structure of nurse training is suggested as being a historical compromise between service (occupational agenda) and education (professional agenda). The professional version of nursing being most credible, when it does not have to contend with the realities of the clinical setting. The service segment, where nurses are socialised into occupational tasks and getting the job done.

For the majority of the NCs in this study, the professional ideology for the role within the clinical area was one of a research active practitioner developing and implementing research findings (Department of Health [DoH] 1999a) which does not align with the service segment priorities which were focused on meeting the needs of leading and shaping a service. Without the input from academia during and after their appointment, the services needs took priority as that is where the NC role was socialised. As suggested in the literature, the majority of the



NCs time within this study was taken up with leadership and consultancy regarding the service rather than research and quality assurance (RCN/DH 2005, Fairley 2006, Ryan *et al.* 2006, Frank and Howarth 2012). For all the NCs in this study with the exception of one, their training had been undertaken in hospital based schools of nursing, managed by Directors of nurse education who were accountable to the local authority. Training was practice based and by means of a national examination, which had no academic currency. Therefore it is of no surprise that the findings of this study supports earlier literature that the research component of the role were perceived by NCs as one of the most challenging to achieve, with the role aspiration an lived reality quite different. (Charters *et al.* 2005, Dawson 2008, McIntosh and Tolson 2009, Hourihane *et al.* 2012, Franks and Howarth 2012, Franks 2014). Added to the challenge of the so called ‘theory practice gap’, is the relative newness of nursing research which meant that NCs in this study had not been socialised into the world of research and academia during their socialisation into the profession. In the clinical area research was not part of the socialisation process unless research mentors were sought by some or opportunities arose ad hoc.

The NCs main experience of research literacy in this study was developed at post graduate level through Masters Education and PhDs, with the latter providing the NCs with a better socialisation into research than the Masters. However, without the socialisation continuing within the clinical area by research mentors most of the NCs struggled to understand and develop the research component of their role. Lack of professional support and supervision was also cited in previous literature as the reason the research function was the first to be dropped when there were competing priorities (Redwood *et al.* 2007, Abbott 2007, McIntosh and Tolson 2009, Gerrish *et al.* 2011, Franks and Howarth 2012, Franks 2014). NCs within this study who had attained a PhD did not continue to undertake research at the time of the interview because of service level responsibilities and variation of time spent on the other domains. Conclusions can be made that doctoral education did not necessarily ensure research delivery or development from practice there were other factors that were reported as far more facilitative such as supervision, mentorship and research leadership.

However, the lack of scholarly activity meant the added value of the role was difficult to demonstrate amongst their peers as and on the organisations that employed them. These

findings support earlier literature, that lack of scholarly activity was viewed as a weakness by NCs and precluded the NC ability to demonstrate their impact with their employing organisations. (Frank and Howarth 2012, Gerrish *et al.* 2013, Frank 2014). It also strengthens previous recommendations that greater thought and commitment is needed to planning the socialisation of the NC role (Aitkenhead 2003, Guest *et al.* 2004, Charters *et al.* 2005, Dawson 2005, Mckenna *et al.* 2006, Woodward *et al.* 2006, Abbott 2007, McSherry 2007, Graham 2007, Dawson 2008, Gerrish 2011, Franks and Howarth 2012, Hourihane *et al.* 2012, Franks 2014). How to measure the impact of the research component of the role was difficult for the majority of the NCs to describe and the management to understand, as both appeared unsure what that needed to look like in most of the participants.

Creating and developing an evidence based culture was valued by all the NCs but cited as more challenging in practice to deliver. Those who were most able to describe what that looked like were those NCs who delivered research in the purist sense as a Chief Investigator/Principal Investigator (Alice, Bethan and Helen). These NC socialisation experience into the research component of the role was completely different to the other NCs within this study and reflected as being nurtured and supported by academia and within the clinical area through supervision and strong nurse research leaders. In contrast for the majority of NCs within this study, the socialisation into the clinical component of their role was a more positive experience.

Performance management by organisations of the value added of the NC role was against specific clinical targets, which were familiar to the NCs and their employees. All of the NCs bar Alice, Bethan and Helen constructed themselves within the service by reverting to the clinical world they had been socialised into and were familiar with and struggled to make links in order to be socialised into research world within academia. These findings correlate with the one of the socialisation theories of symbolic interactionism theory which supports the view that an individual's self is constructed through socialisation where an individual assumes the expectation and attitude of others within a group and the response they receive from others. All NCs within this study with the exception of Alice, Bethan and Helen, assumed the expectations of peers within the clinical area and focused on the clinical component of the role, which received a positive response from their employing organisations

and their peers. Whereas, the research component of the role was not part of the culture of the clinical teams, therefore NCs struggled to justify their time needed to develop research in its purist sense when there were competing clinical priorities. These findings also demonstrate the distinct difference in how the medical profession is socialised into the world of research. Progression in medicine is reliant on obtaining a doctoral qualification (MD). Therefore, medical students engage early in their courses with research, often working alongside a professor. Thus, research is normalised into practice through a medical school which is embedded in a University. Research development for medical students is supported and socialised through research leaders both within clinical practice and throughout academia.

However, in contrast to the other NCs, for Alice, and Bethan the opposite was true and they took an active decision to focus on other aspects of their role and their personal drive facilitated the development of the definition of research and how they found support to deliver on it. This mirrors the findings of Carters 2005, Woodward *et al.* 2005, Gerrish 2011, Hourihane *et al.* 2012, who concluded that the characteristics, interpersonal skills, drive and expertise of the post holder were equally important for the success of the role. An equal allowance was given to the research component as the other components of the job description and where there was none the NC sought mentorship from senior researchers. The findings of Bethan's research in particular had been recognised nationally and internationally, thus informing the development of nursing knowledge. The research process and outcome were shared with members of her team and changed the culture positively within her specialty group. The district nurses involved in the learning process were introduced to research methods related to clinical trials they previously had no experience in and were able to see for themselves how developing nursing knowledge can improve patient care, and how EBP is a tangible reality that is achievable.

## 7.2 Role Clarity

### 7.2.1 Structural constraints of negotiating the role in practice.

In chapter 2, I provided a summary of the NC profile as developed within England, Scotland, Wales and Northern Ireland at a specific point in time of the literature review. Conclusions

were made that despite the NC roles being underpinned by a set of national guidelines the NC roles were not uniformly translated into practice and were suggested to have been shaped to match the needs of their local population in relation to service demands. (Harker 2001, Coady 2003, Hayes and Harrison 2004, Hourihane *et al.* 2012). Reflecting on the development of the NC roles from a professional/clinical level, I could sense the logic in the way the roles were shaped by the service to meet the health demands of the population they served. Nevertheless, in relation to the research component of the role the RCN/DH (2005) suggested from their initial analysis that NCs diagnostic and organisational elements were the distinguishable elements of the NC role and that research only equated to 8% of their workload. Initial reviews of the NC role in Northern Ireland based on five NC appointments were that they had made numerous service improvements and clinical developments and there was potential for research to be embedded within this structure but it was very much work in progress (DHSSPSNI 2005). Similar, findings were suggested in my review of development of the NC role in Wales, but the recommendations for future development went a step further. Employing organisations were strongly recommended to consider the infrastructure to support these roles in relation to building research capacity in service provider organisations. Lack of supporting narrative available at that time within the literature, meant I was unable to capture whether these had been achieved (National Assembly 2008). The literature review suggested from an organisational perspective the roles had been poorly developed and set up and the findings from this study correlate with cited literature in that the strategic vision for the research component of the role for NC was not understood organisationally and the role aspiration and the lived reality were quite different (Charters *et al.* 2005, Dawson 2008, McIntosh and Tolson 2009, Hourihane *et al.* 2012, Franks and Howarth, Franks 2014). The service level responsibilities and the impact that had on NC ability to have time to undertake research was cited as a major barrier within this sample group with the original 50% of NCs time spent on clinical commitments an underestimation. These findings contradict the initial review of the first appointments within Northern Ireland where there was common agreement that a target of 50% direct contact as stated in the original circular as unrealistic if it was to be interpreted literally. However, this contradiction in findings need to be treated with caution as the NCs in Northern Ireland also acknowledged that the term direct patient contact was ambiguous and could be interpreted in a variety of ways.

In relation to the structural constraints of developing and negotiating the role in practice for this sample group there were common themes emerging that supported the conclusions within the literature, that the establishment of the roles were poorly implemented and greater thought and commitment moving forward was required (Aitkenhead 2003, Abbott 2007, Guest *et al.* 2004, Charters *et al.* 2005, Dawson 2005, McSherry *et al.* 2007, Dawson 2008). However, for most of the sample group even if the barriers with clinical commitments had been removed, in clinical practice no infrastructure was in place to support the delivery of the research component of the role, either through links or joint appointments with academia as you would expect for other professional clinical/academic roles. Even for those NCs who did delivered primary research, the research support appeared to be more opportunist than structured. The evidence was clear from the analysis of this study that the NCs specialties all differed in relation to their percentage of clinical time expected from each role. Combined with the lack of infrastructure support for academic development, on appointment clinical delivery remained the focus from management and this is where the value added for service was measured against. Being performance managed against clinical targets and expectations of the service was a priority which meant the research component appeared to be less important to deliver on for some NCs, especially where there were competing priorities and limited time. For the majority of this sample group, they struggled with the structural constraints of the work place prioritising clinical practice, adhering to national drivers (NICE guidance, DoH priorities), the preference of management and balancing that between struggling to understand what was meant by the research component and what they thought achieving this would look like. The reality of the demands of the job was consistently reported by participants as a challenge, with some of the NCs' clinical specialities appearing to influence the research development of the role more than others. With the demands of clinics absorbing most of their work time, it is not difficult to comprehend why research was not prioritised, because, even if they were supported by research champions, without recognition by management that research was part of their job plan, there would never be enough time within a working week to develop or deliver on the research. This raises the point that if these managers did not understand research enough to be able to provide clarity and realistic expectations on the job descriptions, why and how would they appreciate or recognise success even if the NCs had achieved to deliver on the research component. The NCs'

feelings regarding the power of management were similar to the findings from Mooney's (2007) study concerning prioritisation of a management agenda which resulted in NCs muddling through the research component.

Organisational support and lack of understanding by organisations and peers regarding the NC role were also some of the criticisms cited within the literature, and these correlated with the findings of this study. (Aitkenhead 2003, Mckenna *et al.* 2006, Abbott 2007, Graham 2007, Guest *et al.* 2004, Charters *et al.* 2005, Dawson 2005, McSherry *et al.* 2007, Dawson 2008, Franks and Howarth 2012, Franks 2014) However the irony is that the NCs who had delivered on the research component of the role had clearly made a bigger impact on improving the patient outcomes through research evidence for their relevant specialties at both an operational and strategic level. Therefore, if the NCs role had been a joint appointed with academia, the outcomes for the research delivery aspect of the role may have looked very different. For some of the NCs within this study the lack of clarity and understanding regarding the role by clinical colleagues was frustrating and meant that it took some time for some of the NCs to win hearts and minds as to the benefit of the role and for the role not to be seen as a threat. Priorities of management meant that clinical practice took precedence over the other components of the role and for some NCs, there was little or no time to step back, reflect on practice and think about what infrastructure was needed to facilitate the develop the research component of their role.

### **Nature of Expertise**

During my introduction to the NC role I described how NCs were appointed because of their clinical expertise within a specific specialty and in addition were required to have a triad of professional activity to achieve through practice, teaching and research. I also recommended that it was important to be able to describe the role of the expert practitioner and the skills and attributes that an "expert" possess in order that these were compared with the expertise of NCs in relation to the research element of their role. Benner's (1984) Stages of Clinical Competence was chosen as an analytical framework to facilitate understanding of the NC role.

Benner's (1984) Stages of Clinical Competence placed the emphasis on the acquisitions of skills of the nurse rather than their seniority as a nurse, which was common place within clinical areas in 1984. Benner's theory was grounded in clinical circumstance and described under five stages of clinical competence measured from clinical practice. The trajectory of skills ranged from a novice through five stages until they reach the expert phase where they make decision intuitively with a deep understanding of the clinical situation.

It is clear from this study that the NC role has been misunderstood and in particular to the expertise required to deliver the research component of the role and what that needed to look like. NCs are clinicians regarded by their peers as experts in their clinical field, who are expected to be educated to Masters/Doctorate level. They are, therefore, a highly educated nursing group with the added value of having expert knowledge of a particular disease type or clinical area. Nevertheless, although expert clinical practitioners, as defined by Benner (1984), within their clinical specialty, most NCs within this sample group were novices in relation to research experience. This is unsurprising perhaps, given their limited research experience at the time of appointment and the lack of mentorship by research champions to support them post recruitment. However, this study proposes that the definition of the expert nurse changed in 1999 with the development of the NC role where the expert nurse was viewed to incorporate a much broader expertise; one that was not just linked to the clinical area but to also include a research component to their role which on reflection should be aligned and embedded in academia in order for the role to succeed. Since the development of Benner's theory, nursing roles have evolved and the definition of 'expert' as developed by Benner is, in my view, no longer relevant for today's advanced practitioners.

However, despite the clinical emphasis of the theory, Benner alluded to the fact that nursing expertise could be influenced by developing theoretical knowledge linked to the practical base of nursing as new questions concerning patient care can derive from this source. Benner also suggested that nurses had been poor historically at documenting nursing practice and as a result the theory of nursing knowledge had inadequately developed. In Benner's view, the value of the expensive expert practitioner in quantifiable format was challenging given the naturalistic methods that have been used to articulate nursing. In relation to the findings of this study Benner's Stages of Clinical Competence, feels outdated if compared to what an

expert practitioner looks like today. Nevertheless, nursing's invisibility in relation to developing nursing knowledge from practice for the majority of clinical nurses and for the NCs within this study remains a challenge and supports Benner's earlier thinking around the potential barriers to the acceptance of nursing expertise. The findings of this study have found that producing primary research for this group of NCs has been particularly challenging without the academic links and mentorship.

### **7.3 Operationalising the Expert Practitioner in relation to the Research Component of the NC role**

The Department of Health (DoH 1999b) vision for research component of the role where the NC could generate new knowledge nationally and internationally and the reality of doing so has been scrutinised within the development of a conceptual framework and within the findings of this study. Previous cited literature and this study confirms we have a long way to go to ensure NC appointments are developed jointly with academia with a clear vision/job plan of the objectives of the research component of the role and with research mentorship in place within the clinical areas. However, Allen *et al.* (2004) suggested that the lack of clarity regarding the research function of diverse nursing roles could be resolved by using the Cardiff Framework for Research Engagement and suggested nine modes of research engagement to measure progress against for nurses (Allen *et al.* 2004). This work was informed by a working group of nurses with representation from academia and clinical nursing with an acknowledgement that the question of research engagement was so badly articulated in nursing, that there was a need to think systematically what that needed to look like and how that could be supported within the academic nursing school. The CFRE was used as a conceptual framework to analyse this study's findings and facilitate a description of which modes of engagement each individual NC in this study had achieved. The analysis of which of the modes of research had been achieved was determined by comparing the descriptions within the framework against the individual NCs interview data of how they reported their experience of research.

The exploration suggests that for the majority NCs ability to influence the culture of research in practice was their strength despite their lack of awareness of their role in this process. The evidence strongly suggests that the NCs were the conduits in driving the research agenda



forward and have the potential to provide the link between academia and clinical practice and support the evidence based practice agenda for nursing. Therefore, although most of the NCs were not producing primary research, this study has demonstrated that NCs have been involved with the research engagement at many other levels of the research continuum, as described in the CRF, an important finding in relation to thinking how the research component of the role can provide the added value within organisations. (Allen *et al.* 2004). Operationalising the research component of the role will be described in more detail within the next chapter

## 7.4 Thesis Findings

In conclusion following analysis of this study these are my thesis findings;

1. The unintended consequence of the development of the research component of the NC role is that it was set up to fail due to the mutual exclusivity of two different organisations, nursing academia and the nursing profession. By the nature of the way the profession is set up and socialised means it does not have a natural link with academia, the two systems are not naturally linked together and the socialisation processes are different for both
2. There has also been a misunderstanding about the sociological field of the profession of nursing, how nursing is perceived by nurses which does not include research and little attention had been paid to that when the posts were set up.
3. Expert practice is fluid and the definition is changing as nursing practice has evolved. The research component for the NC role should be clearly stated and defined in both areas of the profession and academia in order for the expert nature of the research component of the role be valued and measured.
4. CFRE (Allen *et al.*2004)) offers a framework to operationalise the research component of the role.

## Implications for NC Practice

Most NC within this study would agree that research is vital in providing the evidence needed to transform services and improve outcomes for patients. The governments continued commitment to support the work of the NIHR and other networks of specialists research facilities confirms a national commitment to research within the NHS (DH 2014). The implications of these findings for NCs are that in order to demonstrate added value, the research component needs to be operationalised, integrated and visible within their role. The final chapter offers an opportunity to describe how this is possible through implementation science and the emerging conceptual framework CFRE (Allen *et al.*2004) which could be used to operationalise this process. This framework would demonstrate NCs value of engaging in research to their employing organisations.

## Chapter Eight: Conclusion

This final, concluding chapter will address whether the research has answered the research question and the extent to which the research has modified or advanced theoretical knowledge about the study phenomenon. The study was undertaken because little was known about the development of the research component of the NC role, and it is important to reflect upon the difference this research has made. In chapter 1, I introduced the reader to the topic under investigation the role of the Nurse Consultant (NC) and its influence on the research agenda for nursing in the United Kingdom from a macro, meso and micro perspective. I also discussed how major changes to the nursing workforce have been shaped by the financial pressures on the health service and how my own nursing career pathway had been influenced within this political context. I also described my introduction to nursing research and the term

evidence-based practice, which I was not socialised into until 2001 during the completion of a BSc (hons) in Children's Nursing, almost two decades after I started my nurse training. The aim of this chapter was to set the scene to how new nursing research was when compared to other health professions, particularly medicine and aimed to set the context for understanding the challenges of NCs delivering on the research component of the role. In chapter 2, I presented the latest literature on how the NC role developed against a backdrop of practice and service modernisation, with the practice and service development linked to research and evaluation. The research component of the role was one of the domains designed to afford NCs the same status as medical consultants but equally importantly set them apart from other advanced practitioner nursing roles. Research, development and delivery embedded in clinical practice was viewed as key to determining the value of the NC role (DoH 1999b p.5). This has particular relevance in the political context of current health care delivery and its workforce, when financial constraints continue to dominate the health service agenda and every nursing post is scrutinised for its cost effectiveness and efficiency.

