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Advanced or Advancing Nursing Practice
The Future Direction for Nursing?

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Advanced or Advancing Nursing Practice:

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Certificate of Ethical Approval

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Abstract

The aim of this study:

To examine the features, scope and activity of Advanced Nursing Practice, and explain its relevance and the significance of nursing within this role, as experienced by two groups of nurses recognised as Advanced Nurse Practitioners, and the consultant nurses and consultant medical staff who work with them, in a local university hospital NHS trust

Background:

The emergence of Advanced Nursing Practice as a distinct role within the NHS began in the mid 1980's. A variety of factors led to this including: workforce pressures, especially shortages of medical staff; the need for a different response to growing numbers of patients with complex and chronic health needs; and the desire by nursing to achieve its potential as a distinct profession by re-engaging its focus on the delivery of comprehensive patient-centred care.

This development however has been hindered by widespread lack of clarity about its character and exact purpose. Some believe its purpose as to fulfil a medical substitution role; others as a flexible role responding to current 'gaps' in service provision, be that medical, nursing or both; others still as an Advanced Nursing role focused on patient-centric care and management, but also integrating leadership, education, and research to improve and develop practice and services.

Methods

Constructivist grounded theory methodology shaped the conduct of this study. Participants were recruited using purposive sampling with further participants recruited using theoretical sampling. Two case studies were established, and participants were allocated to one of them according to their roles at that time. Case Study 1 represented acute services, and Case Study 2 represented non-acute services. Consultant nurses and consultant medical staff were also recruited, who worked directly with Advanced Nurse Practitioners in one or other of the case studies. 31 participants took part and 19 interviews took place in three phases over a period of 24 months. Data were obtained initially from small group semi-structured interviews, followed by a further round of individual interviews. Literature retrieved from both the contextual review, and during the data collection phase, fed into the constant comparative analysis activity and was present in the findings.

Findings

Four concepts were generated; Characteristics, Advanced Nursing, Enablers and Restrictors, and from them the Core Concept: 'Advanced Nursing Practice is a Personal and Professional Journey not an End Point'.

Conclusion

The Core Concept was fundamental in the construction of the Grounded Theory explaining that the continuing journey of Advanced Nursing Practice has a momentum inherent within it, and when consistently activated it enables Advanced to become Advancing Nursing Practice: 'The Advanced Nursing Practice Journey transitions from Advanced to Advancing Nursing Practice when enabled by an Advancing Practice Momentum'. Therefore, the answer to the thesis title question, 'Advanced or Advancing Nursing Practice: The Future Direction for Nursing?' is clear: **Advancing Nursing Practice is the way forward for Nursing**.

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Dedication

To my wife Jill

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Glossary of Terms

Explanatory note. Most definitions in this glossary are provided by the researcher and are particular to the content in this thesis, others are by others and identified as such. Note, terms used may be defined differently by others/elsewhere. All are included to bring clarity to the content.

Advanced Clinical Practice: 'Advanced Clinical Practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence. Advanced Clinical Practice embodies the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people's experience and improve outcomes.' (HEE 2017).

Advanced Nursing: 'Nursing practiced by senior clinical nurses who have a level of knowledge, skill and expertise which delivers high quality patient-centred practice. Underpinning knowledge base comes from Nursing theory and research which is current, and I also drawn from a wide variety of associated disciplines as appropriate. Knowledge, along with sound judgement and decision-making informs clinical practice, ensuring it is comprehensive in addressing patient needs. Advanced Nursing role models excellent practice, educating, mentoring, and coaching the team as appropriate. It demonstrates skilled leadership and management abilities which motivate, creating an environment which promotes excellent nursing care and collaborative practice.' (Gray 2022).

Advanced Nursing Practice (Type 1): 'A level of clinical practice delivered by senior experienced registered nurses, able to diagnose and treat healthcare needs, referring to appropriate specialists where needed. Practice is underpinned by expert knowledge base, complex decision-making skills and clinical capabilities. The achievement of an appropriate masters' degree or equivalent is appropriate to underpin the role. Specific characteristics are shaped by the context of practice but demonstrate collaborative working and a level of autonomy. Associated activities where supported may include: education of patients and staff; clinical leadership and service improvement; and research.' (Gray 2022, ICN 2002, NMC 2006, DoH 2010).

Advanced Nursing Practice (Type 2): 'a level of comprehensive patient-centred nursing practice, delivered by senior registered nurses, underpinned by expert knowledge base, complex decision-making skills and clinical capabilities. The achievement of an appropriate Master of Science degree is essential at the outset of achieving this status. Specific characteristics are shaped by the context of practice but demonstrate autonomous and collaborative working which push the boundaries and expand existing practice. Clinical leadership is central, leading nursing practice, pioneering and innovating to ensure timely responses to often complex patient and service needs. Advanced Nursing Practice is actively engaged with education, including

development of colleagues and patients. It is also actively engaged with research that informs practice and with policy formation that shapes and keeps practice current and effective.' (Gray 2022, after UKCC 1995, ICN 2002, DoH 2010).

Advanced Practice: 'a level and scope of clinical practice that is demonstrated by senior experienced and knowledgeable non-medical healthcare practitioners, who having obtained an appropriate Master of Science degree, provide comprehensive responses to patient healthcare needs. Advanced Practice leads professional practice for its profession and others, and act in a collaborative way with colleagues and others to develop and innovate in service delivery', (Gray 2022).

Advancing Practice: 'a continually evolving level and scope of clinical practice, provided by senior experienced and knowledgeable healthcare practitioners, underpinned by a relevant Master of Science degree. Its foundation is continuing direct patient care, demonstrating a comprehensive response to patient healthcare needs. It's defining features are that it deliberately and consistently utilises learning from clinical decision-making involving patient and family encounters, and from colleagues and the clinical environment, leading to dynamic and innovative responses and the continuing progression of practice. It also has a central role in leading professional practice for the health profession of the individual and others, and in developing and innovating in service delivery' (Gray 2022)**.**

Advancing Nursing Practice: 'A continually evolving level and scope of clinical practice provided by experienced and knowledgeable senior registered nurses who hold a relevant Master of Science degree. Its foundation is in continuing direct patient care, demonstrating a comprehensive response to patient healthcare needs. It's defining features are that it deliberately and consistently utilises learning from clinical decision-making involving patient and family encounters, and from colleagues and the clinical environment leading to dynamic and innovative responses which lead to continuing progression of practice. It has a central role in leading professional nursing practice, fostering an active learning environment and in developing and innovating in service delivery' (Gray 2022).

Autonomy: freedom to act on behalf of patients, carers and colleagues on the basis of personal and professional knowledge, skill, judgement and decision-making ability. Two types are identified: **Personal autonomy,** willingness and confidence to act when present within each individual professional; **Structural autonomy,** that granted by the employer to act according to prior agreement about role scope and activity.

Consultant Nurse: a level and scope of clinical practice representing the pinnacle of nursing practice. It is provided by experienced and knowledgeable senior registered nurses who hold at least a relevant Master of Science degree. Consultant Nurse level embodies and extends the four pillars of Advanced Level Practice (HEE 2017), demonstrating expert practice; strategic and enabling leadership; learning, developing and improving across the system; research and innovation. It is a pivotal role providing a powerful voice for nursing practice, and through this for patients and carers. It provides consultancy across all pillars (Gray 2022, after HEE 2017 & 2021).

Clinical Nurse Specialist: a scope of clinical practice demonstrated by senior experienced and knowledgeable nurses, who have completed at least an appropriate degree. They use expert knowledge and clinical judgement in largely autonomous practice to assess, plan and deliver care and clinical management to defined patient/client groups. They ensure the provision of continuity of care and evaluate, with patients, the effectiveness of care and treatment provided, making changes as needed. They often develop and promote nursing at clinical, policy and strategic levels (Gray 2022, after Cannaby et al 2019, RCN 2009, NMC 2005).

Fire-fighting: a term that has come to be regarded as a management and clinical team response to urgent challenges that are hindering service delivery at that point.

Holism/Holistic: a comprehensive response to patient total healthcare needs, underpinned by understanding of the Biopsychosocial Model (Bolton and Gillett 2019).

Journey: the experience of movement in individuals, groups, and organisations. This can be positive and purposeful or negative and lack direction. A wide range of factors internal to and external to a journey impact its momentum.

Medic-centric: focused on doctors, medicine and the biomedical modelof thinking and decision-making.

Medical-lens: a reductionist mindset / disease-centric filter through which patients are seen, and their care and management determined.

Medical replacement / Medical substitution: the role undertaken by non-medical health professionals, often nurses, focusing on carrying out the activity of a registered medical practitioner in their approach to assessment, diagnosis and management of patient healthcare need. Typically, this activity is bounded by an agreed scope of practice and is professionally overseen by a senior registered medical practitioner.

Momentum in Advanced Nursing Practice: 'Momentum implies energetic forward movement. In Advanced Nursing Practice, momentum is present when a wide range of factors supporting the Journey of Personal and Professional growth, both internal to, and external to the individual Advanced Nurse Practitioner produce continuing forward movement. This positively influences, shapes and impacts all aspects of clinical and professional practice and as such it justifies the descriptor Advancing Nursing Practice.' (Gray 2023)

Nursing: 'Nursing is helping people, sick or well in the performance of those activities contributing to health or its recovery, or to a peaceful death, that they would perform unaided if they had the necessary strength, will, or knowledge. It is likewise the unique contribution of nursing to help people be independent of such assistance as soon as possible.' (Henderson 1991).

Nursing-lens: a holistic / patient-centric perspective/ filter or mindset through which patients are seen and understood. Seeing through that lens enables patient need to be comprehensively and collaboratively assessed and effective care and management to be planned and delivered.

Nurse/Nursing-centric: focused on nurses, nursing and the holistic model of patient-centred care.

Patient-centric/centred: focused on the holistic needs of patients, and where appropriate may also include associated family and carers.

Reductionist/ reductionist approach: The primary aim of medicine is to prioritise disease and seek cure for it, analysing and deconstructing patient problems to their constituent parts to understand and prioritise responses to them. This bio-medical approach is criticised for providing a partial view of and therefore partial response to the extent of patient needs.

See/ Seeing/ Seen: the way in which patients and clinical situations are understood, this is generally shaped and influenced by a 'medical-lens'* or 'nursing-lens'*. The type of lens or filter used influences the scope of responses provided to problems identified (*See definitions elsewhere in this glossary)

Service delivery: Clinical activity is directed in response to business plans and contracts designed to deliver a specified clinical service. The priority for service managers is the delivery of services according to predetermined standards and contractual arrangements. Plans are frequently hindered or obstructed by unforeseen issues within and without the service, including but not exclusive to excess demand on the service and staffing resources issues.

Service-centric/focused: where service effort is focused on achieving identified service objectives, this becomes synonymous with the culture in that environment. Staff are expected to support and work according to this mandate. This may or may not include elements of patient-centric activity, but this is primarily only where it also meets prevailing service objectives.

Tool kit: the term is used to illustrate a collection of a wide range of assessment and management skills, approaches and methods (the 'tools'). Individual 'tools' from the tool kit are chosen by the Advanced Nurse Practitioner, following their use of critical thinking and judgement according to patient holistic need, and not simply their medical condition (Leary 2012).

Touch points: key visible attributes of health professionals that appear to define their role and what they do, as determined by other health professionals or students not familiar with their actual role.

Special note

Health Education England (HEE), referred to throughout the thesis, was merged with NHS England in 2023. The functions of Health Education England (HEE), including the Centre for Advancing Practice, continue as an integral part of the enlarged role of NHS England.

Chapter 1. Introduction

1.1 Chapter Introduction

This chapter introduces and provides background to the study and makes transparent my professional background and interest in Advanced Nursing Practice and reveals how my interests raised several questions concerning the purpose and nature of Advanced Nursing Practice. This thesis is written in the first person, to remain congruent with the epistemology underpinning the study (Webb 1992). The chapter concludes with the overall structure of the thesis.

1.2 My background, interest in this subject, and subject overview

As a nurse for over forty years, I worked in a variety of clinical areas, including musculoskeletal/ trauma orthopaedics, and emergency care. The latter half of my career has been as a nurse teacher and academic, and for the recent fifteen years as course director for the masters' degree course in Advanced Practice at a West Midlands university. My clinical career enabled me, at its earliest stages, to work at the interface between nursing and medicine, developing and utilising what have been variously described as expanded or extended roles (Rolfe 2014a, Hunt and Wainwright 1994). This included carrying out advanced skills and experiencing the blurring of role boundaries between nursing and medicine. Alongside this I achieved academic qualifications including a master's degree in Advanced Clinical Nursing Practice. This process had a fundamental impact on my thinking, the expansion of my clinical practice, and an increased value for nursing.

My career trajectory ran alongside the emergence within the NHS of Nurse Practitioner, followed by Advanced Nurse Practitioner roles during the 1980s and 1990s. This was a period of huge change in clinical activity as new services and treatments became available, but also patient expectations began to change. A range of new roles emerged to support service changes, and an emphasis on patient-centred care also developed within sectors of the National Health Service (Duke 2012). The emergence of new roles often happened in an ad-hoc manner, with hugely variable foci and scope (Barton 2006). The nature of the emergency care environments where I worked saw nurses and doctors work collaboratively, and distinctions between working roles became blurred as nurses took on autonomous care of minor injured patients (Walsh 1999). I observed how doctors practiced, what their priorities and concerns were, and how these differed from mine as a nurse. Mutual respect

grew for what were separate but connected contributions to patient care and management (Barton 2006).

This period of the 1980's and 1990's was a time of considerable change within the National Health Service, and particularly for nursing as it sought to establish its professional status (UKCC 1986, 1990), separate from medicine (Barton 2006). Underpinning this ambition was the movement of nurse preparation from a training to an education model (UKCC 1986), relocating teaching from training schools, ultimately to university schools of nursing. Nurses were increasingly challenged to expand their practice (UKCC 1992). Many were drawn into a range of new emerging roles requiring additional skill sets and differing priorities and foci as the NHS responded to increasing demand (DoH 2002b). The NHS itself underwent multiple reorganisations, former professional hierarchies dominated by the medical profession were challenged, though their influence remained. Alongside this, 'general management' became the new approach to achieve efficiency (DoH 2000, Hunt and Wainwright (1994). The advent of evidence-based practice heralded increased focus on improving quality and standards of patient care (DoH 2000).

The 1990's coincided with my move into education as a nurse tutor. Over time I became more and more involved in education for Advanced Nursing Practice, first by teaching elements of physical health assessment. These were a significant addition to the normal assessment skills of nurses and appeared to lead towards practice that was encroaching on medical territory. The nursing press showed great interest in trying to establish whether nurses in new roles should be described as 'mini doctors' or 'maxi nurses' (Castledine 1995). Much discussion focused on the legitimacy of nurses extending and expanding their practice into the medical domain, and if by doing so nurses were abandoning nursing in favour of embracing a medical substitution role. In my clinical career, I enjoyed using advanced knowledge and skills and celebrated the less fragmented care patients received as I was able to function with high degree of autonomy. Combining nursing with aspects of medicine enabled a less fragmented service. However, I did not regard myself or other nurses as medical substitutes but as nurses with a wider scope, additional knowledge and extra skills that enabled patient-centred care (Barton, Bevan and Mooney 2012). As my thoughts about these developments were crystallising, the wider debates and discussions happening nationally proved inconclusive (Rolfe 2014a). Moreover, the nursing regulatory body held back from pronouncing with any degree of clarity (UKCC 1997). Consequently, Advanced Nursing Practice continued to lack common understanding at least from a nursing point of view, whilst more broadly advanced nursing was seen as part of the remedy to medical staff shortfalls (Barton 2006).

In 1998 I was invited to undertake a three week visit to a major university hospital in Kentucky in the United States, to explore how advanced practice education was conducted. This provided ample time to witness nurses working with patients in Advanced Nursing Practice roles. I witnessed that it was possible for nurses to radically move the boundaries of their practice, embrace selected medical skills, and dovetail these with expert nursing practice to provide seamless and comprehensive responses to patient need. Moreover, their master's degree academic preparation enabled a radical confidence in these practitioners' critical thinking and decision-making abilities which underpinned their autonomy of function. I had gained a transformed perspective of how nursing practice could be advanced, combining this with aspects of medicine to better and more comprehensively meet patients' needs.

I returned from America to an enhanced teaching role preparing nurses for Advanced Practice roles. Continuing as a nurse educator at that point, I took up a post in a different university in the West Midlands, where I developed an Advanced Nurse Practitioner course at masters' level with a focus on holistic assessment and patient management.

1.3 Developing thoughts and questions

I continued to work within the field of Advanced Nursing Practice for over twenty years, between 1999 and 2021. During this period, I observed a recurrent theme, which was the way graduates of the Advanced Practice course functioned. There was a prevalence of Advanced Nursing Practice roles characterised by a dominant emphasis on medical substitution (Rolfe 2014a). In contrast, there were a smaller number of roles, often less high profile, which reflected a broader philosophy of Advanced Nursing Practice that retained a central value for nursing and sought to advance it (Rolfe 2014b). This situation raised both questions and potential conflicts. For example, while it appeared that a medical substitution focus delivered patient benefits in supporting a reduced medical workforce, it also reduced the availability of senior nursing staff in providing consistent leadership to nursing clinical practice.

However, I was also aware that some Advanced Nurse Practitioners were content to embrace a medical substitution role even as they become answerable to senior medical colleagues rather than nurse managers for their practice. I was curious about whether opportunities were being missed to extend the impact and advance nursing within Advanced Nurse Practitioner roles, particularly in addressing the major challenges of managing chronic disease and complex long-term conditions

(DoH 2014, 2017). As I reflected on these issues, I formulated five initial questions which led to establishing the aim and objectives for this study:

1. What are the features and the scope of Advanced Nursing Practice?
2. What is the contribution to Advanced Nursing Practice that comes from being a nurse?
3. What does 'Advanced Nursing' look like and what is its significance and impact?
4. What helps 'Advanced Nursing' to develop and be expressed?
5. What are the barriers to the expression of 'Advanced Nursing'?

1.4 Methodology and methods overview

The attractiveness of grounded theory methodology as the foundation for this study, lay in its potential to progress qualitative study outcomes from description to explanation, as intended from the outset by Glaser and Strauss (Charmaz 2014). Moreover, as the title grounded theory suggests, the development of explanatory theory leads to conceptual understandings about the studied subject (Bryant and Charmaz 2014). Glaser, coming from a positivist perspective is recognised for establishing the basic principles of grounded theory, while Strauss, from a pragmatic/ symbolic interactionism perspective, was more interested in the dynamic actions and interactions of people, which he recognised enabled the construction of understanding of self, society and reality. However, Charmaz (2000) challenged the objectivist approaches of both Glaser and Strauss, though she did retain Strauss's Pragmatic and Symbolic Interactionism. Charmaz emphasised the validity of viewpoints and position of the researcher as a subjective participant, but more importantly perhaps, rejected the assumption of external realities (Charmaz, Thornberg and Keane 2018).

As my epistemological and ontological perspectives became clear, constructivist grounded theory became the chosen methodology underpinning this research study (Charmaz 2014). Though I will discuss this more fully in chapter 3, ultimately, I established my ontological position as relativist, and my epistemological position as subjectivist (Mills, Bonner and Francis 2006). Relativism arises from the perspective that reality is found within the specific situation, including what participants and researchers do with and bring to that situation, from this their 'stories' are revealed (Charmaz 2014). Researcher involvement was a significant feature for me, since instead of being compelled to try to be an objective, passive observer, value was placed on researcher involvement in the process. Relativism expressed through the constructivist paradigm makes plain that research events are constructed rather than discovered. This perspective requires reflexivity by the researcher regarding their deliberations, decisions and actions about the context and interactions within the research

situation, and then with skilful interpretation and analysis, learning and knowing is found within that context (Charmaz 2014).

Unlike the initial position of first- generation grounded theorists, constructivists recognise that researchers generally come to a study with pre-existent understanding and experience, and this was certainly the case for me. However, also aligning with the constructivist approach it was necessary to be transparent concerning my understandings, positions, and viewpoints, hence attempts to make these explicit earlier in this chapter and throughout the study. I continue this conversation and include my positionality statement in Chapter 3 (see page 47)

1.5 Initial Research Aim and Objectives

1.5.1 Initial Research Aim

To study and explain the features, scope and activity of Advanced Nursing Practice, and the relevance and significance of nursing, as experienced by two groups of nurses recognised as Advanced Nurse Practitioners in a local university hospital NHS trust

1.5.2 Initial Research Objectives

1. To conduct small group interviews with advanced nurse practitioners, and separately with senior nursing staff working with them, to explore their views and experiences of:
    a. the features and scope of Advanced Nursing Practice;
    b. the perceived benefits of Advanced Nursing Practice;
    c. the significance and relevance of nursing and advanced nursing within Advanced Nursing Practice;
    d. cultural, organisation and wider factors that help or hinder the development of the features and scope of activity of the Advanced Nurse Practitioner, and in particular the expression of nursing and Advanced Nursing within that role.
2. To conduct individual interviews with Advanced Nurse Practitioners, and senior nursing and medical staff working with them, to further explore their views and experiences of Advanced Nursing Practice.
3. To carry out ongoing analysis of data generated from the study.

4. To formulate a grounded theory to explain the significance of Advanced Nursing Practice in a local university hospital NHS trust.
5. To identify areas for future research to further uncover and explain Advanced Nursing in the wider health care context.

The thesis sets out to make visible and explain the nature of the practice of Advanced Nursing within Advanced Nursing Practice, as demonstrated within two contrasting patient services, in a large NHS hospital trust in the Midlands of England. Each of these services will be described as a case study: Case Study 1: Acute Services; and Case Study 2: Non-Acute Services.

1.6 Overview of this Thesis

I undertook this study as a part time doctoral student at Coventry University, between September 2012 and December 2021. The pilot interview took place in September 2017. Data were generated between the first and last interviews, 28th March 2018 and 23rd March 2020 respectively.

The structure of this thesis continues with Chapter 2 providing a scoping review with narrative to provide contextual background to the study. While first generation grounded theorists repudiated this inclusion, and Glaser perpetuated that view (Thornberg and Dunne 2019), second generation grounded theorists, including constructivists, regard literature as being useful at all stages of a grounded theory study (Birks and Mills (2015). This is justified further in Chapter 2. Consequently, literature is presented within the study in three phases (Thornberg & Dunne 2019):

1. in the scoping review and narrative summary in Chapter 2, where critically examining policy and the scope of the literature enabled understanding of the context of the emergence and development of Advanced Nursing within Advanced Nursing Practice;
2. as retrieved concurrently with data generated from and alongside participant interviews, in the methods (Chapter 4) and findings (Chapter 5) chapters;
3. within the synthesis and presentation (Chapter 6), and the discussion and conclusion chapter (Chapter 7).

The literature presented in the review was considered as ‘data’, in line with Glaser’s maxim ‘all is data’ (2002: 1). It was compared and contrasted with data obtained from the participants, and additional literature obtained as the study progressed as part of the ongoing analytical process (Thornberg & Dunne 2019; Birks and Mills 2015).

Chapter 3 sets out the study's guiding methodology, which was constructivist grounded theory.

Chapter 4 addresses research methods used and the research process undertaken to conduct the study, including identification of the two central case studies.

In Chapter 5 the process of data analysis is discussed including the reality of the 'messiness' of the process of moving back and forth throughout the data, through which abstraction of ideas and thoughts about what was happening in the study occurred. This chapter reveals the study findings leading to the construction of four concepts addressing the study research questions, the aim and objectives and which led to the construction of the Core Concept of Personal and Professional Journey explained in Chapter 6.

Chapter 6 synthesises the findings and presents the grounded theory, explaining and illustrating how the four concepts generated from the data enabled the construction of the Core Concept, which then contributed to the construction of the grounded theory, the pinnacle of the study (Birks and Mills 2015).

Chapter 7 draws the thesis to a conclusion providing a critical discussion of how the research questions, aims and objectives of the study were met. The discussion contextualises the key findings and explains how they relate to what is currently known about Advanced Nursing Practice. A critical evaluation sets out the merits of the study, and its implications and recommendations for policy and practice, education and research are critically considered. A presentation of the study's unique contribution to the science base of Advanced Nursing Practice along with its originality claim is provided. Final comments draw the chapter and thesis to a close and directly address the study's title question.

1.7 Chapter summary

This chapter has introduced the study, provided background information about my professional background and interest in Advanced Nursing Practice, and where Advanced Nursing is located within that. It has sought to achieve transparency in making my own thoughts and ideas clear about the subject at the outset of the thesis. This is in alignment with constructivist grounded theory, which is overviewed. Initial research questions, aims and objectives are provided. The chapter concludes with the overall structure of the thesis.

Chapter 2. Context- The Emergence of Advanced Nursing in the United Kingdom

2.1 Chapter Introduction

This chapter presents the results of a scoping review of policy and a narrative summary of literature, together establishing a baseline understanding of the origins of Advanced Nursing Practice in the United Kingdom (Rolfe 2014b). Policy, which had a substantial impact on Advanced Nursing Practice development, and grey literature which revealed arguments for and against different types of Advanced Nursing Practice, formed the bulk of literature included, along with limited pieces of empirical work. The approach of considering literature at the outset of a study is anathema to classic grounded theorists, but not so for studies guided by constructivist grounded theory methodology. Indeed, it recognises a different approach, acknowledging that is unrealistic to deny prior knowledge about a subject, nor to seek gain some familiarity with it from the outset (Thornberg & Dunne 2019; Charmaz 2014). So, in line with this, literature obtained within this chapter was used to provide context for the study. However, to ensure comprehensive treatment of literature overall, consideration of contemporary literature was maintained throughout the study and was used alongside constant comparative analysis of data generated from participants (Thornberg & Dunne 2019). The literature appraised in this chapter enabled understanding of the context of Advanced Nursing Practice and presents 'what was happening' in the world of Advanced Nursing Practice in the United Kingdom between 1990 and 2015. These dates were chosen based solely on the decision to consider contextual literature up to the period preparing for data collection, and is discussed in Chapters 3 and 4.

Conducting this review helped me consider perceptions I held about Advanced Nursing Practice while simultaneously increasing my theoretical awareness (Birks and Mills 2015) to unexplored areas of advanced practice which would require examination with study participants (Xiao and Watson 2019). It was also necessary in line with constructivist perspectives to maintain a degree of scepticism to ideas and frameworks expressed in the literature retrieved to ensure this did not subsequently obscure data generated from participants contributions (Thornberg and Dunne 2019).

2.1.1 Rationale for a Scoping Review

Scoping reviews offer opportunity to consider relevant evidence determined by the limits set (Levac 2010). They provide the nature and extent of research literature available (Thornberg and Dunne 2019) and can indicate if a full systematic review would be useful (Grant and Booth 2009). Perceived weaknesses of scoping reviews are that they neither provide a definitive conclusion, nor subject recommendations, and originally most did not undertake quality assessment of material retrieved (Pham et al 2014). However, these were not considered problematic for this study as the aim was to obtain a grasp of relevant literature to detail the history and context for Advanced Nursing at the beginning of the study. The scoping review examines policy and literature providing context but does not seek to establish a definitive position on this subject (Colquhoun 2014).

2.2. Scoping Review Strategy

Scoping reviews follow a meaningful 'system' of inquiry (Aveyard, Bradbury-Jones & Smith 2022; Booth et al., 2016a). Arksey and O'Malley (2005) were among the first to offer a methodological scoping review approach, see Table 1. Five of the six stages were used in this scoping review, with the sixth considered later in the study.

Framework stages (Arksey and O'Malley 2005)	**Description of stage in scoping review**
Stage 1: Identifying the Review Questions	The scoping review questions are clearly defined using the PEO framework and inform all other stages of the search strategy
Stage 2: Identifying Suitable Literature	Identifying relevant literature and developing a practical plan for where to search, terms to be used, sources to search in a timely manner
Stage 3: Study Selection	Identification of inclusion and exclusion criteria – eligibility criteria
Stage 4: Charting the Data	A data charting form is created to extract data from the literature.
Stage 5: Collating, Summarising and Reporting Findings	An overview of the literature is reported including analysis and discussion
Stage 6 (Optional): Consultation	This final stage is regarded as optional, providing for stakeholder engagement to provide insights beyond the literature.

Table 1: Arksey and O'Malley Framework Stages

2.2.1 Stage 1: Identifying the Review Questions

The review questions were designed using the Population, Exposure and Outcome (PEO) Framework, for qualitative studies (See Table 2).

P	Population Patient Problem	Registered nurses, Nursing (as a profession) potential of Advanced Nursing in delivering patient centric care
E	Exposure	Advancement of nursing role/scope, Key words: Advanced + Nursing+ Practice and Concept+ Policy and Restrictions + Opportunities +Drivers of Advanced Practice
O	Outcome or Themes	Impact of Advanced Nursing Practice on: • Patients, services, nurses and the multi -professional team • Scope of nursing practice, range and character of activity

Table 2: Population, Exposure and Outcome (PEO) Framework to Develop Review Questions

The four review questions are:

1. What significant events and milestones shaped the emergence of Advanced Nursing Practice in the United Kingdom?
2. What key drivers and policy initiatives influenced the emergence of Advanced Nursing Practice in the United Kingdom?
3. What are the features and scope of Advanced Nursing?
4. What debates, contentions, restrictions, and opportunities are set out within existing literature in relation to Advanced Nursing Practice?

2.2.2 Stage 2: Identifying Suitable Literature

Three appropriate databases were searched: Allied and Complementary Medicine Database (AMED); Cumulative Index for Nursing and Allied Professionals (CINAHL); and Medical, Dental, Nursing and Allied Health (MEDLINE). The first search included derivatives of three key words, Advanced, Nursing and Practice. The use of a symbol (*) was utilised to add to the stem of each of these words to capture their derivatives, for example advanc* would include, 'advanced' and 'advancing'. The search terms were thus, 'Advanc*', 'Nurs*' and 'Pract*.

The first search yielded 219,095 results. Having reviewed the titles and abstracts of the first 300, it was concluded that the search needed refining as many sources were irrelevant and search time was therefore not being used productively. Relevant titles were retained in an ongoing search folder.

The second search added the term 'concept' to try and focus the search for papers that would reveal the features of Advanced Nursing Practice. However, the term 'nurs*' was removed at this stage, over concern that it had contributed to some of the irrelevant articles identified. Fewer sources were identified at this stage, but still a large number, 39,103. A number of these were examined

with relevant ones added to the search folder. However, the number was still too large to be productive.

A third search was undertaken, adding the terms: 'nurs*', once more; also, 'Policy', 'Restrictions' + 'Opportunities' + 'Drivers'. Search parameters however were also set to attempt to reduce the total retrieved, by including for example, academic journals only. The original 20- year search period specified (1995-2015) was extended backwards to 1985 to capture important policies that it was clear had a significant influence on stimulating Advanced Nursing Practice.

The final search was supplemented by utilising Google Scholar, grey literature and the author's own resources retrieved from his previous and ongoing subject study.

316 papers were retrieved, 35 were policy documents, 281 were informed comment and a small number of empirical papers. All sources were reviewed, including some from the first two searches. In total 87 papers were found to be useful, 27 policies and 60 of wider literature.

Date	Database	Key words	Results
	AMED, CINAHL, MEDLINE	'Advanc*', 'Nurs*' and 'Pract*	219,095
	AMED, CINAHL, MEDLINE	'Advanc*', 'Pract*, 'Concept' and 'Policy'	39,103
03/08/15	AMED, CINAHL, MEDLINE	'Advanc*', 'Pract*, 'Concept' 'Policy' and 'Nurs*'	316

Table 3: Search Terms and Results

2.2.3 Stage 3: Study selection

Inclusion and exclusion criteria for the literature selection are set out in Table 4.

Inclusion Criteria	Exclusion Criteria
Advanced Nursing Practice, Advanced Nurse Practitioner, Advanced Practice, Advanced Nursing	Articles published in languages other than English were excluded
Work completed by/commissioned by organisations impacting and impacted by Advanced Nursing Practice including policy makers and agencies. The Royal College of Nursing. The Nursing Midwifery Council (previously UKCC). The Association of Advanced Nurse Practitioner Educators.	Non academic journals e.g. non peer reviewed professional journals
A 20 year period was specified initially (1995-2015), but during the retrieval process this was extended from 1985- 2015 to capture earlier policy documents which were judged to be significant. This aligned with the constructivist approach to literature retrieval	Evidence and policy earlier than 1985 and not after 2015 (See Chapter 6)

Table 4: Inclusion and Exclusion Criteria

2.2.3.1 Screening

At first stage screening, duplicates were removed, title and abstract/executive summaries were reviewed to identify those eligible. Second stage screening involved retrieval of full text articles. To collate information, a template was developed, including the following characteristics: Author, year title and country of publication; study aims; design and methods; findings; comments. The completed template is found in Appendix 4.

Policy documents and wider literature including limited empirical research were all appraised, but it became clear that these sources were very different in character and purpose. To make their appraisal clearer, the decision was taken to separate policies from wider literature and empirical studies. This occurred at Stage 4, the charting stage (Arksey & O'Malley 2005). Polices were charted to extract data, and this was followed immediately by Stage 5 analysis of the policies and their critical appraisal. Prisma flow diagrams summarised the process of retrieval: for policies (see Figure 1, page 14); and later in this chapter for wider literature, including informed comment and empirical studies (see figure 5, page 22).

Figure 1: Prisma Flow Diagram- Policy Documents (Haddaway et al 2022)

2.2.4 Stage 4: Charting the Findings

After familiarisation with the eligible policies, key areas of focus aligned with the commonalities and review questions were categorised from policy and devised as; 'nursing centric' to 'service focus'. Charting of this was undertaken to display commonalities of policy engagement with key terms, see Table 5. Terms used* are defined in the glossary, (see page xvii-xx). The appraisal of these policies follows within Stage 5 of Arksey and O'Malley's Framework, see page 17.

Date	Commonalities / Policies	Nursing centric*	Medic centric*	Patient focus*	Patient centric*	Service focus*
1986	Launch of Project 2000 – United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC)	✓				
1986	Cumberlege Report -Department of Health and Social Security (DHSS)	✓		✓	✓	
1990	Post Registration Education and Practice Project (UKCC)	✓			✓	
1991	Proposal of New Deal for Junior doctors -NHS Management Executive (NHSME)		✓			✓
1992	Scope of Professional Practice (UKCC)	✓		✓	✓	
1992	Health of the Nation (DHSS)	✓		✓		
1992	Introduction of Extended Formulary for Nurse Prescribers (DHSS)		✓	✓		✓
1994	Introduction of Standards for Education and Practice Post Registration (UKCC)	✓		✓	✓	
1994b	Standards for Education and Practice Post Registration- Annex 1 to Registrar letter (UKCC)	✓		✓		
1997	The Council's Decision on PREP and Advanced Practice. Registrar's Letter 8/1997 (UKCC)	✓		✓		
1999	Making a Difference (DoH)		✓			✓
2000	NHS Plan (DoH)	✓	✓	✓		✓
2001	Standards for Specialist Education and Practice -Nursing and Midwifery Council (NMC) [successor to UKCC]	✓		✓		
2002	Wanless Report. Securing Our Future Health: Taking a Long-Term View.	✓		✓		

Date	Commonalities: / Policies:	Nursing centric*	Medic centric*	Patient focus*	Patient centric*	Service focus*
2002	Developing Key Roles for Nurses and Midwives a Guide for Managers -United Kingdom Department of Health (DoH).		✓	✓		✓
2003	Nurse Practitioners: An RCN Guide to the Nurse Practitioner Role, Competencies and Programme Accreditation -Royal College of Nursing (RCN).	✓		✓		✓
2005/6	The National Health Service (Miscellaneous Amendments Relating to Independent Prescribing) Regulations (DoH).		✓	✓		✓
2005	Implementation of a Framework for the Standard of Post Registration Nursing, Agendum 27.1 -Nursing and Midwifery Council (NMC).	✓		✓		
2006	The Proposed Framework for the Standard for Post Registration Nursing (NMC).	✓	✓	✓		✓
2006	Modernising Nursing Careers (DoH).	✓	✓	✓		✓
2008	Supporting the Development of Advanced Nursing Practice. A toolkit Approach (Scottish Government).	✓	✓	✓	✓	✓
2008/ 2010	Advanced Nurse Practitioners – An RCN Guide to the Advanced Nurse Practitioner Role, Competences and Programme Accreditation -Royal College of Nursing (RCN).	✓		✓		✓
2009	Advanced Practice: Report to the Four UK Health Departments. Executive Summary -Council for Healthcare Regulatory Excellence (CHRE).		✓	✓		✓
2010	Advanced Level Nursing: A position statement (DoH)	✓	✓	✓	✓	✓
2012	Advanced Nurse Practitioners – An RCN Guide to Advanced Nursing Practice, Advanced Nurse Practitioners and Programme Accreditation -Royal College of Nursing (RCN).	✓	✓	✓	✓	✓
2014	Five Year Forward View (DoH).	✓	✓	✓	✓	✓

Table 5: Charting the Contribution of Policies

2.2.5 Stage 5: Summary of the Scoping Review (Policy Documents)

Stage 5 of Arksey and O'Malley's Framework summarises and reports findings. At this point other literature was separated from policies and therefore isn't considered at this point. The reason for this was the distinction between policies, whose purpose was to frame and drive practice but critically didn't and couldn't reveal how Advanced Nursing Practice was being enacted, and other wider literature which did speak to how Advanced Nursing Practice was being enacted.

Policies influencing the direction of Advanced Nursing Practice, initially originated from professional bodies. As new nursing roles emerged in response to local need, and were locally driven, there was little underpinning national policy (Barton, Bevan and Mooney 2012a). However, this did come later as government responded to what was already happening in practice.

2.2.5.1 Professional Policy Development

[*Note. some reference source dates presented in this section deliberately reflect the historical sequence of events, and not normal referencing order convention]

During the 1980s and 1990s mainly professional policies emerged coming from the nurse regulator, the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC) and the professional body, the Royal College of Nursing (RCN). They sought to advance nursing by challenging nurses in Britain to take on a professional rather than a vocational mantle, (*UKCC 1986, 1990, 1992; RCN 2003, 2008, 2010, 2012); (Castledine 2003). This was preceded by a major piece of reform, with nurse preparation moving to higher education, away from existing training schools (UKCC 1986). Emphasis on personal accountability for practice (UKCC 1992) and establishing autonomy, with clear separation from medicine was the intent. However, this was a huge challenge to existing nurses, subject to a prevailing National Health Service culture and hierarchy, where medicine dominated healthcare (Melling and Hewitt Taylor 2003). To support transformational initiatives the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC) emphasised the need for continuing professional development. A separate imperative arose for different levels of nursing to be established, including 'Specialist' as well as 'Advanced' (*UKCC 1990, 1992, 1994). This mirrored increasing medical specialisation during the 1990s and provided opportunities for 'Specialist' nurses to support that effort by providing nursing input, even where their autonomy was limited by medical oversight.

In response to the emerging needs, senior nurses who had grown in confidence knowledge and skills filled new roles (Rolfe 2014a; Castledine 2003; Castledine 1998). However, these initiatives lacked

cohesion and were locally not nationally driven (Barton, Bevan & Mooney 2012a; Roberts-Davis, et al 1998). This coincided with a period when government policy to shape new roles was largely silent (Por 2008). The UKCC continued providing vision and leadership, formally introducing the term Advanced Nursing Practice (UKCC 1990). Shortly after this, the Scope of Practice (UKCC 1992) signalled a direction of travel away from medicalised roles:

> *'The Council consider that the terms extended or extending roles which have been associated with this system are no longer suitable since they limit, rather than extend the parameters of practice. As a result, many practitioners have been prevented from fulfilling their potential for the benefit of patients. The Council also believes that a concentration on 'activities' can detract from the importance of holistic nursing care' (UKCC 1992: 8)*

It continued to progress understanding of Advanced Nursing Practice as a 'multifaceted concept'. This position had considerable value because of its wide-ranging emphasis on a scope of practice beyond clinical practice alone,

> *'…adjusting the boundaries for the development of future practice, pioneering and developing new roles responsive to changing needs and, with advancing clinical practice research and education to enrich professional practice, making a contribution to health policy and management.' (UKCC 1994: 8)*

In the same paper, distinction was drawn between 'Advanced' and 'Specialist' Nurses, where Specialists…

> *'…exercise the highest levels of judgement & discretion in clinical care… demonstrate higher levels of clinical decision making…monitor & improve standards of care through supervision of practice, clinical nursing audit, developing & leading practice, contributing to research, teaching & supporting colleagues.' (UKCC 1994: 7)*

Castledine (*1995, 1996, 1998), led the United Kingdom Central Council discussions regarding Advanced Nursing Practice, provided his personal perspective, indicating that there was 'tension within the Council over its conflicting responsibilities to: 1) progress and promote nursing; 2) protect the public; and 3) recognise drivers promoting conflicting types of Advanced Nursing Practice. Gary Rolfe, Professor of Practice Innovation and Development, reflected two distinct positions emerging following UKCC (1990) pronouncements. One, favoured by him focussed on holistic care, the second extended the role into the medical cure domain (Rolfe 2014b).

Public protection concerns dominated continuing discussions, pushing the UKCC towards emphasising accreditation and competence (Barton, Bevan and Mooney 2012b). Professional consultation followed and while the consensus reported not favouring medical substitution, inexplicably the final report indicated no consensus had been achieved so it proved impossible to proceed any further at that stage (UKCC 1996). However, in an apparent throwback to its former position, the UKCC publicly recognised that Advanced Nursing Practice needed maximum flexibility

to flourish and refused to set standards or regulate it. Its argument was that setting standards would restrict autonomy and innovation that these new roles sought to engender (Por 2008).

Subsequently the Nursing and Midwifery Council (NMC 2006), the successor to the UKCC, offered a new definition which was medically focussed and arguably lacked ambition for nursing:

> *'Advanced Nurse Practitioners are highly experienced and educated members of the care team who are able to diagnose and treat your healthcare needs or refer you to an appropriate specialist if needed.' (NMC 2006)*

In contrast, the International Council of Nursing (ICN 2002) provided a clearer lead, both defining Advanced Nursing Practice, and requiring the achievement of a masters' degree as the starting point for becoming an Advanced Nurse Practitioner. In the absence of national professional leadership in the United Kingdom, curricula emerged which focussed largely on developing 'clinical' aspects of the role, synonymous with performing medical tasks (Swann et al 2013). Advanced nursing themes did not feature in curricula (Rolfe 2014b).

2.2.5.2 Government Policy Development

Because Advanced Nursing Practice emerged locally in an ad-hoc manner (Barton, Bevan, Mooney, 2012a; Roberts -Davis et al 1998) roles emerged in the 1990s without corresponding government policies to guide them. They emerged gradually, divided between the majority which addressed medical shortages, promoting skills and medicalising nursing roles (DHSS 1991, DoH 1999, 2000, 2002b, 2005, 2006, 2009, 2010); and the minority which supported developing patient-centric roles, and Advanced Nursing (Scottish Government 2008; DoH 2010; 2014). Some attempted to do both (DoH 2000).

The Scottish Government, on behalf of all United Kingdom nations, produced innovative policy, including exploration of distinctions between 'Advanced' and 'Specialist' roles (Scottish Government 2006). This was significant because 'Specialist' carried for many a status lower than 'Advanced'. Their informative explanatory diagram (See figure 3) explained 'Specialist' should rather be considered as one end of a 'Specialist / Generalist' continuum, rather than on a 'novice to expert' hierarchical continuum. 'Specialist' therefore related to a specific patient group or situational context. In contrast, 'Advanced' Practice was a particular point on a 'novice' to 'expert' continuum. This made clear that 'Specialist' Nurses could also be 'Advanced' Nurses where they functioned at the Advanced Level of autonomy and decision-making.

Figure 2: Relationship between Specialist and Advanced Practice (Scottish Government 2006)

The Scottish work also highlighted what would later be widely recognised as the 'pillars' of practice were central to the role (Mantzoukas & Watkinson 2007). This work came closest to establishing a national framework for Advanced Nursing Practice, but it was not widely taken up and its influence lost momentum as individual nations in the United Kingdom established their own plans. In England both the concepts of a 'level' of practice rather than a role, and 'pillars' were echoed in 'Advanced Level Nursing: A Position Statement' (DoH 2010).

2.3 The Narrative Summary of Literature

Literature for this narrative summary section was included using the same scoping and retrieval processes as for policy documents, including expert consultation, hand searching, citation tracing, and looking at reference lists from retrieved documents. The focus for literature types included informed comment, grey literature, and limited empirical studies and research evidence. It is organised to address the review questions. A separate Prisma Chart - Literature is presented (Figure 3, page 22). This approach was intended to maximise application in the discussion, deepening understanding of 'how' Advanced Nursing Practice was enacted (Greenhalgh, Thorne, Malterud 2018), in contrast to the policy section which framed and drove practice but could not speak to its application.

Figure 3: Prisma Flow Diagram- Literature (Haddaway et al (2022)

2.3.2 Significant Events and Milestones in the Emergence of Advanced Nursing Practice up to 2015

It is important to realise that Advanced Nursing Practice in the United Kingdom was influenced by Advanced Practice Nursing in the United States of America. Conflicting philosophical views about its origins and nature there have been repeated here in the United Kingdom context (Rolfe 2014a). Advanced Practice Nursing in American gained momentum during the 1960s. Nurses sought to establish themselves as separate from medicine, as a profession with its own autonomous identity (Barton, Bevan and Mooney 2012a). During that period rapid development of nursing theory was applied to the clinical environment, with 'the patient' and not their 'disease' the central theme (McCrae 2012). However, alongside this specific Nurse Practitioner roles emerged, characterised by direct inclusion of medical skills and a focus on 'disease'. Here the major philosophical divide within nursing was laid bare, the blurring of role identity between nursing and medicine. Nurse leaders there regarded this as a direct challenge to emerging nursing autonomy, challenging the priority of holistic patient care, versus narrowly focussed attention on disease. Nurse Practitioners worked closely with medical colleagues taking on what rapidly became criticised as medical substitution roles (Duffield et al 2009; Silver, Ford, Stearly 1967) underpinned by a biomedical l rather than holistic mindset. This raised huge concerns among nurses who had pursued an autonomous path dedicated to promoting holistic perspectives of patient care and management, along with the risk of renewed medical dominance over nurses. However, pressure for more nurse practitioners continued due to workforce shortages and gaps in service provision (Rolfe 2014b). The 'Advanced Practice Nurse' became the favoured title in America (Hamric, Spross, and Hanson 2014; Barton & Mashlan 2011; Furlong & Smith 2005). Other countries followed similar patterns in the following decade (Mantzoukas & Watkinson 2006).

In the British world of clinical nursing during the 1980s, various roles developed each guided consciously or unconsciously by similar conflicting philosophies to those in the United States. Significant events and milestones in Advanced Nursing Practice development in the United Kingdom are summarised in Table 6 (see page 24-25).

Significant events and milestones in the emergence and development of Advanced Nursing Practice in the United Kingdom

Date	Event	Author	Significance
1980's	Ongoing work of Nurse Development Units at Burford and Tameside/ Primary Nursing.	Leading Nurses including Alan Pearson, Steve Wright and Chris Johns.	Primary Nursing emphasised the importance of nursing as a therapeutic agent in its own right, separate from and independent of medicine.
1986	Launch of Project 2000.	United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC).	Move from training school preparation to college and higher education preparation
1986 / 1989	Recommendation of limited nurse prescribing.	Julia Cumberlege / June Crown.	Recommended limited nurse prescribing, formerly a medical/dentist only role. Confirmed by Crown Report 1 (1989)
1987	'Nurse Practitioner' role introduced in Primary Care.	Barbara Stillwell.	Specific nursing role that incorporated medical skills as an adjunct to nursing skills.
1990	Post Registration Education and Practice Project.	UKCC.	Introduced notion of different levels of nursing. Primary, Advanced, Consultant.
1992	Introduction of Scope of Professional Practice.	UKCC.	Promoted and required accountability of nurses and autonomy for those appropriately prepared
1990's	Emergency 'Nurse Practitioner' role introduced in Secondary Care.	Royal College of Nursing Emergency Nursing Forum.	Senior nurses in Emergency Departments expanded roles including autonomous treatment and management
1992	Introduction of Extended Formulary for Nurse Prescribers.	Department of Health and Social Security (DHSS)	Enabled limited nurse prescribing to happen in primary care settings
1994	Introduction of Standards for Education and Practice Post Registration.	UKCC.	Levels of nursing revised: 'Professional', 'Specialist' and 'Advanced'. Academic levels made explicit – 'Specialist' at degree level and 'Advanced' at master's degree level
1994b	Standards for Education and Practice Post Registration- Annex 1 to Registrar letter.	UKCC.	Initial attempt at definition of the Advanced Nurse Practitioner
1998	Consultant Nurse Role proposed via Royal College of Nursing.	Department of Health/ Professor Kim Manley (RCN).	Consultant Nurse roles proposed and introduced in 2000
1999	Independent Prescribing recommended.	Crown 2 Report.	Concerns patient needs not met. Supplementary Prescribing extended, ultimately leading to Independent Prescribing
2004	Consultation on a Framework for the Standard for Post-registration Nursing.	Nursing and Midwifery Council (NMC).	Consultation paper sets out proposals to introduce a framework for a standard for regulating a level of nursing practice beyond initial registration
2006	Independent Prescribing enabled.	Department of Health (DoH).	Independent prescribing permitted raising level of autonomy as no longer directly medically overseen.

2008	Advanced Practice: Report to the four UK Health Departments.	Council for Healthcare Regulatory Excellence (CHRE).	The report concluded that 'Advanced Practice' did not make additional statutory regulation necessary.
2008-2010	Launch of four UK nation centric policy documents guiding implementation of Advanced Practice roles.	UK Health Departments, Scotland 2008, Wales 2009, England 2010, Northern Ireland 2011	Launch of four UK nation centric policy documents guiding implementation of Advanced Practice roles.
2012	Scottish Toolkit (Updated).	NHS Education for Scotland.	An updated version of the original Advanced Nursing Practice Toolkit (2006). As a repository of proven quality resources to support advanced practice development it aims to promote understanding, benchmarking and application of the role including practice, leadership, education and research.

Table 6: Significant Events and Milestones in the Emergence and Development of Advanced Nursing Practice in the United Kingdom

Disenchantment with 'task focused' practice grew among nurses from at least the 1980's (Castledine 2003) and fostered pioneering patient-centred holistic nursing (Payne and Steakley 2015). This was exemplified by the emergence of Nursing Development Units, such as the Burford Project and by widespread introduction of 'Primary Nursing' and patient-centred care (Johns 1994). The contrast to this, as in the United States, was exemplified in the celebrated work of Barbara Stilwell who introduced the Nurse Practitioner role into the primary care setting in Britain (Stilwell et al 1987). This role employed an experienced nurse, utilising existing nursing knowledge and skills but differed from Primary Nursing significantly by incorporating medical skills of assessment and diagnosis in pursuit of medical diagnosis. This difference between the 'Primary Nurse' and the 'Nurse Practitioner', mirrored similar developments that had caused controversy in America, where nurses utilised medical skills as integral to their roles. The claim, as in America, was that Primary Nursing represented autonomous practice, providing an effective response to the totality of patient need. Nurse Practitioners represented a restricted and medically dominated field of practice. Figure 4 represents these polar extremes, underpinned by different underlying philosophies.

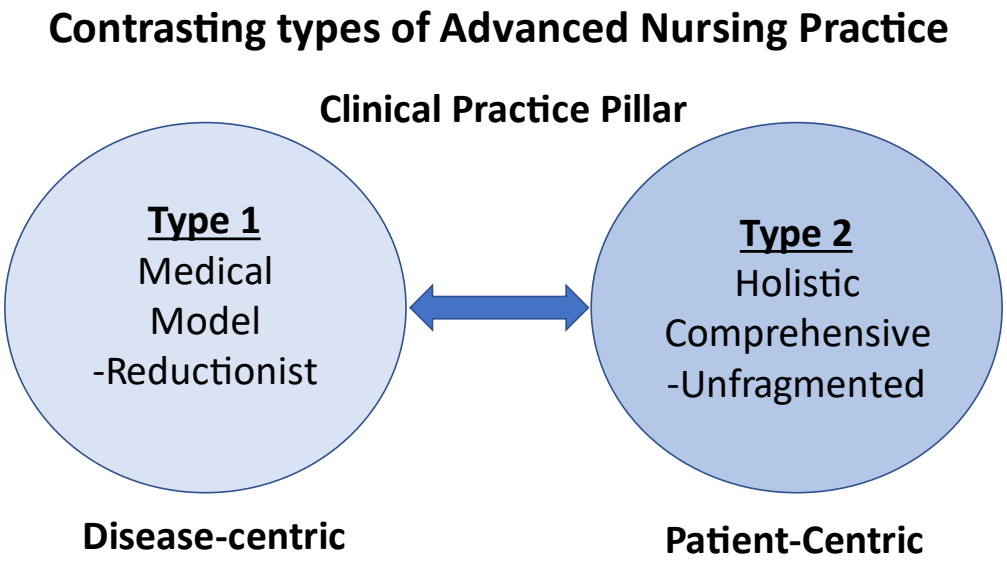

Figure 4: Contrasting Types of the Clinical Pillar Dimension of Advanced Nursing Practice

2.3.2 What Key Drivers and Policy Initiatives influenced the introduction of Advanced Nursing Practice in the United Kingdom?

Key drivers are linked with professional and government policies and set out in Table 6 (see page 27-30).

Profession and Government Policies Influencing the Emergence & Initial Development of Advanced Nursing Practice in the United Kingdom

Date	Profession	Government	Significance and relevance to identified drivers* • **Driver 1* Workforce Challenges** • **Driver 2* Chronic and Complex Health Needs** • **Driver 3* Professional Aspirations of the Nursing Profession**
1986	Launch of Project 2000 – United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC)		Raised aspirations for academic preparation rather than training, commensurate with a move to a professional rather than a vocational emphasis for nursing. Prepared the way for post registration education in Higher Education institutions. **Driver 3**
1986		Cumberlege Report -Department of Health and Social Security (DHSS)	This report suggested that access to treatment and care could be enhanced, and resource used more effectively, where primary care nurses were permitted to prescribe as part of their everyday activity from a restricted list of items. **Driver 2 & 3**
1990	Post Registration Education and Practice Project (UKCC)		Different levels of nursing proposed. Primary, Advanced, Consultant. **Driver 3**
1991		Proposal of new deal for Junior doctors -NHS Management Executive (NHSME)	Reduced working hours for junior medical staff, medical shortfall results and provides opportunity for ad hoc medical substitution activity by senior nurses **Driver 1**
1992	Scope of Professional Practice (UKCC)		Promoted and required accountability of nurses and autonomy for those appropriately prepared **Driver 2 and 3**
1992		Health of the Nation (DHSS)	Specified explicit role for nurses in health promotion and disease prevention with specialist roles for specific patient groups **Driver 2**
1992		Introduction of Extended Formulary for Nurse Prescribers (DHSS)	Enabled limited nurse prescribing to happen in primary care settings **Driver 2 and 3**
1994	Introduction of Standards for Education and Practice Post Registration (UKCC)		Levels of nursing revised: 'Professional', 'Specialist' and 'Advanced'. Academic levels made explicit: 'Specialist' -degree level and 'Advanced' - master's degree level **Driver 2, 3**
1994b	Standards for Education and Practice Post Registration- Annex 1 to Registrar letter (UKCC)		Initial attempt at definition of the Advanced Nurse Practitioner. Emphasised value of nursing as separate from medicine. **Driver 3**
1997	The Council's Decision on PREP and Advanced Practice. Registrar's Letter 8/1997 (UKCC)		Confirms full support for nurses advancing their practice but fails to develop its meaning of the concept from its earlier initial description (1994b) nor set standards for education or practice at the Advanced Nursing Practice level. **Driver 3**

1999		Making a Difference (DoH)	Explicit support for extended roles for nurses, taking greater responsibility for patient care including complex roles. However, tends towards medical replacement activity rather than nursing per se. More detail on Consultant Nurse roles. Value of Education and Research evident and Career framework proposed. **Driver 1, 3**
2000		NHS Plan (DoH)	Detailed plan for NHS reform and transformation. Significant section on Nursing includes Chief Nursing Officer's '10 key roles for Nurses'. **Driver 1, 2, 3**
2001	Standards for Specialist Education and Practice -Nursing and Midwifery Council (NMC) [successor to UKCC]		Reiterated former UKCC position confirming support for nurses advancing their practice but fails to identify a definition nor set standards for education or practice at the Advanced Nursing Practice level. **Driver 2, 3**
2002		Wanless Report. Securing Our Future Health: Taking a Long-Term View.	This report suggested raising the numbers of Advanced Nurse Practitioners to address complex care needs, in light of concerns that the United Kingdom health outcomes had fallen behind other nations **Driver 2, 3**
2002		Developing Key Roles for nurses and midwives a guide for managers (DoH)	Policy guide, includes good practice case studies to aid NHS managers in supporting nurses and midwives to implement the 10 Key Roles, identified in The NHS Plan. **Driver 1, 3**
2003	Nurse Practitioners: An RCN Guide to the Nurse Practitioner Role, Competencies and Programme Accreditation. -Royal College of Nursing (RCN)		Royal College of Nursing steps into professional body gap with recommendations that Nurse Practitioner preparation be at a minimum of degree level, in contrast to International Council of Nurses (2002) which requires master's degree. A definition and competencies are provided. Role now recognised in secondary as well as primary care. It is patient focused and is not a substitute role. Clear ongoing links with interested higher education institutions including RCN accreditation of individuals. **Driver 2, 3**
2005/6		The National Health Service (Miscellaneous Amendments Relating to Independent Prescribing) Regulations (DoH)	Independent Nurse Prescribing enabled, driven by concerns patient needs were not being met. Effect of raising level of autonomy of nurses as no longer directly medically overseen. (This had been recommended earlier in 1999 by Crown Report 2. **Driver 1, 2, 3**
2005	Implementation of a Framework for the Standard of Post Registration Nursing, Agendum 27.1		The NMC proposed regulation of Advanced Nursing Practice, it consulted on this with health interested organisations, further developed by academic course providers, patient groups and the NMC Reference Group. The consequence was a brief definition and description, and a set of wide

	-Nursing and Midwifery Council (NMC)		ranging domains and competencies arising from RCN work, itself derived from American Nurse Practitioner organisations, matched with the Knowledge and Skills Framework. Application was made to the Privy Council for approval to amend The Nurses and Midwives Order (2001). This was delayed by change in Government and subsequently dropped. **Driver 1, 3** The brevity of the definition emphasised clinical practice, even disease centric rather than patient centric, though domains and competencies provided explanation and some patient centric balance. **Driver 1, 3**
2006	The Proposed Framework for the Standard for Post Registration Nursing (NMC)		Included reference to the Nursing and Midwifery Council Advanced Nurse Practitioner definition (NMC, 2005) **Driver 1, 3**
2006		Modernising Nursing Careers (DoH)	Includes emphasis on how nursing roles had changed and how they were likely to change further to meet evolving needs of patients and communities. Highlights Chief Nursing Officer's 10 key roles. **Driver 1, 2, 3**
2008		Supporting the development of Advanced Nursing Practice. A Toolkit Approach. (Scottish Government).	A UK structure for Advanced Level Practice proposed following the publication of NHS Scotland's Advanced Practice Toolkit. Undertaken on behalf of all UK Health Departments. Identified 'four pillars' role framework: clinical practice, research, leadership and education **Driver 2, 3**
2008/ 2010	Advanced Nurse Practitioners – An RCN Guide to the Advanced Nurse Practitioner Role, Competences and Programme Accreditation -Royal College of Nursing (RCN)		This updated version of earlier work (2003) acknowledged NMC intention to regulate Advanced Nursing Practice (2005) and sought to support that work. 'Advanced' is now added to 'Nurse Practitioner', Advanced denotes a level of practice, not a role or title. 'Domains of Practice' representing patient centric activities. Competencies are included and the offer of RCN accreditation remains available. Document revised 2010, no substantial change **Driver 2, 3**
2009		Advanced Practice: Report to the Four UK Health Departments. Executive summary. (Council for Healthcare Regulatory Excellence)	The CHRE had indicated it was not in favour of regulation of Advanced Practice but that 'robust organisational governance arrangements provide the most effective means of controlling for risks to patient safety from an individual professional's practice' (CHRE 2009). The CHRE advised NHS Trusts to respond to this urgently. **Driver 1, 2, 3**
2010		Advanced Level Nursing: A position statement (DoH)	A benchmark position statement intended to enhance patient safety, aid delivery of high-quality care and consistency in titles. Includes four themes that emphasises that clinical practice is accompanied by leadership, development and improvement.

			The paper was generated following the Council for Healthcare Regulatory Excellence's report on Advanced Practice (2009). This confirmed earlier nationally recognised standards for Advanced Nursing Practice (2008) were needed to support governance. **Driver 1,2, 3**
2012	Advanced Nurse Practitioners – An RCN Guide to Advanced Nursing Practice, Advanced Nurse Practitioners and Programme Accreditation -Royal College of Nursing (RCN)		This work builds on previous RCN guides, emphasises that Advanced Nursing Practice maintains its roots firmly in nursing. Identifies Advanced Nursing Practice is a level of practice. No inclusion of previous Advanced Nursing Practice domains and competences, since these largely informed the current positions of the health departments of the four UK countries, as well as the NMC. An expected key impact of this document, in the absence of regulation, was to provide support for Trust governance. **Driver 1,2,3**
2014		Five Year Forward View United Kingdom Department of Health	Societal changes required policy to take a longer- term view to consider what was likely to happen so that wise choices could be made about where and how the health service needs to adapt and change. A greater relationship with patients is needed to enable promotion of wellbeing and prevention of ill-health. **Driver 1,2,3**

Table 7: Profession and Government Policies Influencing the Emergence and Initial Development of Advanced Nursing Practice in the United Kingdom

2.3.2.1 Key Driver 1: Workforce Pressures and Associated Policies

The reduced availability of doctors due to the provisions of the Working Time Regulations (Por 2008; UK Government 1998, 1991) produced a vigorous response by the medical profession, who lobbied for resource to address this (Rolfe 2014a). Senior nurses were identified as a ready resource to address the gap in medical provision with role revision where this could be achieved (Rolfe 2014a). University courses were commissioned to provide skills focussed and disease centric education for identified nurses (RCN 2008). Authors at the time identified that little time was provided for subjects associated with Advanced Nursing (Castledine 2003, 1998). Over time a growing number of acute settings sponsored 'Type 1' Advanced Nursing Practice roles, even positioning Practitioners on the medical team roster (Swann et al 2013; Barton, Bevan and Mooney 2012a).

While much attention was given to medical staff shortages, nursing shortages appeared to pass unnoticed (Lintern 2012). However, a large cross-sectional survey conducted by Ball et al (2013) demonstrated strong evidence that reduced numbers of nurses were associated with worse hospital patient outcomes. Loss of senior nursing expertise negatively impacted quality of nursing and nurse leadership. Indeed, the Francis Report (2013) emphasised actual risk to the quality nursing care, making plain the urgent need for Trusts to address this.

However, policies responding to workforce pressures did so by developing nurses to practice in medical substitution roles, underpinned by biomedical model knowledge and clinical skills (DoH 2002b; 1999). Nurse prescribing was an example of this. Cumberlege (1986) intended nurse prescribing to focus on community care, enabling nurses to be more efficient delivering patient care. Yet, once accepted, its overwhelming purpose supported disease management (Cope, Abuzour, & Tully 2016). While nurses appeared more autonomous, this was in relation only to disease focussed tasks (DHSS 1992, DoH 2005, 2006).

2.3.2.2 Key Driver 2: Chronic and complex health needs and associated policies

As the numbers of patients with complex diseases increased, so a more personalised response than Type 1 Advanced Nursing Practice could offer was needed (DoH 2014; Donald et al 2013; Coulter & Collins 2011; Kucera, Higgins and McMillan 2010; Gardner, Chang & Duffield 2007). The biomedical model, appropriate when primary diseases dominated, was no longer sufficient as healthcare needs became more complex (Coulter, Roberts & Dixon 2013). Type 2 Advanced Nursing Practice, in contrast focused on the total needs of the person, not only the illnesses or diseases affecting them. This approach was 'person' rather than 'disease' centric (DoH 2014; Nancarrow & Borthwick 2005).

Therefore, 'skills', so important to Type 1 practice were only useful to Type 2 practice if they met patient need. Communication, advocacy and negotiation for example, when seen from this perspective were at least of equal importance as physical skills such as patient examination (Coulter & Collins 2011). Skills were thus regarded only as 'tools in a tool-bag', selected according to need (Leary 2012).

The shortcomings of the biomedical model were highlighted in policies addressing chronic and complex health needs (DoH 2014; Wanless 2002; Beresford 2010). This analysis, supported by significant organisations including the Kings Fund, called for a radical rethink of approaches not just to health care delivery but also in its leadership (Ham, Charles and Welling 2018; Coulter and Collins 2011). A significant attempt to respond to this came through introduction of the Consultant Nurse role in the late 1990s (*DoH 1999, 2000). The aim was a role comparable to medical consultants (Pottle 2018), focused on clinical practice, integrated with associated themes of leadership, education, research, and innovation. The nurse regulator at that time, entirely focused on Advanced Practice (*UKCC 1990, 1992, 1993, 1994, 1996), did not meaningfully engage with this agenda and so missed the opportunity to support the potential that the Consultant Nurse could have had in leading nursing practice and Advanced Nursing (Manley 2008). Despite the efforts maintained by those Consultant Nurses engaged in demonstrating the worth of their roles, it failed to gain broad support at that time (Mitchell et al 2010; Manley 2008).

2.3.2.3 Key Driver 3: Professional Aspirations of the Nursing Profession and Associated Policies

The United Kingdom Central Council for Nursing Midwifery and Heath Visiting, signalled strong support for the advancement of nursing (*UKCC 1986, 1990, 1992, 1994, 1998). However, traditional nurse training had not prepared existing nurses to be personally accountable and autonomous (*UKCC 1986, 1992) so these changing perspectives about nursing were difficult to achieve, with opposition and resistance both within and outside nursing (Finlay 2000). Many nurses were only comfortable extending their roles under the 'safety' of medical supervision (Rolfe 2014a; Hunt & Wainwright 1994). Health authorities, concerned with public protection and liability imposed local mandatory training and certification, generally supervised by doctors (Wainwright 1994). This limited nurses' developing autonomy, bolstered the existing hierarchical system, and hindered nurses from advancing nursing (UKCC 1992).

Policies supporting development and advancement of nursing focused on embracing medical substitution and disease focussed roles (DoH 1991 & 2002), recognising that nurses could adapt to address the 'gap' in medical provision (DoH 1999). The glaring misunderstanding of this approach,

within the NHS Plan (DoH 2000) was that it focused on 'nurses' as a resource rather than 'nursing' as the work that nurses do, and how they go about it (Rolfe 2014a).

A significant blow to the advancement and autonomy of nursing came with the refusal by the Privy Council to permit legislation to open a part of the nurse register for Advanced Nurse Practitioners (Barton, Bevan, & Mooney 2012a). The Council for Healthcare Regulatory Excellence (CHRE 2009), contributed to this action by advising that regulation was not needed, but organisational governance instead. However, this placed considerable burden on trusts who already had limited understanding of Advanced Nursing Practice (East, Knowles, Pettman, & Fisher 2015). This did little to advance nursing but fostered medical oversight and control of nurses in Advanced roles (Castledine 2003; 1995).

2.3.3 Features and Scope of Advanced Nursing

Appraisal of the features and scope of Advanced Nursing Practice will be achieved with reference to the two 'Types' of Advanced Nursing Practice, illustrated in Figure 2, page 26, arising from historical literature (Mantzoukas & Watkinson 2006). They are extended here to include all four pillars (DoH 2010). This illustrates the extent of the contrast between Types 1 and 2, see Figure 5:

Four pillars* represent Clinical Practice, Leadership, Education and Research dimensions of Advanced Nursing Practice DoH 2010

Figure 5: Contrasting Types of the Four Pillar Dimensions of Advanced Nursing Practice

Type 2, indicated in figure 5, represented a strong emphasis on Advanced Nursing within clinical practice including other non-clinical activity (DoH 2010). This aimed to provide comprehensive care and management, and service development. Type 1, by contrast, focused on substitutionary practice, solely addressing disease and illness (Castledine 1998). Swann et al (2013) exemplified this within their Emergency Department, where roles were substitutionary placing little emphasis on holistic approaches to care and management. The training programme was entirely disease-centric, mentorship was provided by medical staff, and nurses were placed on the medical rota, no longer associated with the nursing team nor providing leadership for nursing (Swann et al 2013). However, the substitutionary service they provided did achieve its objective, stable consistent contribution to disease-centric management.

Manley (1997) expressed concerns about the Type 1 model, highlighting instead 'Advanced Nursing' as a vital, not peripheral part of patient care. Manley's study and her resultant multidimensional model integrated roles of, educator, researcher, and consultant, vitally connecting clinical practice with leadership, creating a transformational proactive culture of innovation, growth and stability. A key part of this Type 2 Advanced Nursing Practice lay in providing leadership to an integrated clinical team (DoH 2010; Hamric et al 2014) revealing a 'level' of practice that was 'Advanced', rather than merely a substitution role (Leary 2012). Advanced Nursing was demonstrated through effective interpersonal and practice skills, influencing and shaping the culture of the workplace. Overall patient experience was enhanced, Advanced Nursing Practice championing and leading innovation (Williamson et al 2012). It is significant that the integrated four pillar activity presented here was also observed across Advanced Nursing Practice literature in both UK and North America (Hamric, Hanson, Tracy & O'Grady 2014; DoH 2010).

During the 1990s and early 2000s evaluation strategy and evidence base for Advanced Nursing Practice was limited (Wilson & Bunnell 2007; Bryant-Lukosius 2004). Roles often literally emerged, and baseline data prior to their introduction, or use of performance indicators thereafter did not happen. Papers emphasising 'patient satisfaction' with Advanced Nursing Practice roles did exist (Bryant-Lukosius 2004) but rigorous research making visible the 'added value' elements claimed for 'Advanced Nursing' was scarce (Dalton 2013; Bryant-Lukosius 2004; Corner et al 2003). Therefore, conducting impact research was recognised as a priority by senior nurses wanting to promote Advanced Nursing since it would make visible why Advanced Nursing was relevant and worth investment (Corner et al 2003). Type 1 Advanced Nurse Practitioners, focused on clinical practice, had little time to conduct research. Where outcome evaluations did happen, they were limited to

comparing Advanced Nurse Practitioners with doctors, assessing patient outcome standards related to medical not nursing practice (Wilson & Bunnell 2007). The following American example is a case in point. Advanced Practitioners worked collaboratively with medical colleagues and similar if not better care outcomes were demonstrated when compared with doctors practicing alone (Newhouse et al 2011). This systematic review extended what was known about Advanced Nurse Practitioners outcomes. It included all types of Advanced Nurse Practitioner found in the USA and their collaborative work over an 18-year period. While the systems and roles were not the same as in the UK, interesting points were raised about the 'added value' of nursing in providing collaborative input which improved overall patient care. The use of advanced practitioners in acute care settings could reduce length of stay and costs for hospitalized patients. Unfortunately, the review did not make explicit what it was about advanced practitioner input that made the difference.

Dalton's (2013) small scale qualitative cross-sectional design used focus group and individual interviewing of six junior doctors, six ward nurses and six Advanced Nurse Practitioners, selected as a non-probability sample. The aim was to explore perceptions of the Advanced Nurse Practitioner role in an acute hospital setting. Results revealed differences in role understanding between day and night teams; role ambiguity and vagueness; communication and education needs; and system restrictions and barriers. Evaluating effectiveness was challenging because of role variance. The benefit of 'value added' brought to each situation by Advanced Nursing lay in problem solving and decision-making abilities supporting effective clinical practice and collaboration between team members. There was no evidence of role benefits to nursing practice or to leadership of nursing. Some doctors were concerned about the risk of the role to their securing enough access to managing acute patients.

An ethnographic study by Williamson et al (2012) found, in contrast to Dalton's (2013) study that a small team of Advanced Nursing Practitioners, ward based and working in a large acute hospital, were able to facilitate patient care including both nursing and medical practice through use of considerable knowledge, expertise and connections. Their enhanced communication skills powerfully impacted practice, enabling the patient journey. Their role was clearly defined as beyond medical substitution, critically they were recognised as the 'lynchpin' within their service working to bridge nursing and medical practice. This was a small but well-designed study, that including patients as well as staff members providing a rounded view of the subjects.