Indeed, this message was demonstrated at a recent meeting I attended locally for NCs who shared their vision with a Director of Nursing for the future of the NC role. Without demonstrating the value added of the role, suggestions were made that cheaper, alternative advanced practice roles could deliver the clinical expertise required at a senior level currently provided by NCs and that NCs needed to make their impact more visible. The Director of Nursing provided examples of exemplary NCs who were embedded in both the University setting and clinical care and where their research or research knowledge had a direct impact on improved patient outcomes for the clinical service. The Director of Nursing's concern was that NCs that have impacted in this way were, in actual fact, a rarity and that being the case, demonstrating the value added of these posts was challenging. For some NHS organisations that may mean they no longer consider re-appointing to these senior positions as the posts become vacant. The honesty of this message may have felt harsh for all of the NCs around the table, nevertheless it did start preliminary discussions on what the research component of the NC role needs to look like and how that could be made more visible. Therefore, the findings and recommendations associated with this study are important to inform and shape the debate of the value added of the NC role in relation to the research component of the role and what

this component of the role should look like in order to influence on the research agenda for nursing.

The national vision for the research component of the role within the United Kingdom, related to just that, that the NC role could develop new knowledge to help improve patient health outcomes and make improvements to clinical services (DoH 1999b p.5.) Enhancing the quality of care for patients was at the heart of the vision with research cited within the literature as the way NCs could demonstrate their impact under the semblance of organisational significance through generation of new knowledge (Gerrish *et al.* 2013). The NC role also offered nurses a career structure which meant they could combine teaching, research and clinical care without having to move away from the clinical area into an academic career pathway. However, the literature suggested that delivering on the research component of the role was the most challenging with little evidence provided as to what that role needs to look like (Charters *et al.* 2005, Dawson 2008, McIntosh and Tolson 2009, Hourihane *et al.* 2012, Franks and Howarth 2012, Franks 2014).).

The research component, in its purist sense, was discussed in chapter 3 but I also reminded the reader of the tensions that exist between the research agendas of the health service and higher education and, that while that research awareness had improved, nursing as a profession was still a long way from demonstrating the extent to which research evidence is realised in the clinical area (Allen and Lyne 2006). The Cardiff Framework for Research Engagement (CFRE Allen *et al.* 2004) offered an alternative view of how nurses engaged in various modes of research and how each of these presented their own challenges and these were discussed within the chapter when comparing my own findings. The CFRE (Allen *et al.* 2004), supported this study's findings and served as a reminder, of the impossibility for the majority of NCs actually doing research as a Principal Investigator and that it is naïve to think that the world of HEI and NHS organisations fit seamlessly for nursing. Chapter 4 was an opportunity to present two broad theoretical frameworks Benner's (1984) Stages of Clinical Competence and Socialisation theories. The findings of this study identifies that the definition of expert practice has changed as nursing practice has evolved and nursing expertise does not only relate to the clinical area. For NCs, while they could be regarded as experts as described by Benner in relation to their clinical competencies and intuitive

thinking, in relation to the research component of their role they would only be regarded as novices.

This study explores the nature of expertise required to deliver the research component of the role and proposes that the definition of expert practitioner as described by Benner has evolved since 1984 and needs revisiting to reflect the triad of activity that is expected of expert nurses today. The findings of this study were found to concur with the many theories of professional socialisation as described in chapter 4. In particular for nursing, was acknowledging that the socialisation process of two different organisations, nursing service and nursing academia have created their own challenges for the development of nursing research and remains endemic today. The socialisation of NCs to the research component of their role would appear to be a by-product of engrained historical tensions between two very different organisations who shape and influence nursing. In chapter 5, I described why I had chosen the ‘generic’ interpretive methodology of Interpretive Description as proposed by Thorne *et al.* (1997) and described my research design and governance approvals. I also introduced the reader to McCormack’s Lenses 2000a; 2000b which I used as a framework to analyse my data. Chapter 6 provided the reader with an audit trail of the analysis process using McCormack’s Lenses 2000a; 2000b and the themes that arose from the NC stories. . In chapter 7, I described my thesis findings which were;

1. The unintended consequence of the development of the research component of the NC role is that it was set up to fail due to the mutual exclusivity of two different organisations, nursing academia and the nursing profession. By the nature of the way the profession is set up and socialised means it does not have a natural link with academia, the two systems are not naturally linked together and the socialisation processes are different for both
2. There has also been a misunderstanding about the sociological field of the profession of nursing, how nursing is perceived by nurses which does not include research and little attention had been paid to that when the posts were set up.
3. Expert practice is fluid and the definition is changing as nursing practice has evolved. The research component for the NC role should be clearly stated and defined in both

areas of the profession and academia in order for the expert nature of the research component of the role be valued and measured.

4. CFRE ((Allen *et al.*2004)) offers a framework to operationalise the research component of the role.

## 8.1 Implications for Research Practice for NCs.

The overarching aim of this research was to focus on an exploration of the NC role and its influence on the research agenda for nursing. The Department of Health ([DoH] 1999a) set the commitment of retaining research within the clinical area, a commitment to research informing evidence-based practice in principle. Local policy makers were keen to deliver on this agenda for nursing but did not understand what the research component needed to look like and in doing so set NCs inadvertently to fail. Within organisations, the NCs realised that delivering the research component of the role was unrealistic and superseded by the demands within the clinical area. Service demands took priority and as one NC reflected, within the clinical area it would be very difficult to argue with management about bringing down waiting lists and targets in order to focus time on developing a research portfolio. It was clear from the analysis for this study that the NCs specialties were all individual in relation to their percentage of clinical time expected from each role. The job description provides the tool to negotiate the research component of the role in practice but it should not be a logical conclusion that if you get the job descriptions right that the job will flow from that, there needs to be organisational support for the development of the research component of the role in order to change population health outcomes by improving the quality of care agenda.

### 8.1.1 Recommendations:

#### **From Paper to Practice: Implementation Science**

The context of how research should be delivered has changed into something more convoluted and complex from when I started this academic study in 2006. The Health Service reflects the outside world, a world in which we are bombarded with information and

evidence. Much of this is often unsuitable, lacking quality and transparency and irrelevant to large sections of the Service. Key to managing this mountain of information are the specific skills in challenging evidence and the ability to make informed decisions regarding its suitability for use.

However, post Frances (Frances Enquiry 2010), and central to the debates that followed regarding the (lack of) quality of care, one of the positive outcomes was the development of nursing research which was considered as influencing the quality marker of care for patients. However, when viewed within the wider context several tensions are immediately apparent; furthermore, these tensions can be located within the socialisation and expert practice theory fields. Whilst the concept of nurses developing an evidence base to inform and continually improve care and, indeed, the role of the NC within this endeavour is an obvious recommendation a detailed examination of the barriers needs to be conducted. The media's reporting of the various scandals and the reports and campaigns by Camilla Cavendish, Julie Bailey and Anne Clwydd that have already been alluded to, have not been helpful. Indeed a common refrain appears to that of 'over-educating' nurses to the point that they are unable to actually care for patients, with Camilla Cavendish asking why it is necessary for nurses to have a University education (rather than 'learning on the job'). The assumption that higher education creates uncaring nurses who are too 'good' for basic tasks is, at the very least, disingenuous. Yet, it is a belief which is held by many in the general population, and since nurses are drawn from that general population, it is only natural that it is promulgated within the profession.

Certainly, in my own experience of training and practice, the belief that diplomas and degrees had some strange inverse correlation with being a 'good nurse'. Surely, nursing must be the only profession where a practitioner becomes worse at their job the more the study! This, for me, is the very site that the two theories of socialisation and expert practice meet. Expert practice is much more than formal 'tuition' and, as Benner (1984) asserts, the learned, intuitive aspects of practice are just as valuable. Cross (2003) suggests approximately 20% of learning is formal (such as classes, workshops and online events), while the remaining 80% of learning is informal (such as observing others, asking the person in the next cubicle, trial-

and-error, coaches, mentors and simply working with people ‘in the know’). Although the focus and investment of organisations may be centred on formal learning, it may be that informal learning is of equal, if not more, importance. Beliefs such as the described above (and promulgated by various commentators in the media) can have a hugely negative effect on practitioners who aspire to senior positions. The finding from this thesis suggest that there is a way to capture this site of tension and turn it into a positive opportunity. Expert practice cannot be separated from the forces of professional socialisation; the challenge is to ensure that the negative aspects are ‘filtered out’.

Dinmohammadi et al (2013) suggest that the desired outcomes of professional socialisation are the acquisition of a professional identity, ability to cope with professional roles, professional and organisational commitment (and thus improvement in the quality of care). Undesired outcomes may be low motivation and productivity, demoralization, and decreased care of patients. Negative forms of socialisation can also cause other undesired consequences, such as frequent turnover, continuance of ritualised practice and bureaucratic views, role ambiguities, lack of critical thinking, repeated dismissal requests, increased attrition, and gradual desensitisation about humanistic patients needs. Given that socialisation may have both positive and negative consequences, there is clearly benefit in understanding the factors that can influence professional socialisation in a nursing context in order to maximize the desired outcomes of socialisation and minimize the unintended or negative ones.

Where then can the NC be best placed to meet the multiple, if often poorly defined, expectations placed upon them? It is unrealistic to expect a NC to drive the research agenda as this is often politically motivated, with ever-changing priorities. Also, as already discussed, there is plenty of evidence already ‘out there’. It is here, that the challenge for NCs lies; to act as the conduit and develop advanced skills in the synthesis, transfer and implementation of the evidence. Tansella and Thornicroft (2009) have identified that this lag between publishing research findings and their implementation can take years. By which time the intervention or programme can be hopelessly out of date.



The field of implementation science is growing fast but is poorly understood and is specifically concerned with the users of research rather than the production of knowledge *per se* (Peters *et al.* 2013). Tansella and Thornicrofts (2009) editorial summarised what is known about accelerating the transfer of discoveries in health or the translation of evidence into practice. Three levels of implementation are suggested,

- Adoption in principle at a macro level where a commitment to EBP is acknowledged by service commissioners and providers.
- Locally at a meso level, where healthcare policy makers recognise the importance of EBP and set specific requirements for its adoption.
- Professionally at micro level, how far different disciplines give salience to the published reviews of peer reviewed trials. At this level of clinical encounter is where professionals can accelerate or retard engagement with EBP (Tansella and Thornicroft 2009).

One of the delays in knowledge transfer was acknowledged as being between the formulation of clinical guidelines following systematic review and the delivery of clinical practice. The literature suggest that guidelines continue to be underutilised and a variety of strategies to improve their use has been suboptimal. Guidelines are reported as being syntheses of best available evidence that supports decision making by clinicians but continues to be underused and passively distributed because of a lack of knowledge or of how users are to accommodate the recommendations (Gagliardi *et al.* 2011). The literature relating to implementation science acknowledged that the skills required to synthesis and implement best evidence was complex drawing together professional intuition, and analytical decisions, balanced against patient preference and clinical guidelines (Gagliardi *et al.* 2011). The importance of implementation science nevertheless is increasing where the focus is to promote the systematic uptake of clinical research findings and other evidence-based practices into routine practice to improve the quality of health care (Eccles *et al.* 2009).

This study has highlighted that the reality of NCs delivering research as a Principal Investigator or a Chief Investigator, unrealistic for the majority given the imbalance between the clinical and academic demands on the role and the lack of alignment between nursing service and academia. Clarity of what research needs to look like in order to be reported as a success for NCs remains challenging but unsurprising considering the historical context in how the roles were developed and set up. Analysis of this studies data using the CFRE (Allen *et al.*2004) strongly suggests that overall NCs are engaging in research in ways outlined within the CFRE (Allen *et al.*2004) but not necessarily in the way the DoH first envisaged as described in chapter two. Research utilisier/influencer were the two most common categorisation of the research component of the NC role when compared against the CFRE (Allen *et al.*2004). Research Leaders and producers were a minority and since taking up my position as a NC and having NC professional colleagues, I would argue reflects what is happening nationally within the NC role.

### **8.1.2 CFRE (Allen *et al.*2004)**

Nevertheless, this study has highlighted an emerging conceptual framework CFRE (Allen *et al.*2004) which could be used to operationalise this process. This framework could also be used to demonstrate NCs value of engaging in research to their employing organisations.

According to the CFRE (Allen *et al.*2004) at NC level there would be an expectation in relation to their research engagement that NCs would be able to synthesis research based evidence with information from a range of resources, these findings would then be implemented into practice. However, as the literature in chapter 3 and the findings of this study support, training would be needed to do deliver this level of research competency. The importance of developing the skills of interpreting research and synthesising and implementing evidence cannot be underestimated with a new and emerging science on the horizon driving this agenda and relates to implementation science. The CFRE (Allen *et al.*2004) suggests that NCs have a key role to play in this process by providing the conduit between nursing academia and clinical practice and understanding the challenges at both ends of those spectrums.

It is these particular niche research skills that could be developed further for the NC role to include synthesizing research and translating the findings into the clinical area. Synthesizing research based findings with information from a range of sources fits in with the NCs mandate and feeds into the evidence based practice agenda (Allen and Lyne 2006). NC have a key role to play in this process by providing the conduit between nursing academia and clinical practice and understanding the challenges at both ends of those spectrums.

I recommend the creation of the NC as an expert in “Implementation Science” so they act as the conduit between evidence and practice. NCs need to make connections with the CFRE (Allen *et al.* 2004) in order to establish their research competencies and development needs. NCs should be affiliated to a University where the terms of reference are to work with practitioner skills in research synthesis and transfer and to maximise opportunities for research development.

In order that NCs are able to operationalise the research component as recommended by Allen *et al.* (2004) both the NCs themselves and the employing organisations should have a clear agreement and plan of how this training is going to be supported (McSherry *et al.* 2007). By embedding the research component of the role within evidence -based practice, allows NCs to return to support EBP agenda in a format that would benefit not only the patients and the service they provide but understood by the clinical service who employs them.

I also see a window of opportunity, driven by revalidation and appraisal for NCs who are in practice to clarify and propose to their organisations what the expectations are for the research component of the role are in relation to implementation science and how this resource will be delivered and supported in the clinical area, through an affiliation with a HEI who can support the skills of research synthesis.

## **8.2 Suggestions for further research and further collaboration with academia.**

This study has produced understandings of how NCs contribute the evidence based agenda for nursing and the factors that facilitate and inhibit this role. To carry forward the work from this study, I intend to consider interactionist theories of the division of labour in relation to my data. These theories emphasise the negotiated qualities of roles and how the parameters of formal job description are shaped by the constraints of the work setting (Hughes 1984). In the case of the NCs, the structural constraints appear to have not been negotiated and therefore the clinical work carried out by the NC inhibited the research taking place.

I will also explore in more detail the emerging concept of implementation science and the theories, models and frameworks that inform that in order to gain a better understanding of how and why implementation succeeds or fails.

As a result of working with Cardiff University School of Healthcare Sciences during this period of academic study, I have become aware of Wales Centre for Evidenced-Based Care which promotes evidence-based practice through the development and evaluation of international systems for evidence appraisal, translation and utilisation. It is a collaborating centre of the Joanna Briggs Institute. I will be proposing that the NCs I currently work with and the Wales Centre for Evidenced-Based Care work collaboratively to explore the possibility of developing the skills of research synthesis, transferability and implementation science in order to support the delivery of the research component of our roles.

### **8.2.1 Limitations of the Study**

If I were to undertake this study again I would hope to recruit participants across a broader geographical area. Despite invitations being issued to England and all the devolved nations, the sample population were almost exclusively employed within the NHS in England, with the exception of one NC who was employed in Wales. Not having a wider geographical distribution of NCs means that the findings cannot be seen as representative of all NCs from the United Kingdom, but provide insight into the experience of these particular thirteen participants.

A second limitation is that while ‘generalising’ the findings is not possible in qualitative research, it also means that it is very difficult to make any type of prediction as to what the future of the NC actually can look like. A cross-sectional survey of all NCs in the UK would provide a picture of current roles and practices at a given point in time and allow for the analysis of a range of characteristics and variables. These data could inform the future development of this role within the nursing profession and establish what it really is that makes nurse consultants more than a ‘job title’.

Finally, triangulation could have been used as a powerful tool to strengthen the research design. By not relying on a single research approach I could have increased the reliability and validity of the findings.

### **8.2.2 Summary**

Exploration of the data within a theoretical framework has added to the body of knowledge concerning how, in clinical practice, NCs are socialised into the world of research and what support should be available to ensure NCs deliver on the research aspect of the role. Since the start of this thesis, there has been significant progress in relation to sustaining a positive research culture in nursing through the introduction of other clinical posts with research capability engrained in the job description (Giot 2013). There has also been a change in the emphasis of what is important in relation to research and optimising health professional’s ability to implement new knowledge is slowly becoming as important as being a PI or CI on a research study. Nevertheless, without the provision of sustained support in the clinical workplace and collaboration and support from academia, there is a risk that nurse posts where research is part of the job plan will fail. Key to the success of the research component of the NC role is socialisation into research in collaboration with both the clinical service and academia and currently for the majority of the NCs in my sample this remains varied and inconsistent. This study’s findings aim to inform the debate and thinking around the NC role and its contribution to the research agenda for nursing.

## Epilogue

When I started studying for a Professional Doctorate in Nursing, I had no idea of the depth I would learn about the subject I was investigating, what I would learn about myself and the collaborations this thesis would form with other people within academia and the clinical area.

I also did not anticipate that during this long period of study that I would change job roles within the health service several times and during the period of writing up the thesis I would be appointed a nurse consultant, the very role I was investigating. The findings therefore, have become even more relevant for myself and my professional peers where the debate on the added value of the NC role continues to roll on in constrained NHS budgets.

Studying at this level has taught me that occasionally there would be lows and highs along the way and you have to be prepared for both. The highs were when I received positive feedback from my supervisors, or the eureka moments while falling off to sleep where I discovered new ideas and concepts on my research journey. I kept a note pad by the bed throughout the 7 academic years in case I had new thoughts and ideas for developing individual chapters during the night which was often the case. I also gained much more confidence in my writing style and realise the importance of developing your argument, planning your time for reading and re-editing to achieve the standard required in doctoral study. One of the highs was a successful viva, which is I was informed by my supervisor as being just as important to be prepared for as your final thesis submission. Nevertheless, the need to re-write my thesis within 12 months was definitely an initial low post viva. The comments from the examining professors were overwhelming at first, but once I started working through each chapter, the value of these comments became ever more important to me. Since I have completed this process, I now feel I have a study I feel proud of and a clear plan moving forward of how the findings of this study will be used to develop the research component of the NC role through implementation science. These findings will in a small way support the delivery of the governments *five year forward view* (2014) where it is recognised that the time taken to translate findings into practice is far too slow.