Selected examples of international research brought useful evaluation of effectiveness and impact of Type 2 Advanced Nursing Practice. This was revealed most strongly within the long-term conditions arena. Donald et al (2013) conducted the first reported quantitative systematic review evaluating quality of care provided by Advanced Nurse Practitioners in older person care, determining gaps in existing knowledge, so informing future research. Analysis of four prospective studies, reported in 15 papers, were conducted in this North American setting. The research focused specifically on Advanced Nursing Practice rather than multidisciplinary team input. This was important in drawing out focussed findings demonstrating quality and cost effectiveness of care where Advanced Nurse Practitioners were involved. There was also improvement or reduced decline in health status indicators, including depression, incontinence, pressure sores, aggressive behaviour, and also in the achievement of personal goals. This latter point was supportive of United Kingdom government policy promoting patient-centred care (DoH 2014). The relevance of leadership was shown through significant improvement in service impact achieved by Advanced Nursing Practice through clinical leadership and education activities. Transformational leadership has been shown to bring significant impact on patient outcomes (Wong & Cummings 2007). Interestingly, quality clinical leadership was often absent among health professionals at the Mid Staffordshire NHS Foundation Trust and contributed to poor standards of care experienced there (Francis 2013).

A Type 2 model of Advanced Nursing Practice is revealed in narrative accounts collected by Kucera, Higgins and McMillan (2010). This Australian study used a qualitative narrative design. 59 narratives, selected from 142 were analysed. Insight into the existing activities of revealed characteristics and quality of Advanced Nursing Practice that replicate examples in Britain, highlighting the central place in patient care of nurses. Distinctions are made between ordinary nursing and Advanced Nursing. Three themes emerged relevant to Advanced Nursing Practice: complex attributes; its dynamic character; and engagement with patients and colleagues. While role diversity was acknowledged, it was seen as essential to retain core characteristics (Bryant-Lukosius et al 2004). The patient-nurse relationship was key within this example of Type 2 Advanced Nursing Practice (Kucera, Higgins and McMillan 2010). This was at odds with Type 1 Advanced Nursing Practice which was revealed in the physical, technical and disease centric approach of medical practice.

2.3.4 Proposed descriptions of Advanced and Advancing Nursing Practice

Arising from the review findings, tentative descriptions of Types 1 and 2 Advanced Nursing Practice, followed by Advancing Nursing Practice are proposed. Presented together they contrast, 'Advanced', proposed as the current experience of practitioners, with 'Advancing', an aspirational fulfilment of nursing potential.

2.3.4.1 Type 1 Advanced Nursing Practice

> *'A level of clinical practice delivered by senior experienced registered nurses, able to diagnose and treat healthcare needs, referring to appropriate specialists where needed. Practice is underpinned by expert knowledge base, complex decision-making skills and clinical capabilities. The achievement of an appropriate masters' degree or equivalent is appropriate to underpin the role. Specific characteristics are shaped by the context of practice but demonstrate collaborative working and a level of autonomy. Associated activities where supported may include: education of patients and staff; clinical leadership and service improvement; and research.'*
> (Gray 2023, ICN 2002, NMC 2006, DoH 2010).

Box 1: Proposed Description Type 1 Advanced Nursing Practice

2.3.4.2 Type 2 Advanced Nursing Practice

> *'a level of comprehensive patient-centred nursing practice, delivered by senior registered nurses, underpinned by expert knowledge base, complex decision-making skills and clinical capabilities. The achievement of an appropriate Master of Science degree is essential at the outset of achieving this status. Specific characteristics are shaped by the context of practice but demonstrate autonomous and collaborative working which push the boundaries and expand existing practice. Clinical leadership is central, leading nursing practice, pioneering and innovating to ensure timely responses to often complex patient and service needs. Advanced Nursing Practice is actively engaged with education, including development of colleagues and patients. It is also actively engaged with research that informs practice and with policy formation that shapes and keeps practice current and effective.'* (Gray 2023, after UKCC 1995, ICN 2002, DoH 2010).

Box 2: Proposed Description Type 2 Advanced Nursing Practice

2.3.4.3 Advancing Nursing Practice

> *'A continually evolving level and scope of Advanced Nursing, provided by senior experienced and knowledgeable nurses, underpinned at least by a relevant masters' degree. Its foundation is continuing direct patient care, demonstrating a comprehensive response to patient healthcare needs. It's defining features are that it deliberately and consistently utilises learning from clinical decision-making involving patient and family encounters, and from colleagues and the clinical environment, leading to dynamic and innovative responses and the continuing progression of practice through leadership, education and research. It has a central role in leading professional practice for Nursing, and in developing and innovating in service delivery.'* (Gray 2022)

Box 3: Proposed Description Advancing Nursing Practice

In comparing these proposed descriptions, similarities exist, however, the Advancing Nursing Practice description develops the features further and integrating them into a comprehensive whole. Clinical practice in nursing is grounded in providing comprehensive responses to patient need. This is a therapeutic relationship helping patients understand their conditions and manage them, supporting effective patient journeys (Rolfe 2014b). Alongside this, healthy workplace cultures are created, fostering collaborative team working that enables excellent patient-centric care. There is also wider scope of engagement in leadership and innovation, and a forward looking dynamic, actively and continuously moving practice forward.

2.3.5 What Debates, Contentions, Restrictions, and Opportunities Concern Advanced Nursing Practice?

As the two types of Advanced Nursing Practice proposed and articulated in this review emerged, questions were posed from protagonists of Type 2 about the narrow medical substitution focus of Type 1 (Castledine 2003; Manley 1997; Sutton and Smith 1995; Castledine 1995). They did not criticise the quality of the practice, but its disease-centric focus. Whilst this generally dealt with specific disease episodes in a timely way, it failed to respond to the increasingly complex range of long-term conditions and multiple pathologies in a patient-centric manner (Rolfe 2014a), indeed it was not set up to do so. Services themselves remained organised around medical specialities, effectively providing a fragmented rather than an integrated service (Barton and Mashlan 2011).

Nonetheless, proponents of Type 1 Advanced Nursing Practice were delighted with the quality of support Advanced Nurses were able to provide in substitution roles indeed they filled gaps and provided continuity that would have been difficult to provide otherwise (Swann et al 2013).

Studies of patients' views were limited in scope, though did demonstrate that when nurses delivered disease-centric care and management, in medical substitution roles, patients liked this, benefitting when nurses delivered it with a more personalised approach (Wilson and Bunnell 2007).

2.3.5.1 Factors Which Facilitated or Hindered Advanced Nursing Practice as it Emerged in the United Kingdom

Clarity around the purpose for Advanced Nursing Practice was a key factor in creating successful roles (Rolfe 2014b, Castledine 2003, UKCC 1990). Determining which 'type' was appropriate for which service was a critical question for employers/Trusts when establishing new services. Where vision was articulated, effective governance, policy, employment, and infrastructure generally followed (Barton, Bevan and Mooney 2012c). However, a common challenge was that innovative practice was frequently obstructed by organisational structures and cultures reflecting hierarchical structures, bureaucratic working modes and inefficient practices (Barton and Mashlan 2011). Indeed, polices focusing on emerging health needs concurred (DoH 2014) suggesting that structures restricted Advanced Nursing Practice to anything but medical substitutionary roles (Leary 2012). Some trusts, recognising the value of Type 2 Advanced Nursing Practice, identified lead posts to establish effective infrastructure to support services, preparing business plans for roles fit for that purpose (Barton, Bevan and Mooney 2012c). Where roles had emerged without central co-ordination, set up simply to fill an immediate service gap (Melling and Hewitt-Taylor 2003) innovative trailblazer services provided an important challenge, offering examples of a more sustainable way to embed Advanced Nursing Practice roles influential in developing service innovation (Rolfe 2014b).

Moreover, Robert Francis (Francis 2013) pointed to the cost of not doing this, where he contended that had senior nurses been supported to maximise nursing within Advanced Nursing Practice roles, rather than substitution, they could have become effective and visible role models positively influencing nursing practice (Rolfe 2014b). The limiting effect of prevailing culture similarly affected consultant nurses reaching their potential (DoH 1999). They were intended to provide clinical leadership for developing nursing practice (Doody 2014; Mitchell et al 2010; Manley 1997) carrying a mandate to shape practice culture, paving the way for excellent nursing and promotion of Advanced Nursing. Some suggested that nurse consultants should precede the introduction of Advanced Nursing Practice so creating an effective foundation for its introduction. However, relatively few roles embedded and that potential was not realised (Mitchell et al 2010).

Graham's (2007) research revealed something that would emerge as vitally important later in this study, namely the importance of the developmental journey. In his context it was the journey to become a Consultant Nurse, not dissimilar to Benner's (2000) seminal 'Novice to Expert' work and developed further by Benner, Tanner and Chesla (2009). In the wider context it raised important questions about what enabled Advanced Nurse Practitioners to achieve the required level of practice and access to appropriate education, fit for purpose, was revealed as an essential part of this for both proposed types of Advanced Nursing Practice. The Royal College of Nursing provided the lead in course design over several years, filling a vacuum left by the nurse regulator, who had largely vacated the debate by the end of the 1990s. Recognising the need for academic preparation, it indicated preparation at degree level was the minimum needed for Advanced Practice (RCN 2002; Walsh & Crumbie 2003. Initially courses were largely focused on clinical skills and disease management, and competencies were included in the first nurse practitioner training/ education programme (RCN 2008, revised in 2010). Little attention was paid to addressing the other pillars of practice, leadership, education, and research (Scottish Government 2006; DoH 2010). Despite appropriate master's degrees becoming standard preparation for Advanced Nursing Practice during the 2000's, there appeared limited appetite to move beyond a skills/practice domination of curricula and include consideration of, for example, philosophy underpinning practice. Final year dissertations generally followed a traditional research focus, which while helpful in developing research skills, were criticised for being too focused on following positivist approaches answering disease-centric topics, rather than nursing ones (Corner et al 2003). Rolfe (2014b) among others called for specific research to reveal the benefits of Advanced Nursing, patient rather than disease-centred.

Furthermore, it appears that courses had little capacity to challenge students concerning the relevance of their professional background, and how they might develop nursing within their practice. It is not surprising that a number of these students, content to take on substitutionary roles, were unable to confidently articulate the significance of nursing, let alone Advanced Nursing in their roles (Rolfe 2014b). This situation encapsulated the need for nurses concerned about Advanced Nursing to engage with serious questions such as 'what was the point of nursing?' and 'what was the role of the nurse?'. Arguably, only having seriously considered those questions was it possible to consider 'What is the role of Nursing in Advanced Nursing Practice'? It was unclear whether nurse education programmes lacked the ambition to prepare nursing students to address questions of identity at pre-registration, or whether students lacked the intellectual curiosity to ask themselves these questions. However, without establishing this basis it should not be a surprise that

registered nurses undertaking advanced studies have been content to focus on developing advanced clinical knowledge and skills.

Indeed, the emphasis within Advanced Nursing Practice literature, research and policy emphasised 'roles' practitioners filled, activities they carried out, but ignored the potential that Advanced Nursing could have had on patient wellbeing. Bryant-Lukosius et al (2004) in Canada echoed earlier United Kingdom (UKCC 1992) perspectives that Advanced Nursing Practice went beyond a simple description of role and,

> *'...represents the future frontier for nursing practice and professional development. It is a way of viewing the world that enables questioning of current practices, creation of new nursing knowledge, and improved delivery of nursing and health care service.... therefore continued development is of paramount importance for society and the nursing profession.'*
>
> *Bryant-Lukosius et al (2004)*

Such concerns and perspectives mattered to many nurse academics in the United Kingdom. Arguments were regularly published articulating why the essence of Advanced Nursing was important (Por 2008; Mantzoukas & Watkinson 2007; Manley 1997). Por (2008) for instance addressed key features including the relationship between generalist and specialist expert nursing practice, integrated with essential features of educator, researcher, and consultant. Internationally, Jokiniemi & Haatainen's (2012) systematic review, examined comparisons between the UK, Australia and the USA, revealing that a consensus of international opinion was possible in defining Advanced Practice Nursing including key dimensions that went beyond just clinical practice (Hamric et al 2014; Manley 1997). Nurse theorists in North America developed conceptual frameworks that described and explained how features of Advanced Practice both were and needed to be integrated (Dowling et al 2013 & Brown 1998). Por (2008) went on to contrast Advanced with Advancing Nursing Practice, proposing that 'Advancing' characterised an ongoing dynamic process beyond 'Advanced', using expanded knowledge, clinical expertise and research to further the scope of practice. Manley (1997) had previously articulated a similar view, however, one detractor, Christensen (2011) felt Advancing better described the stage of development prior to becoming 'Advanced'. Rolfe (2014b) responded directly and disagreed, going on to develop Por's proposal suggesting 'Advancing' had less to do with what nurses did, but more to do with how they did it, captured in the phrase:

> *…it's not what you do, but the way that you do it. (Rolfe 2014b)*

2.4 Chapter Summary

A foundation for the thesis has been provided by this chapter which has presented the historical background to the emergence of Advanced Nursing Practice in the United Kingdom. The scoping review with critical discussion of policy documents, and the narrative summery of discussion papers and empirical studies together have provided a contextual perspective of the period between 1985 and 2015, ahead of the data collection for this study. Arising from the literature, two types of Advanced Nursing Practice were proposed and a third, Advancing Nursing Practice was proposed from these. This initial contextual review was in line with the three-stage treatment of literature in constructivist grounded theory studies advised by Thornberg and Dunne (2019). The decision to take this approach addressed potential concern that this chapter was incomplete, when actually instead was designed to provide context ahead of data collection, in line with constructivist approaches.

The second stage of this constructivist approach to handling literature, was an ongoing retrieval and review of evidence, which took place during the data collection and analysis phase of the study and is referred to in Chapters 4 and 5 (Thornberg and Dunne 2019). This including evidence concerning the contemporary Advanced Clinical Practice multi-professional emphasis (HEE 2017) and its relationship with Advanced Nursing Practice. The third and final inclusion of evidence took place towards the end of the study, found in the discussion chapter, Chapter 7. This supported the contextualisation of the study's grounded theory, locating it within contemporary Advanced Nursing Practice.

By providing context to Advanced Nursing Practice, this initial review provides justification for the study's aim to achieve a contemporary explanation of Advanced Nursing Practice as practiced in a West Midlands NHS Trust in the years 2016-21. This approach aligns with constructivist grounded theory approaches to literature management (Charmaz 2014). The following chapter will set out the methodology chosen to direct this study.

Chapter 3. Methodology

3.1 Chapter Introduction

This chapter presents the philosophical stance underpinning the execution of this study. It reveals my ontological and epistemological positions (Mills, Bonner and Francis 2006), supporting the choice of constructivist grounded theory as the methodology for this study. Theoretical perspective on data collection and analysis are also considered. Collectively this chapter provides a foundation for Chapter 4, which addresses the process of data collection and analysis in the study.

3.2 Underpinning Theoretical Perspectives

3.2.1 Quid est veritas - What is Truth?

In the Gospel of John, Pontious Pilate questions Jesus' claim that he is a witness to the truth,

> *[37] Pilate therefore said to Him, "Are You a king then?" Jesus answered, "You say rightly that I am a king. For this cause I was born, and for this cause I have come into the world, that I should bear witness to the truth. Everyone who is of the truth hears My voice." [38] Pilate said to Him, "What is truth?"…' John Chapter 18, verse 37-38a (Hayford 2002)*

J. L. Austin, the ordinary-language philosopher, in a symposium on truth, comments on this extraordinary encounter,

> *'What is truth?' said jesting Pilate, and would not stay for an answer. Pilate was in advance of his time. For 'truth' itself is an abstract noun, a camel, that is, of a logical construction, which cannot get past the eye even of a grammarian. We approach it cap and categories in hand: we ask ourselves whether Truth is a substance (the Truth, the Body of Knowledge), or a quality (something like the colour red, inhering in truths), or a relation 'correspondence') …' (Austin et al. 1950)*

The search for what is 'true' about phenomena is the objective of researchers (Robson 2002), but what is meant by truth and what kind of truth was being sought was a central question to grapple with and resolve. I concurred with Ward, Hoare and Gott (2015) who recognised that for inexperienced researchers, the range of philosophical perspectives available are not easy to negotiate and require a good deal of thought, especially where philosophical grounding has been limited in their academic preparation. My experience was that this was not a straightforward process, as I engaged with ideas that I was unfamiliar with, in order to clarify and establish my own position (Birks and Mills 2015; Creswell 2014). However, it also became clear that achieving this had

great value in ensuring the processes used in my study were congruent, thus enabling its effectiveness.

As my thoughts became clear I realised that the answer to critical philosophical questions would arise from how my conceptualisation of Advanced Nursing Practice, my own understandings, connections, and biases affecting this were moderated, understood, and explained (Thomas 2016; Cooper 2008). Research is a process requiring interpretation, yet what the researcher ultimately understands about the subject and data produced from its study is influenced by their own experiences as well as the subject being studied (O'Reilly & Kiyimba 2015).

> *'All research is interpretative, it is guided by the researcher's set of beliefs and feelings about the world and how it should be understood and studied. Some beliefs may be taken for granted, invisible, only assumed, whereas others are highly problematic and controversial.' (Denzin and Lincoln 2005: 22)*

Many researchers at the commencement of their research careers are unaware or have limited awareness of their own preconceptions about reality, and I recognised myself to be among the latter at the start of this study. Responding to this led to my adoption of a reflexive approach, which proved hugely beneficial in achieving clarity as well as enabling the transparency required in the conduct of the study (Holmes 2020). Determining the nature of reality was a critical philosophical question and related closely to what constituted knowledge and therefore data, the fruit of this study. Indeed, establishing my philosophical position on the nature of reality had more influence on my broader decision making regarding the whole research process than I had previously appreciated, including also the methodology chosen to underpin the study (O'Reilly & Kiyimba 2015).

3.3 Philosophical and Personal Positioning for this Study

'Paradigms' or 'worldviews' are generally used by researchers to make clear where they are situated philosophically (Cresswell 2014; Khan 2014) they have core assumptions which interrelate and contrast with those of alternative paradigms (Savin-Baden & Howell Major 2013). Guba and Lincoln (1994) argue that the essential three philosophical questions that characterise research paradigms can be summarised from the investigator's response to three fundamental and sequential questions:

1) The ontological question: What is the form and make up of reality and what can be known about it?

2) The epistemological question: What is the nature of the relationship between the knower and what can be known?
3) The methodological question: How can the investigator conduct a study to find out about what can be known about this subject?

Resolving questions about truth and reality were then at the heart of establishing a firm foundation to enable quality and integrity within the study (O'Reilly & Kiyimba 2015). This was achieved once I had gained an effective grasp of my ontological, epistemological, and methodological positions (Guba and Lincoln 1994; Carter 2007). This process revealed multiple factors that shaped my thinking and enabled my thoughts to be made transparent (Birks and Mills 2015, Savin-Baden & Howell Major 2013) and led to exploration of preconceptions and assumptions about:

1. the subject;
2. how the subject could be studied, including the research questions posed;
3. the research context;
4. intended participants, how I viewed them, and they me as I was well known to them as their actual, or former, course director and lecturer;
5. what processes are used to gather data and explain how understandings and interpretations of that data would be achieved (Savin-Baden & Howell Major 2013).

Engaging with these questions was aided by first articulating my personal position. Birks and Mills (2015) posed four questions leading to determining a researcher's personal position, they are addressed as follows:

3.3.1 Personal Position - Defining self

In identifying the values, views and attitudes that shaped what was significant for me about being a nurse, nursing, and patient care, it became clear that these were derived from my personal characteristics including upbringing, culture, religious affiliation as a Christian, political persuasions, my gender, race, and professional experience. I acknowledged their collective influence on how I perceived and understood Advanced Nursing Practice. The influence of my Christian faith for example, was significant in the value I placed on the primacy of the individual and the moral absolute of doing the utmost to identify, recognise and meet their holistic not just disease specific needs. Moreover, the recognition of individuals' experiences pointed me away from the notion of absolute realities to multiple different human experiences, and therefore the need for multiples

responses to be provided (Birks and Mills 2015). This realisation led me away from positivist, post positive methodologies underpinned by the search for absolute truth, to methodologies which embraced uncertainty and sought rather to release new understandings and meanings from the actors within the situation.

3.3.2 Personal Position - Nature of Reality

Exploring preconceptions enabled me to articulate my understanding of the essence of 'reality' and 'knowledge' (Guba & Lincoln 1994). My own experience demonstrated that it was difficult to point to an objective reality about Advanced Nursing Practice, since there was no absolute truth, nor single perspective, but multiple perspectives and understandings, held by my likely participants and myself. Appreciating diverse perspectives came from my existing knowledge and understanding of Advanced Nursing Practice and my grasp of literature which together developed early 'theoretical sensitivity' about the subject (Mills, Bonner & Francis 2006). Later, once I had determined the methodology and methods to be used, existing theoretical sensitivity increased with subsequent immersion in the data produced from interviews held with participants; from continued reading of professional and research literature; and, through ongoing conversations with recognised leaders from the world of Advanced Nursing Practice.

Charmaz (2000) proposed that rather than there being absolute reality, as positivists would argue, or one waiting for it to be discovered, as post positives would suggest (Charmaz, Thornberg & Keane 2018), reality is found in the words and actions of its members. This is a fluid construction subject to change, representing what is known as a relativist position (Birks and Mills 2015). My alignment with this approach supported the decision to establish my ontological position as a relativist.

3.3.3 Personal Position - Researcher and Participants

While ontology concerns the study of the nature of reality, and epistemology concerns the nature of knowledge and what can be known about a subject, they are absolutely linked. It is inevitable that the ontological position influences thinking and decision making concerning how knowledge can be obtained (Birks and Mills 2015). Moreover, it also shaped my orientation to participants, I had to decide if I was an objective collector of their data, or a subjective participant active in the data generation process. It was clear that I was the latter and so followed that this revealed my epistemological position as a subjectivist, intimately involved in the process of the study (Charmaz 2014).

3.3.4 Personal Position - How Knowledge is Created

In considering how knowledge might be obtained, I focussed increasingly on constructivist grounded theory (Charmaz 2014). Not all forms of grounded theory would have been suitable since some retained a positivist perspective, committed to discovery of 'fundamental truth' (Birks and Mills 2015). Constructivist grounded theory begins with inductive enquiry (Bryant & Charmaz 2007) continues with constant comparative analysis of data, but also actively pursues maximum interaction with participants and data throughout the study. Abductive reasoning is then utilised to provide an interpretative emphasis that enables co-construction and creation of new knowledge and understandings about Advanced Nursing Practice (Charmaz 2008).

Having confirmed my ontological position as relativist, and my epistemological position as subjectivist (Mills, Bonner and Francis 2006), my positionality statement follows, summarising how I located myself regarding this study and its participants.

3.3.5 My Positionality Statement

As a nurse for over forty years, I believe effective nursing is more important than ever. Nursing has been a significant force for good, acting and speaking for patients, carers, and colleagues, and ever reinventing itself to achieve this aim. It has consistently worked collaboratively across the health, and social care sectors to promote patients' interests. Nursing is generally highly regarded, though is frequently taken for granted. Nursing is in many ways an enigma, widely styled as a profession, it also retains strong vocational ties, it's significance and impact is often hard to quantify because much of what nurses do is hidden from view, not least when it is practiced well and effectively. Indeed, it is sometimes only when it is absent, or poorly practiced, that its significance and impact is realised. Nonetheless, the progression of nursing in recent years has not been straightforward and the profession has drawn criticism for having lost the heart of caring. Alongside this, nursing leadership has appeared hesitant, and has failed to give sufficient lead to where nursing is going. This is reflected in continuing debates about Advanced Nursing Practice, where for many this significant new role remains ill-defined and its purpose unclear. The nursing voice speaking out for Advanced Nursing has been weak, and seemingly keener to support medical replacement activities, rather than advance and lead nursing practice.

As nursing, as a graduate profession, progresses in the United Kingdom, effective and consistent promotion of its value and importance is necessary. It is the essential contributor to effective patient care and key to service stability and enhancement. Advanced Nursing Practice has the potential to be at the centre of this, demonstrating excellent nursing practice, making nursing visible, and role

modelling and leading its development. However, this cannot happen if nursing is not wholly embraced and promoted within all Advanced Nursing Practice roles. In recent years understandable and even necessary drivers have emphasised development of a medical dimension within Advanced Nursing Practice. While valuable and relevant for aspects of patient need, it is unhelpful to subsume or replace nursing as its prime focus. Moreover, nursing autonomy must be valued and freed from restriction, and Advanced Nurse Practitioners must remain free of being considered part of the medical workforce. They remain a separate profession and separate accountabilities apply.

As an experienced nurse educator for over 25 years, working with and teaching the concept of Advanced Nursing Practice for almost 20 years, and heavily engaged with the world of Advanced Nursing Practice and Advanced Nurse Practitioners throughout that time, I became discontented with what I directly observed in many Advanced Nursing Practice roles. A lack of priority was given to developing Advanced Nursing and its enhancement within Advanced Nursing Practice roles. Indeed, roles were often dominated by a disease centric focus and medical substitution activity, to the exclusion of other core features of Advanced Nursing Practice. Consequently, 'pushing the boundaries' of nursing practice through clinical nursing, leadership, education, and research/innovation activity were restricted and often absent. These observations became the genesis of this study, to reveal and explain Advanced Nursing Practice as experienced by nurses in these roles and by senior colleagues working with them.

Having set out my own position and my own reality regarding Advanced Nursing Practice and Advanced Nursing within it, a vital aspect of this discussion also lay in establishing where I was positioned in relation to study participants, to data generated from their interviews, and the study overall. Each participant had their own unique and individual perspective that arose from their own experience and understanding, and it was this reality that I intended to understand and explain. In relation to this, as briefly considered earlier, it was necessary to decide my position, either as an impartial disinterested observer and objective instrument of data collection, or as a subjective and active participant in data generation (Birks and Mills 2015). The importance of this was because it would determine the methodology chosen to shape the study, (see page 33). However, before that my Personal Positionality diagram, summarising key thoughts, see Figure 6 on page 49.

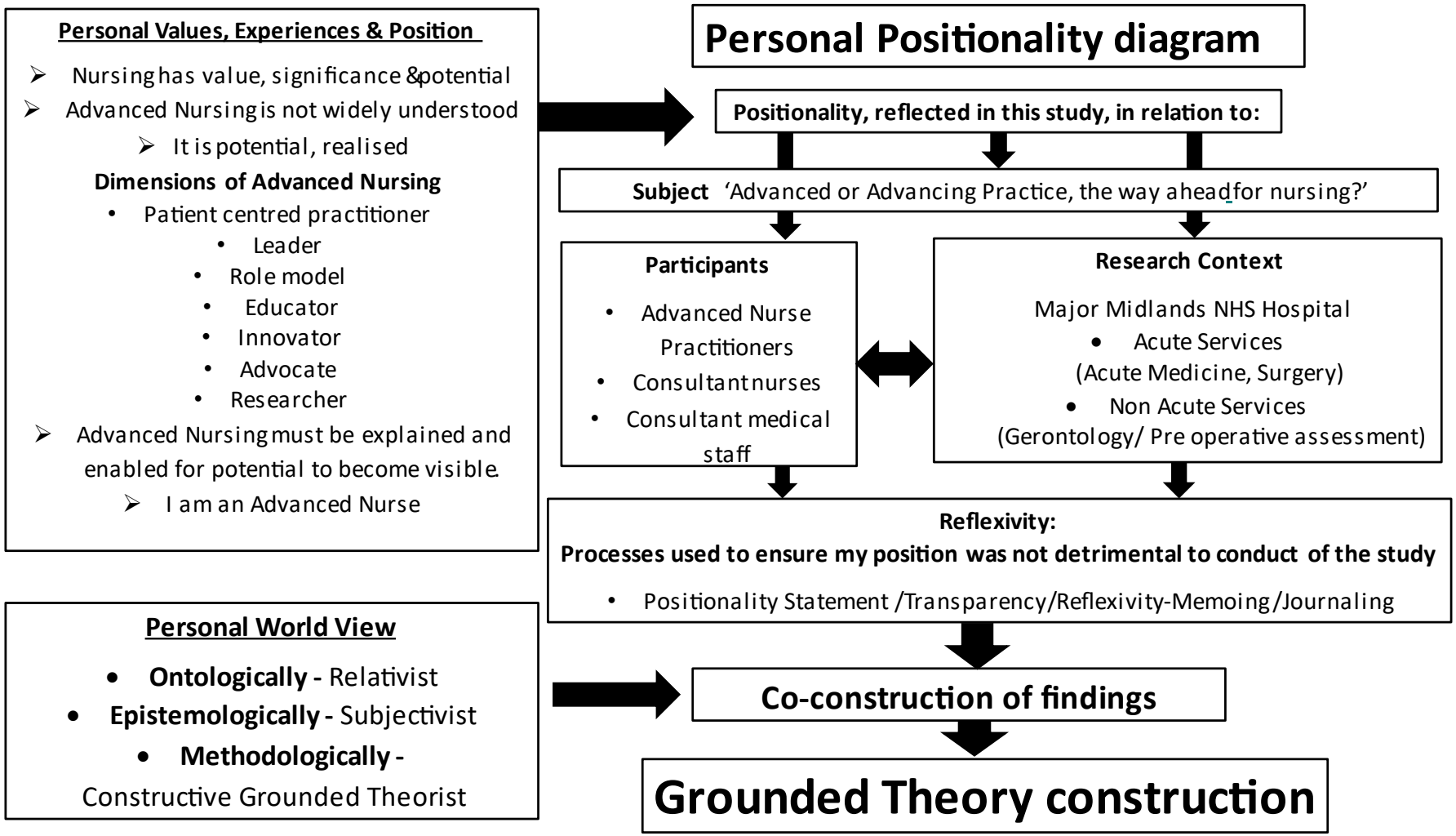

Figure 6: Personal Positionality Diagram

3.4 Philosophy and Methodological Approaches

The achievement of congruence between ontology and epistemology was of central importance in moving on to determine the methodology to gather answers to the research questions and the study's aim and outcomes (O'Reilly & Kiyimba 2015; Charmaz 2014; Cresswell 2014; Norwood 2010). Securing all three elements strengthened later claims for achieving integrity and quality within the study (O'Reilly & Kiyimba 2015; Carter 2007; Guba and Lincoln 1994)

3.4.1 Positivism.

Becoming a nurse in the United Kingdom during the early 1980s coincided with huge changes in the nursing world including: shifts in preparation from training to education (UKCC 1984); the striving for professionalisation, and the autonomy and accountability that are associated with that (UKCC 1992); and the rise of the concept of evidence-based practice (DoH 2000). Arguably this latter influence contributed to the dominance of positivist scientific reasoning within health care, with its claim of objectivity, truth and knowledge able to usefully inform practice (Ward, Hoare and Gott 2015). Scientific enquiry, arising from this 'positivist' philosophical stance, follows a set of controlled procedures with the intention of empirically, systematically, sceptically, but ethically uncovering 'truth'. However, while considering this perspective as a basis for my study, I learnt that its claims have long been challenged by those articulating the value of other paradigms (Guba and Lincoln 1994) arguing that positivist control of elements is both rigid and restrictive for certain types of research. Moreover, very few 'real world' studies are as straightforward as the hard facts or value free processes might imply. Indeed, positivist explanations of phenomena can legitimately be regarded as rather narrow, prescribed and usually in relation to principles already established (Robson 2002).

Typically, positivist research is conducted in controlled environments such as laboratories, designed to control the elements or variables being examined. Where such 'closed' systems are established, all aspects are under the control of the researcher. It follows that the credibility of positivist approaches lies in the fact that those looking at the same phenomena, see the same thing. However, this is manifestly untrue when applied to the world of clinical practice involving patients and staff, where what is experienced or observed is inevitably affected by the perspectives of the observer (Robson 2002). Whilst positivist research has value for answering certain research questions, it is not a universal panacea for answering all research questions. Rather, where people are involved, and the task is to uncover thoughts reactions and experiences, then the control required in positivist

research is neither possible, nor desirable (Ward, Hoare and Gott 2015). Indeed, a positivist emphasis on measurement restricts its scope to gather the breadth and richness of people's behaviour and interaction, as in the unexplored nature and benefits of Advanced Nursing within Advanced Nursing Practice, as experienced by participants, and as discussed in the contextualisation review in Chapter 2. People are not merely objects but partners, informants, even experts, and positivism cannot easily flex to that position.

My exploration for suitable paradigms briefly included post positivism and a symbolic interactionist perspective, but the relative rigidity of this paradigm did not suit my viewpoint, even with Charmaz's helpful suggestion reinterpreting Blumer's stance of, a real world waiting to be discovered, to a world made real in the minds, actions, and words of its participants (Birks and Mills 2015). Some other perspectives I found not to be helpful, including existentialist and post-modern theory, as too abstract to usefully guide this study (O'Reilly & Kiyimba 2015). Clarifying my understanding enabled my decision to focus on interpretivist paradigms to underpin this study since they were in step with my established world view (Gilbert 2008).

3.4.2 Interpretivism

In contrast then to a positivist approach, interpretivist perspectives seek to provide a description or explanation of the issue being researched, rather than emphasising and relying on objective numerical data (Stake 1995). While positivists criticise this for lacking precision, I recognised the significant advantage of the ability to carry explanatory power (Gilbert 2008). I also recognised that this would take this work further than my previous research at master's level, when I obtained the perspectives of participants revealing a rich stream of information leading to fruitful thematic analysis (O'Reilly & Kiyimba 2015) but it remained largely descriptive. Indeed, that earlier attempt at a broad atheoretical qualitative approach was superficial and would have been inadequate for what I wanted to achieve with this study (Polit and Beck 2010; Denzil & Lincoln 1998) since its aim was exploratory and ultimately explanatory. Moreover, each Advanced Nursing Practice participant had their own perspective, and it was their lived experience that was this study's intention to explain.

While it was clear that grounded theory could be a useful approach for this study, given that it supported the generation of explanatory theory, as I continued to explore this further, I also considered phenomenology briefly, and hermeneutics, because of its consideration of context when interpreting findings. This appeared to fit well initially, I liked the notion of a 'case' or 'setting' as the unit of study rather than individual participants per se. This appeared to fit with my intention of

comparing two different Advanced Nursing Practice services. I also liked the focus on meanings arising from participants comments (Tuffour 2017; O'Reilly & Kiyimba 2015). However, as I examined this further, it appeared an overly complex approach to extracting meanings from participants, and though supported by reflexive activity, my personal engagement needed to be 'bracketed' or set aside. Indeed, the notion of my being separated from the study conflicted with my now confirmed view of the need to be immersed in the data with the participants. My own views were well known to my intended participants, so to hide these, pretending they didn't exist nor would exert influence, would be disingenuous and so challenge the transparency I was now committed to (Tuffour 2017).

Framing the study as the examination of two groups, tended towards an ethnography, a method I had used before, or even as a pair of 'cases', which could also have fitted case study methodology. This latter approach would certainly have considered participants own accounts as the origin, although not necessarily the end of the investigative process. Case study has traditionally been seen as a method and means of data gathering (Gilbert 2008) though more recently it has been suggested as a methodology in its own right. It has grown in popularity, not least because of its suggested suitability for making generalization (Stake 2011). This was important among qualitative methodologies because of its potential usefulness for informing practice. Indeed, it had several distinct advantages including, being flexible, supports depth in study, is thorough, is responsive and so appeals to a wide audience (Savin-Baden & Howell Major 2013). Case studies have great value in challenging theoretical positions and presenting new understandings (Yin 2014; Gilbert 2008; Stake 1995). However, it did not fit with my intention to take an inductive approach that drew solely from participants and not from established external theories. Moreover, Stake, a leading proponent of case study, argued that its rich potential for theory building was because of its typical focus on one case (Savin-Baden & Howell Major 2013) clearly conflicting with my design intention to have two groups to enable comparing and contrasting participants' views and experiences. Consequently, in remaining consistent with the research questions and my philosophical stance in addressing them, I concluded that case study as a methodology would not serve my purpose. However, as a method it had potential as a sampling frame to organise participants for data generation (Norwood 2000), this will be considered further in Chapter 4.