I have also learned about my self is new found determination and tenacity that has carried me through the last year, where I re-wrote my thesis while looking after my ill father who has

sadly now passed away. You have to be prepared for writing your thesis during family crisis, holiday times and family celebrations and the long period of study has been spent doing just that. My laptop came everywhere with me so I could research, write and edit whenever I had a chance or opportunity to do so.

Finally I have to remind myself that the Professional Doctorate is an apprenticeship and that the collaborative work that will follow is equally as important and I look forward to continuing to work with Cardiff University to develop this work through my role as the NC working for the NIHR through the clinical research networks. These findings and proposed new ways of effecting change through implementation science will be presented locally by myself to the NC forum at the University Hospitals Bristol NHS Foundation Trust (UHBFT), this month. I am hopeful of an integrated approach between UHBFT and Cardiff University and will work collaboratively with Health Care Science Department to facilitate this process.

## References

- Abbot, S. (2007). Leadership across boundaries a qualitative study of the nurse consultant role in English primary care. *Journal of Nurse Management* 12(7), pp. 703-710.
- Abbot, P and Wallace, C. (1990) "Social work and nursing: a history", in P. Abbott and C. Wallace (eds) (1990) *The sociology of the caring professions*, London, Falmer Press.
- Aitkenhead, S. (2003). Role of the nurse consultant. *Nursing Times* [Online]. Available at: [www.nursingtimes.net/nursing...role-of-the-nurse-consultant.../19958/date accessed 08/02/2010](http://www.nursingtimes.net/nursing...role-of-the-nurse-consultant.../19958/date accessed 08/02/2010)
- Alderson, P. (1993). European charter of children's rights, *Bulletin of Medical Ethics* October, pp. 13-15.
- Allen, I. (2005). Women doctors and their careers; what now? *BMJ* Sep10; 331, pp. 569-572.
- Allen, D. (2001) *The changing shape of nursing practice: The role of nurses in the hospital division of labour*. London: Routledge.
- Allen, D. (2013). The sociology of care work, *Sociology of Health and Illness*, [Online] Available at: [http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1467-9566/homepage/virtual\\_special\\_issues.htm/date](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1467-9566/homepage/virtual_special_issues.htm/date) [Accessed: 06/10/2013].
- Allen, D and Lyne, P. (Eds) (2006). *The reality of nursing research: Politics, practices and Processes*. Oxford: Routledge.
- Allen, D., Lyne, P., Watkins, D., Taylor, S., and Gill, P. (2004) *The Cardiff Framework of Research Engagement*, Cardiff: University of Wales College of Medicine.
- Association of UK University Hospitals (2015) NMAHPs Clinical Academic careers development subgroup submission of evidence of the shape the caring review call for evidence 2014.
- Ashworth, P (2000). Nurse consultant: a role whose time has come. *Intensive and Critical Care Nursing* 16 (2), pp.61-62.
- Ashworth, P.D., Gerrish, K. and McMannus, M. (2001) 'Whither nursing: discourses underlying master's level performance in nursing' *Journal of Advanced Nursing* 34, pp621-8
- Bauman, Z., and May, T. (2001) *Thinking Sociologically (2<sup>nd</sup> ed)*. Wiley Blackwell Publishing
- Benner, P (1984). *From Novice to Expert. Excellence and Power in Clinical Nursing*. Menlo Park, CA: Addison –Wesley.
- Benner, P., Hooper-Kyriakidis, P., & Stannard, D. (1999). *Clinical wisdom and interventions in critical care: A thinking in action approach*. Philadelphia: W.B. Saunders.



- Benner, P., Tanner, C.A., & Chesla, C.A. (2009). *Expertise in nursing practice: Caring, clinical judgement and ethics* (2<sup>nd</sup> ed.). New York: Springer.
- Braun, V., Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* 3: pp77-101.
- Briggs, A. (1972) *Report of the Committee on Nursing*, London: HM Stationery Office
- Bradshaw, PL (2000). Labour's modernising agenda for the British National Health Service: some implications for the ballot box. *Journal of Nursing Management* 8 (3) pp.129-131.
- Butterworth, A., Jackson, C., Brown, E., Hessey, E., Fergusson, J., Orme, M. (2005) Clinical academic careers for educators and researchers in nursing. *Journal of Research in Nursing* 10, (1) pp 85-97
- Caelli, K., Ray, L., Mill, J. (2003) "Clear as Mud": Toward greater Clarity in Generic Qualitative Research, *International Journal of Qualitative Methods* 2 (2). Article 1. Retrieved [ 1<sup>st</sup> November 2015] from <http://www.ualberta.ca/~iiqm/backissues/pdf/caellietal.pdf>
- Carlson, N.R. (2005). *Psychology: the science of behaviour*, 3<sup>rd</sup> edition: Pearson
- Charters, S., Knigh, S., Currie, J., Davies-Gray, M., Ainsworth-Smith, M., Smith, S., and Crouch, R. (2005). Learning from the past to inform the future – A survey of nurse consultants in emergency care. *Accident and Emergency Nursing* 13(3), pp.186-193.
- Christensen, M., and Hewitt-Taylor, J. (2006). From expert to tasks, expert nurse practice redefined? *Journal of Clinical Nursing* 15(12) pp. 1531-1539.
- Clinical Research Training (2004) [Online] (<http://www.clinical-research-training.org/good-clinical-practice-guidelines>, Accessed 17<sup>th</sup> March 2014.
- Clothier Report. (1994) *The Allitt Inquiry: Independent Inquiry relating to the deaths and injuries in the Children's ward at Grantham and Kesleven General Hospital*: London: HMSO.
- CNMHP (2014) [Online] <http://www.wales.nhs.uk/sites3/page.cfm?orgid=890&pid=46354>, Accessed 3<sup>rd</sup> April 2014
- Coady, E. (2003). Role models. *Nursing Management* 10(2), pp.18-21.
- Coster S., Redfern S., Wilson-Barnett J., Evans A., Peccei, R. and Guest, D. (2006). Impact of the role of nurse, midwife and health visitor consultant. *Journal of Advanced Nursing* 55(3), pp. 352-363
- Cross J. (2003) *Informal learning: the other 80%*. Available online at <http://www.internettime.com/Learning/The%20Other%2080%25.htm> (accessed 8 January 2016).

Creswell, J.W. (1998). *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*. Thousand Oaks, CA: Sage.

Cross, E. (1987) Observations on Project 2000. *Radical Nurses News Letter*, Spring Issue, available from. 83 SouthView Road, Sheffield, South Yorkshire, England.

Cross J. (2003) *Informal learning: the other 80%*. Available online at <http://www.internettime.com/Learning/The%20Other%2080%25.htm> (accessed 8 January 2016).

Collins English Dictionary (2000) *21<sup>st</sup> century Edition*, Harper Collins Ltd: London

Cullum, N., Ciliska, D., Haynes, B., and Marks, S. (2007). *Evidence Based Nursing- An Introduction* (ed). London: Blackwell Publishing RCN .

Cullum, N., McCaughan, D., Mulhall, A., Thompson, C., and Thompson D. (2000). Nurses use of research information in clinical decision making: A descriptive and analytical study: A report presented to the NHS R&D Programme in Evaluating Methods to promote the implementation of R&D.

Da Costa, S (2003). Setting up a nurse consultant post: an organisational perspective, *Journal of Diabetes Nursing* (7) pp. 254-256.

Daily Mail Colomist (2007) Dirty wards: Feminism and the Tragic end of Florence Nightingale's Ethos of Patient Care. *Daily Mail* [online] Available at <http://www.dailymail.co.uk/columnists/article-487632/Dirty-wards-feminism-tragic-end-Florence-Nightingales-ethos-patient-care.html> (Accessed: 8/5/2015)

Darbyshire, P. (1994). Skilled expert practice: is it all in the mind? A response to English's critique of Benner's novice to expert model. *Journal of Advanced Nursing* 19 (4) pp.755-761.

Davies, C. (1995) *Gender and the Professional Predicament in Nursing*, Philadelphia, USA.

Davies, C and Rosser, J. (1986) *Process of Discrimination*. Department of Health and Social Security . London.

Dawson, D., and McEwan, A. (2005) A critical care without walls: the role of the nurse consultant in critical care, *Intensive and Critical Care Nursing* (21): pp334-343

Dawson, D and Farnell, S. (2006). It's not like the wards: experiences of nurses new to critical care. *International Journal of Nursing Studies* (45) 3, pp. 319-331.

Dawson, D. (2008). The Current role of the consultant nurse in critical care: consolidation or consternation? *Intensive & Critical Care Nursing* 24(3), pp. 187-96.

DHSS (1983) Inquiry into NHS Management (The Griffiths Report) London: DHSS

Department of Health (1991) *Research for Health. A Research and Development Strategy for the NHS*, London: Department of Health

Department of Health (1994) *The Report of the Task Group on the Strategy for Nursing, Midwifery and Health Visiting*. London: DoH

Department of Health (1994) *The challenges for nursing and midwifery in the 21st century*(The Heathrow Debate). DoH, London.

Department of Health (1998). *A first class service: quality in the new NHS*. London: DoH.

Department of Health (1990) *National Health Service and Community Care Act*. London: The Stationery Office.

Department of Health. (1999a). *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare*. London: The Stationery Office.

Department of Health (1999b). *Nurse, Midwives and Health Visitor Consultants: Establishing Posts and Making Appointments*. Health Service Circular 217. NHS Executive, London.

Department of Health (2000a). *The NHS Plan. A plan for investment, A plan for Reform* London : The Stationary Office

Department of Health (2001) *Governance arrangements for research ethics committees*, London: The Stationary Office.

Department of Health (2003a) *Developing Key Roles for Nurses*, London: The Stationery Office

Department of Health (2003b) *NHS Pay Modernisation Agenda in England: Agenda for Change*, London: The Stationery Office

Department of Health, Social Services and Public Safety (2005), *Review of the Nurse Consultant Role*, Belfast: DHSSPS.

Department of Health, Social Services and Public Safety (2005) *Realising the Vision. Nursing for Public Health*. Belfast: DHSSPS.

Department of Health (2006a) *Modernising Nursing Careers- setting the direction*, London: The Stationery Office.

Department of Health (2006) *Best research for Best Health: A New National Health Service Strategy*, London: The Stationery Office.

Department of Health (2012). *The Handbook to the NHS Constitution*: London: The Stationery Office.

Department of Health (2012) *Developing the role of the Clinical Academic Researcher in Nursing and Midwifery and Allied Health Professionals*: London: The Stationery Office.

Department of Health (2014) *The Five Year Forward View*: London: The Stationery Office

Denzin, N. A. (2005). *Introduction, The Discipline and practice of Qualitative research. Handbook of qualitative research (3rd ed)*. London: Sage.

Dibley, L. (2011) Analysing narrative data using McCormack's lenses. *Nurse Researcher* 18 (3), pp 13-19.

DiCocco-Bloom, B. and Crabtree, BF. (2006). The qualitative research interview. *Medical Education* 40 (4) pp. 314-32.

Dictionary of Sociology 1998. Encyclopedia [Online]. Available at: <http://www.encyclopedia.com/doc/1088-occupationalsocialisation.html> [Accessed 27<sup>th</sup> October 2013].

Dinmohammadi. M., Perovi, H., and Mehrdad, N (2013) Concept Analysis of Professional Socialization in Nursing. *Nursing Forum* 48 (1) pp 26-34.

Dingwell, R. (1977). *The Social Organisation of Health Visitor Training*. London: Croom Helm.

Dreyfus, S., and Dreyfus, H. (1980), in Benner, P (1984). *From Novice to Expert. Excellence and Power in Clinical Nursing*. Menlo Park, CA: Addison –Wesley.

Dowling S., Barrett S., and West R. (1995) With Nurse Practitioners, who needs house officers? *BMJ* 311: pp309-13

Doherty, C. (2009) A qualitative study of the reform on nurses working lives: Learning from the UK National Health Service (NHS). *International Journal of Nursing Studies* 46 pp1134-1142.

Eccles, M., Armstrong, D., Baker, R., Cleary, K., Davies, H., Davies, S., Glasziou, P., Ilott, I., Kinmouth, L., Leng, G., Logan, S., Marteau, T., Michie, S., Roger, H., Rycroft-Malone, J., Sibbald, B. (2009) An implementation research agenda. *Implementation Science Bio med Central* 4 (18)[Online]<http://www.implementationscience.com/content/4/1/18> [Accessed 8 January 2016].

EBNP (2014)[Online] Evidence-based practice. Available at <http://www.ebnp.co.uk/What%20%20EBP.htm> [Accessed 22 April 2014].

English, I. (1993). Intuition as a function of the expert nurse: a critique of Benner's novice to expert model, *Journal of Advanced Nursing*, 18 (3), pp. 387-393.

European Working Time Directive 2003/88/EC *Parliament and the Council concerning aspects of Organisation of working time*. EWTD.

Fairley, D (2006). Evaluation of a nurse consultant's clinical activities and the search for patient outcomes in critical care. *Journal of Clinical Nursing* 15(9) pp. 1106-1114.

Franks, H. (2014) The Contribution of Nurse Consultants in England to the Public Health Agenda. *Journal of Clinical Nursing* 23, pp. 3434-3448.

Franks, H., and Howarth, M. (2012) Daring to be different: A qualitative study exploring the educational needs of the Nurse Consultant. *Nurse Education Today* 32. pp. 406-411

Fulcher, J and Scott, J (2011) *Sociology Oxford*. Oxford University Press

Gabbay, J., Le May, A. (2011) *Practice-based evidence for healthcare: Clinical Mindlines*. London: Routledge

Gagliardi, A., Brouwers, M., Palda, V., Charles-Lemieux, L., Grimshaw, J. (2011) How we can improve guideline use? A conceptual framework of implementability. *Implementation Science Bio Med* 6 (26). [Online]

<http://www.implementationscience.com/content/6/1/26>[Accessed 8<sup>th</sup> January 2016]

Garmarnikow, E. (1978) *Sexual Division of Labour: the case of nursing in Feminism and Materialism* (Kuhn, A. and Wolpe, A. eds) Routledge and Kegan Paul, London.

Gerrish, K., McDonnell, A., Kennedy, F. (2013) The development of a framework for evaluating the impact of nurse consultant roles in the UK. *Journal of Advanced Nursing* 69 (10), pp 2295-2308

Gerrish, K., Guillaume, L., Kirshbaum, M., McDonnell, A., Tod, A., and Nolan, M. (2011) Factors influencing the contribution of advanced practice nurses to promoting evidence-based practice amongst front-line nurses: findings from a cross-sectional survey. *Journal of Advanced Nursing* 67 (5), pp 1079-1090

Gerrish K., Guillaume L., Kirshbaum M., McDonnell A., Nolan M., Read S. & Tod A. (2007) *Empowering Front-Line Staff to Deliver Evidence-Based Care: The Contribution of Nurses in Advanced Practice Roles*. Sheffield Hallam University, Sheffield.

Gerrish, K. (2000). Still fumbling along? A comparative study of the recently qualified nurse's perception of the transition from student to qualified nurse. *Journal of Advanced Nursing* 32 (2), pp730-739.

Gerrish, K., Asworth, P., Lacey, A., Bailey, J., Cooke, J., Kendall, S. and McNeilly, E. (2007). Factors influencing the development of evidence-based practice: a research tool. *Journal of Advanced Nursing* 57(3), pp. 328-338.

Gerrish, K., Mcmanus, M., and Ashworth, P. (2003). Creating what sort of professional? Masters level nurse education as a professional strategy. *Nursing Inquiry* 10 (2), pp. 103-112.

Girot, E. (2013). Shaping clinical academic careers for nurses and allied health professionals; the role of the educator. *Journal of Research in Nursing* 18(1), pp.51-64.

Graham IW (2007). Nurse Consultant – consultant physician. *Journal of Clinical Nursing* 16, pp. 1809-1817.

Graham IW, and Wallace, S. (2005). Supporting the role of the nurse consultant: and exercise in leadership development via an interactive learning opportunity. *Nurse Education Today*, 25 (2), pp. 87-9

- Gray, M (1997). [Online] Evidence-based practice. Available at <http://www.ebnp.co.uk/What%20%20EBP.htm> [Accessed 22 April 2014].
- Greenhalgh & Co. (1994)*The Interface Between Junior Doctors and Nurses*. Greenhalgh, Macclesfield.
- Greenfield, T.K., Midanik, L.T., and Rogers, J.D. (2000). Effects of Telephone versus Face-to-Face Interview Modes on Reports of Alcohol Consumption. *Addiction* 95(20), pp. 277–84.
- Guest D.E., Peccei R., Rosenthal P., Redfern S., Wilson-Barnett J., Dewe P., Coster S., Evans A., Young C., Montgomery J., and Oakley, P. (2001). *An evaluation of the impact of nurse, midwife and health visitor consultants*. King's College London.
- Guest D.E., Peccei R., Rosenthal P., Redfern S., Wilson-Barnett J., Dewe P., Coster S., Evans A. & Sudbury A. (2004). *An evaluation of the impact of nurse, midwife and health visitor consultants*. King's College London.
- Harden, J. (1999) *Becoming a nurse: Cultural identity and self-representation for mature women*, Unpublished Thesis. Northumbria University.
- Harker, J. (2001). Role of the Nurse Consultant in Tissue Liability, *Nursing Standard* 15 (49) pp. 39-42.
- Hayes, J., and Harrison, A. (2004). Consultant Nurses in Mental Health: a discussion of the historical and policy context of the role. *Journal of Psychiatric and Mental Health Nursing* 11(2) pp.185-188.
- Heaslip, V., Hewitt-Taylor, J., and Rowe, N. (2012). Reflecting on nurses' views on using research in practice. *British Journal of Nursing* 21(22) pp.1341-1346.
- Heath Inspectorate Wales (HIW 2007/2011) Consultant posts scrutiny panel, driving improvement through independent review [Online] Available at <http://www.hiw.org.uk/page.cfm?orgid=477&pid=29384> [Accessed 11/03/2014].
- Hennessy, D.(2000)"*The emerging themes.*" *Health Policy and Nursing: Influence, Development and Impact*. London: Macmillan.
- Holliday, M., and Parker, D. (1997) Florence Nightingale, Feminism and Nursing, *Journal of Advanced Nursing* 26 (3): pp483-488.
- Holloway, I., and Todres, L. (2003) The status of method: flexibility, consistency and coherence, *Qualitative Research* 3 (3): pp 345-357.
- Hoskins, R. (2008) Should aspiring consultant nurses follow a medical training programme? *International Emergency Nursing* 16 (1), pp29-34.
- Hourihane, G., West, N., Barnes, R., Rees, S., Bowyer, A., Dundon, A., and Allen, D. (2012). Supporting trail blazing: A systematic review of the factors that facilitate or inhibit the implementation of new nursing roles: the experiences of UK consultant nurses. *JBIC Library of Systematic Reviews* 10 (50), pp3146-3294.

House of Commons (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volumes I, II and III (Chaired by Robert Francis QC), HC 898. London: The Stationery Office. [Online]. Available at: <http://www.midstaffspublicinquiry.com/report> [Accessed 11/03/2014].

Hughes, E.C. (1984). *The Sociological Eye*. New Brunswick and London: Transaction Books.

International Council of Nurses. (2008). *The Scope of Practice, Standards and Competencies of the Advanced Practice Nurse*. ICN Regulatory Series. Geneva: ICN.

Jackson, C. (2005) The experience of a good day: A phenomenological study to explain a good as experienced by a newly qualified RN. *International Journal of Nursing Studies* 42, pp. 85-95.

Jackson, C., Callinan, C., Cowell, A. (2012) Professional roles: A study of the professional populations within nursing and midwifery, social work and allied health professions, *Journal of Research Nursing* 17, pp 395-411.

Jolin, L. (2009). Challenging established thinking. *British Journal of Cardiac Nursing* 4, (9), pp .438-439.

Jolley, M (1989) The professionalisation of nursing: the uncertain path, in Jolley, M. and Allen , P. (Eds) *Current issues in nursing*, London: Chapman and Hall.

Kahlke, R.M. (2014). Generic qualitative approaches: Pitfalls and Benefits of Methodological Mixology. *International Journal of Qualitative Methods* pp.37-51

Kitzinger, J. (1994). The methodology of focus groups: the importance of interaction between research participants. *Sociology of Health and Illness* 16 (1) pp.103-121.

Kennedy, F., McDonnell, A., Gerrish, K., Howarth, A., Pollard C. and Redman, J. (2011). Evaluation of the impact of nurse consultant roles in the United Kingdom: a mixed method systematic literature review. *Journal of Advanced Nursing* 68 (4), pp. 721-742.

Kvale, S. (1983). The qualitative research interview: A phenomenological and a hermeneutical mode of understanding. *Journal of Phenomenological Psychology* 14, pp. 171-196.

Lai, P.K., and Lim, P.H., (2012) Concept of professional socialization, *IeJSM* 6 (1) pp 31-35.

Lankshear, A., Sheldon, T., Maynard, A., and Smith, K. (2005) *Health Policy Matters-Nursing Challenges: Are Changes in the Role and Skill mix Improving Patient Care?* University of York, UK 10 (7)

Macleod-Clark, J., Maben, J., and Jones, K. (1997). Project 2000: Perceptions of the philosophy and practice of nursing: Shifting perceptions of a new practitioner? *Journal of Advanced Nursing* 26 (2), pp.246-256.

- Manley, K. (1997). A conceptual framework for advanced practice: an action research project operationalizing an advanced practitioner/consultant role. *Journal of Clinical Nursing* 6(3), pp. 179-90.
- Manley, K., and A. Titchen . (2012) "Being and becoming a consultant nurse: towards greater effectiveness through a programme of support." *Royal College of Nursing, London*.
- McCormack, C. (2000a). From interview transcript to interview story: part1-viewing the transcript through multiple lenses. *Field Methods* 12 (4), pp.282-297.
- McCormack, C. (2000b). From interview transcript to interview story: part 2-developing an interpretive story. *Field Methods* 12 (4), pp.298-315.
- McIntosh, J and Tolson, D. (2009). Leadership as part of the nurse consultant role: banging the drum for patient care. *Journal of Clinical Nursing* 18 (2), pp. 219-227.
- McGarry, J. (2007). Nursing Relationships in Nursing Research: What of rapport! *Nurse Researcher* 14(3), pp. 7-14.
- Mckenna, H., Richey, R., Keeney, S., Hasson, F., Sinclair, M., and Poulton, B. (2006). The Introduction of Innovative Nursing and Midwifery Roles: the perspective of health care managers. *Journal of Advanced Nursing* 56 (5), pp. 553-562.
- McLeod, S. A. (2013). Erik Erikson. Retrieved from [www.simplypsychology.org/Erik-Erikson.html](http://www.simplypsychology.org/Erik-Erikson.html)
- McLean, S., Mondo, C., and Divers, F. (2007) The cardiology nurse consultant in Scotland. *British Journal of Cardiology Nursing* 2 (12) pp. 589-591.
- McSherry, R., Mudd, D., and Campbell, S. (2007) Evaluating the perceived role of the nurse consultant through the lived experience of health care professionals. *Journal of Clinical Nursing* 16, pp 2066-2080.
- McSherry, R. and Warr, J. (2008) *An Introduction to Excellence in Practice Development in Health and Social Care*, McGraw Hill: Open University Press: England
- Melia, K. (1984). Student Nurses' construction of occupational socialisation. *Sociology of Health and Illness* 6 (2), pp.132-151.
- Melosh, B (1989) Not merely a profession, nurses and resistance to professionalism, *The American Behavioural Scientist*: 32.6 pp668
- Miles, M., and Huberman A.M. (1994). *Qualitative Data Analysis: An Expanded Sourcebook*. Sage
- Mitchell, T., Butler-Williams, C., Eaton, K., Ingledew, I., Parkin, D., Wade, S., and Warner, R. (2010) The consultants nurse- expert practitioner and much more, *British Journal of Nursing* 19 (8), pp481-488.



- Morse, J.M. and Field, P.A. (1996). *Nursing Research: The Application of Qualitative Approaches (2nd ed)*. Cheltenham: Stantley Thornes.
- Morgan, D. (1997). *Focus groups as qualitative research (2nd ed)*. London: Sage.
- Mooney, M. (2007) Professional Socialization: The key to survival as newly qualified nurse. *International Journal of Nursing Practice* 13(2), pp. 75-80.
- National Assembly for Wales (2005) *Designed for Life: Creating World Class Health and Social Care for Wales in the 21<sup>st</sup> Century*. Cardiff: NAFW
- National Assembly for Wales (2008). *Post Registration Career Framework for Nurses in Wales*. Cardiff: NAFW.
- National Institute for Health Research (NIHR) (2010). *Clinical Academic Training for Nurses, Midwives and Allied Health Professionals*. [Online] Available at <http://www.nihrtcc.nhs.uk/cat/> (accessed 4<sup>th</sup> April 2013)
- Needlement and Nelson (1998) *Policy Implications In The Worth of Women's Work, A Qualitative Synthesis*, Stantham, A., Miller, E.M., Mauksch, H. New York Press.
- NHSME (1991) *Junior Doctors: the New Deal*, London: NHSME.
- NHS statistics (2008)[Online]. Available at: [http://www.ic.nhs.uk/webfiles/publication/nhsstaff/2008/nomed\\_date](http://www.ic.nhs.uk/webfiles/publication/nhsstaff/2008/nomed_date) [Accessed 11th February 2010]
- Organisation for Economic Co-operation and Development (2010). *Nurses in advanced roles: A description and evaluation of experience in 12 developed countries*. Available at: [www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=delsa/hea/wd/hwp%282010%2](http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=delsa/hea/wd/hwp%282010%2)
- Olesen, V. and Whittaker, E. (1968). *The silent dialogue: A study of the social psychology of professional socialization*. San Francisco: Jossey-Bassey.
- Opdenakker, R. (2006). Advantages and disadvantages of four interview techniques in qualitative research. *Forum: Qualitative Research* 7, 4, Art 11.
- Page, G. (2005). Professional socialisation of valuers: What the literature and professional bodies offers. *International Education Journal* 5 (5), pp. 105-116.
- Patton, M.Q. (2002) *Qualitative research and evaluation methods 3rd edition*. Sage Publications, California
- Payley, J. (1996) Intuition and expertise, comments on the Benner debate, *Journal of Advanced Nursing* 23 (4) pp 665-671.
- Peters, D., Taghreed, A., Olakunle, A., Agyepong, I., Tran, Nhan. (2013) Implementation Science: what is it and how do we do it? *BMJ* 347: 6753

- Petryshen, P.R., and Petryshen, P.M. (1992) The case management model: an innovative approach to the delivery of care. *Journal of Advanced Nursing* 17 (10) pp1188-1194
- Pearson, H. (2013) Science and Intuition, do both have a place in clinical decision making? *British Journal of Nursing* 22 (4) [Online] Available at <http://www.magonlinelibrary.com/doi/abs/10.12968/bjon.2013.22.4.212> [Accessed 30th January 2016].
- Porter, S. (1992) The poverty of professionalisation, a critical analysis of strategies for the occupation of the advancement of nursing. *Journal of Advanced Nursing* 17: pp 720-726
- RCN/DH (2005) Maxi Nurses. Advanced and Specialist Nursing Roles, Royal College of Nursing [Online] Available at <http://www.rcn.org.uk/publications> [Accessed 11th March 2014]
- RCN (2014) Nurse Consultant Job Profile, royal College of Nursing [Online] Available at [https://www.rcn.org.uk/-data/assets/pdf-file/008/105587/nurse\\_consultants.pdf](https://www.rcn.org.uk/-data/assets/pdf-file/008/105587/nurse_consultants.pdf) [Accessed 01 April 2014].
- Redwood,S., Carr, E., Hancock,H., Mcsherry, R., Campbell, S., and Graham, I. (2007). Evaluating nurse consultants' work through key informant perceptions. *Nursing Standard* 3(21) 17 pp. 36-40.
- Reeves, S., Kuper, A., Hodges, B. (2008) Why use theories in qualitative research? *British Medical Journal* p 337[Online] Available at <http://dx.doi.org/10.1136/bmj.a949>.
- Read, S., Lloyd-Jones, M., Collins, K., McDonnell, A., & Jones, R. (1999) *Exploring New Roles in Practice: Implications of Developments within the Clinical Team* (ENRiP). Report for the Department of Health by a team from Sheffield University, Sheffield, UK.
- Ritchie, J. and Lewis, J. (2003) *Qualitative research practice: A guide for social science students*. London: Sage.
- Ritchie, J. and Spencer, L. (1994). Qualitative data analysis for applied policy research. In: *Analysing Qualitative Data* (Bryman, A .and Burgess, R.G. eds). London: Routledge, pp. 173–194.
- Roberts, J. I (1995) *Feminism and Nursing: a historical perspective on power status and the political activism in the nursing profession*, Praeger: London.
- Rolfe, G. (1997)Beyond expertise: theory, practice and the reflexive practitioner, *Journal of Clinical Nursing* 6 (2) pp93-97.
- Ryan, S., Hassell, A., Thwaites, C., Manley, K., Home,D, (2006). Exploring the perceived role and impact of the nurse consultant. *Musculoskeletal Care* 4(3), pp. 167-173.
- Sackett, D.L., Rosenberg, W.M.C., Gray, J.A.M. and Richardson, W.S. (1996). Evidence based medicine: what it is and what it isn't. *British Medical Journal* 312 (13), pp. 71-72.

Salvage, J. (1992) *The New Nursing: empowering patients or empowering nurses?* In J. Robinson, A. Gray and Elkan, R. (eds) *Policy Issues in Nursing*, Milton Keynes, UK: Open University Press.

Scottish Executive Health Department (2002) *Coronary Heart Disease and Stroke Strategy for Scotland*. Edinburgh: The Stationery Office. Chapters 1, 3 & 4

Sheer, B. and Wong, F.K.Y. (2008) The Development of Advanced Nursing Practice Globally, *Journal of Nursing Scholarship*, 40: pp204-211.

Shuy, R. (2001). In-person versus telephone interviewing. In J. A. Gubrium, *Handbook of Interview Research*. London: Sage, pp. 537-556.

Smith, F.T. (1981) Florence Nightingale: Early Feminist. *American Journal of Nursing* 81(5), pp1021-1024

Smith, J., and Bekker, H., and Cheater, F. (2008) Theoretical versus pragmatic design challenges in qualitative research. *Nurse Researcher* 18 (2) pp39-51.

Srivastava, N., Tucker, S., Draper, E., and Milner, M. (2008) A literature review of principles, policies and practice in extended roles relating to UK intensive care settings. *Journal of Clinical Nursing* 17, pp 2671-2680.

Stats soft (2012) *Electronic statistic textbook, Designing an experiment, power analysis* [Online] Available at: <http://www.statsoft.com/textbook/power-analysis/> June 12 2012. [Accessed 12<sup>th</sup> June 2012].

Sturges, J. A. (2004). Comparing telephone and face- to- face qualitative interviewing: a research note. *Qualitative research* 4 (1), pp .107-118.

Tansella, M., and Thornicroft, G. (2009) Implementation Science: understanding the translation of evidence into practice. *The British Journal of Psychiatry* 195 283-285.

The Foundation of Nursing Studies (2001). *Taking Action: Moving Towards Evidence-based practice*. London: The Foundation of Nursing Studies.

Taylor, S. and Allen, D. (2007). Visions of evidence-based nursing practice. *Nurse Researcher* 15(1), pp. 78-82.

Thomas, M., Burt, M., Parkes, J. (2010). The emergence of evidence based medicine. In McCarthy, J., and Rose, P. (ed) *Value Based Health and Social Care: Beyond Evidence*. London: Sage Publication Ltd

Thorne, S., Kirkham, S., and MacDonald-Emes, J. (1997) Interpretive description: A non-categorical alternative for developing nursing knowledge. *Research in Nursing and Health* 20, pp169-177

Timmermans, S. and Berg, M. (2003). *The Gold Standard: The Challenge of Evidence-Based Medicine and Standardization in Health Care*. Philadelphia: Temple University Press.

UKCC (1987) *Project 2000: The Final Proposals*, London: UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1990) *Post registration education and practice project (PREPP)*. Register no 6, p4-5. UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992a) *The scope of professional practice*. UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992b) *Code of professional conduct*. UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1993) Consultation on the Council's proposed standards for post registration education. UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1994) *The future of professional practice - the Council's standards for education and practice following registration*. UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1995) *PREP and you*. UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1996) *Position statement on clinical supervision for nursing and health visiting*. UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1997a) *PREP the nature of advanced practice*. UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1997b) *The Council's decision on PREP and advanced practice*. Registrar's letter 9/97. UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1997c) *PREP specialist practice*. Consideration of issues relating to embracing nurse practitioners and clinical nurse specialists within the specialist practice framework. UKCC, London.

United Kingdom Central Council for Nursing and Midwifery and Health Visiting (2002) *Higher level of Practice Pilot Project*. UKCC, London.

Unsworth, J., and Cook, G. (2003) *The Impact of Nurse Consultants on Clinical Practice: An Evaluation*. Northumbria University, Primary Care Development Centre, Newcastle-upon-Tyne.

Wærness, K. (1987) "On the Rationality of Caring" in A. Sasson (ed) *Women and the State*. London: Hutchinson.

Welsh Assembly Government (2004) *Realising the potential: Briefing Paper 6: Achieving the Potential through Research and Development. A Framework for Realising the Potential through Research and Development in Wales*, Cardiff: Welsh Assembly Government.

Walsh, M. (2004) *Introduction to Sociology for Health Carers, Foundations in Nursing and Health Care*. Great Britain: Ashford Colour Press.

Woodward, V.A., Webb, C., and Prowse, M. (2005) Nurse consultants: their characteristics and achievements. *Journal of Clinical Nursing* 14, 845–854.

White, R. (1988) The influence of nursing on the politics of health in White, R. (ed) *Political issues in nursing past, present and future*. vol 3, Chichester: John Wiles.

Wilson-Barnett, J., and Beech, S. (1994) Evaluating the clinical nurse specialist: a review. *International Journal of Nursing Studies* 31 (6): 561-571.

*Witches, Midwives and Nurses: A history of women healers* (Barbara Ehrenreich with Deidre English) 1972 [Online] Available at <https://www.marxists.org/subject/women/authors/ehrenreich-barbara/witches.htm> July 17 2015 [accessed July 17 2015].