Because the intention of this study was to go further than merely describing Advanced Nursing within Advanced Nursing Practice, my thoughts returned to grounded theory because of its ability to do this, to explain and then to develop theory with potential to feed-back and speak into practice (Streubert & Carpenter, 2011). Further reading revealed grounded theorists use various methods,

and constructivist grounded theorists often use the recording and tracking of 'stories' to describe phenomena. This appeared very useful as I sought to understand and explain the social processes involved in Advanced Nursing Practice, as experienced by the participants revealing the reality of Advanced Nursing Practice for them.

3.4.3 Grounded Theory

As qualitative research became more popular during the 1960s, attracting the interest of researchers eager to find new but effective approaches to their research enquiries, Glaser and Strauss's ground-breaking work in establishing grounded theory, helped the advancement of qualitative research theory considerably. The origins of their work, particularly for Strauss lay originally in pragmatism and symbolic interactionism (Birks and Mills 2015). In their 1967 publication, The Discovery of Grounded Theory, they promoted the legitimacy and value of utilising an exploratory and iterative approach to data collection, rather than coming from existing theories or preconceived notions (Streubert & Carpenter, 2011). Their genius, particularly Glaser's, lay in emphasis on providing structure to procedures and processes to uncover data. Undoubtedly the establishment of step-by-step procedures underpinning the process of constantly comparing cases and generating theory inductively, leading to explanation of a phenomenon or process, has been the abiding legacy of their early work. One of their key departures from convention lay in eschewing the notion of establishing existing knowledge about an area of enquiry via an initial literature review (Birks and Mills 2015; Savin-Baden & Howell Major 2013). Later as their thoughts evolved, they recognised that examining other work could yield positive benefits for a study (Polit and Beck 2014).

Various typologies of grounded theory emerged since the early work due to differences in philosophical perspective, including between Glaser and Strauss themselves. Subsequent work by Corbin and Strauss further modified notions of grounded theory (Corbin and Strauss 2008). While some held to it being a paradigm others criticised its origins, particularly Glaser's stance for being too positivistic with too rigid an approach. As grounded theory was modified and developed further, Charmaz among others was significant in promoting grounded theory as a paradigm, bringing a constructivist perspective to bear on the debate. Charmaz regarded the use of grounded theory strategies as a craft not least because of the creative flexibility that was encouraged in its execution (Charmaz 2014).

3.4.4 Constructivist Grounded Theory

In developing further my thoughts about why I should choose constructivist grounded theory to be the methodology for this work, I subscribed to the first aspect of Glaser and Strauss's emphasis, that research in this methodology should be grounded in data rather than from a preconceived issue, hence the title (Charmaz 2014; Polit & Beck 2014). However, I did not subscribe to their second point rejecting any sense of a 'preconceived idea' initiating a study. Moreover, in terms of practical reality in health care research, accepting their second point was problematic for two reasons: first, researchers, including this one, commence their study with questions, observations, and perspectives. These undoubtedly influence the first round of enquiry at least; second, obtaining ethical approval and necessary financial support for a study, hinge on a competent presentation of a solid proposal, which generally requires a detailed literature review to support it. This somewhat challenges the notion of the 'blank sheet' advised by first generation grounded theorists (Thornberg and Dunne 2019).

However, further reading reassured me that after his early grounded theory work, Strauss, joined now by Corbin (Polit & Beck 2014) developed thinking further and took a more flexible view, recognised that relevant literature and the researcher's experience, both professional and personal, and not just the research itself could lead to an appropriate identification of the research issue. Indeed, this process sensitised researchers further to what was happening within the phenomenon being studied (Thornberg and Dunne 2019). The caution in this however was for researchers to keep open to what was emerging through data generated from participants, and so remain creative and open to discovery (Thornberg and Dunne 2019). This spoke directly to my position, background, and experience, and reminded me of why when scoping the literature in the early stages of this study, I was drawn to grounded theory, because of its potential to go beyond simply describing the situation. It carried the potential for uncovering and explaining the substance of Advanced Nursing within Advanced Nursing Practice, and hence theorise about it.

Charmaz contrasted constructivist grounded theory with Glaser's, and Strauss and Corbin's objectivist approaches. Her criticism lay in their assumptions of an external reality and of objective observations, in attempts to achieve generalisation (Thornberg and Dunne 2019). In contrast, Charmaz identified constructivist grounded theory as recognising multiple realities, and respective subjectivities of both researcher and participants, and their situated knowledge. Moreover, she saw data therefore as intrinsically partial and problematic (Charmaz, Thornberg & Keane 2018). While using classic methodological strategies, constructivist grounded theory takes a relativist epistemology and look for understandings that are interpretative rather than analyses that lead to

abstract generalisations fundamentally unconnected with the realities of the participants. Critically for me, constructivist grounded theory finds its analyses in the contexts of participants and the researcher's position and standpoint (Charmaz, Thornberg & Keane 2018). This matched my own ontological and epistemological positions as discussed earlier, so identifying the trio of ontology, epistemology and now methodology as aligned for this study.

In considering now how methodology links with methods used in the study, I reflected on the interest shown by constructivists in the collection, construction, and quality of data because this was seen to enhance considerably the analysis undertaken. Yet they also operate under the assumption that data and their analyses are not neutral but reflect positions held as well as the context of their construction (Charmaz, Thornberg & Keane 2018). Aligning with this, I went on to design the study recognising my entry the study context to enable co-construction of the data through my interaction with the participants. This is further developed and exemplified in Chapter 4. I recognised that data reflected the historical, situational, and social circumstances of all involved, including myself. The stance of constructivist grounded theory is that data and theories are constructed and not discovered, as it was in this study by myself as I interacted with my participants and the developing analyses (Charmaz 2014).

An objectivist approach to data gathering by contrast does not ask questions of the researcher's position or assumptions, since it believes data is simply 'present' and not 'constructed'. However, the inherent risk of this position is that researchers bring unacknowledged presuppositions into the analysis and conclusions. To avoid this obscuring of findings, constructivists engage in reflexive activity throughout their research, especially concerning their interpretations and construction from the data. Taking this approach enabled me to play an active not passive engagement with knowledge production that was essential to theory generation. Interaction between researcher and participant in this constructivist work would enable me to get closer to the participant's reality, to understand and explain it.

3.4.5 Importance of Reflection and Reflexivity

Engaging reflexively with the data enabled my position to remain explicit (O'Reilly & Kiyimba 2015) and aided transparency about my input to the construction of meanings and understandings throughout the study and particularly during the process of data analysis. As indicated earlier it was important to acknowledge that as an experienced nurse, educator, course director for the MSc

Advanced Nursing Practice course- undertaken by most participants, and advocate for Advanced Nursing Practice, collectively these features carried weight and influence. So, for me an integral part of reflexivity was the continuing writing of memos (Birks and Mills 2015; Charmaz 2014), which revealed rather than hid my thoughts, values and beliefs making them explicit and visible. The word 'continuing' here was important, since no matter how critically reflective and reflexive individuals are, aspects of self can easily remain hidden or be obscured. The Johari Window proposed by Luft and Ingham (1955) is insightful identifying 'blind areas' known to others but not to self; 'hidden areas' unknown to others nor to self. Ongoing reflexivity sought to address this with increasing honesty over time (Holmes, 2019), therefore adding to my claim for integrity within this study. The approach to ensuring integrity, from a qualitative point of view, was seen to mirror the parallel issue of addressing 'bias' in quantitative work. It was clear that my engagement through constructivist methods would enhance rather than diminish the process, enriching and bringing fresh insight to the study.

3.4.6 Relevance of Constructivist Grounded Theory Studies

In terms of the value of grounded theory studies, one of the relevant questions raised about them is the degree to which findings from them can be useful, even 'generalisable', and representative of wider contexts (Gomm, Hammersley & Foster 2000). While many qualitative researchers take the view that this is not the role of qualitative study (Robson 2002; Schofield 2000), nonetheless if research is to be useful, it must have potential if not actual relevance and its findings the ability to carry meaning. It was therefore necessary to consider the implications of this in relation to the study design and confirm that this constructivist grounded theory study would have potential impact by increasing understanding and therefore 'knowledge' about Advanced Nursing Practice (Stake 1995). This led onto considering how knowledge would be created from the study findings and hence, through the generation of concepts, a core concept, and ultimately the theory grounded in the data.

3.5.2.1 Generalizability

Generalisability of findings remains a key objective in quantitative research, its asserted significance lying in its ability to generalise its findings to other situations (Lincoln & Guba 2020). In exploring this further, several types were noted, most clearly associated with the positivist paradigm, including 'statistical' and 'empirical' generalisation which were not relevant for this study because of their philosophical underpinnings (Yin 2004). However, two other forms were of interest: first, 'analytical' generalisability (Yin 2004) referring to data analysis and concept formation; and second 'reader' generalisability, or as Stake (1995) suggested 'naturalistic generalisation'. Both point to the centrality

of the role of the consumer or reader of research recognising the relevance of the study, or indeed aspects of the study to their situation, and not the researcher dictating or controlling this.

However, generalizability is not an uncontested term, with Lincoln and Guba posing a counter challenge to the notion and value of generalisability, summarised by the following:

> *'…Local conditions, in short, make it impossible to generalise…'* and, *'If there is a 'true generalisation, it is that there can be no generalisation.'* (Lincoln & Guba 2000: 39)

They argued that every supposed generalization could only have relevance if it was filtered through the local situation and circumstance for which it was being applied, and it was at that point that every supposed generalisation would come under intense scrutiny. Indeed, in pointing instead to the 'tentative' nature of findings they put forward the notion instead of 'working hypotheses' (Guba and Lincoln 1982). They could then be considered against their preferred concepts of 'transferability' and 'fittingness' rather than generalisability. The need follows from this for the active engagement of consumers/readers of research to be actively involved in its appraisal, determining its relevance for their situation. This position fits very well with recommendations of how the findings of qualitative work should be disseminated to audiences of interested people (Charmaz 2014). More on this in Chapter 7 (see page 257).

To return to the design of this study, the two case studies created were done with intent, because of their perceived 'typicality' as areas of clinical practice where Advanced Nursing Practice is carried out (Schofield 2002). The two cases, while they had similarities also had significant differences and depth of enquiry and data collected from them gave rise to the potential for 'thick description' (Schofield 2002) which increased the potential for 'transferability' and 'fittingness' (Schofield 2002; Lincoln and Guba 2000, Gomm, Hammersley & Foster 2000) of the findings. These perspectives lent some support for comparisons to be made with key recognised characteristics of Advanced Nursing Practice revealed in the literature (Robson 2002) both in the initial scoping exercise revealed in Chapter 2 and with ongoing literature review carried out alongside the constant comparative analysis of generated data (Charmaz 2014).

3.5 Methods Chosen Informed by Methodology

3.5.1 Ethical Approval

Ethics has been recognised simply as a 'principled sensitivity to the rights of others' (Bulmer 2008). Ensuring this study was conducted in an ethical manner was important, I did not regard it as just a stage to go through, but as a vital part of the process to gather high quality data, demonstrating respect for participants, their data, and for those who in the long term would read the thesis and might consider acting on its recommendations (Thomas 2016). Because of this, ethical considerations were included from the outset of the study, shaping, and influencing the design, recruitment, and management of participants. Underpinning these and all other elements mentioned below, official ethical approval was required from authorised bodies before I sought engagement with participants. Practically, this was from university and potentially local NHS ethics committees. The former was required and completing that process successfully meant the study was approved and a certificate issued confirming this (see page iii).

The objective of achieving quality findings is an important part of all research but must be pursued with consideration for potential risks to participants taking part (Thomas 2016). The essential ethical concern of health care research when involving human participation is to not cause harm (Denscombe 2012). To ensure this and reduce potential for harm, this study was directed by the principles of the Department of Health (2005) Research Governance Framework for Health and Social Care.

Essential features of effective research governance include gaining and maintaining informed consent from participants both at the outset and throughout the study (Bulmer 2008). To obtain good quality information, while bearing in mind potential risks to participants, invitations should only be given to directly relevant individuals. Participants must have the freedom to stop their engagement without penalty at any stage and without reason, with their contributions removed and confidentially destroyed. Protecting their privacy is likewise a very high priority and the maintenance of confidentiality a key method of achieving this (Bulmer 2008). All data retrieved must be kept safe, regarded as confidential, and be retained securely, with all equipment used encrypted. Data retrieved must only be used for the purposes of this study (Bulmer 2008). Each of these features were followed to ensure compliance.

3.5.2 Sampling, Recruiting and Accessing Participants in Contrasting Clinical Services

Sampling for participants is a significant aspect of the study design and illustrates succinctly the differences between paradigms in research, how and why choices are made and the logic on which alternative methodologies are built (Patton 1990). Indeed, how sampling is done reflects the nature, and impacts the quality and ultimately conclusions drawn from studies (Thomas 2016; Iphofen, Krayer and Robinson 2009). Remaining congruent with methodological principles meant being consistent with constructivist principles throughout this process, including the use of theoretical sampling (Birks and Mills 2015).

To compare the two broad paradigms: quantitative research typically uses a bigger sample, selected randomly; while qualitative research generally uses a smaller sample, selected purposefully, as suggested by Barbour and Kitzinger (Cronin 2008). However, while the methods for sampling are different, more importantly so their underpinning logic. The cornerstone for sampling in quantitative research is probability, with random selection of a statistically representative group, which it is argued supports generalization from that group to others.

By contrast, sampling in constructivist studies is based on different assumptions. Initially, purposive sampling is used to gather participants relevant to the study focus. Theoretical sampling, unique to grounded theory, is used thereafter and is best described as the way of recognising and 'following clues' that arise during constant comparative analysis (Birks and Mills 2015).

3.5.3 The Process of Recruiting Participants

To remain congruent with constructivist processes (Birks and Mills 2015), once ethical approval had been granted potential participants were invited, and gathered as small groups, described in this study as Case Studies 1 and 2. Participants were mainly:

- Advanced Nurse Practitioners, employed by one Trust, who had undertaken a Master's degree in Advanced Practice, preparing them for their roles.
- Additionally, a smaller number of consultant nurses/senior nurse leaders who led/managed services where Advanced Nurse Practitioner participants were working.

As the interviews progressed, the design plan was to adopt theoretical sampling processes to seek additional participants (Birks and Mills 2015). To achieve this, participants were asked which consultant medical staff in their service would be best to be approached to seek their participation

in providing a medical perspective on Advanced Nursing Practice as carried out within each case study that their service was associated with. Names were suggested and it was interesting to see the same names repeated. It was reassuring that suitable people, valued and respected by their colleagues were potential and on invitation became actual participants. By the end of the interviews in phase three, (see Chapter 4, page 93), agreement to participate had been obtained from three medical consultants. They proved to be generous with their perspectives and thoughts and experiences of working directly with Advanced Nurse Practitioners in their identified services.

As indicated, recruitment began after ethical approval was achieved, and a formal invitation was extended by me to identified participants by email. Although there is no consensus regarding the recommended limit to numbers of participants overall, it appeared that between two and eight participants per interview was a suitable number for me as researcher to administer (Cronin 2008). In fact, as recruitment progressed in this study, due to the challenge of getting participants together at the same time, my interview small groups were generally of a smaller size. However, this did not appear to reduce participants engagement with the interview process, or the depth and richness of responses provided. This will be considered further in Chapter 4.

3.5.4 Documentary evidence

Constructivist grounded theory values a wide-ranging inclusion of different data sources, providing they serve the aim of the study (Savin-Baden & Howell Major 2013). In line with this general permissive attitude towards data collection method, I considered early on the potential for inclusion of documentary evidence, arising out of my engagement with participants in the small groups. It seemed to me that this could provide the study with a further rich data stream that would enable further understanding and explanation of Advanced Nursing Practice as experienced by participants. Although not seen as prominent in contemporary social science research, documents are recognised as a useful source of additional data, they have a long history in sociological studies, through triangulating data and thereby raising confidence in findings (Thomas 2016; Macdonald 2008; Stake 1995). Constructivist's see this slightly differently in terms rather of extending the research to make findings more fruitful (Flick 2019).

In my original design plan (see Figure 7, page 61) I intended to consider documentary evidence following the interview phases, so that participants could identify those documents which spoke to their roles and activities as Advanced Nurse Practitioners, and which variously enhanced, restricted, or impacted their roles and activities. While not required by the study methodology, this approach

is long- established among grounded theory studies. Glaser and Strauss were forerunners recognising the usefulness of qualitative not quantitative analysis of these valuable sources of evidence. The documents I was aware of included those displaying the activity and scope of Advanced Nurse Practitioners in their relevant clinical areas: participants' job descriptions, their case notes and case reports, and relevant policy sources guiding and directing their practice (Gomm 2004). It was also recognised that documentary evidence could also reveal something of the attitudes and beliefs of senior managers towards Advanced Nursing Practice and further enhance available data.

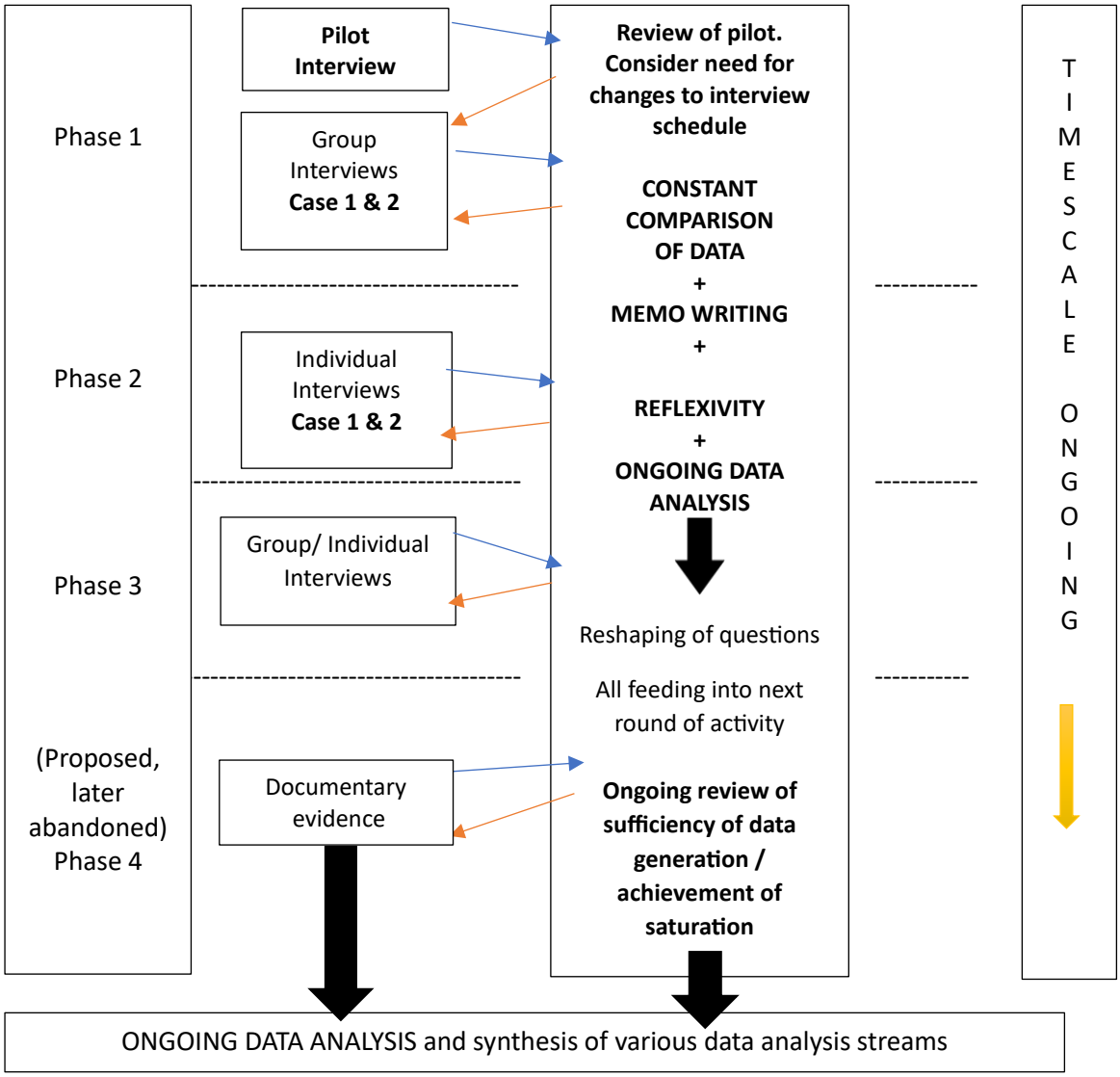

Figure 7: Diagrammatic Representation of Original Sequenced Plan for Data Collection

3.5.5 Data Collection

Interviews are regularly used in constructivist grounded theory studies especially when researchers have extensive experience, as was the case in this study (Charmaz 2014). Using investigative interviewing strategies are particularly helpful in uncovering hidden actions and intentions. Learning that grounded theory methods are most effective when researchers using this approach engage directly in data gathering and generation as well as analysis, was ample justification for undertaking the interviews myself. This was despite recognising the challenge that both researcher and participants would come to the interview with own priorities, knowledge, assumptions, and concerns, and they might not be compatible. Despite that potential, small groups retain the reputation as effective and useful research seeking to explain phenomena (Polit and Beck 2010), having the power to capture insight into group interaction and cultural impact (Thomas 2016). The dynamic interaction between participants and myself as the co-constructor of data, had potential to establish a deeper understanding of Advanced Nursing Practice, as experienced by participants in their identified clinical services. Small groups are further recognised as useful because of the added benefit that they enable the gathering of useful data relatively quickly and cheaply (Parahoo 2006).

3.5.6 Concurrent Data Organisation, Handling and Processing.

In considering data organisation and processing, one of the first questions considered was whether, or not to record and transcribe data obtained. It was initially surprising to learn that some grounded theorists including constructivists, with whom I had aligned myself, questioned whether transcription was beneficial or even appropriate, with some disregarding it as irrelevant in terms of ensuring the accuracy of what is retrieved. Charmaz, for example, argued that the priority to test the argument is the 'theoretical usefulness' of what is retrieved, not accuracy per se (Charmaz 2014). While I took note of her position, nonetheless I was concerned that the analytical process could be compromised with data being lost and therefore participant's meanings obscured. Consequently, it was decided to record and transcribe the interviews in their entirety. Moreover, this was planned to happen after each interview, and as far as possible before the next, to ensure congruence with constant comparative analysis, which continuously fed back into the ongoing interview process (Strauss & Corbin 1998).

Whilst data collection is conducted in 'the field', awareness grew of the important theoretical distinction between data and evidence (Thomas 2016). Data may be regarded correctly as information, but data transitions to become evidence, when it is used to develop conceptual

understandings. This realisation was important since it helped me move purposefully towards the generation and creation of categories that would lead to the formation of concepts, the core concept and theory about Advanced Nursing within Advanced Nursing Practice (Savin-Baden & Howell Major 2013). Indeed, I recognised at this point in developing the design process that methods, while important, must only be recognised as tools in the hands as the researcher. They are useful only when combined with the researcher's careful thought and energy to facilitate a deep understanding and appreciation of understanding emerging from the data obtained (Charmaz 2014).

Qualitative researchers are frequently asked questions concerning, 'How many participants?' and particularly, 'How much data?' as tests of adequacy and 'richness'. Some disregard these questions, including Glaser who argued against undue concern over the amount of data collected. Nonetheless, this was a concern early on during this study as I wondered if I had recruited enough participants and was able to generate enough data. However, I took note of Charmaz's 'questions' to shape consideration of data sufficiency (Charmaz 2014). Selected questions included:

- 'Have I collected enough background data about persons, processes, and settings to have ready recall and to understand and portray the full range of contexts of the study?
- Have I gained detailed descriptions of a range of participants views and actions?
- Does data reveal what lies beneath the surface?...
- Have I gained multiple views of the participants range of actions?' (Charmaz 2014: 33).

My final data collection methods design is illustrated using diagrammatic representation (See Figure 8, page 64). The complete collection and analysis process is also illustrated diagrammatically and is discussed more fully in Chapter 4 (See Figure 10, page 96).

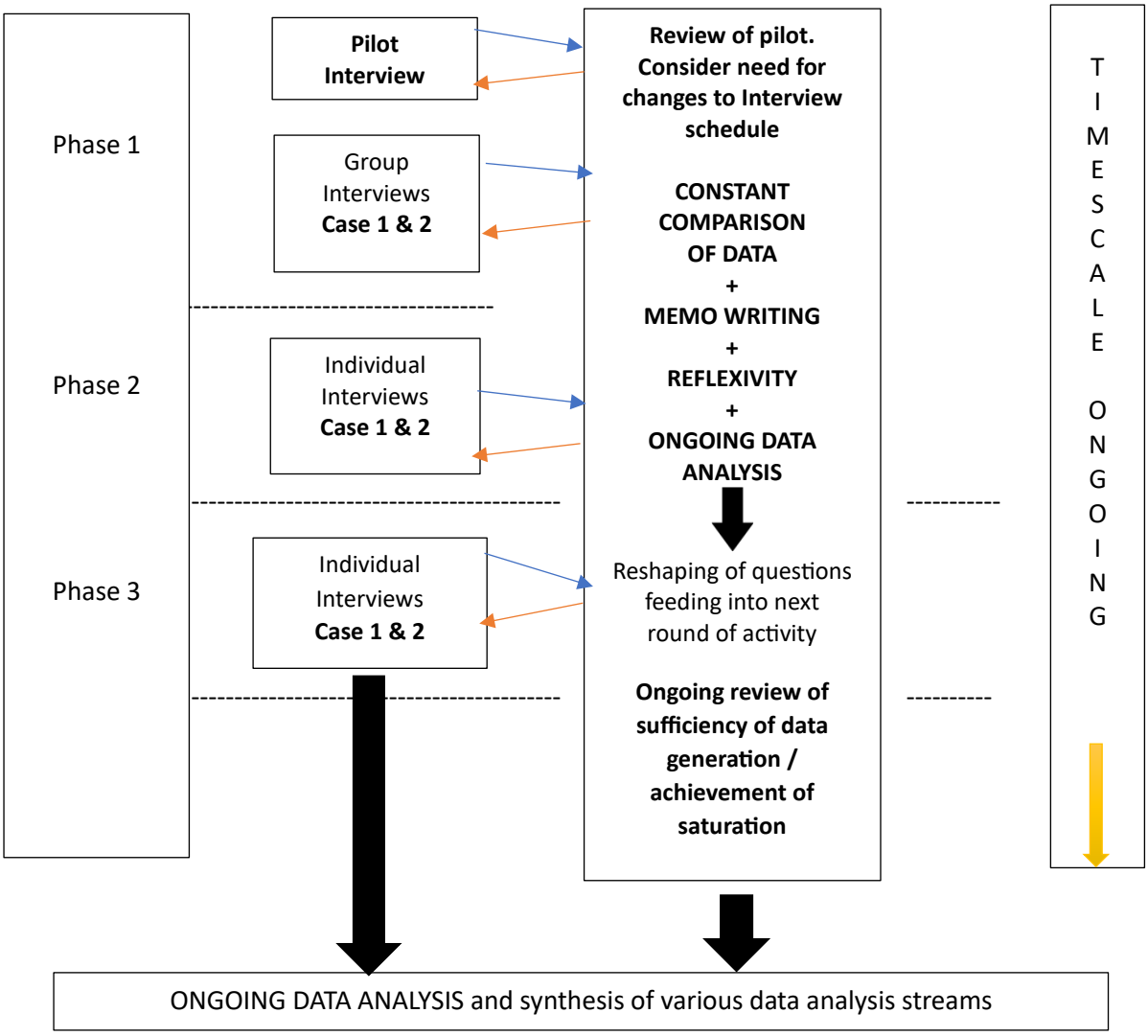

Figure 8: Diagrammatic Representation of Final Sequenced Plan for Data Collection

3.5.6 Data Sufficiency

Before continuing this consideration of 'how much data?' it was important to note that the terms data saturation and data sufficiency are contested terms. They have been used simply to recognise when no further new data is being revealed, and the essential features of established categories have been achieved (Savin-Baden & Howell Major 2013). However, the grounded theory perspective about this is a more complex matter (Birks and Mills 2015). Indeed, Charmaz posed the question about when to stop data gathering, and what criteria would be used to determine this? Her advice was to follow the process thoroughly, establishing robust categories that make sense of the patterns identified from the data. Stopping should not therefore be equated with a simple appreciation of nothing new happening, but it really depends on how thorough the search and how effective the

questioning (Charmaz 2014). Moreover, the key to avoiding superficiality and premature closure lay not in a repetitive approach to gathering data, but in an iterative analytical approach, leading to categorising and conceptualising and then returning to data generation once more (Morse 2010). Consequently, my design plan was for data collection small group interviews to continue as planned in Phase 1 and 2, but to include a separate round of individual interviews as a further phase, Phase 3.

While undertaking concurrent analysis, I recognised the risk of forcing the data to agree with or confirm existing ideas I had (Glaser 2004) rather than truly allowing it to emerge without restriction from participants, as the process of data collection and generation progressed. My design sought to avoid a charge of forcing, by my commitment to the ongoing process of constant comparison of data between and within cases, and with literature previously considered and ongoing retrieval of current literature. This was complimented and energised by parallel ongoing reflection and memoing my thoughts and reactions to what was retrieved. Data collection continued until clarity and understanding about what had been generated occurred, sufficient to move positively towards developing theory from evidence generated from the data obtained (Morse 1995).

I concurred with Morse's view that saturation ultimately is an abstract term, represented in living research as a form that makes sense to the researcher (Morse 2007), and ultimately is a matter for their judgement (Weiner 2007). I did however, compliment this with continuing discussions with my supervisory team, who engaged in reviewing my thoughts and tentative conclusions, acted to check, clarify and determine new thoughts and interim outcomes, while I moved progressively towards conceptualisation. My team's support is exemplified in Chapter 4 (see Box 10, page 103, and Box 12, page 123) and discussed further there. As the generated data increasingly fitted with and reinforced emerging categories and concepts, I determined I was moving towards data sufficiency and therefore would not need to gather more data from existing or new participants. Moreover, considering this further and because of views that had been expressed from a number of participants about the limited relevance of existing documents to their role and work, I decided not to pursue formal documentary review as a separate phase of the study.

3.6 The Process of Analysis

Data analysis organises, provides structure, and enables meaning to be obtained from data obtained (Polit & Beck 2014). In qualitative studies generally data is obtained before any analysis is undertaken, but in grounded theory studies concurrent data analysis begins at the outset of data collection (Corbin & Strauss 1990). Indeed, data collection and data analysis are interconnected processes (Charmaz 2014; Parahoo 2006) and the strategy taken to achieve this combination needs careful thought. Three particular challenges are noted for the researcher: first, the absence of universally accepted rules to guide the process; second, the researcher having capacity to undertake effective interpretivist analysis of large amounts of gathered data, appreciating the meanings and understandings that participants have about the reality of their worlds (Thomas 2012); third, the researcher having effective inductive skills, since the nature of the constructivist process of analysis requires categories to be established that draw together associated aspects of data.

As discussed already, analysis of data commenced as soon as the first piece of data was obtained, and continuing through the ensuing process. The process of analysis proceeds through constant comparison, where each piece of data is analysed and compared and contrasted, with other pieces (Morse 2010). This is replicated through several cycles as data is categorised and then progressively reduced, alongside a concurrent abstract theorising process (Charmaz 2014). In this study between each round of small group and then individual interviews, the challenge was to consider if the questions planned were still appropriate or needed revising in view of meanings that were being generated. Remaining true to the process of systematically and sequentially collecting and then analysing data was the hallmark of ensuring the capture of all potentially relevant material so that the theory which emerged was truly grounded in the data (Polit & Beck 2014; Corbin & Strauss 1990).

Among grounded theorists, the terms ‘codes’, ‘categories’ and ‘concepts’ are used interchangeably, but together form the way to increase depth of analysis and become the building blocks of theory (Birks and Mills 2015). In this study codes come first, progressing to categories, super-categories, reduced and final categories to become concepts. Categories follow on from codes, revealed by participants as being regularly or continually observed; or, conversely as being absent. Theoretical sampling is important here, as the means of picking out main issues, with the intention of maximising opportunities for meaningful comparison, so it becomes possible to assess variations within, as well as between, categories. Overall, this is not so much about the participants

concerned, but more about ‘events’ and ‘incidents’ that they encounter which reveal their responses and action (Charmaz 2014).

‘Coding’ is the process for observing, naming and labelling data, breaking it down into small ‘chunks’ (Savin-Baden & Howell Major 2013). Line by line coding enables the beginnings of conceptualising ideas revealed (Charmaz 2014). The two analytical procedures which served as the foundation for the coding processes used in this study were: first, making constant comparisons, as identified earlier, where similar and different examples from the data are compared, and contrasted, to reveal multifaceted perspectives; and second, ‘asking questions of the data’. Both are necessary and appropriate in informing the next and ensuing rounds of activity. This is particularly evident in this context between the group and individual interviews, but equally between the group and individual interviews, and between the different cases. Coding was accompanied by ‘memoing’, followed by continuing rounds of ‘sorting’ the data obtained into meaningful collections.

Memoing was an essential part of the process, and involved writing memos or short notes concerning immediate thoughts about the emerging categories and how they might relate to each other (Charmaz 2014; Streubert & Carpenter, 2011; Strauss & Corbin 1998; Corbin & Strauss 1990). ‘Sorting’ was the stage of the process concerned with reading and reviewing memos as a means of revealing and clarifying categories and their relationship with one another. Memos were helpful in arranging data into coherent groupings as chunks of data were put back together as categories (Savin-Baden & Howell Major 2013). During this process further memos recorded further and new thoughts and ideas. Indeed, fresh insights and understandings of connections between analyses occur at any and all points in the research process, these are important and should be retained formally throughout the study (Charmaz 2014). This dynamic process is followed until saturation or data sufficiency, as detailed earlier, has been achieved.

3.6.1 Data Reduction

This coincided with what became a more pressing concern and challenge, of how to streamline and reduce the data I had collected, without trivialising comments, missing important points, or rendering what had been retrieved superficial. The risk at that point was of having an inadequate basis for drawing authoritative conclusions. To aid my assessment of this and of transparency in that regard, an extensive spread sheet was constructed containing the various stages of reducing data collected. An extract representing each concept is provide in Appendix 5, (see pages 297-300). The detail of the data management and analysis, including data reduction will follow in Chapter 4.

3.7 Chapter Summary

This chapter has clarified my philosophical stance which has shaped the methodological approach to the conduct of this study. It has set out my somewhat challenging journey to achieve that conclusion, justifying and explaining my progression in thinking, moving from a mixed qualitative methodology, to employing grounded theory, to narrowing this to embrace constructivist grounded theory and an inductive exploratory and explanatory approach. The principles and processes of constructivist grounded theory progressed to inform the study methods, data collection strategy and the ongoing analysis. A sampling frame was used to select participants, positioning them into different groups carrying unique characteristics, or 'case studies', the term used hereafter in this study to identify which group participants represented. This approach supported constant comparison of data collected between as well as within the case studies - Case Study 1: Acute Services, and Case Study 2: Non-Acute Services created because of their contrasting features. They were also created in respect of a question about whether the Advanced Nurse Practitioners function differently in each case study and represent Type 1 or Type 2 Advanced Nursing Practice as proposed and presented in Chapter 2. Specifically, Case 1 with greater emphasis on a medical substitution role, while Case 2 has a broader focus on Advanced Nursing, yet often including elements of medical practice, but integrating active engagement with clinical leadership, education, and research activity. The input of consultant nurses and consultant medical staff within each case was included to provide additional unique and valued perspectives.

The small groups, created for in depth interviews, and subsequent individual interviews were designed to be facilitated by me as main researcher and planned to explore participants' views and experiences of the following: the features and scope of Advanced Nursing Practice; the relevance and perceived benefit of advanced nursing; cultural and organisation factors that help or hinder the Advanced Nurse Practitioner role; and, whether a perceived distinction between Advanced and Advancing Nursing Practice exists, as proposed in Chapter 2.

Finally, theoretical perspectives on data analysis have been considered. Overall, this has articulated a clear view of the methodology used to shape and guide this study. It has provided clear underpinnings for detailed consideration of how data analysis was conducted. The next chapter (Chapter 4) will progress the discussion to examine the methods used to collect data for the participants.