## Appendix 1

**Critical Analysis Grid**

Author	Research Question	Population	Sample Size	Research Approach	Method of Data Collection	Findings	Limitations	Critical comments
Franks (2014)	Exploration of the contribution of NCs to the public health agenda	NCs & stakeholders	4 NCs & 6 stakeholders	Qualitative approach	Data was collected through semi structured and day to day activity collected from NCs by a researcher over a 4 week block	<p>NCs used clinical expertise to facilitate change.</p> <p>Two barriers to role development. Little time or will to undertake research.</p> <p>Lack of understanding by organisations regarding the remit of the role</p>	The research study represents a small sample of NCs in a branch of public health and therefore while pertinent to public health may not be considered generalisable.	<p>Lack of research input precluded NCs ability to demonstrate their impact to the employing organisation.</p> <p><b>(research component challenging</b></p> <p><b>Role development)</b></p>

Gerrish <i>et al</i> 2013	To develop a framework to evaluate the impact of the NCs on patients, professionals and organisational outcomes and identify associated indicators of impacts	NCs & health care staff, managers, patients and carers	6 NCs	Multiple instrumental case study design	Interviews  Exploring participants perception of the impact of NCs and indicators of potential or actual impact	Three domains of impact clinical significance, professional significance and organisational significance	Study relied on self -reported indicators of impact rather than empirical data. Larger study would enable the findings to be generalisable	The <b>research component</b> was reflected under the theme of organisational significance through the generation of new knowledge. Primary focus varied dependant on specialty
Franks & Howarth (2012)	Exploration of the education needs of the NC	NC & Stakeholders	4 NCs & 6 stakeholders	Qualitative approach	Historical and current data collected  Diaries for a full working week.  Current JDs and specifications.  Semi - structured interviews with NCs and stakeholders to elicit attributes, evolution, educational and developmental needs in the role	Majority of time taken with leadership and consultancy and expert practice relating to supervision of practitioners. Research and quality assurance only taking up 11% of their time. Lack of scholarly activity regarded as a weakness. Research and evaluation were seen to be an opportunity to demonstrate impact to organisation.  Delivery on components dependant on the experience, expertise understanding of organisation and the ability to undertake professional supervision. Interpersonal skills were perceived to be of paramount importance	The research study represents a small sample of NCs in a branch of public health and therefore while pertinent to public health may not be considered generalisable.	Need for organisations to develop NCs not only in their clinical specialist subject but more broadly in the four domains.  <b>(Education)</b>

Manley and Titchen (2012) (working with the RCN)	Exploration of how the NC role had developed and how the role could be embedded in the culture of health providers	NCs and aspiring NCs	19 NCs and 7 aspiring NCs	Emancipatory research over an 18month period	Action learning Process evaluation 360 degree feedback	NCs needed to understand their multiple roles and how they interplayed in order to demonstrate this to organisations	Research undertaken 2002-04 not published until 2012 because of illness	Researchers concluded the results were relevant to date  <b>(role development)</b>
Gerrish <i>et al.</i> (2011)	Examined the contribution made by nurses in advanced practice roles including NCs in the empowerment off front line staff to deliver evidence based care.	Advanced Nurse Practitioners (ANP)	855 ANP working in 87 hospitals/primary care settings in 7 strategic health Authorities	Survey	Questionnaires Analysed using descriptive statistics	ANP skills in EBP varied with few considering themselves experts. Those with Masters qualifications perceived themselves to be more skilled than those without.  ANP were well placed to promote EBP but need assistance to do so	Due to difficulties determining the number of questionnaires distributed to eligible ANPs directly it was not possible to determine accurate ratio	ANPs rely more heavily on research findings processed into tools such as guidelines and knowledge gained experientially in the workplace than knowledge gained by reading journals.  ANPs should be supported to develop expertise through masters education.  <b>(education)</b>
Hourihane <i>et al.</i> 2012	Systematic review of factors that facilitated or inhibited the NC role			Qualitative and mixed methodology and also narrative opinion papers		Lack of clarity regarding the leadership and research function. Role clarity was a facilitator and role development was dependant on the NC having clinical expertise a vision and clear	Paucity of research papers	NCs should be <b>educated</b> to Masters, supportive environment, understanding or roles core



						objectives. Role preparation key		function. <b>Research</b> the most challenging to deliver
McIntosh and Tolson (2009)	The extent to which the NCs fulfilled each of the four components	NCs & Stakeholders	4 NCs 23 Stakeholders	Qualitative approach	Documentary analysis focusing on policy context and JDs  31 semi structured interviews with 4 NCs who were interviewed twice over 4 to 6 months. And 23 stakeholders with whom they worked and a focus group interview.	NCs reported they found it difficult to balance the 4 components with the research and education function the most challenging	Despite a small sample a multi method approach facilitated data collection	Integral to developing leadership was developing <b>evidence based practice.</b>
Hoskins (2008)	Investigation of the level of preparation appointed NCs felt was required to prepare aspiring NCs to the role	NCs	18	Survey	Survey undertaken by the DoH NC emergency group	Master's level education was relevant to NCs delivering on this role and broadening their knowledge base.	Small scale study representing only 2% of population	More work need to be undertaken regarding collaborative working with medical staff to develop national programmes for NCs in emergency care  <b>(education)</b>

Dawson (2008)	Follow up of to review the role and function of NCs in critical care to provide a contemporary profile of the NC in critical care. Identify changes from 2003-2006	Survey of all known critical care NCS	47	survey		<p>Static NC population. Demonstrate advanced academic skill through 94% higher degrees.</p> <p>Carry a 93% national and 53% international profile. 62% multi authored</p> <p>47% single authored publication</p> <p>Increasing strategic input at organisational level</p>	Reliance on self-reported role involvement and consequently self-presentation cannot be ruled out	Little Development or investment by organisations
Redwood <i>et al.</i> (2007)	Invited key informants to provide information on their work with NCs	NC	<p>14 NCs 9 acute and 5 Mental Health Trust</p> <p>10 key informants for each nurse included academic and clinical colleagues</p>	360 feedback process and case study methodology	Invited key informants to provide information on their work with NCs	<p>Common themes associated with NC role,</p> <p>Expert practice and specialist knowledge prerequisites. Strategic aspect of the role and the ability to influence people and policy differentiated the role from other specialists role for the role</p>	NC hand-picked informants may have biased outcome	<b>Research</b> least developed component

McSherry <i>et al.</i> (2007)	Evaluated the perceived role of the nurse consultant through the lived experience of health care professionals	NC and clinical medical colleagues	3 NCs and 10 key colleagues	A descriptive qualitative research design	360 semi structured interviews	With the exception of personal qualities the NC can bring to the role, the role can be enhanced by involving and informing and engaging staff and developing a phased approach to implementing and evaluating the role	Small scale nature of the descriptive study makes any generalizable and transferability of findings to other NCs difficult	<b>More structured approach</b> to its implementation and evaluation within employing organisations. Should begin prior to drawing up the business case or personal specification plan.
Abbott (2007)	Exploration of the emerging role of 4 NCs in an English Primary Care Setting	NCs & key stakeholder	4 NCs 19 Stakeholders	Qualitative Approach  Case study methodology	Semi-structured Interviews with stakeholders and NCs	Negotiating priorities and relationships are time consuming tasks took time to identify priorities	Focus on one setting primary care.  Study carried out to soon for 2 of NCs	<b>Healthcare organisations</b> need to provide high quality support to staff who fulfil these posts
Fairley (2006)	Evaluation of her role as a NC in critical care	NC	1	Evaluation	Diary to record activity four months with 39 sessions	61% time spent on clinical activities  28% clinical leadership  Education, training and research	Reflection of her own role not research	Did not separate the % of <b>research</b> component with other components or indicated what research meant
Ryan <i>et al.</i> (2006)	Perceptions of peer and patients perceptions of the NC role in rheumatology	Peers of the NC Patients.  Rheumatology Patients	2 Consultants 1 rheumatologist  1 Manager  2 OPD Nurses  In-patient sister	Qualitative Approach	Semi-structured Interviews	Themes identified from interview. 1. Development of new model of care. Move away from a medical model. 2. Holistic patient centred care reported	Difficult to determine whether success of role was down to the individual rather than the role	<b>Research component</b> of the role was the least visible at the time but may develop at a later stage or that the research approach may be

			1 Consultant physio 5 patients cared for by the NC			3. NC provided leadership and education		different.
Mckenna <i>et al.</i> 2006	Exploration of issues arising from innovative nursing and midwifery roles from the perspective of health care managers	Directors of Nursing 18, Chief Nurses 4 and Directors of primary care in health and social service trust boards 4		Qualitative approach	Semi-structured interviews to explore current organisational position with regards to innovative roles	Four themes identified professional identity and number of innovative roles, impact on patient care, stimuli for role development, organisational support	Did not distinguish the innovative roles	For an innovative role to be successful clarity about the role and support from <b>organisations</b> necessary
Charters <i>et al.</i> (2005)	Explore the experiences of preparation for the role of NC in emergency medicine and gauge the NCs perspective of how their role should be prepared	NCs	25	Qualitative approach	Semi structured questionnaires	Recommendations from NCs that they would benefit from a tailored Masters  And there should be broad preparation in all four components	Small study but a 58% response rate	Research focuses on one specialty emergency medicine so not generalisable  <b>(education)</b>

Woodward <i>et al.</i> (2005)	NC characteristics and the achievements in the role	NC	10	Qualitative approach	In-Depth, tape recorded interviews	Four themes identified: 1. Characteristics of post holder 2. Role achievement 3. Support systems 4. NHS Influences	Research undertaken in one English region involving only 4 NHS Trusts with several NCs involved employed by the same organisation	Variation in academic ability Msc appeared to influence their ability to achieve four domains <b>(education)</b>
Graham and Wallace (2005)	Evaluation of learning sets through a process of interactive	NCs	Does not state just states a group	Action learning sets	Consultants were given papers and articles from professional, academic and general press to shape consultants learning. This content was woven into the interactive learning process.  Evaluative focus groups	Contesting professional jurisdictions became an important theme.  Distribution of responsibility. Medical profession routinely assumed responsibility except when things went wrong. Nursing profession advocated a joint responsibility model.  Evidence -based perspective important moving forward.  Chance rather than organisational structure determined the structural arrangements.  Discourse between vision for the future and realities of practice	Does not state how many NCs	Fundamental to success of NC role is development of well- educated clinically competent workforce to lead and create new systems of working. Need academia and service unite to provide appropriate education and development with an enabling infrastructure for nursing. <b>(education)</b>

Guest <i>et al.</i> (2004)	Development and evaluation of the NC role by King's College London on behalf of DH	NCs	448 1 <sup>st</sup> survey 528 2 <sup>nd</sup> survey 10 NCs interview 32 NCs longitudinal interviews	Qualitative and Quantitative approach	Two questionnaire surveys  In- depth Interviews,  Longitudinal telephone interviews	Still scope to give greater thought to commitment to the planning and support for the NC roles.	Function for research and evaluation was combined with practice and service development with no indication of what percentage was related to research	The survey did not explicitly capture <b>organisational culture</b> as influencing the NC role but it was implied by the survey results
<b>Narrative Opinion Papers</b>  <b>NOT Sure Whether to Continue Adding</b>  Theresa Mitchell et al (2010)  I	Analysis of CNs own written professional accounts to demonstrate their extra -ordinariness of practice	Nurse Consultants	6	Qualitative interpretative approach	Own professional accounts  Concept maps	The terms 'expert', 'advanced' and 'specialist' are often used to describe similar nursing roles, but the diversity and complexity of the  consultant nurse role is not explored in the existing literature.  JDs written by all NCs involved. Stated it added to longevity of posts.  The nurse with a PHD contributed to research the most	Reflection of own practice not research	2 nurses had contributed to the <b>research agenda</b> on with PhD the other unknown qualification

## Appendix 2

### **National Assembly Wales (2008)**

#### **Recommended Essential Criteria**

- Registered practitioner, with active registration with the Nursing and Midwifery Council
- Recent post registration experience in a position of responsibility in the area of practice defined for the post
- Evidence of professional excellence
- A record of scholarship and continuing professional development with a minimum of a Master's Degree. This should be in a subject area relevant to the sphere of practice of the Consultant post
- Evidence of leadership and innovation
- Experience of teaching, assessing and developing professional staff and/or students in academic and clinical settings
- Evidence of a sound understanding and application of research to practice with a track record of practice development based on evidence.

## Appendix 3

### CFREII

#### Cardiff Framework for Research Engagement (CFREII)

Nurses in clinical and educational settings engage with research in different ways according to their particular role. It is not always easy to describe these modes of engagement and the activities associated with each one. Every nursing role will require engagement with some, but not necessarily all, activities and the levels of expertise required for each will clearly depend on the nature of the role. We have developed an instrument in order to clarify this complex area and to support nursing research development and planning processes. It is also intended to demonstrate the full extent of the work that nurses undertake as they include research related activity as part of their clinical or educational roles and to ensure that this is properly recognised and supported by appropriate professional development.

The instrument can be used in a number of ways:

- By organisations to identify the type and level of research engagement required of a particular role.
- By individuals to map their existing skill set against the requirements of a particular role.
- By individuals to support continuing professional development and career planning.
- By organisations and individuals to support training needs analyses.

**CFREII** comprises 7 modes of research engagement. These are:

- Research production
- Research utilisation
- Research teaching
- Research management
- Research leadership
- Research influence/facilitation



- Research Supervision

Some nursing roles will require engagement in all modes, but in many cases the clinician or educationalist will not be expected to be concerned with them all and it is important to identify the modes which are relevant to any given role.

For each mode of engagement several activities are described. Each activity has 6 "levels". These describe the progression of expertise within that activity, and each level builds on the preceding one. However, they are not levels in the sense of being standards that are comparable across the activities. For example, level 1 is always the baseline for a particular activity, but all level 1 descriptions are not comparable in terms of the complexity or sophistication of the work described. It follows that, within a particular dimension, the required profile may consist of activities at different levels.

The descriptions have been developed to provide a flexible framework in order to support workforce and individual professional development planning. It is for organisations to agree on the modes of engagement and levels of activity that underpin a particular role. Individuals may then use CFREII to map their current activities against role requirements.

CFREII builds on CFRE (Allen et al 2004; Allen and Lyne 2006), the Joint Skills Statement of the Research Councils, the NHS Knowledge and Skills Framework (2004) and the joint negotiation committee for Higher Education Academic Role Profiles (2005).

## How to use CFREII

The last page of **CFREII** is an assessment pro-forma which can be used to record the relevant modes and levels of research engagement for a role or an individual. It can be copied as required. Worked examples of CFREII's application have been provided along with FAQs.

### 1. Assessing a role:

- ❖ Use the descriptors of each mode of engagement to identify those relevant to the role under consideration. Read all the descriptors through first before making a decision.
- ❖ If there are some modes of research engagement which *do not* apply to the role, insert N/A on the assessment proforma.
- ❖ Use the assessment proforma for each relevant mode of research engagement to identify the appropriate level for each of the activities described. All role assessments should be based on what *should* be happening in a role.

### 2. Assessing an individual:

- ❖ Use CFREII to identify your current skill set against all modes of research engagement.
- ❖ Enter your activity levels for each mode of research engagement in the assessment proforma. Since CFREII is designed to support professional development planning, it is important to select the level which best describes the majority of your current activities, even if you are engaged in some activities at a higher level.

### 3. Professional development, career planning and training needs analysis:

- ❖ Complete a role assessment and an individual assessment following the instructions outlined in 1 and 2.
- ❖ Identify any mismatch between the skills required
- ❖ Incorporate this into professional development and career planning

RESEARCH PRODUCTION		The conduct of primary or secondary research				
DESCRIPTION						
<i>This mode of engagement refers to the activities related to the conduct of primary or secondary research. Related modes of engagement include: research utilisation, research management, research leadership.</i>						
LEVEL DESCRIPTORS						
Activities	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
<b>Research and scholarship</b>	<p>Conducts literature and database searches under supervision.</p> <p>Produces narrative reviews under supervision which bring together the findings from a body of publications, without detailed critique of the methods from which those findings have emerged.</p>	<p>Undertakes technical aspects of research for example, by preparing, setting up, conducting and recording the outcome of experiments and field work, the development of questionnaires and conducting surveys under supervision or working to a research protocol.</p> <p>Produces narrative reviews from a body of publications based on a critical appraisal of the methods and analysis at the level of understanding corresponding to existing technical expertise.</p>	<p>Contributes to the development of research objectives and proposals for own or joint research.</p> <p>Independent data collector on a managed project, locating and reviewing literature, managing data, assisting with analysis and contributing to report writing and publications</p> <p>Continually updates knowledge and understanding in field or specialism.</p> <p>Translates knowledge of advances in the subject area into research activity through critical appraisal of the methods and analysis of a body of publications.</p> <p>Participates in the review of research based books.</p>	<p>Develops research objectives, projects and proposals on small scale projects with supervision.</p> <p>Conducts individual or collaborative research projects.</p> <p>Identifies sources of funding and contributes to the process of securing funds.</p> <p>Extends and applies knowledge acquired from scholarship to research and appropriate external activities.</p> <p>Writes or contributes to publications or disseminates research findings using other appropriate media.</p> <p>Makes presentations at conferences or exhibits work in other appropriate events.</p> <p>Participates in peer-review of research publications.</p>	<p>Contributes to the development of research strategies in the department.</p> <p>Leads the development of research objectives, projects and proposals for research projects which will make a significant impact by leading to an increase in knowledge and understanding and the discovery or development of new explanations, insights, concepts or processes.</p> <p>Actively seeks research funding and secures it as far as it is reasonably possible.</p> <p>Acts as Principal Investigator on major research projects.</p> <p>Generates new research approaches and identifies, adapts, develops and uses research methodologies and techniques appropriate to the type of research.</p>	<p>Leads the development and implementation of research strategy.</p> <p>Leads and co-ordinates research activity in the subject.</p> <p>Leads research and collaborative partnerships with other external bodies.</p> <p>Leads bids for research, consultancy and other additional funds.</p>

					<p>Reviews and synthesises the outcomes of research studies.</p> <p>Interprets findings obtained from research projects and develops new insights, expanding, refining and testing hypotheses and ideas.</p> <p>Contributes generally to the development of thought and practice in the field.</p> <p>Participates in the review of proposals for external funding.</p>	
<p><b>Initiative, problem solving and decision making</b></p>	<p>Makes use of evidence location strategies under supervision.</p> <p>Identifies problems which might affect the achievement of research objectives and deadlines and seeks advice.</p>	<p>Makes use of evidence location strategies.</p> <p>Uses standard (well tried and tested) research techniques and appraisal methods, under supervision.</p> <p>Deals with problems which may affect the achievement of research objectives and deadlines.</p> <p>Contributes to decisions affecting the work of the team.</p> <p>Analyses and interprets the results of own research and generates original ideas based on outcomes.</p>	<p>Uses standard (well tried and tested) research techniques and appraisal methods</p> <p>Uses new research techniques and methods, under supervision.</p> <p>Uses initiative and creativity to identify areas for research, develops new research methods and extends the research portfolio.</p> <p>Uses creativity to analyse and interpret research data and draws conclusions on the outcomes.</p> <p>Contributes to collaborative decision making with colleagues in areas of specialist knowledge.</p>	<p>Assesses, interprets and evaluates outcomes of research.</p> <p>Develops new research techniques and methods.</p> <p>Develops new concepts, and ideas to extend intellectual understanding.</p> <p>Resolves problems of meeting research objectives and deadlines.</p> <p>Develops ideas for generating income and promoting research area.</p> <p>Develops ideas for application of research outcomes</p> <p>Decides on research</p>	<p>Resolves problems affecting the delivery of research projects within own area and in accordance with regulations.</p> <p>Makes decisions regarding the operational aspects of own research programme.</p> <p>Contributes to decisions which have an impact on other related programmes.</p> <p>Provides advice on issues such as ensuring the adequate balance of research projects, appointment of researchers and other performance matters.</p> <p>Spots opportunities for strategic development of new projects or appropriate areas of activity and</p>	<p>Determines the final allocation of resources within own area of responsibility.</p> <p>Acts as the final arbiter in local disputes.</p> <p>Contributes to strategic decisions at institutional level.</p> <p>Leads the development of new and creative approaches in responding to research and commercial challenges.</p> <p>Initiates new and original solutions to problems.</p> <p>Provides advice to external bodies.</p>

				programmes and methodologies, often in collaboration with colleagues and sometimes subject to the approval of the head of the research programme on fundamental issues.	contributes to the development of such ideas.	
<b>Communication</b>	Writes up results of own research/scholarship under supervision.	Contributes to the production of research reports and publications.  Presents information on research progress and outcomes to bodies supervising research e.g. steering groups.  Prepares papers for steering groups and other bodies.	Deals with routine communication using a range of media.  Prepares proposals and applications to external bodies, e.g. for funding and contractual purposes.  Communicates material of a specialist or highly technical nature	Communicates complex information, orally, in writing and electronically to peers and those with limited knowledge and understanding using high level skills and a range of media.	Routinely communicates complex ideas and concepts to a wide variety of audiences using appropriate media and methods to promote understanding.	Routinely involved in complex and important negotiations internally and with external bodies.
<b>Liaison and networking</b>	Liases with fellow students and supervisors.	Liases with research colleagues and support staff on routine matters.  Makes internal and external contacts to develop knowledge and understanding and form relationships for future collaboration.	Liases with colleagues and students.  Builds internal contacts and participates in internal networks for the exchange of information and to form relationships for future collaboration.  Joins external networks to share information and identify potential sources of funds.	Collaborates actively within and outwith the institution to complete research projects and advance thinking.  Participates in and develops external networks, for example to identify sources of funding, generate income, obtain consultancy projects, or build relationships for future activities.	Leads and develops internal networks for example by chairing and participating in institutional committees.  Leads and develops external networks for example with other active researchers and leading thinkers in the field.  Develops links with external contacts such as other educational and research bodies, employers, professional bodies and other providers of funding and research initiatives to foster collaboration and generate income.	Chairs committees and participate in institutional decision making and governance.  Leads and develops internal and external networks to foster collaboration, share information and ideas, and to promote the subject and the institution.  Contributes to the enhancement of research quality and thinking in the field by being involved in quality assurance and other external decision making bodies.  Promotes and markets the work of the department in the subject area both nationally and internationally.

<p><b>Team work</b></p>	<p>Attends and contributes to relevant meetings.</p> <p>Active member of peer group.</p>	<p>Actively contributes as member of a research team.</p> <p>Attends and contributes to relevant meetings.</p>	<p>Works with colleagues on joint projects as required.</p> <p>Collaborates with academic colleagues in areas of shared research interest.</p>	<p>Acts as team leader where appropriate.</p> <p>Develops productive working relationships with other members of staff.</p> <p>Coordinates the work of colleagues to ensure equitable access to resources and facilities.</p>	<p>Leads teams within areas of responsibility.</p> <p>Ensures that teams within the department work together.</p> <p>Acts to resolve conflict within and between teams.</p>	<p>Develops and communicates a clear vision of the unit's strategic direction.</p> <p>Ensures the enactment of institutional strategic plans.</p> <p>Develops team spirit and team coherence and fosters interdisciplinary team working.</p>
<p><b>Planning and managing resources</b></p>	<p>Plans own activities.</p>	<p>Plans own day-to-day activities within the framework of the agreed programme.</p> <p>Coordinates own work with that of others to avoid conflict or duplication of effort.</p> <p>Contributes to the planning of research projects.</p>	<p>Uses research resources, laboratories and workshops as appropriate.</p> <p>Plans and manages own research activity in collaboration with others.</p>	<p>Plans, coordinates and implements research programmes.</p> <p>Manages the use of research resources and ensures that effective use is made of them.</p> <p>Manages or monitors research budgets.</p> <p>Helps to plan and implement commercial and consultancy activities.</p> <p>Plans and manages own consultancy assignments.</p>	<p>Contributes to the overall management of the department.</p> <p>Involved in departmental level strategic planning and contributes to the institution's strategic planning process.</p> <p>Plans and delivers research, consultancy or similar programmes, ensuring that resources are available and required income levels are achieved.</p> <p>Contributes to the management of quality, audit and other external assessments.</p>	<p>Takes overall responsibility for the organisation and deployment of resources within the area.</p> <p>Plans and implements research projects and monitors progress to ensure the achievement of financial and research objectives.</p> <p>Contributes to institutional planning and strategic development.</p>

<b>Research governance</b>	Awareness of issues relating to the ethical conduct of research.	<p>Responsible for ethical conduct of own projects.</p> <p>Appreciates standards of good practice in their institution and/or discipline.</p> <p>Understands relevant health and safety issues and demonstrates responsible working practices.</p> <p>Awareness of issues relating to the rights of other researchers, or research subjects, and of others who may be affected by the research e.g. confidentiality, ethical issues, attribution, copyright, malpractice, ownership of data and the requirements of the Data Protection Act.</p>	Responsible for ethical conduct of research project for team.	<p>Responsible for ensuring Principal Investigators are aware of the requirements for the ethical conduct of their studies.</p> <p>Develops knowledge of institutional standards with respect of research governance and management.</p>	Develops and communicates departmental frameworks for the ethical conduct and appropriate management of research projects.	Contributes to the development of national and international frameworks for the ethical conduct and management of research.

RESEARCH UTILIZATION				<i>The use of primary or secondary research directly or indirectly</i>		
DESCRIPTION						
<i>The use of research underpins a range of nursing roles and is perhaps the fundamental and generally accepted mode of engagement with research for nurses. The level descriptors in this mode of engagement are designed to capture the many facets of research utilization across a diversity of nursing roles and their associated activities and underlying skills. It is closely linked to several other modes of engagement, e.g. research production and research teaching.</i>						
LEVEL DESCRIPTORS						
Activities	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
<b>Evidence location</b>	<p>Aware of major databases and sources of evidence based information in field of expertise.</p> <p>Makes use of information retrieval and evidence location strategies under supervision for educational or professional development purposes.</p>	<p>Familiar with major databases and sources of evidence based information in field of expertise.</p> <p>Makes use of information retrieval and evidence location strategies.</p>	<p>Knowledge of broad range of data bases.</p>	<p>Develops detailed search strategies in order to locate evidence to address a clearly specified research question.</p>	<p>Maintains knowledge of information resources and help others to access and use them.</p>	<p>* Like all the elements this builds on the demands in the profiles at lower levels. In this case there is no additional demand.</p>
<b>Research appraisal/ evaluation and evidence synthesis.</b>	<p>Uses a critical appraisal framework under supervision for educational or professional development purposes.</p> <p>Produces narrative reviews under supervision which bring together the findings from a body of publications, without detailed critique of the methods and analysis from which those findings have emerged.</p>	<p>Uses a single method critical appraisal framework for educational or professional development purposes.</p> <p>Produces narrative reviews under supervision which bring together findings from a body of publications based on a single method, with a detailed critique of the methods and analysis from which these findings have emerged.</p>	<p>Uses a single method critical appraisal framework to inform systematic reviews of the literature.</p> <p>Contributes to single method systematic reviews.</p>	<p>Uses critical appraisal frameworks to inform systematic reviews of the literature.</p> <p>Contributes to comprehensive multiple method systematic reviews.</p>	<p>Contributes to the development of specialist appraisal frameworks.</p> <p>Principal Investigator in a single method synthesising systematic reviews to inform the development of best practice protocols or guidelines</p>	<p>Appraises best practice guidelines and protocols.</p> <p>Principal Investigator in comprehensive synthesising systematic reviews to inform the development of national guidelines.</p> <p>Contributes to the advancement of evidence synthesis</p>



<p><b>Evidence translation, and implementation</b></p>	<p>Uses the products of research, such as technologies, text books.</p> <p>Uses research as a stimulus to thinking, scholarship and reflective practice.</p> <p>Follows guidelines and/or evidence based policies or protocols.</p> <p>Participates in audit and evidence utilization cycles.</p>	<p>Continually updates knowledge and understanding in field or specialism.</p> <p>Translates knowledge of advances in the subject area into professional activity.</p> <p>Makes changes in own practice and offers solutions for improving services.</p> <p>Identifies areas where research is indicated.</p> <p>Uses research papers as a stimulus for teaching purposes.</p>	<p>Provides information to others to help their development</p> <p>Uses secondary research in the production of teaching materials.</p> <p>Leads departmental audit and evidence utilisation cycles.</p>	<p>Uses secondary evidence to inform departmental service improvements.</p> <p>Uses secondary research to inform curricula.</p> <p>Leads clinical governance at departmental level.</p> <p>Develops departmental audit policies and strategies.</p>	<p>Leads clinical governance at institutional/organisational level.</p> <p>Leads and develops institutional audit and evidence utilisation cycles.</p> <p>Leads curriculum development based on secondary evidence.</p>	<p>methodology.</p> <p>Uses secondary evidence to inform national service improvement, policies and strategies.</p> <p>Develops national clinical governance frameworks.</p> <p>Develops national audit policies and strategies.</p>
--	---	--	--	---	---	--

RESEARCH TEACHING		<i>The transfer to others of expertise in certain types of research or aspects of the activity</i>				
<i>DESCRIPTION: Many of the dimensions associated with this mode of research engagement are generic activities which would be present in the teaching of any subject. Here they relate specifically to teaching research and refer to the use of research findings to inform teaching and the teaching of research activity.</i>						
LEVEL DESCRIPTORS						
Activities	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
<b>Research teaching and learning support</b>	<p>Teaches the principles of evidence based practice and leads by example.</p> <p>Inculcates an appreciation of research activity and its impact.</p>	<p>Uses research to develop own teaching materials, with assistance and support.</p> <p>Teaches the principles of evidence based health care at diploma and undergraduate level.</p>	<p>Transfers research knowledge in the form of practical skills, methods and techniques.</p> <p>Develops own research based teaching materials, methods and approaches.</p> <p>Teaches at an introductory level in a single research method i.e. ethnography.</p>	<p>Designs teaching material based on research findings and delivers either across a range of modules or within a subject area.</p> <p>Contributes to the planning, design and development of objectives and material.</p> <p>Teaches at an advanced level in a single research method i.e. Randomised Control Trials.</p> <p>Develops research or research based teaching programmes and the provision of learning support in field of subject expertise.</p>	<p>Teaches introductory research methods in broad specialist methodological field i.e. qualitative methods.</p>	<p>Oversees the design and development of the overall curricula.</p> <p>Leads the development and clarification of academic standards for the subject area.</p> <p>Contributes to the development of academic policies across the Institution.</p> <p>Develops the quality assurance framework within the institution's overall framework e.g. for the validation and revalidation of courses and student admission and assessment.</p> <p>Encourages the development of innovative approaches to course delivery and ensures that teaching delivery achieves the educational standards of the department.</p> <p>Teaches advanced research methods in broad specialist methodological field i.e. qualitative methods.</p>

						<p>Contributes to developments in the subject in national and international arena.</p> <p>Develops new knowledge, innovation and understanding in the field.</p>
<b>Research and Scholarship</b>	<p>Reflects on practice and development of own teaching skills.</p>	<p>Reflects on practice and development of own teaching and learning skills.</p> <p>Locates research materials to support teaching activities with guidance.</p>	<p>Locates research materials to support teaching activities.</p> <p>Uses pedagogic research to inform teaching.</p>	<p>Engages in subject, professional and pedagogical research as required to support teaching activities.</p> <p>Locates, appraises and analyses research materials to support teaching activities</p> <p>Conducts individual or collaborative scholarly projects.</p> <p>Identifies sources of funding and contributes to the process of securing funds for own scholarly activities.</p> <p>Extends, and applies knowledge acquired from scholarship to teaching and appropriate external activities.</p> <p>Develops and produces learning materials and disseminates the results of scholarly activity.</p>	<p>Contributes to the development of teaching and learning strategies.</p> <p>Works in conjunction with others to apply subject knowledge to practice.</p> <p>Develops new knowledge and understanding within field of subject expertise.</p>	<p>Leads the development and implementation of teaching and learning strategy.</p> <p>Conducts research into learning and teaching methodologies and disseminates best practice within and outwith the institution.</p> <p>Develops and promotes the use of innovative assessment methods.</p> <p>Leads collaborative partnerships with other educational institutions or other bodies.</p> <p>Leads bids for consultancy and other additional funds.</p> <p>Makes presentations at national and international conferences and similar events.</p>

<p><b>Liaison and networking</b></p>	<p>Liaises with colleagues, students and education providers as appropriate.</p> <p>Attends relevant local seminar programmes and conferences.</p>	<p>Liaises with colleagues and students.</p> <p>Joins appropriate internal networks.</p> <p>Contributes to relevant local seminar programmes, journal clubs and conferences.</p>	<p>Joins external networks to share information and ideas.</p> <p>Participates in national conferences and colloquia.</p>	<p>Participates in and develops external networks, for example to contribute to student recruitment, generate income, or build relationships for future activities.</p> <p>Organises national conferences and colloquia.</p>	<p>Leads and develops internal networks for example, by chairing and participating in institutional committees.</p> <p>Acts as an external examiner to other institutions and provides professional advice.</p> <p>Leads and develops external networks for example with external examiners and assessors.</p> <p>Develops links with external contacts such as other educational bodies, employers and professional bodies to foster collaboration.</p>	<p>Chairs committees and participates in institutional decision making and governance.</p> <p>Leads and develops internal and external networks to foster collaboration and share information and ideas and to promote the subject and the Institution.</p> <p>Promotes and markets the work of the department in the subject area both nationally and internationally.</p>
<p><b>Teamwork</b></p>	<p>Actively participates as a member of a community of practice.</p> <p>Attends and contributes to relevant meetings.</p>	<p>Actively participates as a member of a teaching team.</p> <p>Attends and contributes to relevant team meetings.</p>	<p>Collaborates with academic colleagues on course development and curriculum changes.</p> <p>Attends and contributes to subject group meetings.</p> <p>Collaborates with colleagues to identify and respond to students' needs.</p>	<p>Acts as a responsible team member, leading where agreed, and develops productive working relationships with other members of staff.</p>	<p>Leads teams within areas of responsibility.</p> <p>Ensures that teams within department work together.</p> <p>Acts to resolve conflicts within and between teams.</p>	<p>Develops and communicates a clear vision of the unit's strategic direction.</p> <p>Ensures the enactment of institutional strategic plans.</p> <p>Promotes a collegiate approach and develops team spirit and team coherence.</p> <p>Fosters inter-disciplinary team working.</p>

<p><b>Managing people</b></p>	<p>Manages own activities.</p>	<p>Manages with guidance, own teaching activities.</p>	<p>Manages own teaching, scholarly and administrative activities with guidance if required.</p>	<p>Mentors colleagues with less experience and advises on personal development.</p> <p>Co-ordinates the work of others to ensure modules are delivered to the standards required.</p> <p>Coordinates the work of colleagues to identify and respond to students' needs.</p>	<p>Provides academic leadership to those working within programme areas, as course leader or equivalent, by for example, agreeing work plans to ensure that courses are delivered effectively and organising the work of a team by agreeing objectives and work plans.</p> <p>Contributes to the development of teams and individuals through the appraisal systems and providing advice on personal development.</p> <p>Acts as a personal mentor to peers and colleagues.</p> <p>Resolves problems affecting the quality of course delivery and student progress within own areas of responsibility referring more serious matters to others, as appropriate.</p>	<p>Exercises academic leadership for all subject area teaching and scholarly activities.</p> <p>Acts as line manager for matters relating to the employment of staff and ensuring the work is allocated fairly, according to skills and capacity.</p> <p>Ensures staff are suitably qualified to work within their own area.</p> <p>Appraises and advises staff on personal and career development plans.</p>
<p><b>Initiative, problem solving and decision making</b></p>	<p>Identifies problems which may affect student learning in the practice setting.</p> <p>Contributes to decisions affecting the practice setting as a learning environment.</p>	<p>Deals with problems which may affect the delivery of own teaching.</p> <p>Contributes to decisions affecting the work of the team.</p>	<p>Develops initiative, creativity and judgement in applying appropriate approaches to teaching and learning support and scholarly activities.</p>	<p>Identifies the need for developing the content or structure of modules with colleagues and make proposals on how this should be achieved.</p>	<p>Resolves problems affecting the delivery of courses within own educational programme and in accordance with regulations.</p> <p>Makes decisions regarding the operational aspects of own educational programme.</p>	<p>Determines academic standards within own areas of responsibility.</p> <p>Contributes to the determination of the academic standards framework across the institution</p>

			<p>Responds to pedagogical and practical challenges.</p> <p>Shares responsibility in deciding how to deliver modules and assess students.</p> <p>Contributes to collaborative decision making with colleagues on academic content and on assessment of students' work.</p>	<p>Develops ideas for generating income and promoting the subject.</p> <p>Develops ideas and finds ways of disseminating and applying the result of scholarship.</p> <p>Takes sole responsibility for the design and delivery of own modules and assessment methods.</p> <p>Collaborates with colleagues on the implementation of assessment procedures.</p> <p>Advises others on strategic issues such as student recruitment and marketing.</p> <p>Contributes to the accreditation of courses and quality control processes.</p> <p>Tackles issues affecting the quality of delivery within scope of own level of responsibility, referring more serious matters to others, as appropriate.</p>	<p>Contributes to decisions which have an impact on other related programmes.</p> <p>Monitors student progress and retention.</p> <p>Provides advice on strategic issues such as the balance of student recruitment, staff appointments and student and other performance matters.</p> <p>Identifies opportunities for strategic development of new courses or appropriate areas of activity and contributing to the development of such ideas.</p>	<p>Determines the final allocation of resources within own area of responsibility.</p> <p>Acts as the final arbiter in local disputes.</p> <p>Contributes to strategic decisions at Institutional level</p> <p>Leads the development of new and creative approaches in responding to teaching and learning challenges.</p> <p>Initiates new and original solutions to problems.</p> <p>Provides advice to external bodies</p>
<b>Planning and managing resources</b>	Plans own day-to-day activity in order to incorporate learning support into service delivery activities.	<p>Plans own day-to-day activity within the framework of the agreed programme.</p> <p>Coordinates own work with that of others in order to avoid conflict or duplication of effort.</p>	<p>Uses teaching resources and facilities as appropriate.</p> <p>Plans and manages own teaching and tutorials as agreed with mentor.</p>	<p>As module leader or tutor, liaises with others to ensure student needs and expectations are met.</p> <p>Manages projects relating to own area of work and the organisation of external activities such as placements.</p>	<p>Responsible for the delivery of own educational programmes.</p> <p>Contributes to the overall management of the department in areas such as resource management, business and programme planning.</p>	<p>Takes overall responsibility for the organising and deployment of resources within own areas of responsibility.</p> <p>Contributes to institutional planning and strategic development.</p>