Chapter 4. Methods

4.1 Introduction and Overview

This chapter sets out the design of the study and how this was operationalised. As has been articulated so far, briefly in Chapter 1, and fully in Chapter 3, choosing constructivist grounded theory as the methodology underpinning this study, gave shape to and directed the thinking about the research design (Day 2007). This included appropriate methods to: select participants, generate data, carry out constant comparative analysis and, interpret data generated to progress to formulate my constructivist grounded theory. Each element was selected with care and served to challenge my assumptions, making them plain and building on my answers to Guba and Lincoln's (1994) first two philosophical questions, first the ontological question concerning 'reality', and second the epistemological question articulating how I could find out 'what could be known' about Advanced Nursing Practice (O'Reilly & Kiyimba 2015). The design process ran alongside achievement of ethical approval addressing the need to ensure integrity, trustworthiness and quality within the study.

4.2 The design of this study

As noted at the outset of Chapter 3 there remains little consensus about how to conceptualise carrying out a study (Iphofen, Krayer and Robinson 2009), though Day (2007) does argue that grounded theory in particular offers practical advice about conducting qualitative studies. However, over and above this, studies are fundamentally underpinned by the researcher's ontological, epistemological and therefore methodological positions, and in this instance constructivist grounded theory (Charmaz 2014).

This study set out to explain the complexities and nuances of Advanced Nursing within Advanced Nursing Practice, achieving a detailed explanatory study focussing on and studying two related clinical services (Robson 2002). To achieve this, the initial and tentative research questions supporting the development of the initial aim and objectives, found in Chapter 1, were revisited following appraisal of sources retrieved during the review in Chapter 2. This supported continuing exploration of perceptions about Advanced Nursing Practice enabling me to grow in theoretical sensitivity to that initial data (Birks and Mills 2015; Denscombe 2012).

The final research questions and the research aim and objectives are set out providing a clearer and more precise focus:

4.2.1 Four Research Questions

1. What are the features and the scope of Advanced Nursing Practice?
2. What is the contribution to Advanced Nursing Practice that comes from being a nurse?
3. What helps nursing to develop and be expressed within Advanced Nursing Practice?
4. What barriers exist that hinder or limit the expression of nursing within Advanced Nursing Practice?

4.2.2 Final Research Aim and Objectives

Research Aim

The aim of this study is to:

Explore the features, scope and activity of Advanced Nursing Practice, and explain the relevance and significance of nursing within this role, as experienced by two groups of nurses recognised as Advanced Nurse Practitioners, and the Consultant Nurses and consultant medical staff who work with them, in a local university hospital NHS trust.

Research Objectives

The research objectives of this investigation are:

1. To explore participants' views and experiences of:
    a. the features, scope and activity of Advanced Nursing Practice;
    b. the significance and relevance of nursing as practiced within Advanced Nursing Practice;
    c. factors that facilitate the expression and enaction of nursing within Advanced Nursing Practice.
    d. factors that hinder or restrict the expression and enaction of nursing within Advanced Nursing Practice.
2. To formulate a grounded theory to explain the relevance of nursing within Advanced Nursing Practice in a local university hospital NHS trust.

Two primary professional groups were selected to be participants in this study, nursing and medicine. While closely associated their fundamental positions were very different, arising from different philosophical positions. Nursing came from a patient focused perspective, shaped by

holism and supported by an enabling empowering paradigm (Corbin 2008) while medicine came from a traditional scientific base, focussing on the disease and cure paradigm (Rolfe 2014a). In recent years there has been a blurring of these distinctions particularly in relation to the development of 'Type 2' Advanced Nursing Practice described in Chapter 2 (Rolfe 2014a; Barton Bevan and Mooney 2012a; Castledine 2003) and Advanced Nursing Practice has generally evolved to embraced both art and science.

4.2.3 Overview of Study Design Strategy

The following diagram provides an overview of the strategy for design of the study, including elements and processes involved in progressing the study aim and objectives to generation and construct a grounded theory.

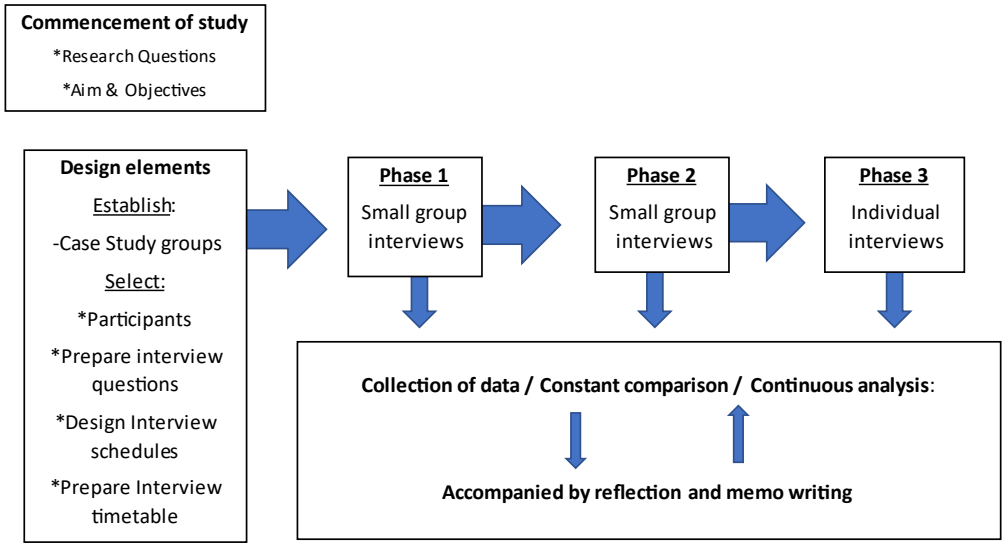

Figure 9: Overview of Study Design Strategy

4.3 Methods Used in this Study

4.3.1 Justification for Selection of Participants

Two clinical services were identified and selected within the local NHS Hospital Trust. Their selection was because they displayed contrasting approaches to service delivery and the use of Advanced Nurse Practitioners within them. They were therefore chosen purposefully, because of notable differences between them concerning their patient groups, nature of illnesses experienced, treatment modalities, and how I therefore perceived Advanced Nurse Practitioners operated within them. The two services are referred to within this study as 'cases' and 'case studies' rather than 'groups', though this terminology should not be taken to refer to case study method or methodology

which is not so. Rather, the two services were organised as separate sampling frames. Regarding the cases themselves, Case Study 1 and 2, the interest in these two services was based upon direct observation that Advanced Nurse Practitioners working in acute services tended towards a disease centric/medical replacement and service delivery focus, similar to Type 2 Advanced Nursing Practice discussed in Chapter 2. Advanced Nurse Practitioners working within non- acute services tended towards a more holistic and patient centred focus, similar to Type 1 Advanced Nursing Practice also discussed in Chapter 2. Moreover, Type 2 appeared to have developed a consistent approach to advancing their practice and the patient centred services they delivered. They were not just engaged in day-to-day practice but were also engaged in improving the broad environment of that day-to-day practice. Once the decision had been made to establish the groups they were treated and identified as separate case studies and as such became the units of analysis for this study.

The first case study, Case Study 1: Acute Services, included the Acute Medicine Department. These were services responsible for assessment and initial management of patients presenting with acute medical problems. Later, in phase two, I recruited participants from the Surgical Department, this later addition will be explained shortly.

Case	Names	Description	Justification for selection
Case 1	Acute Service	This case was established to represent acute care services. The original design for this case was that it would consist of one area, the Acute Medicine Department. Seeking to increase the numbers of participants, theoretical sampling led to drawing upon a similar, the Surgical Department, and this was subsequently included. Participants were mainly Advanced Nurse Practitioners, but also included Consultant Nurses and consultant medical staff working in the same environment.	Participants were drawn from these services, since they represented those which had employed Advanced Nurse Practitioners to address the gap created by insufficient availability of medical staff. There was therefore an expectation that these roles would feature a strong emphasis on medical replacement with minimal emphasis on Advanced Nursing of explicit four pillar activity (leadership, education, research) Participants were chosen because they had personal experience of, working as Advanced Nurse Practitioners, or working with Advanced Nurse Practitioners in the same service environment.

Table 8: Justification for Selection of Cases - Case 1: Acute Services

	Names	Description	Justification for selection
Case 2	Non-Acute Service	This case was established to represent non acute care services, to provide a clear difference with Case 1. The case included participants from the Gerontology Department and the Medical Specialities (neurological diseases) Department. To increase numbers of participants further, theoretical sampling was utilised which included the Preoperative Assessment Department. Participants were mainly Advanced Nurse Practitioners, but also Consultant Nurses and consultant medical staff working in the same environment.	Participants were drawn from these services, since they represented those which had employed Advanced Nurse Practitioners to address patient needs from a holistic perspective. There was therefore an expectation that these roles would feature a strong emphasis on advanced nursing as part of a broad role including explicit four pillar activity (leadership, education, research) Participants were chosen because they had personal experience of, working as Advanced Nurse Practitioners, or working with Advanced Nurse Practitioners in the same service environment.

Table 9: Justification for Selection of Cases - Case 2: Non- Acute Services

4.3.2 Sampling and Recruitment

Participants were recruited to one or other of the case study groups based on which service they were working in. As the study progressed, I utilised a combination of sampling techniques to recruit two further groups of Advanced Nurse Practitioners who worked in services with similar characteristics as the original case study groups. Constructivist grounded theory encourages this approach since it arises from the iterative process that is underway through data generation. This had the potential to significantly add to the data already gathered, but significantly as a tool of theoretical exploration, rather than merely confirmation of what had already been learned (Day 2007) thus it continued the process of challenging perspectives raised from the data (Flick 2018; Parahoo 2006; Strauss & Corbin 1998). Moreover, it enabled fresh insight and understanding of the tentative categories that were being formed from the process of ongoing data collection and analysis and coding (Streubert & Carpenter, 2011). Making constant comparisons was key to enabling a continuing flow of further perspectives to be generated, and new understandings of similarities and variations between the case studies to be developed which would establish deeper understandings (Strauss & Corbin 1998).

4.3.2.1 Selecting Participants - Purposeful Sampling

The main group of participants were purposefully recruited for this study because they were working as Advanced Nurse Practitioners and so would be able to speak from their own knowledge and experience directly about the aim and objectives of the study (Flick 2018). Purposeful sampling has

previously been regarded as one dimensional, but several different categories of this have been identified with distinct features (Patton 1990). Among those identified by Patton, several could have been useful including: intensity sampling, where cases rich in information display a particular phenomenon of interest; homogenous sampling, where the focus is to describe a case in detail; critical case, where the characteristics of the case stand out sufficiently to draw strong conclusions, and of particular interest was that in some instances they could tend towards a potential for generalization,

> *"if it happens there, it will happen anywhere," or, vice versa, "if it doesn't happen there, it won't happen anywhere." The focus of the data gathering in this instance is on understanding what is happening in that critical case. Another clue to the existence of a critical case is a key informant observation to the effect that "if that group is having problems, then we can be sure all the groups are having problems."* (Patton 1990)

Nonetheless, three others stood out because they fitted well with the sort of participants needed and the purpose of this study:

4.3.3.1 Criterion Sampling

Its purpose to examine cases that meet predetermined criterion set for their groups. Both Cases 1 and 2 participants had predetermined criteria of membership in so far as they were employed as Advanced Nurse Practitioners, or Consultant Nurses within one of the selected case study groups.

4.3.3.2 Opportunistic Sampling

Involves taking advantage of being open to unplanned opportunities once fieldwork has commenced. This is a strength of qualitative research and makes for the collection of rich data not possible in quantitative work. This became useful when the interviews were underway, and I wondered if the number of Advanced Nurse Practitioner participants that I had recruited and the data that was being generated was sufficient. I was not confident it was, and so I decided to recruit from two further departments that I believed were similar and therefore could make suitable additions to each case study group respectively. In this I also acted to theoretically sample, learning from my ongoing analysis, and so recruited from the Surgical Department to Case 1: Acute Services, and the Pre-Operative Assessment Service to Case Study 2, Non-Acute Services. This acted to strengthen the data pool.

4.3.3.3 Snowball Sampling

This relies on asking participants, and others situated in the field to suggest colleagues who may make additional and valuable contributions to data collection. This was particularly relevant later for consultant medical staff needed for both Case 1 and 2, since I was not directly familiar with suitable

consultant medical staff. I asked both Advanced Nurse Practitioner and Consultant Nurse participants to suggest medical consultants linked with their services and who they felt could provide useful insights. I was particularly interested in individuals whose names were repeatedly mentioned to me. I was grateful that participants made initial connections for me with the medical staff concerned and this worked very well.

4.3.4 The Participants

4.3.4.1 Advanced Nurse Practitioner Participants

Almost all the non-medical participants (n=25/26) had been educated on the same Advanced Practice master's degree course at the local university where I was course director. In selecting participants, I was conscious of the potential, if not actual, imbalance of power between myself and the participants, as they were mostly my former students. Participants were invited via email to join the study therefore allowing them to decline without embarrassment of having to explain why. I was encouraged by the fact that no one approached declined to take part. I considered that this was an indication that these participants felt sufficiently confident and able to engage freely in the study (Hermanns 2004). It was of significance that the Advanced Practice course the participants undertook had, since its inception been designed to produce confident, assertive, challenging, critically aware and autonomous practitioners. These were health professionals who actively led, intervened, and provoked innovation, but who were also able to justify and explain their positions to a wide audience of professional colleagues. A selection taken from course aims and outcomes (Coventry University 2012) illustrate course expectations:

> *Educational Aims of the Programme, including:*
> *Students will be enabled to:*
> *Influence the **strategic direction** of patient care within one's own field of practice/across the life span at local and national level.*
>
> *Intended Learning Outcomes, including, Cognitive (thinking) Skills*:*
> *Students will be enabled to:*
>
> *CS1 Demonstrate knowledge of methods of leadership, enquiry, reflective practice and new ways of learning **to develop a highly motivated self directed Advanced Practitioner**.*
> *CS3 **Champion continuity of care** and support inter-professional working practices.*

Box 4: Selected Educational Aims of MSc Advanced Practice Course

While recognising and acknowledging my own position and the degree of my potential influence on participants, I asserted a measure of confidence is in their ability to confidently state their own views and thoughts without their need to defer to my acknowledged positions and views on this subject

area. Nonetheless, I did adopt strategies to mediate restrictive influences by myself (Birks and Mills 2015). These were considered in Chapter 3, but an element of the strategy worth considering here was moving the location of interviews between the first, and the second and subsequent interview phases. They were moved from the university to the hospital site, where participants worked. These surroundings were more familiar to the participants than to me. To aid transparency, in addition to the recorded interviews and transcripts, my adoption of a reflexive posture through memos and to some extent field notes enabled me to continually assess my impact on the participants, during the interviews and therefore on the data collected (Birks & Mills 2015).

4.3.4.2 Consultant Nurse Participants

Consultant Nurses were also purposefully selected as significant informants. As senior nurses, and former Advanced Nurse Practitioners they were, prior to and during the time of the study working as Consultant Nurses in the services being investigated (Birks and Mills 2015). Most of these Consultant Nurse participants (n=5/7) were also former students of the local Advanced Practice course referred to already. They had since developed into mature, independent, confident senior colleagues, and I had enjoyed a collegiate relationship with them for some time prior to their participation in this study. Nevertheless, I took a reflexive approach when collecting and analysing data from them, to maximise their contributions and minimise negative or restrictive influences I might have had on their contributions. A measure of my success in me facilitating and not dominating the interviews was evident in Interview 2, when I found myself wanting to join in the conversation but restrained myself. One of the participants was aware of this and commented as follows:

> *Participant 5 – "I always say to my patients, "I'll come back, give me five minutes" and I'll go off and then come back and say "did you understand?" that that's what they need*
> *(Alastair – yes)*
> *Participant 5- "Yeah"*
> *Participant 5 – "erm…erm…"*
> *Alastair – "I'm agreeing… I'm agreeing right…* ***I was finding myself ready to join in there."***
> *Participant 7 – "it must be so hard for you Alastair"*
> *ALL Laughing*
> *Alastair – "it's extremely hard but I'm doing my best….."*
>
> Case Study 2, Interview 2, Lines 935-943, Participants 5, 7 and me

4.3.4.3 Consultant Medical Practitioner Participants

Consultant medical practitioner participants were recruited, as the study progressed, on the recommendation of Advanced Nurse Practitioner and Consultant Nurse participants. I had worked with One of them previously during curriculum development work related to the MSc Advanced Practice course referred to throughout this thesis.

4.3.5 Data Collection Methods

Constructivist grounded theorists often use intensive interviews since they support gathering rich data about participants experiences (Charmaz 2014). This aligned with the study's objectives to explore participants' views and experiences of Advanced Nursing Practice and was congruent with the ontological and epistemological approach underpinning the study.

4.3.5.1 Small Group Interviews

Small group interviews were chosen because they were judged to best enable participants to express their views and perspectives about Advanced Nursing Practice, whilst also enabling the opportunity for other participants in the group to clarify, add to, corroborate or challenge perspectives being discussed (Cronin 2008). Small groups are considered as potentially less threatening or intrusive enabling maximum contribution from each participant as well as being practically straightforward to complete (Birks, Chapman & Francis 2008). I contacted potential participants by email, providing them with information regarding the research and its purpose, see Participant General Information Sheet (page 78-9).

Participant General Information Sheet

Study title: Advanced or advancing practice: the future direction for nursing?
Research Investigator: Alastair Gray

What is the purpose of the study?
This study will explore and present the features, significance and impact of 'Advanced Nursing', as understood and demonstrated by: those in recognised Advanced Practitioner roles; and other clinicians supporting/leading those roles; all of whom are working in a local university hospital trust.

Why have I been approached?
You have been approached because you are employed in a local university hospital trust, where nurses carry out advanced practitioner roles in a variety of clinical services. For the purposes of the study, I need to recruit Consultant Nurses and medical practitioners who have experiential understanding of 'Advanced Practice' when carried out by nurses in recognised Advanced Practitioner roles. Such individual who are therefore able to make informed comment on the degree to which the features, impact and significance of 'Advanced Nursing' can be recognised within Advanced Practitioner roles, in that setting.

Do I have to take part?
No. Participation is entirely voluntary. If you change your mind about taking part in the study you can withdraw at any point during the small group session and/ or subsequent individual interview, and at any time in the two weeks following your involvement. All participants will be provided with a personal participant number and all participant data will be coded with those numbers so it can be easily removed. You can withdraw by contacting me on email and providing me with your participant information number. If you decide to withdraw all your data will be destroyed and will not be used in the study. There will be no consequences in deciding that you no longer wish to participate in the study.

What will happen to me if I take part?
You will be invited to come along to a group interview session to be held in March/ April 2018. The group of participants will be made up of your peers, including approximately eight participants. The session will last for approximately one hour and will be held in the Richard Crossman Building at the Coventry University campus.
Following the small group, you may be invited to take part shortly afterwards in an individual interview in April 2018 lasting up to 60 minutes. The purpose will be to clarify and expand upon comments made during the earlier group interview.
All interviews will be audio-digitally recorded.

What are the possible disadvantages and risks of taking part?
You may find the group interview uncomfortable if the conversation is stilted or if some participants talk excessively. I will be facilitating the groups, so it is my responsibility as the group moderator to facilitate contributions and minimise this happening. The aim is for everyone to be able to express their views freely and honestly without fear or favour. It will be made clear from the outset that there are no right or wrong answers. Indeed views expressed that disagree with or are contrary to my own previously expressed views and comments are equally valued and welcome.

What are the possible benefits of taking part?
As a postgraduate student, by taking part in this study you will gain an insight into how group interviews are conducted, what it is like to be a participant in such process and how these feed into a wider case study based research project.

What if something goes wrong?
If it becomes necessary to cancel a group interview/ individual session I will do my very best to contact you as soon as possible using the method indicated by you on the consent form.
If you change your mind about taking part in the study you can withdraw at any point during the session(s) you are involved in and at any time in the two weeks following that session(s) by contacting me using the email address stated below. If you decide to withdraw all your data will be destroyed and will not be used in the study.

Will my taking part in this study be kept confidential?
Yes. All participants will be asked to sign a confidentiality agreement indicating that they will not reveal who has taken part or what was said during the session they have participated in. Only I and in some instances a research assistant, assisting with transcription, will have access to data collected. Anonymity of participants and their data will be achieved by identification of data by participant number only. Access to audio recorded data, and data subsequently transcribed will be stored electronically with password protection. All consent forms will be stored electronically, separately from data collected in a secure (locked) location.
In accordance with current University policy, transcribed data from the project will be retained in the University Repository for up to five years following successful completion of PhD studies, and will then be destroyed. However, all audio recordings will be destroyed following successful completion of PhD studies.

What if things go wrong? Who to complain to?
No risks were identified in the proposal of this project, however, if you have any concerns at any point, please contact the researcher, or research supervisor, Professor Jane Coad, Associate Dean (Research), Faculty of Health & Life Sciences, Coventry University: Jane.Coad@coventry.ac.uk
If you wish to make a complaint, please contact Prof Olivier Sparagano, Associate Pro-Vice Chancellor of Research, Coventry University: olivier.sparagano@coventry.ac.uk

What will happen to the results of the research study?
The study finding will be written up and presented as part of my PhD Thesis. I would hope that my findings and conclusions will be presented at academic conferences and / or written up for publication in peer reviewed academic journals.

Who is organising and funding the research?
The research is organised by myself, Alastair Gray. I am a PhD student at the Coventry University, School of Nursing, Midwifery and Health. This project is not externally funded.

Who has reviewed the study?
The Coventry University Ethics Committee has reviewed and approved this study.

Contact for Further Information
Alastair Gray, Research Investigator
Research Student No. 6075073
PhD Nursing and Health Studies (HLSR009)
graya14@uni.coventry.ac.uk 07773027950

Box 5: Participant General Information Sheet

This approach was used so that potential participants could decline easily should they not want to or feel pressurised into taking part. This was part of the strategy for reducing the power differential between us (Birks and Mills 2015). Further clarification was available to participants upon their request. Written content provided was also repeated at the beginning of each interview. At that point I also raised the potential for a subsequent request for a one-to-one interview with selected

participants. I indicated that this would be where I felt individuals were best placed to provide further insights, clarifications, or potentially richer perspectives. Written consent was obtained from all participants, (see Box 6). A similar one was provided for subsequent individual interviews, see Appendix 4, page 296

Participant Consent form: Small group Interview

Study title: Advanced or advancing practice: the future direction for nursing?

1. I confirm that I have understood the above study (as explained by the researcher and the written information provided) and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason. ☐
3. I agree to take part in the above study. ☐
4. I agree to my individual contributions being audio recorded. ☐
5. I agree to the use of anonymised quotes in publications. ☐
6. I agree to maintain confidentiality regarding the names of participants in this research and details of conversations that I participate in during my involvement in this research ☐

Name of Participant	Date	Signature
Alastair Gray Researcher	Date	Signature

Participant Number…….. (to be added by researcher as per Small group participant number)

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Box 6: Participant Consent Form: Small Group Interviews

To enable each interview, I took Charmaz's advice (2014) for novice researchers to prepare a small number of questions to give shape to the interviews. These questions arose from my understanding of the concept of Advanced Nursing Practice and from the research questions, aim and objectives for the study. They were articulated tentatively at the outset of the study to meet the requirements for university ethical approval, see Chapter 1, and were confirmed and presented at the start of this Chapter, see page 70.

Themes for discussion: Small groups

Outline the purpose for the small group and the broad areas that the research is aiming to investigate:

1. the features and scope of Advanced Nursing Practice;
2. the perceived benefits of Advanced Nursing Practice;
3. cultural and organisation factors that help or hinder the Advanced Nursing Practitioner role and function;
4. whether a perceived distinction between Advanced and Advancing Nursing Practice exists

Prompt questions to aid discussion within the small group, only if the areas are not covered as the discussion progresses

- What are the main features of the Advanced Nurse Practitioner role that you have seen or experienced? Give examples.
- What are the main benefits of the Advanced Nurse Practitioner role? Give examples.
- As far as you are aware does the organisation help or hinder the Advanced Nurse Practitioner role? Give examples.
- In so far as you understand the terms, do you perceive a distinction exists between Advanced and Advancing Nursing Practice? How would you describe the difference? Have you seen this in this locality, give examples

Box 7: Themes for Discussion - Small Groups

It is acknowledged at this point, that first generation grounded theorists would refute this approach, because it would be regarded as contaminating both the data set and its analysis (Mills, Bonner, Francis 2006). However, my study aligned with second generation grounded theorists, who recognise and indeed value the researcher's contribution to the theoretical reconstruction of the subject being investigated.

To directly support participant discussion and subsequent comparative analysis of data generated from their small group interviews, a specific small group interview schedule was prepared (see page 82), (King, Horrocks and Brooks 2019; Birks and Mills 2015). This was prepared to facilitate comparison of data between different small groups and the two case study groups (Schofield 2002) It was anticipated that each interview would yield a transcript of up to 30 pages (Cronin 2008). The sessions were planned to be audiotaped, to facilitate transcription and immersion in the data generated by each group. In considering who would conduct and undertake questioning during the

interviews, facilitator ability and confidence was important. I recognised that individuals behave differently in groups so effective facilitation would be key to enable interaction between group members, maximising the generation of meaningful data (Cronin 2008).

Small Group Interview Schedule

Study title: Advanced or advancing practice: the future direction for nursing?

1. **Introduction**

   - Welcome (Nb. Participants will know each other, and me, so no need to introduce each other. However, my role will be clarified [principal researcher/study lead]).
   - To reiterate the purpose of the study.
   - Explanation of what will happen with data collected
   - Reassurance that there are no right or wrong answers
   - Ground rules regarding confidentiality will be set out. A reminder to use numbers not names will be given (Large numbered badges will be distributed at the outset)

2. **Introductory questions**
   - General question: I would like to start by asking the group 'what you would consider are the features and the scope of Advanced Practice, as you experience it'?

3. **Specific questions**
   - Depending on comments made to opening question
   - Having identified features in yours and others' practice, are there others missing from the list, that you feel could or should be part of Advanced Practice?
   - Can you identify reasons why additional elements proposed are missing?
   - What is the significance and impact of Advanced Practice as you understand and experience it?
   - Within your 'Advanced Practice' how would you characterise the contribution that arises from you being a nurse?
   - Can you provide examples of what 'Advanced Nursing' looks like, from yours or others practice? What is its impact?
   - Are there barriers to the expression of 'Advanced Nursing'? What are they? How may they be overcome?
   - What helps the expression of 'Advanced Nursing' to happen?
4. **Ending questions**
   - Any final comments?
5. **Final comment**
   - Thanks for attending. Reminder that results will be published and circulated to participants

Devised with reference to Cronin, A. (2008) 'Small groups' in *Researching Social Life* ed. by. Gilbert, N. London: Sage

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Box 8 Small Group Interview Schedule

Constructivists welcome researchers staying close to the participant interactions to aid co-construction of the data (Charmaz 2014) so rather than using a research assistant I facilitated the interviews myself.

Primarily this acted to minimise distance from the participants, and the potential for analytical and cognitive confusion between them and myself (Morse 2010). In addition, I had confidence that my experience and abilities as a facilitator in a teaching and learning environment would enable me to facilitate the case study groups effectively (Cronin 2008); also, having designed the initial questions I was best placed to deviate from these meaningfully should the direction of a given interview warrant this; finally, I wanted to be fully immersed in the process and in the data generated at first hand. I planned for each small group to be scheduled to last for approximately one hour, which is recommended as sufficient for both interviewees and interviewer to remain focused and for time spent to be maximally fruitful. Although I was well known by the participants, I made every effort throughout data collection to maintain the existing positive relationship, by building effective rapport in each encounter. A high priority was to demonstrate respect for each participant and their individual contributions.

4.4 Establishing Integrity, Robustness and Trustworthiness

As referred to in Chapter 3, early grounded theorists had not value for researchers' relationships with participants, rather concentrating attention on participants' actions and words as data (Thornberg & Dunne 2019). Indeed, the priority for those researchers was for data to handled objectively (Charmaz, Thornberg and Keane). However, over time constructivist grounded theorists argued that interaction between participant and researcher could lead to the co-construction of understandings between them (Birks and Mills 2015), meanings that were grounded in participants' lived experience. Indeed, this was highly relevant for this study since it both supported and encouraged engagement with participants, co-creating data and its interpretation leading to explanatory power.

The creation of theory in constructivist grounded theory is essentially an interpretive activity, handling knowledge which is neither objective nor fixed (King, Horrocks, Brooks 2019). Yet undertaking this interpretive endeavour poses risks to rigour throughout the investigative process, up to and including the conclusions of the study. Consequently, I realised that it was necessary that my position as the researcher remained transparent, and so be available for scrutiny at all points in the study (Birks, Chapman & Francis 2008; O'Reilly & Kiyimba 2015). Indeed, Birks and Mills (2015)

recommended that the researcher be their own critic, recognising and addressing limitations, so producing work of quality. A four-stage strategy was established to ensure the integrity of this study, addressing hidden and actual influence arising from me being a former teacher to many of the participants.

4.4.1 Strategy to Address Integrity in the Process

4.4.1.1 Obtaining Genuine Participant Thoughts

Participants were assured that the point of this study was to gather their genuine thoughts and responses, even if they knew from previous classroom debates with me as the lecturer, that I had a contrary view. This was addressed as follows:

- First, both in written communication ahead of interviews, see page 60-60;
- Second, verbally at the outset of each interview;
- Reinforced by considered responses to participants comments during interviews, avoiding negative reactions to views expressed;

4.4.1.2 My Continually Evolving Thoughts

I explained to participants that my own views were continually being challenged and adjusted considering new perspectives. Reflexivity and in particular the continuous act of memo writing in every stage of the study was very helpful in practically achieving and articulating this (Birks, Chapman & Francis 2008).

4.4.1.3 Only Genuine Views Provide a Meaningful Study

I explained to participants that it was only in gathering their genuine views can an accurate picture be obtained to support a meaningful study.

Moreover, this was matched with decisions made about handling participant data, asking questions of the data and looking for actions and the story within participants responses (Charmaz 2014). In making explicit and acknowledging my position, fresh insights arose from purposeful engagement between participants and myself (Chamberlain-Salaun, Mills, Usher 2013). Transparency was maintained (Savin-Baden & Howell Major 2013) supported by reflexivity and memo writing, and these features supported a claim of quality research (Corbin and Strauss 2008). Credible qualitative work is founded on methodological congruence and coherence, and in how it is used and applied with decision making about this clearly visible (Birks and Mills 2015). This was demonstrated by the production of a meaningful audit trail (Hoare et al 2012), including extensive inclusion of participants direct comments, (see Chapter 5).

Adopting a constructivist position freed me to utilise my experience to enter a degree of co-construction with participants, alerting me to possibilities and processes within the data (Charmaz 2014). However, this was difficult at first since I had not made a complete shift in my thinking about taking a co-construction role. Nonetheless progressively this enabled a more dynamic interactive process than I had originally considered possible (Chamberlain-Salaun, Mills, Usher 2013). Once engaged in data collection, memo writing was useful in supporting my ongoing internal dialogue, as indicated in this memo extract:

> *As I read more about different approaches to grounded theory, I became interested in the significance of 'story telling' and how there was very clear benefit in regarding contributions from participants in them actually telling their story about their practice. Participants were not simply revealing facts, but their attitudes, beliefs, knowledge, skills and impact of their activity. The parts that reflected the whole of being advanced nurse practitioners. In the recounting of the story so was now possible to see things previously hidden in the ordinariness of everyday practice. As I considered this, I was reminded of the work by Kucera, Higgins and McMillan (2010) who examined the 'stories' of advanced nurse practitioners to reveal their beliefs and attitudes towards their work and their patients so much of what the actors were engaged in. They commented:*
>
> > *"Many studies that describe nursing roles and the boundaries of practice are limited in that they place little relevance on the nurse's view. The focus of many studies, the nature of the questions, and the methodologies employed, has limited the contribution to an understanding of practice from the nurses' perspective. In general,* ***studies that focus on competencies or activities of nursing provide little insight as to how nurses perceive their work.****" Kucera, Higgins and McMillan (2010: 52)*
>
> *As I reflected on my pilot interview in the study, I realised one of the participants revealed her story, what she was trying to achieve and how this was variously hindered or helped. It was for me a powerful story, where apparent blocks on autonomy, in this instance not being able to request a study, did not stop this participant from pursuing the wider best for her patient.*
>
> > *"Yes..yeah absolutely I think that* ***those things aren't the be all and end all of that and often they don't have the greatest impact on what the patient needs anyway*** *the small things that you can refer and get, need doing like you can't get a CT head but I can access someone who can that's not going to impact so much on my patient, but other things might so then I might want to extend my scope in another direction if I have a block in another…"*
>
> Memo 1: Story Telling Revealed the Whole of Being Advanced Nurse Practitioners

Moreover, in making internal dialogue visible with use of text, it also supported the creation of an audit trail of the procedural parts of my study (Birks & Mills 2015). As reflexivity progressed through my memo writing, I learned this should not be limited to procedural parts (Birks, Chapman & Francis 2008) but extend much wider than this.

4.4.2 Reflecting on, Generating and Recording Data

The small group interviews were audio recorded, along with limited field notes (Birks and Mills 2015). Initially, I did not note take efficiently, I was not entirely sure what to note down and was distracted by simultaneously recording, trying to put participants at ease and assessing participant responses. This resulted in me resorting to summarising what was being said rather than recording my own comments, thoughts, questions, and observations about what was being said, and how. I did improve my efficiency with this technique over time, and it became useful to a degree. However, by that time I had already decided that I would not pursue this technique with vigour as I had also learned that field notes are not universally regarded as useful within grounded theory research, (Birks and Mills 2015). I was nonetheless grateful that I had decided to both record and have transcribed all the interviews conducted. The interviews were transcribed by a trusted colleague, to save time and improve my efficiency in organising the data, and so I could engage in immersing myself in the content of both the audio and written recordings. Indeed, I listened to each recordings several times to gain understanding and sense of what was being said as well as the words spoken. I was also checking and ensuring the accuracy of each transcription. I was pleased that they were largely very accurate, although there were a very few occasions when voices were obscured, or I heard more accurately than the transcriber what had been said. Listening to the transcript and reviewing notes taken during the interviews allowed me to supplement my original comments in readiness for the first analytical stage of line-by-line coding and commentary.

4.4.3 Reflecting on First Steps in Analysis

Line-by-line coding and commentary was labour intensive and demanded high levels of concentration. I became more efficient over time, especially once I had got into a rhythm of looking not just for topics but actions (Charmaz 2014). I revisited the early interviews to ensure I had been consistent, which reflected the process of constant comparison across the range of interviews conducted. The next stage of the process led on to establishing categories, to construct meanings from the data. Regularly taking note of my position was necessary to ensure the design aligned with my ontological beliefs regarding the ‘nature of reality’ thus rendering an accurate representation of what participants said about their reality.

This process was a challenging aspect of the study for me. As referred to earlier, it had become clear in the early stages of planning the data collection, that my status within the Advanced Nursing Practice community locally, regionally and nationally, and my established credibility as course lead

role for a regionally recognised Advanced Practitioner course, provided a detailed grasp of Advanced Nursing Practice. However, despite choosing constructivist grounded theory as the methodology, I did question my ability to come to the subject with sufficient rigour required for quality research as the following memo from my reflective diary demonstrates:

> *Indeed, the notion of maintaining distance and not engaging with the participants, to ensure objectivity, was challenged in the first data collection interview, where I was so enjoying the interaction between the participants that I found myself wanting to join in the conversation based upon my own understanding and viewpoints. Reflecting on the dilemma of my reactions to this event led to further reading. This revealed that as a methodology, grounded theory has evolved through several phases, from its positivist roots, through a post positivist perspective (Strauss and Corbin 1998) with the latter developing a very different perspective to the relationship between participant and researcher. As it became clear that to seek to be a 'neutral' and 'objective' observer was a denial of the reality of my own position. So, it equally became clear that my role within my chosen methodology was to enable my participants to tell their own story. Yet in working with their stories, the data, and engaging or reacting to this, a level of co-construction of meanings and understandings with the participants would occur (Charmaz 2014: 165).*
>
> Memo 2: Maintaining Distance

In the early phases of this study, as I had progressively clarified my philosophical stance and chose constructivist grounded theory, I had taken a relatively superficial approach to reflexivity. Yet, as I began to see the level of clarity and illumination that reflexivity brought to all aspects of the study (Savin-Baden & Howell Major 2013; Lempert 2007) it became clear what an error this had been to neglect this powerful tool prior to that point. Indeed, Charmaz emphasis on the obligation upon constructivists to utilise reflexivity in their study design, proved relevant in addressing assumptions made about the world and how these can easily shape and influence researcher's actions and decisions (Charmaz 2014). As my confidence grew in taking a constructivist position, it became clear the considerable difficulty of separating researcher from participant in the generation of data (Birks and Mills 2015).