		<p>Contributes to the planning of teaching programmes.</p>			<p>Takes responsibility for setting standards and monitor progress against agreed criteria for own area of responsibility.</p> <p>Contributes to departmental level strategic planning and contribute to the institution's strategic planning processes.</p> <p>Plans and delivers consultancy or similar programmes and ensure that resources are available.</p> <p>Takes responsibility for quality, audit and other external assessments in own areas of responsibility.</p>	
--	--	--	--	--	---	--

RESEARCH SUPERVISION/MENTORSHIP				Supervision and mentorship of less experienced research producers		
DESCRIPTION						
<p>Research supervision/mentorship is essential at all levels of research production. It requires subject expertise, increasing research producer experience across the levels of research production and an understanding of the appropriate trajectory of supervised projects at the specified level. This mode of engagement is typically strongly aligned with the research production and research teaching modes of engagement. Research supervisors themselves require supervision and mentorship to support their development across the spectrum of activity.</p>						
LEVEL DESCRIPTORS						
Activities	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
<p><b>Teaching and learning support</b></p>	<p>Supervises the work of undergraduates undertaking literature review dissertations in field of subject expertise within an established programme of study, with the support of a mentor if required.</p> <p>Understands the required standard for the programme of study.</p> <p>Identifies learning needs of students and defines appropriate learning materials.</p> <p>Develops own supervisory methods and approaches with guidance.</p> <p>Assesses student progress and provides feedback.</p>	<p>Supervises the work of Masters students undertaking literature review dissertations in field of subject expertise within an established programme of study, with the assistance of a mentor if required.</p> <p>Understands the required standard for the programme of study.</p> <p>Contributes to departmental policies and strategies in relation to research supervision at undergraduate and Masters' level.</p> <p>Understands the trajectory of supervised projects at this level and applies a range of strategies necessary to ensure student's progress.</p>	<p>Supervises the work of Masters students undertaking systematic literature review dissertations and/or empirical projects in field of subject expertise within an established programme of study, with the assistance of a mentor if required.</p> <p>Understands the required standard for the programme of study.</p> <p>Identifies where current provision is in need of revision or improvement.</p> <p>Understands research governance processes.</p> <p>Takes responsibility for the ethical conduct of any empirical projects.</p>	<p>Supervises the work of doctoral students undertaking systematic review dissertations or empirical projects in field of subject expertise within an established programme of study, with the assistance of a mentor if required.</p> <p>Contributes to departmental policies and strategies in relation to research supervision.</p> <p>Supervises the work of researchers on a managed project.</p> <p>Understands the trajectory of supervised projects at this level and has knowledge and applies a range of strategies necessary to ensure students' progress.</p>	<p>Supervises postdoctoral researchers, supporting professional development and career planning.</p> <p>Takes the lead in developing strategies and policies for the application, registration and supervision of research students within the department.</p> <p>Develops the quality assurance framework within the institution's overall framework e.g. for the validation and revalidation of courses and student admission and assessment.</p> <p>Encourages the development of best practice and ensures that supervisory standards are at the required level for the department.</p>	<p>Contributes to the development of strategies and policies for the application, registration and supervision of research students within the institution.</p> <p>Contributes to the development of strategies for the professional development of early stage researchers.</p> <p>Develops the institutional quality assurance framework.</p> <p>Contributes to external bodies and national policies and strategies.</p>



	<p>Marks dissertations, with support.</p> <p>Engages in continuous professional development.</p> <p>Aware of expectations of supervisors within the department and institution.</p> <p>Engages the interest of students and inspires them.</p> <p>Understands equal opportunity academic content and issues relating to student need.</p> <p>Understands the trajectory of supervised projects at this level and has a developing knowledge of the strategies required to support student progress.</p>		<p>Understands the trajectory of supervised projects at this level and applies range of strategies necessary to ensure student's progress.</p>		<p>Develops and monitors departmental strategies for the professional development and management of early stage researchers and research staff.</p>	
<b>Research and scholarship</b>	<p>Reflects on practice and the development of own teaching and learning skills.</p>	<p>Conducts individual scholarship in specialist field.</p> <p>Continually updates knowledge and understanding in field or subject expertise.</p> <p>Translates knowledge of advances in the subject area.</p>	<p>Conducts individual and collaborative research projects.</p> <p>Identifies sources of funding and contributes to the process of securing funds.</p> <p>Extends, transforms and applies knowledge acquired from scholarship to supervision, research and appropriate external activities.</p> <p>Writes or contributes to publications or disseminates research findings using appropriate media.</p>	<p>Determines relevant research objectives and prepares research proposals.</p> <p>Contributes to the development of research strategies.</p> <p>Carries out independent research and acts as a Principal Investigator and project leader.</p> <p>Makes presentations or exhibitions at national or international conferences and other similar events.</p>	<p>Leads the development and implementation of departmental research strategy.</p> <p>Leads and coordinates research activity in the subject.</p> <p>Leads research and collaborative partnerships with other educational institutions or other bodies.</p> <p>Leads bids for research, consultancy and other additional funds.</p>	<p><i>* Like all the elements, this builds on the demands in the profiles at lower levels. In this case there is no additional demand.</i></p>

			Makes presentations at conference or exhibits work in other appropriate events.		Makes presentations at national and international conferences and similar events.	
<b>Pastoral care</b>	<p>Appreciates the needs of individual undergraduate students and their circumstances.</p> <p>Refers students to appropriate services providing further help.</p>	<p>Appreciates the needs of individual Masters students and their circumstances.</p> <p>Refers students to appropriate services providing further help.</p>	Takes responsibility for dealing with referred issues for students supervised.	Provides first line support for colleagues, referring them to sources of further help if required.	Takes responsibility for the initial resolution of all student issues within and outwith standard procedures.	Develops institutional frameworks for the resolution of student issues.
<b>Managing people</b>	Manages own supervisory activities.	Mentors colleagues with less experience and advises on personal development.	Mentors colleagues with less experience and advises on personal development.	Provides leadership in supervisory activities.	<p>Contributes to the development of strategies and policies for mentorship, career planning and continuing professional development.</p> <p>Appraises and advises staff on personal and career development plans.</p>	Manages matters relating to supervisory capacity ensuring the work is allocated fairly, according to skills and capacity.
<b>Liaison and networking</b>	<p>Liaises with colleagues and students.</p> <p>Builds internal contacts and participates in internal networks for the exchange of information and to form relationships for future collaboration.</p>	Joins external networks to share information and ideas.	Develops external academic networks in field or discipline.	Participates in and develops external networks, for example to identify sources of funding, contribute to student recruitment, market the institution, or build relationships for future activities.	<p>Leads and develops internal networks, for example, by chairing and participating in institutional committees</p> <p>Leads and develops external networks for example with external examiners and assessors.</p> <p>Develops links with external contacts such as other educational bodies, employers and professional bodies to foster collaboration.</p>	Develops links with major external bodies.

RESEARCH LEADERSHIP				<i>Development and communication of a vision for research and strategies for achieving this</i>		
DESCRIPTION:						
<i>Research leadership is typically associated with advanced level skills. This mode of engagement tries to capture the dimensions of this important facet of research activity as it develops over the full range of the research career trajectory.</i>						
LEVEL DESCRIPTORS						
Activities	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
<b>Vision</b>	Develops personal research plan within the context of a wider programme of work.	Develops and communicates a vision for a programme of research within a wider departmental and institutional strategy, as a nationally recognised authority in a field.	Develops and communicates a vision for a departmental research programme within a wider institutional and national/international strategic context, as a leading authority in the field with a national/international reputation.	Develops and communicates a vision for an institutional research strategy within wider national/international strategic context.  Understands research communities and the higher education and wider policy context.	Develops and communicates a vision for national research strategies.  Understands the national research policy context.  Understands the needs of national research communities.  Understands the needs of national users of research.	Develops and communicates a vision for international research strategies.  Understands international research policy context.  Understands the needs of international research communities.  Understands the needs of international users of research.
<b>Planning and managing resources</b>	Develops strategies to progress personal research plan within the framework of an agreed programme.  Coordinates own work with that of others to avoid conflict or duplication of effort.	Develops strategies to progress research programme plan.  Identifies short, medium and long term priorities.  Manages the use of resources and ensures that effective use is made of them.	Takes responsibility for the delivery of own research programmes.  Develops strategies to progress departmental research programme.	Ensures the enactment of the institution's strategic direction.	Ensures the enactment of national strategic plans.  Commissions research at national level.	Ensures the enactment of international strategic plans.  Commissions research at international level.

	<p>Identifies relevant funding sources.</p> <p>Uses research resources and infrastructure as appropriate.</p>	<p>Manages or monitors research budgets.</p> <p>Helps plan and implement commercial and consultancy activities.</p> <p>Plans and manages own consultancy assignments.</p>	<p>Contributes to the overall management of the department.</p> <p>Contributes to departmental strategic planning and contributes to the institution's planning process.</p> <p>Plans and delivers research, consultancy or similar programmes, ensuring that resources are available and required income levels are achieved.</p> <p>Contributes to the management of quality, audit and other external assessments.</p> <p>Ensures the enactment of institutional strategic plans.</p>			
<b>Liaison and networking</b>	<p>Liaises with colleagues.</p> <p>Builds internal contacts and participates in external networks for the exchange of information and to form relationships for future collaboration.</p>	<p>Understands the research community in own field.</p> <p>Identifies potential collaborators and builds strategic alliances.</p>	<p>Understands the research community in the discipline.</p> <p>Leads and chairs internal networks for example by participating in institutional committees.</p> <p>Leads and develops external networks for example with other active researchers and thinkers in the field.</p> <p>Joins relevant inter-disciplinary networks.</p>	<p>Understands multiple research communities within academe.</p> <p>Chairs committees and participates in institutional decision making and governance.</p> <p>Leads and develops internal and external networks to foster collaboration and share information and ideas and to promote the institution.</p> <p>Promotes interdisciplinary collaboration.</p>	<p>Understands national research communities and international research context.</p> <p>Chairs committees and participates in national level decision making and governance.</p> <p>Fosters institutional collaboration.</p>	<p>Understands international research communities.</p> <p>Chairs committees and participates in international decision making and governance.</p> <p>Fosters international collaboration.</p>

			Develops links with external contacts such as other educational and research bodies, professional bodies and other providers of funding and research initiatives to foster collaboration and generate income.			
<b>Managing people</b>	<p>Manages own activities.</p> <p>Leads by example, through the production of nationally excellent scholarship.</p>	<p>Supports individuals to develop personal research plans within the context of a wider research programme.</p> <p>Leads team of researchers contributing to a programme of research activity.</p> <p>Leads by example through the production of internationally excellent scholarship.</p> <p>Develops team spirit and team coherence.</p> <p>Mentors colleagues with less experience and advises on personal development.</p> <p>Coaches and supports colleagues in developing their research techniques.</p> <p>May act as line manger of research teams.</p>	<p>Supports programme leaders to develop programme plans within the context of the departmental strategy.</p> <p>Provides departmental leadership to research programme leaders.</p> <p>Leads by example through the production of world class research and scholarship.</p> <p>Acts as personal mentor to peers and colleagues.</p> <p>Contributes to the development of teams and individuals through the appraisal system and providing advice on personal development.</p>	<p>Supports research programme leaders and heads of department in the context of departmental strategy.</p> <p>Liaises with relevant external bodies.</p>	<p>Supports national research leaders and senior higher education managers in the context of national strategy</p> <p>Liaises with relevant policy makers.</p>	<p>Supports international research leaders and senior research managers and policy makers in the context of international strategy.</p>

RESEARCH MANAGEMENT				<i>The management of research activities</i>		
<i>This mode of engagement spans a wide spectrum of activities in academic and clinical contexts ranging from those that underpin the production of individual research projects through to those that inform the practice of a professional research manager operating on an international stage.</i>						
LEVEL DESCRIPTORS						
Activities	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
<b>Planning and managing resources</b>	<p>Plans own day-to-day research activity within the framework of the agreed programme, through the setting of research goals, intermediate milestones and prioritisation of activities.</p> <p>Designs and executes systems for the acquisition and collation of information through the effective use of appropriate resources and equipment.</p> <p>Uses information technology appropriately for database management, recording and presenting information.</p> <p>Coordinates own work with that of others to avoid conflict or duplication of effort.</p> <p>Contributes to the planning of research projects.</p> <p>Contributes to organisational research governance, for example, co-ordinating grant applications.</p>	<p>Plans day-to-day activity for small research team/project or one arm of a larger study such as a clinical trial according to protocol.</p> <p>Uses research resources, laboratories and workshops as appropriate.</p> <p>Plans and manages own research activity in collaboration with others.</p> <p>Manages or monitors research budgets.</p> <p>Plans day-to-day activity in relation to a key element of research governance at the level of the institution/organisation, for example, manages ethical approval of grant applications.</p>	<p>Plans, co-ordinates and implements complex projects and programmes of research, including multi-centre studies and large trials.</p> <p>Manages the use of research resources and ensures that effective use is made of them.</p> <p>Helps to plan and implement commercial and consultancy activities.</p> <p>Plans and coordinates a team responsible for several elements of organisational research infrastructure e.g. research governance, research contracts.</p> <p>Manages research unit or clinical research facility.</p> <p>Understands and communicates institutional management systems and the wider higher education environment, including equal opportunities issues</p>	<p>Plans, co-ordinates and manages overall departmental research programmes.</p> <p>Contributes to the overall management of the department in areas such as budget management and business planning.</p> <p>Contributes to departmental level strategic planning and to the institution's strategic planning processes.</p> <p>Plans and delivers research, consultancy or similar programmes, ensuring that resources are available and required income levels are achieved.</p> <p>Contributes to the management of quality, audit and other external assessments e.g. the Research Assessment Exercise.</p> <p>Takes overall responsibility for the organising and deployment of resources within own areas of responsibility.</p>	<p>Plans, coordinates and manages overall institutional/organisation research infrastructure and support system.</p>	<p>Plans, coordinates and manages research at national/international level.</p> <p>Manages and monitors commissioned programmes of research activity, networks of excellence.</p>

<p><b>Managing People</b></p>	<p>Manage self and relationship with supervisors, peers and colleagues.</p> <p>Provides guidance as required to support staff and any students who might be assisting with a project.</p>	<p>Mentors colleagues with less experience and advises on personal development.</p> <p>Coaches and supports colleagues in developing their research techniques.</p> <p>Co-ordinates the work of others to ensure that research projects are delivered effectively and to time or organises the work of a team by agreeing objectives and work plans.</p> <p>Could act as line manager (e.g. of research teams).</p> <p>Understands equal opportunities issues as they may impact on areas of research</p>	<p>Contributes to the development of teams and individuals through the appraisal system and providing advice on personal development.</p>	<p>Acts as line manager for matters relating to the employment of staff and ensuring the work is allocated fairly, according to skills and capacity.</p> <p>Ensures that staff are suitably qualified to work within their own area.</p>	<p>Leads on research management and governance at organisational level.</p> <p>Acts as line manager.</p> <p>Manages teams working within area.</p>	<p>Leads on research management at national/international level.</p>
<p><b>Research governance</b></p>	<p>Takes responsibility for ethical conduct of own projects.</p> <p>Appreciates standards of good practice in the institution and/or discipline.</p> <p>Understands relevant health and safety issues and demonstrates responsible working practices.</p> <p>Aware of issues relating to the rights of other researchers, or research subjects, and of others who may be affected by the research e.g. confidentiality,</p>	<p>Takes responsibility for ethical conduct of a research project for team.</p>	<p>Takes responsibility for ensuring Principal Investigators are aware of the requirements for the ethical conduct of their studies.</p> <p>Develops and communicates knowledge of institutional standards with respect of research governance and management.</p>	<p>Develops and communicates departmental frameworks for the ethical conduct and appropriate management of research projects.</p>	<p>Develops and communicates institutional frameworks for the ethical conduct and appropriate governance of research projects.</p>	<p>Develops and communicates national/international frameworks for the ethical conduct and governance of research projects.</p>

	ethical issues, attribution, copyright, malpractice, ownership of data and the requirements of the Data Protection Act.					
--	---	--	--	--	--	--

<b>RESEARCH INFLUENCE//FACILITATION</b>		<i>Promoting the production and utilisation of research and the development of a research culture</i>				
<i>DESCRIPTION</i>						
<i>This mode of engagement is designed to capture the diverse ways nurses can influence the production and utilisation of research by participating in and promoting a research culture.</i>						
<i>LEVEL DESCRIPTORS</i>						
Activities	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
<b>Influence and facilitation</b>	<p>Reviews literature with support and identify gaps in knowledge and understanding.</p> <p>Identifies clinical questions for which the research evidence is unclear.</p>	<p>Makes decision about the focus of personal research plan within the context of a wider research programme, with the support of a mentor as necessary.</p> <p>Contributes to the development of strategic plans for wider programme of research activity.</p> <p>Undertakes reviews of research-based papers/books.</p>	<p>Leads and develops strategic plans for a programme of research.</p> <p>Peer reviews externally funded research.</p>	<p>Leads and develops strategic plans for department programmes of research.</p> <p>Leads and develops strategic plans for research utilisation within a clinical area.</p> <p>Contributes to research commissioning through membership of national/international committees</p>	<p>Leads and develops institutional strategic research plan.</p> <p>Makes strategic decisions in relation to selective investment and disinvestment in institutional research activity.</p> <p>Leads and develops strategic plans for research utilisation and service development within an institution/organisation.</p> <p>Chairs committees and participates in institutional decision making and governance</p>	<p>Contributes to decisions about national/international research priorities.</p> <p>Contributes to the commissioning of national/international research programmes.</p> <p>Chairs committees and participates in national and international research agenda.</p>



<p><b>Liaison and networking</b></p>	<p>Liaises with colleagues/students.</p> <p>Attends relevant local seminar programmes and conferences.</p>	<p>Builds internal networks.</p> <p>Attends relevant local and national conferences.</p> <p>Joins external networks.</p> <p>Contributes to relevant local seminar programmes, journal clubs and conferences.</p>	<p>Participates in and develops external networks to exert influence and build strategic alliances.</p> <p>Collaborates actively within and outwith the institution to influence the direction of research and build a research culture.</p> <p>Participates in the organisation of national conferences and colloquia.</p>	<p>Leads and develops internal networks for example by chairing and participating in institutional/organisational committees.</p> <p>Leads and develops external networks for example with other researchers and leading thinkers in the field.</p> <p>Develops links with external contacts such as professional bodies, research funding councils etc.</p> <p>Organises national conferences and colloquia.</p>	<p>Contributes to the enhancement of research quality in the field by being involved in quality assurance and other external decision making bodies.</p> <p>Promotes and markets the work of the institution both nationally and internationally.</p>	<p>Builds relationships with a broad range of research communities in order to understand their needs and expectations.</p> <p>Builds relationships with a broad range of research users in order to understand their needs and expectations.</p>
<p><b>Team work</b></p>	<p>Attends and contributes to relevant meetings</p> <p>Works with colleagues on joint projects as required.</p>	<p>Develops productive relationships with other members of staff.</p>	<p>Acts as team leader.</p>	<p>Leads teams within context of departmental programme.</p> <p>Develops and communicates a clear vision of department's strategic direction.</p> <p>Develops productive relationships with other teams/departments which have strategic impact on activity.</p> <p>Acts to resolve conflict within and between teams.</p>	<p>Fosters interdisciplinary team working.</p>	<p>Fosters inter-institutional and interdisciplinary team working as appropriate.</p>

## Appendix 4

NO. 14

NUMBER 1

7000/10/28 11.1.06 5002

**FILE COPY**



Canolfan Gwasanaethau Busnes  
Business Services Centre

**South East Wales Research Ethics Committee**  
Direct Lines: 029 2037 6623 / 029 2037 6822  
Facsimile: 029 2037 6835

Mrs S T Taylor  
41 Dale Road  
Newport  
NP18 9DZ

09 April 2009

Dear Mrs Taylor

**Full title of project: An exploration of the nurse consultant roles in relation to evidence based practice**

Thank you for seeking the Committee's advice about the above project.

You provided the following documents for consideration:

Covering Letter dated 06 April 2009  
Research Protocol

These documents have been considered by the Chair Dr D E B Powell.

I enclose a copy of our leaflet, "Defining Research", which explains how we differentiate research from other activities. Dr Powell has advised that the project should be regarded as a service development and is not considered to be research according to this guidance therefore it does not require ethical review by a NHS Research Ethics Committee.

You should check with the Trusts what other review arrangements or sources of advice apply to projects of this type. Guidance may be available from the clinical governance office.

This letter should not be interpreted as giving a form of ethical approval or any endorsement of the project, but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements.

However, if you, your sponsor/funder or any NHS organisation feels that the project should be managed as research and/or that ethical review by a NHS REC is essential, please write setting out your reasons and we will be pleased to consider further.



Canolfan Gwasanaethau Busnes  
Ty Churchill  
17 Ffordd Churchill  
Caerdydd, CF10 2TW  
Ffôn: 029 20 376820 WHTN: 1809  
Ffacs: 029 20 376826

Business Services Centre  
Churchill House  
17 Churchill Way  
Cardiff, CF10 2TW  
Teleffôn: 029 20 376820 WHTN: 1809  
Facs: 029 20 376826

Man o Adlysgu: Ewrdd Iechyd Lleol Powys / part of Powys Teaching Local Health Board

**Professional Doctorate in Nursing: An Exploration of  
the Nurse Consultant Roles in relation to Evidence  
Based Practice**

V2

I am registered nurse who is carrying out a research study as part of a Professional Nursing Doctorate with Cardiff University. The research I am interested in, aims to develop a better understanding of the research component of the nurse consultant role and how this has developed and influenced other nurses. I hope to gain a better understanding of this by interviewing 20 nurse consultants throughout the United Kingdom.

The results of the study will be written as a thesis and presented to Cardiff University.

If you are interested in participating in this study or would like further information of what this would involve, please contact:

Mrs Susan Taylor  
Education Centre  
Bristol Royal Infirmary  
suetaylor41@hotmail.co.uk  
07939407984

## **PARTICIPANT INFORMATION SHEET**

### **Study Title: An Exploration of the Nurse Consultant Roles in Relation to Evidence Based Practice**

You are being invited to take part in a research study which explores the nurse consultant roles in relation to evidence based practice. Before you decide you need to understand why the research is being done and what it would involve for you.

This leaflet explains why the study is being carried out and what would be required from you if you decided to take part.

#### **What is the purpose of the research study?**

I am a registered nurse who is carrying out the research study as part of a Professional Nursing Doctorate. The results of the study will be written as a thesis and presented to Cardiff University.

This research aims to develop a better understanding of the research component of the nurse consultant role and how this has developed and influenced other nurses. I hope to gain a better understanding of this by interviewing 20 nurse consultants throughout the United Kingdom.

#### **Why have you been invited?**

This is primarily research undertaken for educational purpose, in an area I have particular interest. A sample of nurse consultants who currently work within the National Health Service and have done so for a minimum of one year, are invited to take part in this study.

### **What am I asking you to do?**

If you do decide to take part, complete the attached questionnaire and return it to me in the stamped addressed envelope within the next two weeks to arrange an appointment at a time and place convenient to you. I will be in touch with you within two weeks of hearing from you.

The research involves an interview, which should take about an hour. During the interview I will be asking you to talk about your experiences of the research component of your role. The interview will be conducted by myself and with your permission will be audio taped. If you would like a transcript of your interview, this can be sent to you for electronically for your approval

### **Do you have to take part?**

You do not have to take part in the study. You can withdraw from participation in the study at any time and do not have to give a reason.

### **What are the possible benefits of taking part?**

There may be no benefit to you personally. However, it is hoped that this study provides knowledge which may help to inform the evidence based practice in nursing. The results from the study will be included in my final thesis.

### **What are the possible disadvantages and risks of taking part?**

During the interview, it is possible that some people may become upset whilst talking about individual experiences where the research component of their role may not be fulfilled. If you feel distressed and want the interview to stop, we can terminate the interview at any time.

### **Who will see the information about you?**

All of the information you disclose during the interview will be treated as strictly confidential and anonymously. No individuals or individual Trusts will be identified in publications that result from the research. The Interview will be audio taped, with your permission, and the tapes will be destroyed following transcription. Transcripts will not contain your name, but will instead be allotted a number and kept in a locked cupboard. Data will be kept for 15 years after which it will be destroyed. You will be given the right to withdraw consent at any time during the course of the study.

This project has been approved by Cardiff University and Multi Research Ethics Committee. A summary of the report will be sent to everyone who took part should they wish to receive this.

**What happens if you have any concerns about the study?**

If you would like any further information, or have any concerns or queries (before, during or after your participation in the study), please do not hesitate to contact

Sue Taylor,

Researcher

Tel. 07939407984

[suetaylor41@hotmail.co.uk](mailto:suetaylor41@hotmail.co.uk)

PARTICIPANT INFORMATION SHEET V.1

---

**An Exploration of the Nurse Consultant Roles in Relation to Evidence Based Practice**

I have received the information on the above study, and would like to talk to the researcher to find out more about taking part.

Please contact me to arrange a convenient time and place to meet.

Name: \_\_\_\_\_

I would prefer to be contacted by:

E- Mail Address (please provide address)

\_\_\_\_\_

POST (please provide address)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

TELEPHONE (please provide telephone number)

\_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

# PARTICIPANT CONSENT FORM

An Exploration of the Nurse Consultant Roles in Relation to Evidence Based Practice

Researcher: Sue Taylor

*Please initial  
each box*

1. I confirm that I have read and understand the information sheet dated .....  
(version ...) for the above research study. I have had the opportunity to consider the  
information provided and to ask questions, which have been answered adequately.
2. I understand that participation is entirely voluntary and that I can withdraw from the  
study at any time, without giving any reason.
3. I understand that the interview will be audio taped and that the audiotape will be kept  
confidential, which will be immediately destroyed following transcription.
4. I understand that anonymised data collected during the study will be made publicly  
available, which I give permission for. I understand that all documentation relating to the  
research will be destroyed within fifteen years of the study being completed.
5. I agree to participate in the above research study.

---

Name of participant	Signature	Date
---------------------	-----------	------

---

Name of researcher	Signature	Date
--------------------	-----------	------

Copies: x1 to participant; x1 to researcher



## Appendix 5

### Semi Structured Interview Schedule

The interview schedule was developed from the key findings of the literature review which were role development, academic attainment and role clarity regarding the research component of their role.

**Opening statement: Researcher:** The core functions of the nurse consultant role are described as expert practice, professional leadership, education and training, service development and research and evaluation. For the purposes of this research I am focusing on the research aspect of the role.

I would like to start this interview by asking questions about your nursing background, your education in order to learn a little more about your professional development and your appointment as nurse consultant.

In your job description how was the research component of your role described?

Have you been able to achieve or work towards this aspect of your role?

In comparison to your job description, how do you interpret the research component of your role?

Do you feel that the educational attainments and nursing experience have prepared you for the research aspect of the role?

How do you feel that the research aspect of the role has impacted on the nurse consultant service?

How do you feel the research aspect of the role has impacted on other health professionals?

Based on your experience how do you see this aspect of your role developing in the future?

## Appendix 6

### Influence of Job Descriptions

Research Participants	Influence of Job Descriptions
Alice	Research clearly defined in job descriptions. Did not know how the job description was developed and by whom. Strong mentorship the biggest influence of delivering on the research component.
Bethan	Research clearly written in job description. Written independently and scrutinised by a regional panel. Job description influenced the legitimacy of taking time out to undertake research.
Carl	Within the job description, research defined as having formal links with University. Carl chose to interpret this as curriculum planning as he did not have the experience in research and strategic demands of the role took priority.
Dawn	Service Design became the main focus of job description not research. University was not involved in the development of the job description.
Elsa	Involved in writing own job description. University not involved.
Frank	Written in job description that NC post had an affiliation to University. Unsuccessful in the delivery of research due to lack of experience and mentorship. Reverted to the domains of the role they felt comfortable with.
Gabrielle	Job description written by service manager developed with Gabrielle in mind. As long as the NC were engaged in research in some way it was felt acceptable. University not involved in developing the job description.
Helen	General Manager with head of nursing wrote job description. University not involved but did state applicant must be working towards a PhD.
Irene	Job description written to fit Irene. Irene felt uncomfortable with this. University not involved in the process.
Jacqui	Directorate manager and Head of Nursing wrote job description. Unrealistic expectations of what the research component needed to look like. Included National, international research leading by publication. University not involved in the development of the job description.
Kathleen	Asked to write the job description for the NC post they subsequently applied for.
Lauren	Nurse Director wrote job description. Research Element weak. University not involved in the process.
Melanie	Did not know who wrote job description but research the least fulfilled of their role.

## Influence of a higher degree

Research Participants	Influence of a higher degree
Alice	Mentorship within clinical practice was the biggest driver for success which supported Principal Investigator status.
Bethan	Masters education made Bethan more aware of the research process but conducting research and learning on the job and also learning from good mentors and experienced researchers was equally if not more important.
Carl	Masters education facilitated a better understanding of the process but did not prepare for the mechanics of doing studies. Exploring funding opportunities or linking with HEIs was cited as a barrier to their research role and too daunting to take forward without experience.
Dawn	Masters education undertaken. Could possibly write a research proposal as a result but not sure.
Elsa	Concerns raised regarding Masters education being more prevalent as extended literature reviews. Research experience depleted. Elsa felt that an expert in research someone who had completed a PhD. Felt it would strengthen research component and admitted she needed research training.
Frank	Completed a Masters. Unsuccessful in the delivery of research due to lack of experience and mentorship. Honorary lectureship with University.
Gabrielle	Masters education undertaken as a research project. Not really prepared Gabrielle for the research component of their role. Quite liked the research but not the scrutiny of Masters education.
Helen	PhD gave Helen the credibility with professional peers. Publications were directly linked to clinical services and were regarded as an important aspect of her work for the service Helen provided. Other professionals saw the value of research as a result.
Irene	Concerns repeated: regarding Masters education being more prevalent as extended lit reviews. Research experience depleted. PhD attained but did not undertake research as a lead at time of interview
Jacqui	Educated to Masters, most of her post Masters qualifications related to the clinical needs of Jacqui's role to ensure she could deliver as an independent practitioner.
Kathleen	Despite completing PhD while newly appointed to the NC role Kathleen stated that it did not make her an expert in research especially if the research skills are not constantly used. Chaired a research and development committee. And governance assurance for studies.
Lauren	Currently undertaking Masters therefore too early to comment on the influence of higher degree.
Melanie	Research module was good in their Masters education but all Melanie's research education was through research experience and working within a team.

## Socialisation into Research Aspect of their role from Education through to Service Setting

Research Participants	Socialisation into Research Aspect of their role from Education through to Service Setting.
Alice	Opportunity to develop research skills by working alongside influential leader in nursing researcher. That experience enabled other clinical nurses to be socialised in the research process.
Bethan	An experienced researcher who acted as a mentor to Bethan was the catalyst for her success and taught her skills in relation to practical research in clinical practice. Bethan acknowledged you could not do research single handed and needed a research team support. Research was also regarded as a legitimate part of her job. Research evidence produced of Bethan's studies demonstrated to other team members that the research evidence and recommendations have improved patient outcomes and changed care pathways.
Elsa	Socialisation into research was described in the context of a team approach and related to Elsa contributing to the evidence based practice agenda and contributing to the research agenda at national level through discussions with peers in her specialty and awareness of current research outcomes. Undertaking research but retaining key clinical links was viewed by Elsa as the key to the connection to the real world of clinical and academia and referred to it as a powerful combination for improving care.
Helen	Helen believed that educational attainments and nursing experience were the only skills to deliver on this aspect of the role and in her view NCs should make their own opportunities by making sure they are in the right place at the right time. Helen described this as putting herself forward for national work and engaging with researchers in academic institutions.
Irene	Irene was undertaking a PhD at the time of this research. In Irene's view research was not really welcomed by other nurses and this was a frustration for Irene. Nevertheless Irene stated that the research interview had reinforced what she had achieved in research to research development of her role; nearly completing a PhD, changing a work environment to engage with research, supporting Masters students. Irene also handpicked a research champion to provide the support needed to develop the research component of their role.
Jacqui	The emphasis was on clinical work due to government targets and Trust initiatives and the research component of the role had not been developed. Jacqui supports nurses who are undertaking courses with a research component based on her MSc experience but has not been supported to deliver on the research component of her role.

Research Participants	Socialisation into Research Aspect of their role from Education through to Service Setting.
Melanie	Melanie acknowledged that the main introduction to research was to work alongside a team who were research active led by an enthusiastic medic. The link with the University was also cited as being an essential component of the NC role, by have the facilities to seek other research support and be more aware of the evidence generated or developed from practice. The results of research were defined as having an impact on the way Melanie worked.
Kathleen	Socialised into research component while undertaking a PhD once appointed. Kathleen had not been research active as a lead since PhD but was keen to publish, but has had to explore support in order to learn how to write for publication. Kathleen felt that medics had ring fenced time for research whereas for nursing that was not the case. Being able to deliver on this aspect of the role in Kathleen's view was dependent on the research culture within the organisation and medical staff would be more supportive of Kathleen's research time than nursing management who in her opinion were more clinically focused.

## Structural constraints of negotiating the role in practice

Research Participants	Structural constraints of negotiating the role in practice.
Alice	Time spread so thinly in relation to service development and other things it was tricky to match up the research time with all the other things associated with delivering a service Alice needed to do.
Carl	Least research active and referred to being pulled lots of different ways and in his original job plan he expected to spend half a day a week doing research and education. It has turned out much less than that with the main reason being that clinical practice takes precedence. Carl also did not consider himself to be research savvy and therefore had not personally driven this side of his role forward. Carl had gravitated to things he had felt more comfortable with.
Elsa	Elsa recognised the connection between research and service but acknowledged the challenge of undertaking research as part of her role and stated that the majority of her practice was regarding service evaluation. Elsa conceded that while an NC with an academic background can support and facilitate research Elsa felt that this was probably as much as you can expect from someone who has a massive workload. Elsa commented on the potential need for research practitioner roles.
Frank (NC6)	Frank stated that his line manager was a Professor so originally his focus was to undertake research. He was provided with an honorary principal lecturer role but with different workloads Frank only managed to undertake case studies.
Gabrielle	NICE guidance had an impact on workloads with so much of Gabrielle's work being audit against the implementation of those guidelines because the service remains the priority.
Irene	Juggling all four components has been challenging and the role did not come with a job plan.
Jacqui	Jacqui stated that 75% of her work was clinical and that she would find it difficult to argue with management about bringing down waiting lists and targets and concentrating on developing a research portfolio.
Melanie	Melanie stated that the educational and clinical aspect (teaching on university modules) of the role had also been time consuming and had a detrimental effect on taking the research component forward. Unrealistic expectations of two ideologies.

## Nature of expertise

Research Participants	Nature of expertise
Alice	<b>Research Producer/Implementer</b> <b>Research Utiliser/Influencer</b>
Bethan	<b>Research Leader</b> Bethan's research had impacted clinically, locally and nationally.
Carl	<b>Research Utiliser/Influencer</b> Despite research not being his bag he had encouraged and supported others to write for publication.
Dawn	<b>Research Utiliser/Influencer</b> Research to underpin practice exploring different research studies using evidence based practice to underpin clinical care. Journal clubs and national guidelines.
Elsa	<b>Research Utiliser/Influencer</b> Research terminology confusing but contributes to the debate about nursing research through her national work.
Frank	<b>Research Utiliser/Influencer</b> When writing serious cases Frank incorporated research to underpin and evidence his/teams thinking and lectures. Questions what research means for practice in relation to outcomes.
Gabrielle	<b>Research Utiliser/Influencer</b> Mentoring within teams supporting them through their research modules that are educationally linked.
Helen	<b>Research Utiliser/Influencer</b> <b>Research Producer/Implementer</b> Quarterly multi-professional meetings where there is an allotted agenda item for research where research papers are shared or any professional who is engaged in research (MSc or small research project). Active participant in research award panels and committees. Principal Investigator on a study in the past and has published. Currently not participating as a lead researcher.
Irene	<b>Research Utiliser/Influencer</b> Completing PhD, changing research culture within workplace, supporting Master's students and engaging clinical champions in her chosen specialty
Jacqui	Could not articulate nature of research expertise. Most clinically demanding of NCs.
Kathleen	<b>Research Utiliser/Influencer</b> Acknowledged the benefits of linking research to academic process and was keen to explore those links in relation to publication.
Lauren	<b>Research Utiliser/Influencer</b> Focuses on the latest research that is evidenced as making a difference and share information to improve care.
Melanie	<b>Research Utiliser/Influencer</b> Role within research teams development of an educational package and then developing this as part of the research project amongst sites.