4.5 Timetable for the Phases of Data Collection

4.5.1 The Ethical Approach Underpinning this Study

An essential part of developing quality research was for me to act in an ethical manner throughout the study. I sought to behave in a way commensurate with the principle of beneficence, (King, Horrocks, Brooks 2019) reflected in my establishing a mutually open and cordial relationship with participants. My intention was to enable them to benefit from and enjoy the lively verbal exchanges that I anticipated would take place during the interview process (Birks and Mills 2015).

The broad ethical principle of protecting participants from harm was an important consideration and was addressed through the research governance processes required for the study, (King, Horrocks, Brooks 2019). To address and minimise the issue of risk in the study, research was led by the principles of the Department of Health (2005) Research Governance Framework for Health and Social Care.

To gain good quality information, while bearing in mind potential risks to participants, invitations to participate were only offered to relevant individuals, Advanced Nurse Practitioners, Consultant Nurses, and consultant medical staff. During the design phase, I considered the involvement of a patient voice and consulted informally a senior clinical colleague who had been a very experienced Advanced Nurse Practitioner and Consultant Nurse, to gain their perspective on the feasibility and value of this. We concurred that while the patient voice would be valuable, it would be very difficult to select patients who could clearly identify where care had been provided by Advanced Nurse Practitioners in contrast to other health professionals. Reviewing the quality and experience of intended participants it was concluded that both the combined and individual insights of the intended participants would offer unique and valuable perspectives sufficient to answer the research questions, aim and objectives of the study (Staley and Minogue 2006).

A major step in achieving the status of an ethical study was to obtain approval from the University Ethics Committee, (see page iii of this thesis). This process reflected King's (2018) nine ethical considerations relevant for qualitative studies, and participant documentation reflected these principles, (see Box 5, pages 78-79; Box 6, page 80; Appendix 4, page 296). A substantial part of this approval application was to enable me to conduct small group interviews at the university site. However, after the first set of interviews, it was clear that that it was difficult for participants to do that. I was also aware that conducting interviews at participants preferred location was beneficial in achieving engagement (King, Horrocks and Brooks 2019) and that responding proactively to this could further the data collection effort. In consultation with my supervisors and intended

participants, it was concluded that moving data collection interviews to the hospital site would solve the problem.

The process for achieving necessary permissions from the trust were delayed, with paperwork mislaid, and coupled with the demands of my professional work delayed engaging in data collection for several months. The dates and times originally planned and allocated for data collection had long since passed. The small group interviews, and subsequent individual interviews, were originally planned as two phases, with a third being for review of written sources. However, as discussed in Chapter 3, an unexpected turn of events led to participant interviews being grouped instead into three phases, one and two for small groups, (see Tables 10, page 90 and 11, page 91) and the third for individual interviews, (see Table 12 page 93). All were summarised in Table 13, see page 95). A further significant change occurred during phase 2, when I decided not to progress with formally collecting and examining written sources. This will be justified later in this chapter.

Gaining and maintaining informed consent from participants at the outset and throughout the study was of high importance to me (Bulmer 2008). Participants were made aware that they were at liberty to withdraw at any point, without having to explain why. Protecting privacy was likewise a very high priority and the maintenance of confidentiality a key method of achieving this (Bulmer 2008). Data obtained was regarded as confidential, was held securely, and all equipment used was encrypted. Data retrieved was only available and used for the purposes of this study (Bulmer 2008).

4.5.2. Phase 1: Small Group Interviews

Phase 1 small group interviews (see Table 10, page 90) were conducted on the university site. They were planned to last for about an hour, deemed an optimum time to enable participants to relax into the discussion, long enough to obtain a reasonable depth and breadth of response, but not so long that participant fatigue might set in (Robson and McCartan 2016).

4.5.2.1 The Pilot Interview

The first small group interview was planned and conducted as a pilot, to test interviewing skills and approach. As an experienced nurse I was used to interviewing, but equally was aware that this was a different circumstance, with the aim of generating data to create a constructivist grounded theory. This experience was invaluable in refining my approach, maximising flexibility in using or not the intended question prompts while focussing on enabling participants to tell their stories (Birks and Mill 2015).

Reflecting on the pilot interview I wrote a second memo about the event, noting this:

> *'… I now realised that one of the participants was very much revealing her story, what she was trying to achieve and how this was variously hindered or helped, it was for me a powerful story, where apparent blocks on autonomy, in this instance not being able to request an (investigation) did not stop her from pursuing a 'workaround' to get the wider best for her patient.* ***Pilot interview, Participant 4, Line 73:*** *"Yes..yeah absolutely I think that* ***those things aren't the be all and end all of that, and often they don't have the greatest impact on what the patient needs anyway*** *the small things that you can refer and get, need doing like you can't get a CT head but I can access someone who can that's not going to impact so much on my patient, but other things might so then I might want to extend my scope in another direction if I have a block in another…"*
>
> Memo 3: Participant Sharing Story Reveals Creative 'Work Around'

4.5.2.2 Phase 1: Small Group Interviews

Phase 1 Small group interviews	**Participant No/ Biographical**	**Participant No/ Biographical**	**Participant No/ Biographical**	**Participants Total**
Interview 1 Pilot	No.3 Senior Lecturer / Advanced Nurse Practitioner	No.4 Senior Lecturer / Advanced Nurse Practitioner		x2
Interview 2 Consultant Nurses (representing both cases)	No.5 Consultant Nurse: Acute Medicine	No.6 Consultant Nurse: Acute Medicine	No.7 Consultant Nurse: Gerontology	x3
Interview 3 Case 1: Acute Services-Medicine	No.8 Advanced Nurse Practitioner	No.9 Advanced Nurse Practitioner		x2
Phase 1 Group Interviews				**Case Pilot x2** **Case 1 x4** **Case 2 x1** **Total x7**

Table 10: Phase 1 Small Group Interviews

Alongside the first phase of small group interviews, concurrent data analysis and reflexivity was underway, along with the beginning of line- by-line coding of the transcripts (Birks and Mills 2015). Even at this early stage, I was alert to maximising data and reflected on Birks and Mills observation that researchers are not always alert to the myriad of opportunities for data collection that are present in the field (Birks & Mills 2015). Continuing data analysis, further development of theoretical sensitivity and alertness to opportunities, were needed so that with broader theoretical sampling, the richest data set would be achieved to enable movement towards the development of theory.

This process led to considering an additional data source, a group of Advanced Nurse Practitioners working in the surgical department that I hadn't considered before. Exploring their activity further, they were operating in a similar way to existing Case 1: Acute Service participants (acute medicine).

Opportunity sampling (Patton 1990) built on the ongoing theoretical sampling process as data generation and analysis continued, and led to their inclusion within Case 1: Acute Services.

4.5.3 Phase 2: Small Group Interviews

The next set of small group interviews were like those in phase 1, but included participants representing Case 2: Non-Acute Services for the first time. Considering the gap in time between undertaking the first set of interviews (phase 1) and this larger set, this round was identified as phase 2 (see table 11). Phase 3 was also identified as the focus for forthcoming individual interviews.

Phase 2 Group Interviews	**Participant No/ Biographical**	**Participant No/ Biographical**	**Participant No/ Biographical**	**Participant No/ Biographical**	**Participants Total**
Interview 4 Case 1: Acute Services- Surgery	No.10 Advanced Nurse Practitioner	No.11 Advanced Nurse Practitioner	No.12 Advanced Nurse Practitioner		X3
Interview 5 Case 2: Non-Acute Services - Long term conditions	No.13 Advanced Nurse Practitioner	No.14 **Advanced Nurse Practitioner**			X2
Interview 7 Case 1: Acute Services - Medicine	No.15 Advanced Nurse Practitioner	No.16 Advanced Nurse Practitioner	No.17 Advanced Nurse Practitioner		X3
Interview 9 Consultant Nurses (representing both cases)	No.18 Consultant Nurse: Gerontology (Case 2)	No.19 Consultant Nurse: Emergency Department (Case 1)	No.20 Consultant Nurse: Surgery-Pre-Operative Assessment (Case 2)		X3
Interview 10 Case 2: Non-Acute Services - Gerontology	No.22 Advanced Nurse Practitioner	No.23 Advanced Nurse Practitioner	No.24 Advanced Nurse Practitioner	No.24 Advanced Nurse Practitioner	X4
Phase 2 Group Interviews					**Case 1x 7 Case 2x8 Total x15**

Table 11: Phase 2 Small Group Interviews

Regarding recruiting consultant medical staff for a small group interview in phase 2, I sought to theoretically sample for who might be suitable and discussed with existing participants who might be suitable to speak about their experience of Advanced Nursing Practice in their service. Clarity around this was forthcoming from both Advanced Nurse Practitioner and Consultant Nurse

participants. However, it proved difficult to meet as a small group for a various operational and logistical reasons, so it was concluded that interviewing them individually might be more realistic.

Reflecting on why this difficulty was encountered, it did occur that perhaps this was because of limited interest in the study and/or the concept of Advanced Nursing Practice. I noted assumptions about those participants for further consideration and exploration later during interviews with them. Nurse participants provided reassurance that the invitation email was appropriate, and some offered to undertake 'recruitment' for me. This provided a sense of the trust and respect that existed between us with participants willing to actively help the study progress (King, Horrocks and Brooks 2019). Practically it proved to be fruitful with a key suggestion of communicating through the consultants' secretaries. However, logistics forced a change in plan from undertaking a small group interview, to conducting individual interviews with each consultant medical practitioner. Consequently, they were invited to join phase 3 for individual interviews.

4.5.4 Inclusion of Documentary Evidence

In Chapter 3 reference was made to collecting documentary evidence, to enhance the data set. I noted Charmaz's suggestion that 'adequate' grounded theory can be established on limited sources but that she went on to indicate that it may become 'excellent' with inclusion of more and particularly different types of data (2014: 162) to provide fresh perspectives (Birks and Mills 2015; Charmaz 2014; Mills, Bonner & Francis 2006). Consequently, I considered further the merits of inclusion of documentary evidence. However, data collection and analysis in grounded theory methodology is a dynamic process and towards the end of phase 2, in view of the amount and quality of data already obtained, and aware of interviews yet to be conducted with consultant medical staff, I decided that a separate phase to formally collect documentary evidence was not necessary. Indeed, I wondered whether it could actually detract from the main thrust of my continuing data analysis and comparison of evidence already taking place.

Participants had not so far referred to trust or directorate documents or policies as influencing or directing their work as Advanced Nurse Practitioners. I was surprised by this expecting that documents such as their job descriptions would inform and guide their activity, but this was not the case. I concluded that the extent of documentary and policy influence on their activity was not significant, which was in itself was an interesting finding. Moreover, this contrasted with the evident influence of national policy documents, as discussed in Chapter 2, including specifically the four pillars of Advanced Practice as set out in the Multi-Professional Framework for Advanced Clinical

Practice (HEE 2017) which several participants did refer to and which was said to influence, shape and guide their roles (HEE 2017). Nonetheless, the potential relevance of documents was not dismissed, and I remained alert to indications of relevance in interviews still to take place.

4.7.1 Phase 3 Individual Interviews

Phase 3 focused on undertaking individual interviews. Participants were identified from phases 1 and 2 small group interviews as those who could offer further insights and understanding of the concept and activity of Advanced Nursing Practice.

Phase 3 **Individual Interviews**	**Participant No/ Biographical**	**Participant Total**
Interview 6 Case 2: Non-Acute Services - Long term conditions	No.13 Advanced Nurse Practitioner	X1
Interview 8 Case 1: Acute Service - Medicine	No.9 Advanced Nurse Practitioner	X1
Interview 11 Case 2: Consultant Nurse	No.7 Consultant Nurse / Senior nurse manager	X1
Interview 12 Case 2: Non-Acute Service- Pre-Operative Assessment	No.21 Advanced Nurse Practitioner	X1
Interview 13 Case 2: Non-Acute Service Pre-Operative Assessment	No.26 Advanced Nurse Practitioner	X1
Interview 14 Case 1: Acute Service - Medicine	No.27 Advanced Nurse Practitioner	X1
Interview 15 Case 1: Consultant medical practitioner	No.28 Consultant physician (Acute Medicine)	X1
Interview 16 Case 2: Non-Acute Service, Gerontology	No.22 Advanced Nurse Practitioner	X1
Interview 17 Case 2: Consultant medical practitioner	No.29 Consultant physician (Gerontology)	X1
Interview 18 Case 1: Consultant Nurse	No.30 Consultant Nurse	X1
Interview 19 Case 1: Consultant medical practitioner	No.31 Consultant Surgeon (General Surgery)	X1
Phase 3 **Individual Interviews**	**Case 1 x5** **Case 2 x6**	**Total x11**

Table 12: Phase 3 Individual Interviews

The approach to questioning in phase 3 was revised in light of continuing data analysis and the constant comparison of data which had taken place to this point. The Individual Interview Draft Schedule is provided, (see Box 9, page 94).

Individual Interview Draft Schedule

Study title: Advanced or advancing practice: the future direction for nursing?

1. Introduction
   - Welcome
   - Reminder Purpose for study
   - What will happen with data
   - Reassure no right or wrong answers

2. Introductory questions
   - General question: what comments would you like to make following your involvement in the recent group interview?
   - Specific questions arising from contributions made at group interviews

3. Specific questions

Depending on comments made to opening questions

   - Can you identify the features, significance and impact of 'Advanced Nursing' as you understand it within 'Advanced Practice'?
   - Can you provide examples of what 'Advanced Nursing' looks like from yours or others practice?
   - What barriers do you see to this happening?
   - What helps 'Advanced Nursing' to develop and be expressed?

4. Ending questions
   - Any final comments?
5. Final comment
   - Thanks for attending. Reminder that results will be published and circulated to participants

Devised with reference to Fielding, N. & Thomas, H. (2008) 'Qualitative Interviewing' in *Researching Social Life* ed. by. Gilbert, N. London: Sage

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Box 9: Phase 3 Individual Interview Draft Schedule

4.5.6 Summary of Interview Phases 1- 3 divided into Case Study Groups

Phase 1 Small Group Interviews	(Case Pilot x2) Case 1 x4 Case 2 x1	Total x5 (+2)
Phase 2 Small Group Interviews	Case 1 x7 Case 2 x8 Case 3 x3	Total x15
Phase 3 Individual Interviews	Case 1 x5 Case 2 x6	Total x11
Total Interviews by case	**Case 1** **Acute ANPs x10, Consultant Nurses x4** **Consultant Medical Practitioners x2** **Case 2** **ANPs x10, Consultant Nurses x4** **Consultant Medical Practitioners x1**	**Total x31 (+2)**

Table 13- Summary of Case Study Groups

4.6 An Overview of Data Analysis in this Study

Data analysis within constructivist grounded theory is demanding because of the intensity of continuous analytical activity needed to determine the key elements of interest arising from the data generated, and the amount of time needed to do it thoroughly. Moreover, constructivist methodology requires the collection and analysis to be carried out continuously throughout the study (Corbin & Strauss 1990) with analysis and collection considered interdependent processes (Charmaz 2014). Moreover, throughout this process I sought to adopt and maintain a flexible and responsive stance to the data (Corbin and Strauss 2015) while remaining true to the research questions, aim and outcomes I had developed at the outset of the study.

4.6.1 The Strategy Illustrating the Process of Simultaneous Data Collection and Analysis

Developing a practical strategy and process to illustrate carrying out simultaneous collection, generation and analysis of data was helpful in providing shape to the study and momentum to achieve its completion in an efficient manner (Charmaz 2014). Earlier in the study others' approaches were considered, including Kneafsey's Analytical Process model (Kneafsey 2013: 1622) this helped with understanding but challenged me to design my own approach, more closely suited to this study, see Figure 10, page 96.

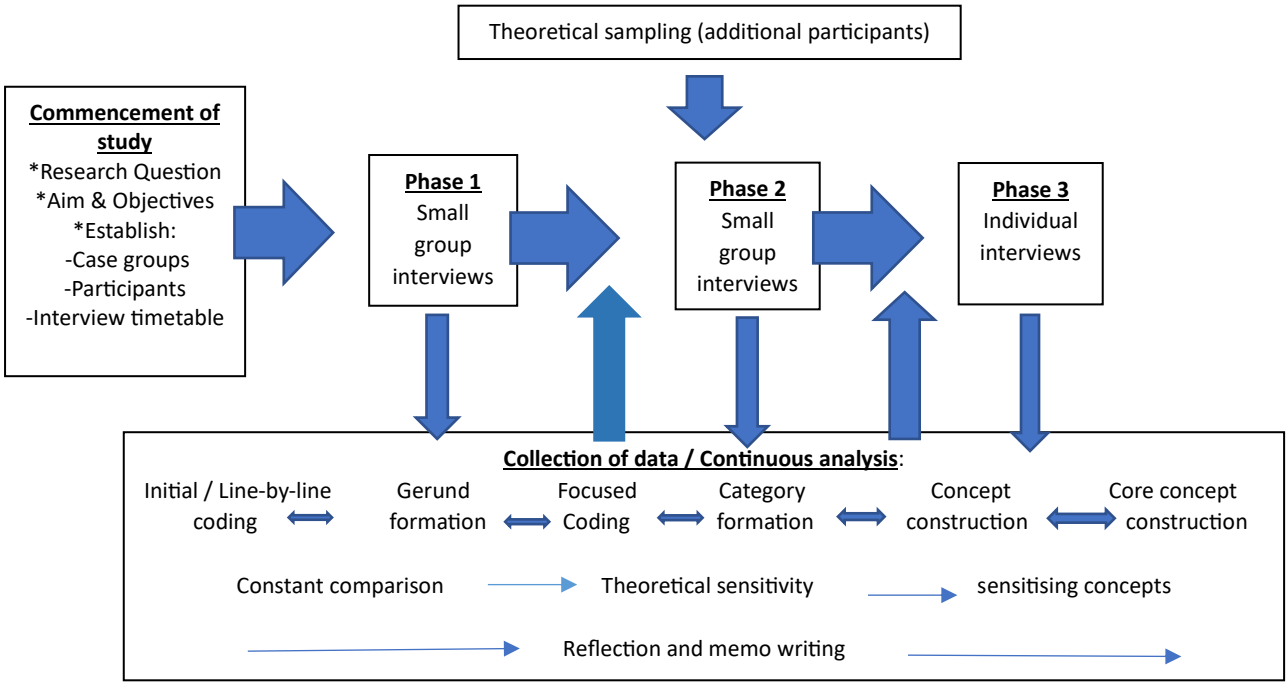


Figure 10: The Strategy and Process for Carrying out Simultaneous Collection, Generation and Analysis of Data in this Study

Constructivist grounded theory methodology considers data not as 'collected' but rather 'generated' (Birks & Mills 2015) underpinned by dynamic interaction between participants and myself (Charmaz 2008). Alongside the continuing review of recordings and transcripts to support data immersion, the completion of memos was increasingly appreciated as it enabled the recording of information, questions, thoughts, and ideas (Hoare, Mills and Francis 2012). Data generated was treated tentatively and flexibly so that I was able to be theoretically sensitive to meanings within participant responses. An iterative approach led to returning to some participants from phases 1 and 2, through individual interviews with them in phase 3, to achieve clarity about the codes and categories that were generated from their earlier comments (Mills, Bonner & Francis 2006), achieve further understanding and ensure an accurate participant voice was retained.

Consequently, I embraced my position not as a neutral objective and disconnected observer, but ultimately as co-constructor of the data (Charmaz 2008). As indicated earlier, participants in the small group interviews were known to each other and me as the researcher. However, their knowledge of me was primarily as their former course director and not as a fellow Advanced Nurse Practitioner. In reflecting on this I realised that I had taken for granted that because they were former students of mine, they might not have made the leap of seeing me in a different light. This was an assumption on my part and mitigated against by the fact that I made every attempt to explain and emphasise that I really was interested in their uncensored views and thoughts, and in

obtaining those views and thoughts (King, Horrocks and Brooks 2019). This extract demonstrates such an exchange between me and a participant:

> ***Alastair*** *– yes I see what you are saying, yes, ok thank you for that* [Seeking to demonstrating respect]. *Right if we look about this a little bit more you have identified the features you've identified the importance about the four pillars within this and also considered the masters level preparation for this course* (Correction) *for this role, rather. Do you think there are any other features to being an Advanced Practitioner that would separate an Advanced Practitioner from a non- Advanced Practitioner any other features? You've talked about the scope, I understand the sort of things that you'll be doing and you've helpfully elaborated on how that might look like. Is there anything else about an Advanced Practitioner that would set them apart from an ordinary nurse?*
> ***Participant 9*** *– I personally think not really, however, as an Advanced Practitioner you know currently in practice, you have to have something about you, you have to be confident you have to be competent, you know you have to be erm…. willing to learn pause … but I'd also say that those are those should be skills of a normal staff nurse…*
>
> **Case 1: Acute Services- Medicine Interview 3, Participant 9**

Although the social interaction between myself and participants was not formally recorded, other than when captured incidentally in the interviews themselves, the tone of exchanges before, during and afterwards were easy and pleasant. I was nonetheless aware that before each interview actual and/or perceived power differentials between us could lead to negative interaction and have the potential to spoil the atmosphere and damage the interview process. Aware of this, I made every effort to ensure participants were greeted in a friendly way and put at ease (King, Horrocks and Brooks 2019). In fact, if anything it was me who was slightly nervous due to wanting this to go well.

4.6.2 Interview Transcription

After each interview took place, the recordings were sent for transcription on the same day to a trusted secretarial colleague and experienced transcriber, suggested by my director of studies. This was a huge time saving, though I noted the potential confidentiality risk for participants. However, they and their locations were anonymised and they were asked to refer to each other by number not name and I concluded the risk was minimal. Completed transcriptions were generally returned within two weeks, but as copies of the recordings were retained, I was able to listen to them promptly and therefore add comments and questions to the field notes I had taken during the interview. It was hard to gauge the benefit of the field notes in themselves. Although notes were retained in a formal book prepared for the purpose, they consisted initially of my attempt to record what was being said, rather than of key thoughts which would have been more useful (Birks and Mills 2015). I did continue to make jottings in some of the subsequent interviews, but they did not

feel helpful and were even a distraction from immersing myself in the data as it was being retrieved. Consequently, some interviews had only the most perfunctory of comments recorded, so it was decided to stop this to more fully immerse in the interactive process with transcriptions. Charmaz (2014) points to the value of transcriptions in preserving detail of what was said, but also enabling review of the construction of interview content. This was particularly helpful in taking generated phenomena apart which supported ongoing theorising.

Once each transcript was returned, the more formal process of listening to the tape of each interview and reading the transcript simultaneously took place. This enabled further engagement with the data, releasing a more complete sense of each interview (Corbin and Strauss 2015; Charmaz 2014), hearing what participants were saying, and sensing what they were experiencing. As I gained confidence, this was increasingly accompanied by the inclusion of raw data in memos, to enable participants' 'voices' to be heard and highlighted (Charmaz 2014). This example from one of my memos demonstrates this:

> *There was a clear sense in this response that yes, complex medical interventions by ANPs were legitimate and required, but still the Advanced Nurse Practitioners remained, at their core, nurses and that they recognised the importance of them acting as a support and in many ways a lead for nurses and nursing practice (Interview 2 Case 2: Line 459-462 Participant 5):*
> *… we are there as a support to the medical need within our speciality but we are also there to support nurses and I think the other part of our role would be having a big impact I see our band fives look up to us to say oh…. can you help me with this, I need this to be explained.*
> Memo 4: Importance of Capturing Participant Voices

The process of analysis is often supported by software packages, and some recommend their use (Noble & Smith 2014) but there are conflicting views on the level of their efficiency and perhaps more importantly the restriction they may post on creativity in the analytical process (Richards, 2015). While NVivo is the local institution's preferred softwear, attempts to use it proved cumbersome and unhelpful, its mechanistic nature acted to hinder rather than help interactive engagement with the data (Richards, 2015) so it was not used in this study opting instead for a manual approach (Birks and Mills 2015).

Having listened now several times to the recordings, and taken notes adding to field notes I had made, the next stage of the process was to undertake line by line coding arising from participants' comments. 'Coding' is the process of labelling and naming data revealed and observed, reducing this to small units or 'chunks' (Savin-Baden & Howell Major 2013). This approach enabled a thorough

review of what was being said, the aim being to capture actions rather than topics (Charmaz 2014). Progressively, over time these codes were compared with the same or similar thoughts captured in the other interviews taking place. This process reflected the process of constant comparison (Mills, Bonner & Francis 2006; Morse 2010), but was also important since it was raising the level of analysis towards theory development (Birks and Mills 2015). As the interviews progressed the prompt questions in the small group interview schedule (see Box 8, page 82) were reviewed to ensure they were neither prescriptive nor leading (Charmaz 2014) and that they were enabling participants to present their own experience about their role as Advanced Nurse Practitioners, and their relationships and interactions with colleagues (King, Horrocks and Brooks 2019). Methodically and systematically analysing the collected data is at the centre of maximising the collection of the richest data that supports the generation of theory truly grounded in the reality of participants (Polit & Beck 2014; Corbin & Strauss 1990).

4.6.3 Theoretical Sensitivity

It is worth adding comment at this point about 'theoretical sensitivity' as an underpinning technique in supported awareness and responsiveness to participants' engagement in their world of Advanced Nursing Practice. It was important as a means of revealing participants actions and activity in relation to the areas I expected and intended to explore arising from the research questions and study aim and objectives. Though not an easy concept to explain, it has helpfully and simply been defined as:

> *'…The ability to recognise and extract from the data elements that have relevance for your emerging theory. (Birks and Mills 2015: 58)*

Three key features have been defined: 1) It characterises the totality of personal, professional and experience life, as considered in Chapter 1; 2) Techniques, tools and strategies can enhance it; 3) It progresses alongside the investigative process (Birks and Mills 2015). Indeed, reflecting further on this led me to appreciate once more the importance of understanding my own baseline understanding of Advanced Nursing Practice and the part this played in developing my own theoretical sensitivity. It aided not forcing my own perspectives onto the data being generated from participant responses and supported my justification for undertaking the early literature scoping presented in Chapter 2, rather than waiting until literature was appraised alongside data collection.

In the early period of analysis, when engaging in line-by-line coding I found myself drawn to identifying 'topics', rather than 'actions' recommended by Charmaz (2014). Actions better uncover depth within the data, leading to making analysis explanatory, rather than descriptive and ultimately increasing the power of conclusions drawn. While this proved challenging, the process of constant comparison, and the twin additional processes of reflexivity and memo writing, helped progressively to address the challenges in the process of analysis. One extract from an early theoretical memo makes visible the process I was undergoing:

> *In reading about the concept of 'Theoretical Sensitivity' and its importance in supporting my attempts to be attuned to participants' comments and particularly their actions (Charmaz 2014: 244). I reached some clarity about the importance of not focussing on 'topics', which I had been doing and which are more akin to description. Instead need to focus more on actions which tend to the explanatory and hence have more depth and power (Charmaz 2014:121).*
>
> Memo 5: Actions not Topics

Since constructivist grounded theory regards participants and researcher as co-constructors, so I decided to further engage a selection of participants in an exercise to review my line-by-line coding, to assess if they were recognised by those participants. Arrangements were made therefore to get feedback from those who were invited to take part in an individual interview in phase 3 of the study. Those participants asked to review their small group's coded transcripts when they subsequently attended their individual interview. This approach was taken to minimise inconvenience and maximise engagement. There appeared to be a high degree of recognition by these participants of the codes I had identified in their small group transcript. This was very encouraging. One example is shown here:

> *Alastair: "…thank you for looking at the transcript and does it look that that what was said?"*
> *Participant 22: "yeah"*
> *Alastair "…do you feel that that is a valid? Good, that in its own right is helpful for me to know that. Is there anything that you want to say before we go any further that you either want to adjust, or well, actually now I have thought about that it didn't I didn't express really what I wanted to express… this is what I actually felt..*
> *P 22 "no not really."*
> *Alastair- no*
> *P 22: "I think it reflects what I said at the interview and I still maintain that.*
>
> Case 2 Interview 13 Lines 7-16 Participant 22.

4.7 Data Analysis: Extracts and Examples

In remaining aligned with the constructivist approach discussed in Chapter 3 and applied here in Chapter 4, examination of the text within each transcript led to the generation of large number of codes, representing key ideas participants spoke about that appeared significant, more so if they were recurrent in participant dialogue. I initially regarded these ideas as 'provisional', though that status was enhanced if, and when, they appeared repeatedly during the process of constant comparison within and between cases. Similarly, the codes gained a reduced significance if, and when, by contrast they were absent within and especially between case groups when I had anticipated they would be present (Corbin & Strauss 1990). Provisional coding was shaped by grouping codes together under broad headings arising from the study research questions, aim and objectives. This was necessary to ensure those features remained of central importance in guiding the analytical process.

4.7.5 Phase 1: Pilot Interview

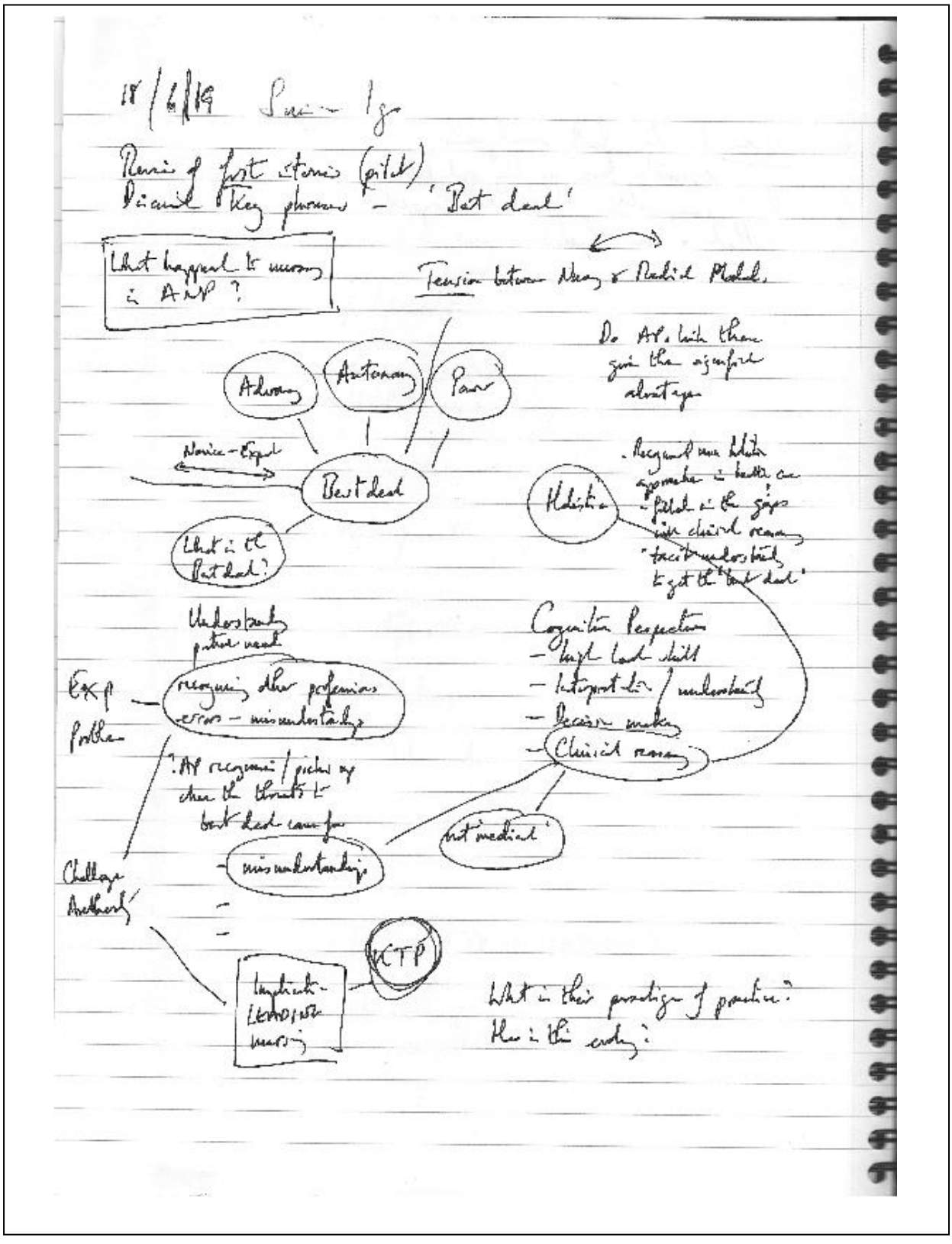
An inductive approach to analysis shaped the approach taken with each of the interviews and began with the pilot interview (Huberman and Miles 1998). Analysis commenced with line-by-line commentary of the transcript to generate codes from participant comments (Charmaz 2014). The first question enquired about the 'features' of the Advanced Nurse Practitioner's role. At this early stage of my understanding of the analytical process, my approach was limited in so far as I sought to identify topics or themes, rather than actions and action phrases. After concurrent reading about constructivist approaches, I appreciated the need to focus on actions and stories and this became the approach taken, as discussed earlier in this chapter (Birks and Mills 2015). Topics and actions identified were matched with same or similar in subsequent interviews, taking note of Huberman and Miles' 'tactics for generating meaning' (1998). Alongside this, continuing attempts were made to compare topics identified with findings from known and new literature on Advanced Nursing Practice. New literature obtained at that point revealed that Advanced Nursing Practice was being increasingly associated with four essential features, recognised as 'pillars' of activity, clinical practice, management and leadership, education and research (Tracy & O'Grady, 2019; HEE 2017). While this notion was not new, what was new was that it was being set in the context of multi-professional Advanced Clinical Practice, whereas it had been identified with Advanced Nursing Practice in the review of literature in Chapter 2 (DoH 2010; Scottish Government 2008).

The second part of the first question enquired about role 'scope', which participants revealed as**, 'broader'**, 'extra responsibilities', and a **'level'** of practice. Other apparently significant descriptors were evident including, '**pushing the boundaries**' (Por 2008) and directly linked with this, '**driven by patient need**':

> *Participant 2: '….so I think for **the scope of Advanced Practice would be** erm… **pushing through boundaries** and .. and currently there's not particularly a set limit of what a clinical advanced practitioner can do. So it is trying to see what the role is but also going beyond…. that is part of advancing clinical practice… Pause……*
> *Participant 3 ' **So the scope should fit into really what the Advanced Practitioner recognising what the patient's needs are and trying to provide them** pause … would help to push their scope and their boundaries..'*
>
> Pilot Interview Participants 2 and 3

Comparing and contrasting key codes or repeated words from the data was carried out to capture the participants' main ideas. The following ideas appeared important, emerging repeatedly: the role of '**communication with colleagues'** and '**negotiating**' to achieve objectives, and especially the phrase '**Getting the best deal for patients**'. This was compared with the principle of **holism** found in the literature (Jokiniemi & Haatainen 2012) which was associated strongly with nursing practice (Rolfe 2014a, Castledine 2003). Also, 'Take responsibility' and 'Will step up' implied proactivity and **leadership** as attributes of attitude and behaviour. Other responses addressed **restrictions** placed on these practitioners by their managers who demonstrated different priorities. This impacted on participants by controlling and restricting their activity. Hindrances to the scope of Advanced Nursing Practice were identified, but the response to minimise and overcome this was evident, with aim to keep pursuing the primary focus, '**patients first**'.

After this first phase of analysis of the interview, a review was carried out with a member of my supervisory team, (see Box 10 page 103).



Box 10: Identifying Themes from Interview 1

As the codes were examined again, the phrase '**best deal**' emerged as a key significant theme and a potential category. Indeed, this was clearly important to one participant and was reflected in associated comments she made:

> *'- erm.. because* ***if you are seeing your patient on a holistic level then you are really aware of the other areas where things are falling down and it may be occupational health, mental health, physiotherapy err.. it maybe that where the patient access or services that they are not getting of areas that you know that you can tap into to get that patient fully supported*** *erm.. so I think that it's not defined in your scope experience and..and seeing the patient holistically and* ***trying to get the best deal for them for whatever they need*** *erm…tends to be fall into what you're defining what your scope is..'*
> Pilot Interview Participant 3

Understanding this enabled me to progress my analysis to draw out further elements in the data that were associated with that theme. Key questions concerned:

1) What does 'best deal' look like?
2) What were the associated influences within and without the participant, advocacy, autonomy and power?
3) What does leadership of nursing look like, and who is providing that leadership?
4) What were the threats to the 'best deal'?
5) What were the apparent tensions between nursing and medicine?

The analytical process for this study continued to be shaped by: first, the making of constant comparisons to reveal multidimensional and rich understanding, which has been considered earlier; and second, asking questions of the data, see example on page 82, which informed each successive stage of analytical activity (Charmaz 2014). This approach is evident in comparisons between the group interviews (phases 1 & 2) and the individual interviews (phase 3), but equally also between the different cases, Case 1: Acute (Medicine/ Surgery) and Case 2: Non-Acute (Gerontology/ Pre-Operative Assessment/ Medical Specialities). As discussed earlier, these cases were so created to reveal similar and contrasting perspectives, viewpoints, and specific clinical and other activities of participants.

The analytical process was accompanied by reflexive activity including 'memoing', regarded as 'the critical lubricant of a grounded theory machine' and 'the mortar which holds together the data or building blocks (data) that comprise grounded theory' (Birks and Mills 2015). This facilitated expression of my thoughts about the codes/concepts emerging from the data, and in particular their

relevance and how they related (Charmaz 2014; Streubert & Carpenter, 2011; Lempert 2007; Strauss & Corbin 1998; Corbin & Strauss 1990). As discussed earlier they also contributed to the maintenance of an audit trail as a contemporary record of actions undertaken (Birks and Mills 2015). In this regard they remained necessary throughout the process, ensuring as many of my thoughts as possible were captured (Charmaz 2014). As the analytical process continued, they became a crucial link between the data and the emerging theory (Lempert 2007).

4.7.2 Phase 1: Interview 2 Consultant Nurses

Participants in this interview were Consultant Nurses, experienced practitioners who were also former Advanced Nurse Practitioners, who between them had experience in one or other of Case 1: Acute Service, and Case 2: Non-Acute Service. An inductive approach to analysis was continued in this second and subsequent interviews (Huberman and Miles 1998). It commenced with establishing codes, the intention being to remain as close as possible to the participants' actual comments and observations so capturing an insider's view of the data (Charmaz 2014). Greater emphasis was placed on establishing 'gerunds', otherwise known as the 'action' form of nouns, rather than merely the 'topics' I had been seeking from the pilot interview, because the former approach tended towards a more descriptive rather than explanatory analysis. The purpose was to achieve a greater depth to meanings arising from participants' comments (Charmaz 2014).

4.7.3 Progressing the Analysis and Reducing the Data

In progressing the analysis to move towards theorising, the next stage of the analytical process was to look for opportunities, when comparing my data sets, to reduce the data by narrowing down the numbers of codes to form categories. This involved looking for similarities and where there was scope for amalgamation, to establish instead more inclusive, focused categories of data. This process was also informed by my ongoing development of theoretical sensitivity to what was 'going on', and what 'actions' were taking place within the participant narrative. Richer and deeper understanding, between and within categories resulted (Birks & Mills 2015). My purpose within this was not to examine each participant per se, but their responses and actions within the incidents and events in the story that they were sharing (Charmaz 2008) as part of the 'unit of study' that was represented by the case study they were part of.

A robust and progressive approach was taken to manage the data by meaningfully connecting and reducing codes to produce categories. The categories were themselves subject to the same process of reduction to form super-categories. This accelerating process was enhanced by a gradual shifting

of focus away from the static and fixed topics found in the initial codes, to the more dynamic 'events and incidents' that participants referred to and which uncovered their 'actions' involved in the Advanced Nurse Practitioners experience of their daily work (Charmaz 2014). As the process continued, so the super categories were themselves reduced to form four concepts, which in turn were narrowed down to establish the core concept, the basis for the grounded theory founded in this study (Strauss & Corbin: 1998).

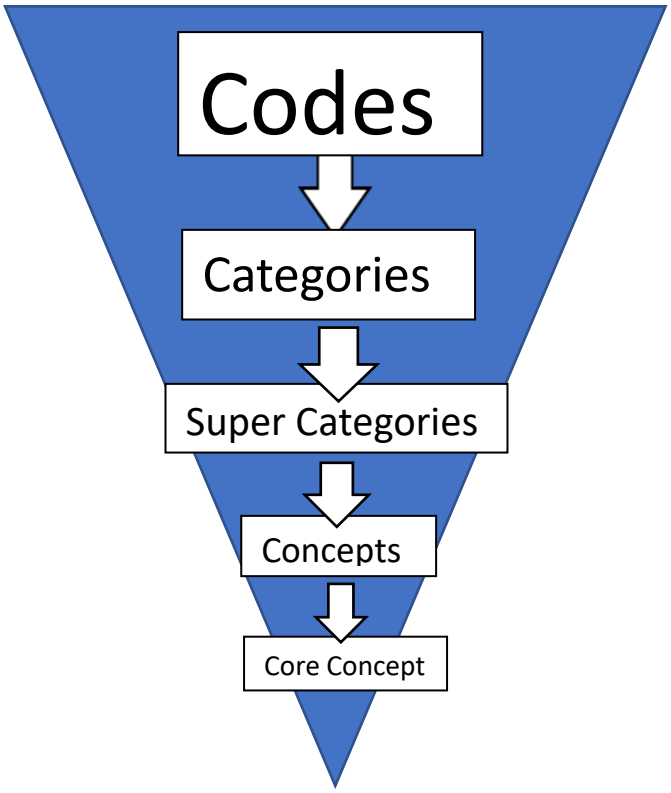


Figure 11: Process of Data Reduction

4.7.4 Developing and Generating Initial Findings

Findings usually emerge in research once analysis is completed, but in constructivist grounded theory analysis is an extensive enterprise with constant comparative analysis occurring. This back-and-forth approach, visiting and revisiting data leads to findings emerging which are then subject to the same back and forth process as theory is progressively generated. Theory was using this structured and meaningful approach and took note of two key factors:

- First, to retain focus on the main point of the study (Birks and Mills 2015), embodied within its research questions, aim and objectives, set out initially in Chapter 1, and refined in

Chapter 3. This meant searching out participant contributions which individually, collectively, and progressively led to understanding:

  - the features and scope of Advanced Nursing Practice; and
  - those things which enhanced or restricted the expression of nursing and Advanced Nursing within Advanced Nursing Practice.

- Second, keeping central the units of analysis (Birks and Mills 2015). It would have been easy to have regarded each individual participant as a unit of analysis, however I concluded it better to focus on the case studies themselves. This was because they represented different clinical services and that supported broader effective comparative analysis that would better lead to the construction of a quality grounded theory about Advanced Nursing Practice.

The detail of the case studies, to remind the reader are: Case Study 1: Acute Services (Acute Medicine and Surgery) and Case Study 2: Non-Acute Services (Gerontology, Medical Specialities, and Pre- Operative Assessment). The case studies were populated mainly by Advanced Nurse Practitioners, but also benefitted from the mature insights and perspectives of other senior clinicians, Consultant Nurses (senior nurses) and consultant medical staff, all of whom were associated directly with one or other of the clinical services being studied.

During the process of data collection, and analysis, progressing to the generation of theory, I periodically drew together my emerging findings about ‘what was happening’ (Charmaz 2014) as experienced by participants representing their case study group. I collected these findings as a series of mind maps, which when taken together represented both case studies, see Mind Maps 1-4, pages 108-111, snapshots of my tentative findings about each case study. Significantly they also included specific connections with the scoping literature in Chapter 2, and with current literature retrieved throughout the study process some of which was identified by the participants themselves during their interviews.

FEATURES OF ANP
- Four Pillars - integrated
- Extended role
  - Supported by competencies
- Research important
- Educated to masters level
- Extra responsibilities
  - Same level as doctor
- Medical Replacement
- Scope broader
- Extra training
- Knowledgeable
- Level of practice
- Experienced
  - How experience used
- Educator/ role model
- Networker

Key points raised by participants

SCOPE OF ANP
- Driven by patient need
- Beyond speciality

ATTRIBUTES OF ANPs
- Confident
- Competent
- Willing to learn
- Committed
- Passionate
- Compassionate
- Think outside the box
- Strategic thinker

SIGNIFICANCE OF 'NURSING' IN ADVANCED NURSING PRACTICE (ANP)?
- Patient focussed willing to listen
- Caring, holistic support
- Able to prioritise/multitask
- Able to carry out a wide range of interventions
- Broader thinker

BARRIERS TO ANP
- Limited vision/ understanding ANP
- Variation of roles called ANP
- Constraints on roles
- Operational demand
- Managed by medics
  - Positioned on medical rota
- Lack of research
- Lack of agreed national standard

Significant thoughts
- 'Not many ANPs have that'
  - Long wide experience
- 'Able to stand ground'
- AHPs in ACP roles don't have the experience nurses who have led and managed the clinical environment have.

Reflections on participant responses in relation to Purpose of study
- Participants responses reflected the nature of their clinical speciality
  - **Case 1-Acute Medicine** : symptom-label-management
  - But desired to and were able to reflect nursing values/ actions too in their work

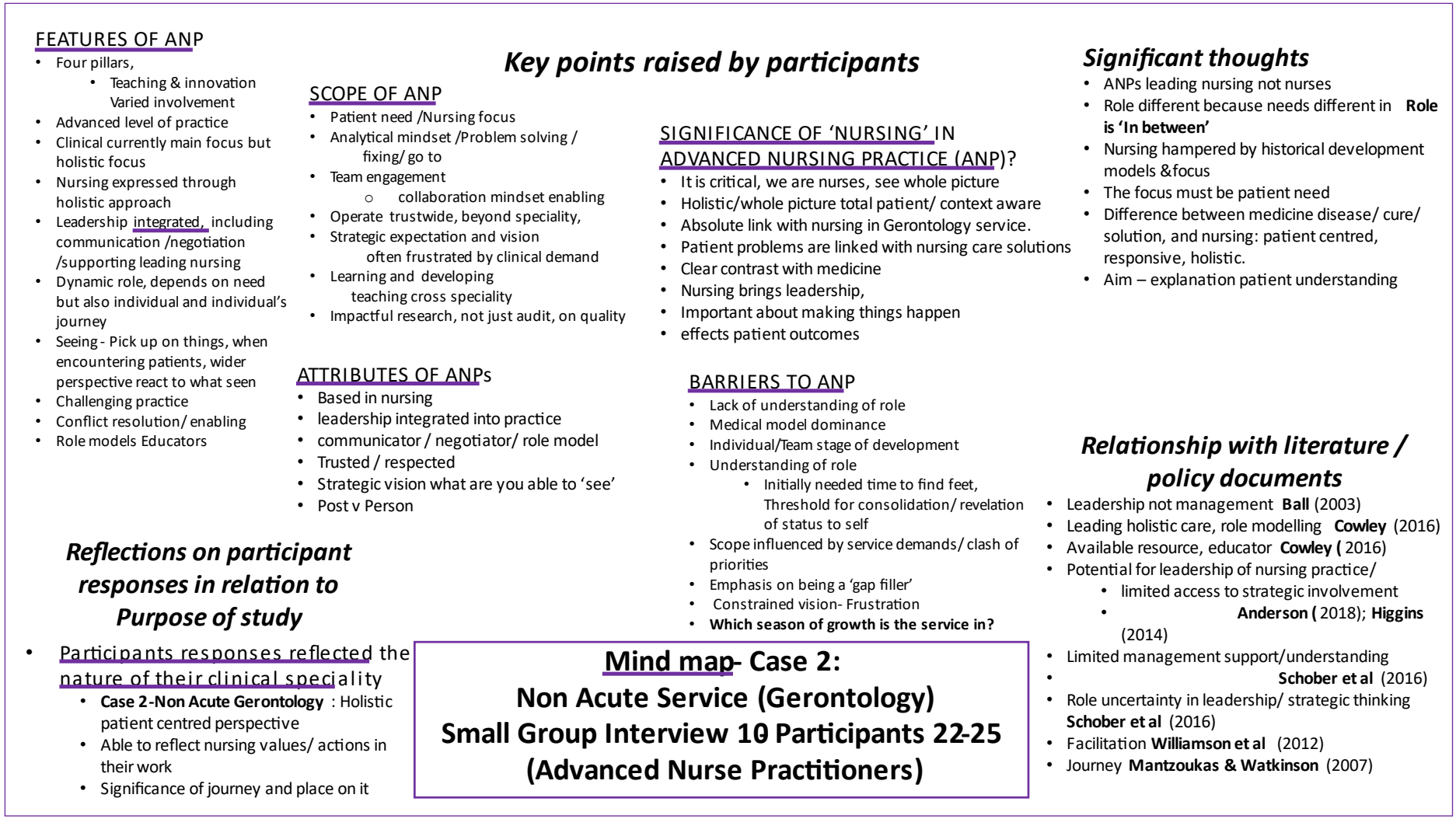
Mind map- Case 1:
Acute Service (Acute Medicine)
Small Group Interview 3-Participants 8 & 9
(Advanced Nurse Practitioners)

Relationship with literature / policy documents

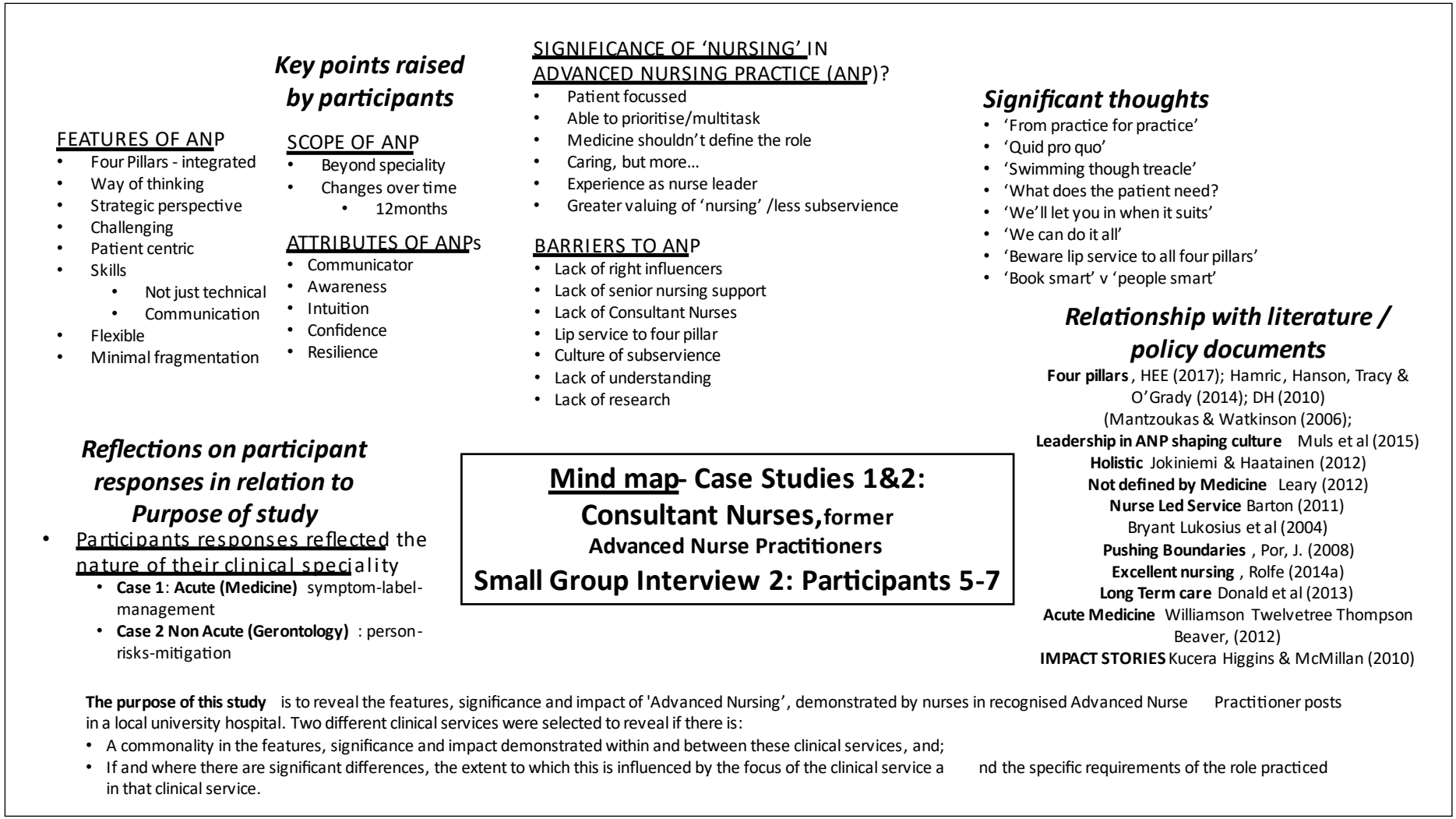
Four pillars, HEE (2017); Hamric, Hanson, Tracy & O'Grady (2014); DH 2010
(Mantzoukas & Watkinson (2006);
Leadership in ANP shaping culture Muls et al (2015)
Holistic Jokiniemi & Haatainen (2012)
Medical Replacement Dalton (2013)
Not defined by Medicine Leary (2012)
Pushing Boundaries , Por (2008)
Excellent nursing , Rolfe (2014a)
Acute Medicine Williamson Twelvetree Thompson Beaver (2012)
IMPACT STORIES Kucera Higgins & McMillan (2010)

The purpose of this study is to reveal the features, significance and impact of 'Advanced Nursing', demonstrated by nurses in recognised Advanced Nurse Practitioner posts in a local university hospital. Two different clinical services were selected to reveal if there is:
- A commonality in the features, significance and impact demonstrated within and between these clinical services, and;
- If and where there are significant differences, the extent to which this is influenced by the focus of the clinical service and the specific requirements of the role practiced in that clinical service.

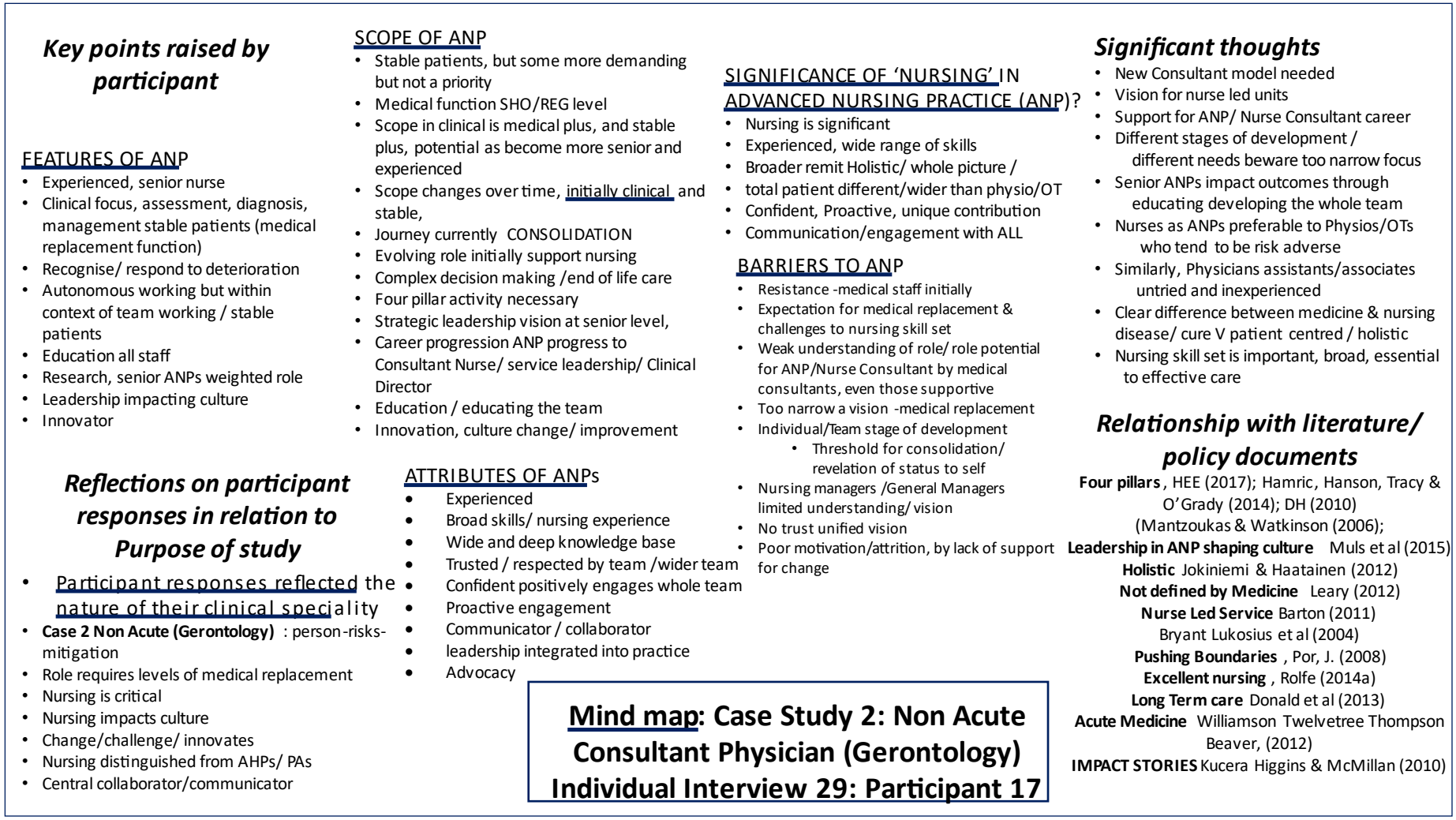
Mind Map 1: Case Study 1- Acute Services - Advanced Nurse Practitioners



Mind Map 2: Case Study 2 - Non-Acute Services - Advanced Nurse Practitioners



Mind Map 3: Case Study 1 and 2 - Consultant Nurses



Mind Map 4: Case Study 2 - Consultant Physician

4.7.5 Collapsing or Reducing Categories to Form Concepts

As I progressed to review the categories established, it was necessary for the analytical process to progress to support theory generation by reducing those categories. The first step was looking for apparent similarities in focus or emphasis of named categories. What appeared as a category at first sight often proved to be an aspect or dimension of another one. Progressing to review all the categories enabled me to simplify the data by making connections between them and allowed them to be reduced to form super categories. Following a further round of analysis, the super categories themselves were reduced to form one of the four concepts constructed. As the analysis progressed the concept of '**journey'** began to stand out among each of these interviews as a significant element. It encapsulated different but overlapping journeys, of individual participants, their teams, the services in which they worked and in the trust which employed them all. The notion of journey was evident in them all, and it became clear that could be or play a significant part in the Core Concept supporting the construction of the grounded theory from this study.

The following examples present a selection of **codes** from a selection of interviews representing the range of interviews conducted. These examples are presented to indicate the process undertaken of developing **categories** from the codes, ultimately leading to establishing **concepts** through the process of continuous comparative analysis. They include the pilot interview and examples from both Case 1: Acute Services, and Case 2: Non-Acute Services, from both small group and individual interviews.

4.7.5.1 Pilot Interview: Interview 1, Advanced Nurse Practitioners/Academics.

Key codes	Tentative Category	Suggested Concept
Patient need, mitigators/ advocates	Getting the best deal	Main driver for Advanced Nursing Practice work
Person of Advanced Nurse Practitioner, sensitivity, intuitive, ability to see, insightful	Ability to see bigger picture	Enabler of becoming an effective Advanced Nurse Practitioner
Level, proactivity, challenger, creative thinkers, pushing boundaries	Level	A journey to grow characteristics associated with Advanced Nursing Practice
Management / medical constraints, blocks	Organisational obstruction	Hinderance to becoming an Advanced Nurse Practitioner
Improvement/simplification, Role expansion, contextualised, myth busters, collaborators, active connectors, communicators, rapid learner, leadership, enabler/empowerer	Leadership	Scope of an Advanced Nurse Practitioner

Table 14: Pilot Interview – Examples of Moving from Codes to Concepts

- **What was happening here?** Taken from the pilot interview, two Advanced Nursing Practice academics, both former Advanced Nurse Practitioners who previously worked in the Case 1: Acute Services settings as Advanced Nurse Practitioners, identified and responded to patient need, pursuing 'the best deal' for those patients. This included using personal skills and attributes to communicate, negotiate, collaborate with colleagues. Important features of post holders included their personal characteristics in providing leadership of the service, challenging and developing the service provided, initiating and leading improvements, underpinned by the ability to think critically and work around management obstruction and misunderstanding.
- These actions reflected a journey of developing professional maturity and seniority in their roles.

As a pilot interview, this event provided me with lots of opportunity to consider my own role in the interview, was I was conducting the interview well, asking the right questions, and was my approach appropriately facilitative and not coercive or leading? The quality of the responses was so rich, that I decided to include them in the comparative process.

4.7.5.2 Case Study 1: Acute Services - Interview 4, Surgical Advanced Nurse Practitioners

Key codes	Tentative Category	Suggested Concept
Flexible, responsive, learner, journey, autonomous	Development/ growth	Ongoing journey of becoming an Advanced Nurse Practitioner
Pillars integrated into role	Not restricted/ Functioning beyond clinical focus	Enabler of becoming an Advanced Nurse Practitioner
Innovator/ boundary shaper / trailblazer, transformational, seeing/wide perspective,	Level ability to see bigger picture	Essential characteristics of Advanced Nursing Practice
Team builder, go between, constant presence	Collaborator	Team building role of Advanced Nurse Practitioner
Contextually driven, composite role/integrated medicine and nursing	Broad role	Scope of an Advanced Nurse Practitioner

Table 15: Case Study 1 - Interview 4 – Example of Moving from Codes to Categories and Categories to Concepts

- **What was happening here?** A story of developmental growth of individuals, the team and the service in integrated practice incorporating the four pillars. The role integrated clinical medicine with clinical nursing plus the adjunct roles of education, research, and leadership.
- This reflected a three-year journey, incorporating stages of personal, team and organisational development and transformation.

4.7.5.3 Case Study 1: Acute Services- Interview 8, Acute Medical Advanced Nurse Practitioner

Key codes	Tentative Category	Suggested Concept
Nursing, holistic, empowering, patient focus	Patient/person centred enabled by advanced nursing skills coupled with level and ability to see bigger picture	Ongoing journey of becoming an Advanced Nurse Practitioner
Advanced Nursing Practice is a level, leading, seeing (vision), advancing, autonomy,	Seeing/ global perspective enables movement	Essential characteristics of Advanced Nursing Practice
Developing, a journey	Dynamic developing growth process	Ongoing journey of becoming an Advanced Nurse Practitioner
Restricting/disempowering, reductionist mindset	Broad role restricted	Hinderance to developing the role

Table 16: Case Study 1, Interview 8 – Example of Moving from Codes to Categories, from Categories to Concepts

- **What was happening here?** Management understanding of what Advanced Nursing Practice was and its potential transformative impact was absent for this participant. In addition, hierarchical bureaucratic styles of management were reported with a strong managerial rather than a leadership philosophy predominating. This was a story of a restricted, frustrated practitioner whose practice was limited. Its effect was to hinder the full impact of the Advanced Nursing Practice role being expressed. It also served to limit the development journey and their ambition in the Advanced Nurse Practitioner participant's thinking.

4.7.5.4 Case 2: Non-Acute Services- Interview 13, Advanced Nurse Practitioner

Key codes	Tentative Category	Suggested Concept
Journey started before the course/trainee role, Experience shaped thinking,	Dynamic developing growth process	Ongoing journey of becoming an Advanced Nurse Practitioner
Passion for speciality, Invested, expectations/ ambition, seeing/awareness,	Seeing/ global perspective	Personal attributes
Patient focus, nursing, problem solving, critically thinking	Patient/person centred focus is enabled by Advanced Nursing abilities coupled with high level critical thinking and problem solving. Nursing is central	Advanced Nursing
Innovating, connector, communicator, challenger, collaborators, expectations/ambition, culture creation - team building,		Essential characteristics of Advanced Nursing Practice
Strong medical lens, time constraint	Broad role restricted	Hinderance to developing the role

Table 17: Case Study 2, Interview 13 – Example of Moving from Codes to Categories and Categories to Concepts

- **What was happening here?** A participant demonstrating a clinical role that was highly specialised, engaging with varied complex patient needs, hence this post not amenable to transferability. However, their non-clinical Advanced Practice activity had potential for transferability and hence wider benefit. Noted here was **the presence of a personal learning journey.** There was also clear evidence of service improvement culture present, and the impact of the Consultant Nurse / service manager was evident in that they provided space for innovation despite ever present pressure for service delivery. The participant took advantage of this and demonstrated an ever-present awareness of service improvement opportunities, reflecting **a service journey of forward movement**. However, a lack of Trust clarity and precision around title, status and reward for Advanced Nurse Practitioners created confusion and hindered progression of common understanding about and among Advanced Nurse. Practitioners. One part of the workforce, senior female anaesthetists, clearly did not understand the role of Advanced Nurse Practitioners and hindered Advanced Nurse Practitioners from taking on medical activities. While experience was seen as important so also was the importance of the personal qualities of the Advanced Nurse Practitioner. Some junior nurses seeking to become Advanced Nurse Practitioners and who sought access to the course, failed to understand the necessity of experience or of consolidation of education and training which was essential to enable a firm foundation to support the accountabilities required at the Advanced Practice level.

4.7.5.5 Case 2: Non-Acute Services- Interview 5, Medical Specialities Advanced Nurse Practitioners

Key codes	Tentative Category	Suggested Concept
Journey	Dynamic developing growth process	Ongoing journey of becoming an Advanced Nurse Practitioner
Autonomy, experienced, empowering	Not restricted/ functioning beyond clinical focus	Enabler of becoming an Advanced Nurse Practitioner
Nursing, patient focussed, holistic, person/ therapeutic relationship, communicating/ enabling, seeing	Patient/person centred enabled by advanced nursing skills coupled with level and ability to see bigger picture	Essential characteristics of Advanced Nursing Practice
Leading, transforming, networking/ collaboration	Collaborating	Scope of an Advanced Nurse Practitioner
Restricting, reductionist/managerial mindset, disempowering	Broad role restricted	Hinderance to developing the role

Table 18: Case Study 2, Interview 5 – Example of Moving from Codes to Categories and Categories to Concepts

- **What was happening here?** Both participants described **a developmental journey, evidencing transition from a perspective dominated by medical skills focus to broader based perspective embracing a fuller range of clinical practice incorporating Advanced Nursing skills integrated with elements of four pillar activity**. This was accompanied by changed perspectives about their own role and the significance and importance of nursing as an essential part of both roles. There was a clear contrast between facilitated and unfacilitated change between the two participants, P13 was enabled and flourished in and as a transformative role, supported by her managerial and medical colleagues; By contrast P14 was restricted, and was in a largely medical replacement role being minimally transformative in terms of service change. However, advanced nursing skill was evident in advanced communication with patients that was holistic in focus.

4.7.5.6 Case 1 & 2: Acute Services/ Non acute services- Interview 9, Consultant Nurses

Key codes	Tentative Category	Suggested Concept
Nursing, holistic, patient focus	Patient/person centred enabled by advanced nursing skills coupled with level and ability to see bigger picture	Ongoing journey of becoming an Advanced Nurse Practitioner
Advanced Nursing Practice is a level, advancing leading, seeing (vision), autonomy, empowering,	Seeing/ global perspective enables movement	Essential characteristics of Advanced Nursing Practice
Developing, a journey	Dynamic developing growth process	Ongoing journey of becoming an Advanced Nurse Practitioner
Restricting/disempowering, reductionist managerial mindset	Broad role restricted	Hinderance to developing the role

Table 19: Case Studies 1 & 2, Interview 9 – Examples of Moving from Codes to Categories and Categories to Concepts

- **What was happening here?** A complex mix of an ever-present pressure for service delivery against a background of **development journeys being attempted/undertaken for services as well as the individuals working in those services. Individuals were on a journey of development and growth in their role and scope of Advanced Nursing Practice.** However, growth was limited by constraining and disempowering features, often by managers and their need to drive service imperatives. Some empowering features were present. The importance of experience is emphasised several times, and also how many seeking to pursue Advanced Nursing Practice education often fail to understand the necessity of experience and consolidation to enable a firm foundation for accountabilities required at that level.

4.8 Quality Strategy

The differences between quantitative and qualitative work, and particularly constructivist grounded theory was highlighted when considering evaluation of the quality of the study. Criteria and benchmarks, which fitted easily with quantitative research were not suitable for this constructivist study (Flick 2018). Indeed, evaluation becomes fraught when trying to assess the value of new knowledge, and the suitability of methods used which did not have fixed criteria. This was not an abstract theoretical conversation but was of considerable importance noting that when it comes to the consumers of research findings, they generally desire 'certainty'. Policy makers who fund research often carry the tendency to err towards qualitative studies, as evidenced by the stances of both UK and USA government research bodies (Torrance 2018) because it offers a reassuring sense of certainty and familiarity. However, this is short-sighted since it misses the benefit of depth of analyses and rich contributions that can come from well-designed and executed qualitative studies and explanatory theories which are generated from constructivist grounded theory (Birks and Mills 2015).

However, well-designed is the point, since with qualitative methodology and method, it is counter-productive trying to apply quantitative methods to qualitative research, when they simply don't fit (Seale 1999). Despite general pressure from funders to tilt researchers in the positivist direction (Torrance 2018) as with other constructivists it was necessary for me as a constructivist researcher leading this study, to deliver research with rigour and findings grounded in the data that carried relevance. Over time grounded theorists identified many criteria for evaluating grounded theory studies (Birks and Mills 2015). Lincoln and Guba suggested that 'trustworthiness' of a study was central in evaluating its worth, confirmed by four factors: 'credibility', or confidence in the 'truth' of the findings; 'transferability', or demonstrating that findings have applicability in other settings; 'dependability', or consistency of findings; 'confirmability', or the extent to which findings are shaped by the respondents and not controlled by the researcher's perspectives (Lincoln and Guba 1985). However, Charmaz simplified her evaluative approach to four criteria applied through the lens of 'context' and 'purpose' of a given study. Her four criteria were: 'credibility', reflecting logic and conceptual soundness; 'originality', including the significance of the work; from which came 'resonance', or meaning for those for whom the study is relevant; and 'usefulness', in the sense of development of knowledge and practical relevance (Birks and Mills 2015).

The broad strategies used to achieve quality in this study were formulated at the research design stage, referred to in Chapter 3 and were applied flexibly (Flick 2018). They are summarised as: setting clear research questions, aim and objectives; recording the process, including problems and issues; practice reflexivity and write memos; obtaining relevant research training; actively work with and share process and outcomes with the supervisory team, see pages 83 and 100 in this chapter.

4.8.1 Strategies to Consider 'Usefulness' including 'Transferability' of Findings

Qualitative research, including constructivist grounded theory research, has frequently been challenged about its relevance for clinical practice given its lack of generalisability, however, for constructivists that viewpoint is looking at the issue from the wrong point of view. The term generalisable is typically associated with quantitative not qualitative studies, where a completely different set of rules apply, as considered earlier in Chapter 3. Indeed, Guba and Lincoln's famous phrase 'the only generalisation is: there is no generalisation' (2000, 1985) is often quoted in relation to qualitative studies to support that position. However, this doesn't mean that constructivist research has no applicability or usefulness. The key therefore is to understand when, how and under what circumstances.

Guba and Lincoln progressed their argument, cited earlier, to address these questions. They spoke about the potential for 'transferability' of findings, from one location to another, and the notion of 'fittingness', the degree to which there is comparison between differing locations (Flick 2018; Guba and Lincoln 2000). However, they posited that 'trustworthiness' of a research study was of overarching importance in evaluating its worth, and that this could be achieved through their four criteria. While the first two criteria, credibility and transferability appeared relevant for evaluation of the study, the last two, dependability - showing that the findings are consistent and could be repeated; and confirmability - a degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest, were problematic for this constructivist approach. Indeed, the findings only reflect the experiences of the participants in this study in their case study group, not elsewhere, consequently the notion that findings could be repeated is not appropriate. Moreover, researcher neutrality and avoiding bias is equally unhelpful since the aim of constructivism and certainly for this study was to achieve a level of co-construction of new ideas. By contrast Charmaz (2014) identified four criteria, credibility, originality, resonance and usefulness, suggesting their appropriateness for constructivist research. These, associated with Lincoln and Guba's (1985) first two criteria, credibility and transferability, were used and are discussed in their application in Chapter 7, see page 256.

It is worth noting at this point that the two case studies represented in this study were selected purposefully because they carried characteristics similar to those in other acute hospital settings in England. It was recognised that this might enable 'transferability' (Lincoln and Guba 2015) of findings as a realistic outcome of this study. It can also be reasonably supported by participant sampling methods discussed in Chapter 3. Sampling included: criterion sampling initially, inviting participants who were the Advanced Nurse Practitioners providing the services that made up the selected cases; theoretical sampling and snowball sampling, added participants to Case Study 1 to support the generation of sufficient data. During phase two of the study, both theoretical and opportunistic sampling was employed to recruit medical staff (Patton 1990). The study design was first intended to achieve 'internal' transferability of findings, as data was reduced and theory was developed, to enable consistent conclusions to be drawn within each case study, and so that comparisons could be made between them (Maxwell, Chmiel 2014). It was therefore considered possible that Advanced Nurse Practitioners working in similar services, might recognise that findings from this study had degrees of relevance for their situation.

Specific methods for supporting transferability claims included: the consistent use of constant comparison method, considered in Chapter 3; and the inclusion of contrasting cases, and analytic induction (Flick 2018) as central design features. Case 1: Acute Services, including Acute Medicine and Surgery, and Case 2: Non-Acute Services, including Gerontology and Preoperative Assessment were included as 'common types', typical of important services found in every major acute hospital setting in England (Gerhardt 1994). Moreover, the participants, Advanced Nurse Practitioners, senior nurses in Consultant Nurse roles, and senior medical staff, represent the main staff types intimately and actively engaged in Advanced Nursing Practice and found working in similar services throughout the National Health Service. My use of analytic induction related to my stated assumption early in the study, found in Chapter 1, proposing that Advanced Nurse Practitioners in Case 1: Acute Services are more likely to focus on disease-centric /medical substitution activity, than those in Case 2: Non-Acute Services. My expectation was that inductive analysis of the findings would serve to confirm or disprove this notion.

4.8.2 Process Evaluation and Quality Management

Dialogue about the relevance of quality management principles within the research process in qualitative research has led to an emphasis on audit and in particular procedural audit. However, an

effective evaluation of quality in a qualitative study needs to take account of the use of all the methods employed in all aspects of the study, and how they relate to each other in the overall context of the study, rather than just looking at isolated individual aspects (Morse 2018). Consequently, remaining mindful of this throughout the study enabled me to evaluate the character of the study while maintaining transparency through an audit trail. This was accomplished in this study through involving participants and members of my supervisory team, see page 83 and 100. Both participants and supervisory team members were utilised for a 'sense' of the accuracy of the findings but also for inspiring creativity and generation of ideas. This is illustrated with reference to the following examples.

4.8.2.1 Case 1: Acute Services, Interview 7 (Study Phase 2)

On reviewing the recording and its transcript for Interview 7, I had difficulty in distinguishing between two participants' voices. I decided to address this by inviting them to nominate one of them to take part on a further short interview to confirm their own contribution, and hence the others by default. One duly volunteered (Interview 7: Participant 17) and confirmed her own contribution. I offered the opportunity to review the transcript and comment on the accuracy of codes identified. She did this, agreed with what had been said, but had nothing further to add to her existing contribution in the interview. I also considered this as an example of 'member checking', (Morse 2018) which while not strictly a grounded theory method, is recognised as useful in supporting the assertion of transparency (Birks and Mills 2015).

4.8.2.2 Case 2: Non- Acute Services, Interview 17 (Study Phase 3)

A further example of ensuring transparency involved asking the individual interviewee (Participant 26 from Interview 13) from the non-acute case group, if the transcript and codes generated represented accurately her thoughts. She provided additional feedback, which was fed into the analysis for her interview:

> 1. *Yes, I feel that the transcript captures my thoughts well.*
> 2. *During my prescribing module I spent time on various ('ACUTE'- changed to protect anonymity) wards and the (SPECIALIST ACUTE- changed to protect anonymity) ward working alongside other ACP's and came away feeling very grateful to be in pre-op assessment where there is not an expectation that I will work in the role of a junior doctor. Of course, I only got a snap shot of what is like to be an ACP on these wards.*

Box 11: Feedback Assessing Transparency - Case 2, Interview 13, Participant 26

4.8.3 Supervisory Team Quality Role

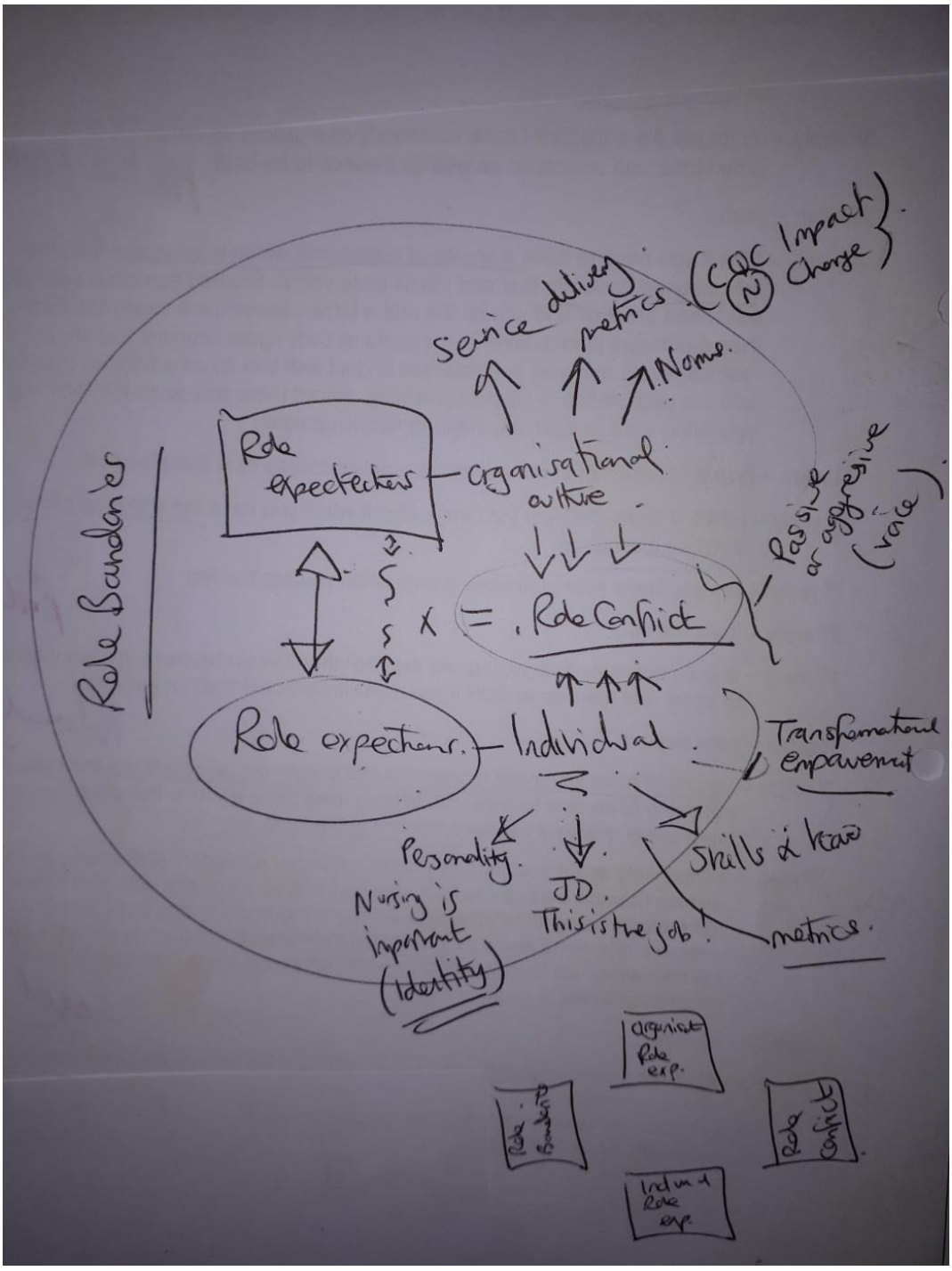
4.8.3.1 Case 2: Non- Acute Services, Interview 10 (Study Phase 2)

In the first stage of data analysis of this interview, data emerging revealed many codes in common with earlier interviews conducted for both Case 1 (Acute) and Case 2 (Non-Acute) participants. However, the opportunity was taken to enlist the perspectives of another member of the supervisory team to gain their insights and further verification of the congruence between researcher and participant understandings, see Box 12, page 122.

This proved to be valuable from two points of view, firstly in confirming that congruence was evident, supporting confidence in my emerging findings during the study and not merely afterwards (Morse 2018). Secondly, also in providing challenge to me to look deeper into 'meanings' being expressed by participants. In this participant example I identified the code, 'insufficient staffing', whereas my supervisor suggested the 'frustration of role conflict' which revealed a deeper understanding of what was going on:

> *'we are not staffed to do anything else really currently, so ours is mainly clinical I would have said'*
> Case 2: Interview 10, Line 16 Participant 23

My associated memo revealed both the encouragement in a level of congruence confirmed, but also some frustration of still looking too superficially, challenging me to go to a deeper explanatory rather than descriptive level (Charmaz 2014). 'Role issues' and in particular 'role conflict' was not a new but a familiar topic and this episode led to me looking for this in other interviews, both completed and for it to be present in those yet to come, as I compared and contrasted data.



Box 12: Identifying Themes from Interview 10

Further analysis of the following section, which both researcher and supervisor agreed raised questions of the data. It addressed the subject of role transition and in this instance, 'how long does (role) transition take?'

> *provision there is still an element of the medical focus and the leadership around it's very much doctors and it's changing I don't deny its changing but I think still very much a work in progress and I think that's why its sort of saying you know at some point our role as ANP's or ACP is we could really use our leadership skills but* ***how to time it right and when is the right time to do it is still a little bit of a conundrum at the moment*** *because you are prioritising things so obviously you have to prioritise what you are doing now but I think in the future that's definitely we covered this in the module Alastair talking about the ICM talking about the leadership in nursing and being more visible being more politically out there I think that is happening but I think from the grass roots point of view I think it is slow to happen*

Box 13: Role Transition Case 2: Interview 10, Lines 251-260 Participant 22

4.8.4 Practical Considerations Supporting the Study

4.8.4.1 Timescale

Establishing an effective timeline for specific events was important to ensure timely completion of the study, even to the extent of regarding the study as a project (Finn 2005). The key features of the study timeline ran alongside my doctoral studies timeline, however, specific features of the study plan included: the preparatory phase, including a pilot interview to ensure feasibility; the wider investigative phases, which commenced once ethical approval had been granted, including data collection schedule; the analysis and write up phases; finally, the publication phase to be initiated once the thesis has been approved.

4.8.4.2 Funding

The funding of research is an important topic for various reasons, not least because conducting it can be expensive, but also because funders must have confidence that projects are worthwhile and are likely to yield results which contribute to the achievement of either funding body objectives or a notion of 'the common good' (Bulmer 2008). Making transparent who is funding is also important to potential participants in gaining their trust and involvement; and absolutely so when results and findings are published to maximise confidence in assertions made. The study was sponsored by the university, who along with the local university Trust provided indemnity cover for me as a member of staff. Administration costs, covering printing of information, consent, small group interview sheets and instruction sheets were covered by the university (Kruger &Casey 2015).

4.9 Conclusion

This chapter has discussed the approach taken to conduct early analysis, presenting tentative examples of parts of that analysis. It has identified delays in the process of data collection and explained their impact on the study journey. This led to the establishment of three phases of data collection activity. The difference between phase 1 and 2 being the change of site for conducting group interviews to facilitate access to participants. Phase 3 marked the move to individual interviews to generate further depth of data. While the commentary in this chapter is clearly tentative and incomplete, initial meanings are starting to emerge. Identifying meanings from data demonstrates alignment with principles of constructivist grounded theory. The dynamic process of constant comparison raises the reach of the grounded theory method above merely descriptive analysis to explanatory understandings. The next chapter will complete the reporting of the critical analysis of the data and detailed presentation of findings.

Chapter 5 Findings

5.1 Chapter Introduction

This chapter will present the findings generated from the process of analysis to meet the aims of the study. Findings reported here arise from the issues, ideas, and thoughts that participants shared from their own experience of Advanced Nursing Practice. The key questions, 'what was happening', 'what were the events, actions and processes that were involved?' were of prime importance since this aligned with the principles of constructivist grounded theory, deriving meanings from participants perceptions of their reality (Charmaz 2014).

In presenting these findings, extensive use of participants words through their experiences and stories are included to ensure their voice is represented and that the findings reveal what they were saying. In constructivist grounded theory, participant stories serve the analyses (Charmaz 2014) and come together as a storyline integrating different strands of understanding and leading to the formation of a grounded theory. That grounded theory itself is revealed as the central story within the study and is fully discussed in the next chapter (Birks and Mills 2015).

5.2 Findings: Constructing the Concepts

This section will consider the construction of the four concepts, ahead of consideration of their reduction to form the study's Core Concept, and thus the grounded theory, the culmination of this study.

The four concepts were generated from the inductive process of analysing participant responses, gathered first from small group and second from individual interviews discussed in Chapter 4. The process of establishing concepts began with line-by-line coding of participant responses designed to provide answers to one of more of the four research questions. Codes were then progressively reduced to form, Categories, Super Categories, and then Concepts.

Participant interviews were designed to generate responses to address the four research questions, for ease they are repeated here:

1. What are the features and the scope of Advanced Nursing Practice?
2. What is the contribution to Advanced Nursing Practice that comes from being a nurse?
3. What helps nursing to develop and be expressed within Advanced Nursing Practice?
4. What barriers exist that hinder or limit the expression of nursing within Advanced Nursing Practice?

5.2.1 Constructing Concept 1: Characteristics

Concept 1- Characteristics, was constructed from the range of participant views and perspectives about what Advanced Nursing Practice was to them, its significance and consequence, its actual and potential impact. Categories generated from codes and during the analytical process were reduced to form two Super-Categories, SC1- Features and SC2- Scope. The findings are summarised in Table 20 below and are then discussed, with examples from both case studies.

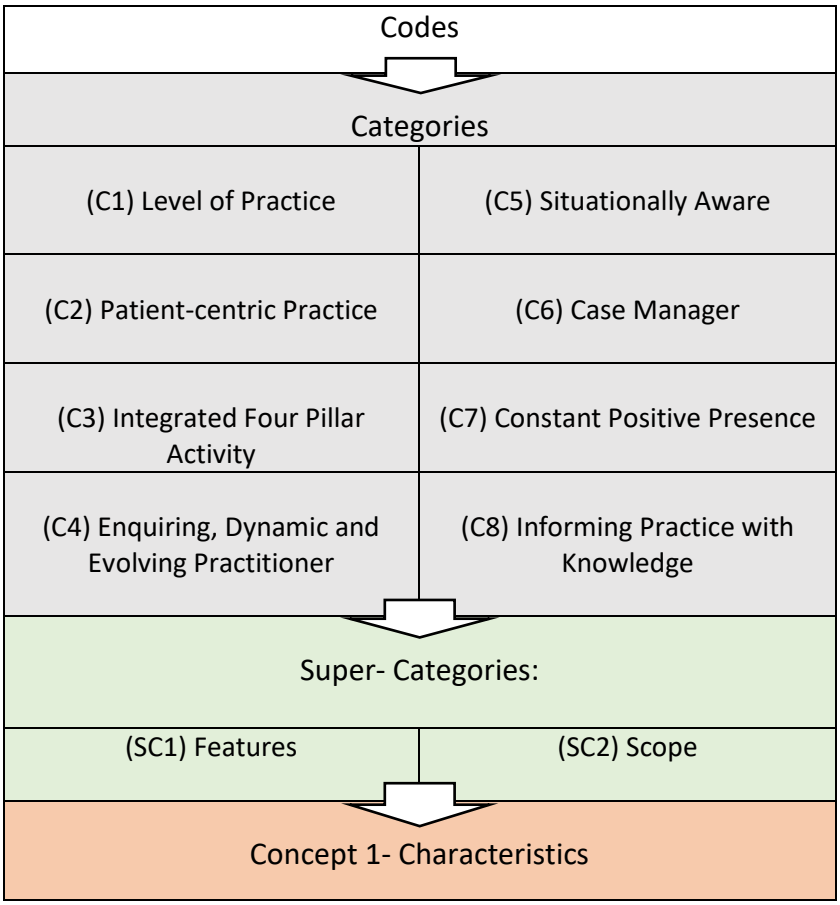


Table 20: Categories Analysed and Reduced to Form Super Categories, then Reduced to Construct Concept 1- Characteristics

At the end of this section, on page 140, Summary Table 21 compares and contrasts the findings in relation to Case Study 1 and 2. This set of findings addressed the first research question, and led to the generation of Concept 1.

5.2.1.1 Super-Category: (SC1) Features

The 'features' of Advanced Nursing Practice were identified by participants. Clinical practice was the main component of the role, and while central to Advanced Nursing Practice, there were differences of view about what constituted clinical practice. Other non-directly clinical activities were present but varied in their perceived importance.

- Category: (C1) Level of Practice

The notion of a 'level' of practice was articulated by participants as a central defining feature, associated with the four pillars of practice (HEE 2017):

> *"I think the features are it's around,* ***it's a level of clinical practice****, it's about the* ***utilisation of the four pillars*** *of advanced practice whilst in clinical practice, and the improvement of it (practice)."*
>
> Case Study 2: Interview 2 Lines 19-20 Participant 7

'Level' referred to ability to apply critical thinking to problems, make sound judgements in solving problems:

> *"…so I think it's more I know it's dead cliché,* ***it's more a level of practice****, it's about* ***your decision making and what you are basing the knowledge on, what you are basing that decision making on,*** *for me really, and I* ***don't think people necessarily get that****…"*
>
> Case Study 2: Interview 12 Lines 493-495 Participant 12

There was also an indication of wider understanding about what Advanced Nursing Practice was. In this extract, the ability to think, analyse, and provide sustained argument, and, a process of growth, development and momentum that will be revealed throughout this chapter as a central explanatory process within the findings as a whole:

> *"…however I would say in terms of what you know, a masters qualification given me or is in* ***the process of giving me,*** *is that* ***I am able to analyse things more (and) produce a more sustainable argument…"***
>
> Case Study 1: Interview 3 Lines 443 Participant 9

The MSc Advanced Practice course that participants had undertaken was reported to have enabled acquisition of a wide and deep knowledge base, supported by practical knowledge acquired from mentored clinical practice. It included applied research and research- based knowledge. The level of knowledge used was supported by extensive experience participants brought to their activities. As confidence grew so did an autonomous mindset, further shaped by participants' values, beliefs, attitudes, and vision. This was enhanced or hindered by the attitudes and behaviour of senior managers. However, for autonomy to be meaningful and effective there was a critical need for congruence between participants and their seniors. The 'level' of practice for this participant

reflected a dynamic interactive role, where he was able to challenge boundaries and assumptions, providing a proactive response and comprehensive practice. He compared his experience of working in a Case Study 1 Acute Services environment previously, with that of currently working in a Case Study 2 Non-Acute Services environment, where there was greater autonomy within collaborative environment:

> ***"…autonomy was limited*** *I'd say it was more limited yeah* ***compared to where I am now,*** *autonomy* ***I'd definitely say now that we have got a very good collaborative (relationship) with the consultants****, it's much more encouraged in fact…"*
> *(Alastair – hum.mm)*
> ***"I wouldn't say that its explicit it's almost like implied because that's the nature of the work…*** *you are constantly working with these complex patients the management of the case load because we have to our own independent case load that we manage (Alastair – hum.mm)*
> *"*[but] *we are constantly communicating with the consultants and so it's always that kind of interaction…"*
>
> Case Study 2: Interview 16 Lines 125-134 Participant 22

- Category: (C2) Patient-centric Practice

Participants identified that much of their preparation for Advanced Nursing Practice roles focussed on developing an enhanced skill set, focussed on medical skills, advanced assessment, diagnostic and case management including prescribing, which enabled primarily 'disease-centric'* rather than 'patient-centric'* management [NB. These terms* are defined in the glossary, see page xv]. According to one of the Consultant Nurse participants, Advanced Nursing Practice was intended to have a level of autonomy and independence such that:

> *"…the role of the Advanced Nurse Practitioner is to….'intervene more and escalate less'…"*
>
> Case Study 2: Interview 11 Lines 568 Participant 7

However, the scope of "intervene more and escalate less" was enabled or hindered by whether the role was disease-centric or patient-centric. Participants recognised that their expanded roles were enhanced and became truly patient-centric when participants were allowed and supported to include and develop 'Advanced Nursing'* [NB. This term* is defined in the glossary, see page xvii] as an active part of their role. Participants observed 'Advanced Nursing' as the ability to holistically assess patient need, using relevant knowledge and skills to provide a comprehensive response to that need. This drew upon a wide range of knowledge and skills base, including both medical and nursing. Clinical practice flowed between disease-centric and patient-centric provision according to patient need. The degree to which they were able to utilise the full range of their knowledge and skills, and develop them further was influenced by four factors:

1. The role focus expected by their service manager(s);

2. The extent to which participants valued a patient-centric mindset, and viewed patients through a nursing lens; *together with-*
3. The level of confidence in asserting a patient-centric mindset and a nursing lens perspective in the assessment and management of patients they were responsible for;
4. The degree to which they were determined to develop Advanced Nursing knowledge and skills.

That 'Advanced Nursing' was characterised by a 'patient-centric' focus was evident from the outset in the pilot interview, where a key category was 'getting the best deal' for the patient. There was a strikingly similar emphasis in Case Study 2: Non- Acute Services responses. One of the consultant nurse participants from this case study described how they would characterise the contribution to patient care and management that arose from being a nurse:

> *"I think I can easily **for Gerontology as a speciality** (Case 2 Non-Acute Services) …. **Advanced Practice is what your patients need it to be.."**' (Alastair- erm…) "..if I think about what our gaps are, what our issues are, and what our challenges are, as far as patient care and delivering service provision…" (Alastair – hum mm..) "… A lot of those problems, risks, can be related to nursing care and Advanced Nursing Practice will allay those risks to patients. A lot of what happens, falls, issues around polypharmacy, around medication, problems erm…around skin hydration, integrity, nutrition, the fundamental elements of nursing if you like…" (Alastair – yes) "…complicated by diseases, by conditions, and by changes…" (Alastair – yes) "…so it's about the person, and **for me the difference between medicine and nursing, medicine gives me a list of symptoms and results, I'll give you a label for it and a treatment plan…**" (Alastair – yes) "… **Nursing gives me a person.** I'll give you a list of risks… **advanced level nursing is understanding all of those risks**, the risks of their clinical condition, their trajectory, their prognosis, **and managing that person's total needs…**that lends itself to advanced level practice, because it's a natural progression of what nursing already does,…."*
>
> Case Study 2: Interview 2 Lines 317-343 Participant 7

Another participant described taking a patient-centric approach to their assessment, enabling the recognition, or 'seeing'* of broader needs and issues through a 'nursing lens'* (*see Glossary of Terms, page xiv) leading to a comprehensive response to identified and assessed need:

> *"… if a patient is falling, **we will then assess them**,* [including] *for example **(looking at) bone protection, we would drill into those signs more than sometimes the medics do, we'll give perhaps a lifestyle advice that goes with it. We'd look at what the research is …"** (Alastair- "hum mm") "…and I think **keeping up to date with those kinds of things and current is an additional value that we add to our consultations** from the clinical side of things, … its mixing those other elements from advanced practice into the consultation, I'm finding I'm doing more and more…"*
>
> Case Study 2: Interview 5 Lines 248-257 Participant 13

Participant 13 suggested that medical colleagues might not 'see' or recognise patients wider need because of their different priorities and filters through which they perceive patients and their problems, otherwise recognised as a 'medical lens'* (*see Glossary of Terms, page xviii) which provided a more narrowly focussed set of interventions. In contrast, patient-centric orientation was

directed not just at individual patients, but critically considered how learning from each encounter might inform future improvements to practice and service:

> *"…you might have done that memory test* ***but then an Advanced Nurse might have thought is this the most appropriate tool to use looking at? if not why not?*** *Also, what are other people doing with tools erm…what about general practice?* ***It's thinking about other things that feed into your services and how you can improve services as well as an Advanced Practitioner …*** *yeah* ***thinking outside the box and also collaborating*** *erm… not just other areas, maybe other nurses outside of erm… the area where you work, and bringing you know and bringing their practice back into your own practice, expanding on it."*
>
> Case Study 2: Interview 5 Lines 570-78 Participant 13

- Category: (C3) Integrated Four Pillar Activity

Participants referred frequently to the '**four pillars'** of practice, as recognised by a range of health policy documents over the last twenty years, most recently in the multi-professional framework for advanced clinical practice in England document (HEE 2017):

> *"the* ***features of Advanced Practice are obviously looking at the four pillars*** *that's where our role is very focused towards these four pillars of advanced practice in terms of clinical, education, research erm… and leadership …"*
>
> Case Study 1: Interview 3 Lines 11-18 Participant 8

However, participants noted that using these individually was not the same as them being an integral part of daily activity. Engagement with the four pillars was dependent on at least three critical factors:

1. What level of support would managers and medical colleagues lend to the inclusion of Advanced Nursing in Advanced Nursing Practice roles?
2. What level of understanding did the wider team and service have in relation to the Advanced Nursing Practice role? Were the four pillars seen as an essential part of their activity?
3. What level of insight about the scope of Advanced Nursing Practice did individual Advanced Nurse Practitioners have?

It was significant that despite dependencies referred to, this Case Study 1 example emphasised the importance of four pillar engagement, despite the huge pressure to focus on disease-centric activities:

> ***Participant 16*** *"…because without erm… fulfilling all those elements I don't think you get the job satisfaction and that feeling that you are progressing perhaps or as a team you aren't progressing so yes I feel yes that all four are important," (Alastair "Hum.mm") " and obviously you expect the right balance for the job that you are in given that ours is a high pressured environment,* ***but yeah… I still think that all four aspects are important."***
> ***Participant 15*** *"yes I agree, and I think* ***you need to be using all four elements in order to advance nursing practice because if we're not we're not changing things for the future nurses we're not improving things, we're, things are stagnant…"***
>
> Case Study 1: Interview 7 Lines 17-24 Participants 15 and 16

The following response was not untypical among those who valued the four pillars, regarding them not as separate activities, but as integrated and integral to effective practice:

> *"So you could say, I'm clinical, I have advanced clinical practice, and today I'm going to be an educator, you can separate them out almost see them as separate projects, but most of the time you are a clinician.* ***But, I think advanced practice in its truest form is around a way of thinking a thought process, a level of practice, and recognising whilst you are working clinically you're looking for areas of innovation, for requirements for education, what is it you're going to educate and why, and how will that advance practice for your department, for the needs of your patient group?"***
>
> Case Study 2: Interview 3 Lines 32-37 Participants 7

Advanced Nursing for the following participant from Case Study 2 was a dynamic process of patient centred activity and innovation, utilising all four pillars. In both case studies higher levels of judgement and decision making were present, but differences were revealed in how this was applied: Case Study 1 - Acute Services, where direct physical skills were important exemplified by 'chest drain insertion'; and Case Study 2 - Non-Acute Services, where skills used included 'end of life' discussions. Each reflected complexities in their use. The distinction was described in this account:

> *"…because they're (skills) are not technical, because* ***we don't stick chest drains very often in care of the elderly, but we do advanced care planning,*** *and we do de-escalation of treatment, and we have* ***end of life discussions, that's advanced level skill that most people can't do****, and I would count that your surgical team wouldn't be able to do, nor your acute medical team" (Alastair "yeah...")* ***"it doesn't matter what your advanced skill is, it matters if it is reflected in the care of your patient group…"***
>
> Case Study 2: Interview 11 Lines 287-292 Participant 7

The emphasis here was not the skill but what did patients need, the focus was patient-centric not disease-centric. This focus was also seen in this advice about how to set up Advanced Nurse Practitioner services:

> *"****Yes what they need, and that's the thing****, if I'm ever* ***talking to people about setting up a service, I always say, start with your patients wants, needs, do they have… what needs have been met?*** *What are the conditions that you see? What is the top ten clinical interventions you will do, the top fifty drugs that you see, that writes itself …"*
>
> Case Study 2: Interview 2 Lines 164-170 Participant 7

The following extract exemplifies the determined attitude of this group of Case Study 2 participants, that 'Advanced Nursing' and all four-pillar activity must be included if patients are to receive comprehensive care. Significantly, this was a priority even when there was service pressure to focus on disease-centric/medical replacement activity:

> *"so as far the clinical speaks for itself (as a priority),… we have…. added things into advanced practice…often the silent ones that get forgotten, and* ***people often say that we haven't got time to do those but I think you have to make time to do them,*** *" (Alastair "sure")* ***"…they are part of the role, and if people see that they are part of the role they are more likely to buy into your service,…*** *(Alastair "yes") "…* ***if they don't see you doing those things and you just carry on doing the clinical erm… you know a hundred percent of the time, because you haven't got time to do it, erm… then nothing will ever change, and you'll always be seen as just that, clinical replacement, just that medical replacement,*** *just that you know," (Alastair "hum mm") "…clinical, just clinically focused person,* ***but you need time to do other stuff,"*** *(Alastair "hum mm")* ***"…and it needs to be embedded into the role,"*** *(Alastair "hum mm") "…and that is where I feel that I am now, it's embedded into it, and that's why I think this they (Managers) are actually listening more and engaging because they are noticing the audit and research behind it," (Alastair "right") "…and the teaching," (Alastair "yeah")*
>
> Case Study 2: Interview 6 Lines 92-112 Participant 13

Integration of the pillars into daily activity was highly desirable, but often difficult to achieve, so individual pillars tended to be utilised singularly alongside clinical activity. Addressing the research pillar was particularly challenging, with general acknowledgement that this was only addressed in a limited way. All participants expected and were expected to be 'consumers of research' (NMC 2020), reading others' research, considering its implications for their own and others' practice. The differentiating feature was the degree to which that research was then applied, and the extent to which practitioners engaged in undertaking research themselves or in partnership with others.

The leadership pillar by contrast was utilised in a variety of ways, developing progressively as participants became central figures within the team, becoming the indispensable 'go to' people (Williamson et al 2012). However, multiple demands did lead in some instances to becoming stretched. In effect they became, doctor, social worker, nurse, wearing many hats. In part, because Advanced Nursing Practice had evolved and matured and become central to solving the variety of problems services faced. Despite almost becoming overwhelmed, participants found it hard to know what to relinquish. What remained clear though was the paramount need to retain their nursing emphasis to enable them to remain available for therapeutic relationships with patients:

> *"...because to me if you are entering into any… you know a therapeutic relationship with a patient you should be compassionate, you should recognise the impact that (you have)….* ***(the) driver for me, the main driver and desire for nursing is to see the person and the impact of whatever is happening to them on everything about them and to treat them like that ……(****Alastair – ok) …****as opposed to*** *you know…****the appendectomy in bed five*** *and, but we should all do that really because we are all dealing with people (Alastair – yeah..) because* ***nursing has a particular strength in that,*** *but some of that becomes, comes from the fact that nursing has become all things to all men and some of the challenges that nurses have now is trying to continue to do that, because patients are becoming more complex so you are doing everything from the sublime to the ridiculous, and you think if we lose this bit…(Alastair – yes)… that that stops us being a nurse."*
>
> Case Study 2: Interview 11 Lines 622-3 and 628-629 Participant 7

- Category: (C4) Enquiring, Dynamic and Evolving Practitioner

Participants were active learners, keen to develop knowledge and understanding, many spoke of their own perspectives changing as they progressed through the MSc Advanced Practice course. Their changed perspectives and priorities not infrequently led to conflict between them and their service managers:

> ***"… when I started I thought it (the role) was mainly going to be clinical… that we would do a lot more on health assessment, blood interpretation, x-rays that sort of thing…"***
> *(Alastair – sure) "… making up short fall where ever we're needed…" (Alastair – hum mm) which I think* [now] *is wrong, because* ***having done the course it makes you realise that you just can't focus on the clinical*** *and I'm finding that I feel that I am just going around doing my job in a straightjacket because you've got the skills to do other things but I'm only required to do the clinical." (Alastair – right)*
> *"I've only witnessed it (Advanced Nursing) working in* [Case 2- Non-Acute Services], *they Do everything there….but* ***when I've seen it in other areas like…*** **[Case 1 Acute services]** ***it's ninety eight percent clinical,…"*** *(Alastair – hum mm)* ***"…and it's all about who can put in the best chest drain****… who can do whatever…* ***before I did the course I thought that was what it was all about."*** *(Alastair – sure)* ***"but it was only in year two you have the light bulb moment it actually clicked what it was all about... it wasn't just about the clinical it was much broader than that much more focussed on the patient, not just what was wrong with them."***
>
> Case Study 2: Interview 5 Lines 37-73 Participant 14

5.2.1.2 Super-Category: (SC2) Scope

Contrary to the widespread view expressed in both older and recent literature (Lawler et al 2020; Dowling et al 2013) participants were clear what the scope of Advanced Nursing Practice was. Moreover, they recognised the importance of their practice being empowered by personal vision and values, and by the particular 'lens' that they saw their patients and services through. Participants noted that there was added value brought to encounters when a nursing lens was used. This arose from the breadth of knowledge, skill, and personal attributes of practitioners, shaped by their nursing values and perspectives. However, this was not to minimise the relevance, even importance, of the 'medical lens' when considering the whole care and management of patients,

especially in the acute phase of illness when participants noted disease-centric management often played a more urgent role. However, integration of both perspectives became appropriate when considering the totality of patients' needs. The problem with delivering Advanced Nursing arose when holistic patient focused action was compromised by medical priorities retaining precedence when this was no longer appropriate.

- Category: (C5) Situationally Aware

While participants reported that the 'nursing lens' enabled them to 'see' their patients through a holistic perspective, it was more far reaching than that since it also enabled a wider 'global view'. This led participants to be situationally aware and sensitive, and therefore highly responsive not just to people but their situations. Patients were not 'seen' in isolation but in the context of, their condition, similar patients, the clinical environment in which they were being cared for, and the wider service. When this 'global' perspective was expressed not just through clinical practice, but through leadership, education, and research, it enabled real differences to be made:

> *"It comes from* [what I observe in practice and returns to my] *practice, yes, because …as an individual practitioner* [I might note…] ***that's the fifth patient that I've seen this week that we haven't quite done*…[all that was really needed]** ***then you might speak to your colleagues, someone from another discipline and say what do you think about that? Then you take the lead in challenging practice… liaising with management you could be writing guideline, all of it links together from what you see when being in clinical practice. This is different from being an advanced level clinician who is very good at seeing one patient at a time, but has no concept how the other pillars tie into*** **[the role]."**
>
> Case Study 2: Interview 2 Lines 50-55 Participant 7

It also led to, as one participant commented, the sense of making real progress with change:

> *'if we're not changing things we're stagnating',* ***the role is about <u>Advancing</u> Nursing practice***
>
> Case Study 1: Interview 7 Lines 23 Participant 15

- Category: (C6) Case Manager

The role of participants as case managers was revealed in two distinct senses. First, the more conventional sense of organising the total package of patient care:

> *"****So I think it's more of the holistic... there's more continuity with the patients that I see erm****… I think* ***it would be very easy to get sucked into the things that the anaesthetist doesn't want to do erm.. but I think I see myself as more of a co-ordinator almost of that patient's Journey so between the decision for surgery and them getting to surgery I'm responsible for that patient really,"*** *(Alastair "yeah")*
> ***"…it's me they will contact if they have any issues very few of them go to the surgeons*** *I think because they can't get hold of them,"(Alastair "yeah …")* ***"I think I am there with the rest of the team so I'm more aware of the resources that we have on a day to day basis and the resources that we need to do things or change things*** *erm.. we don't get that with medics in the service…"*
>
> Case Study 2: Interview 12 Lines 395-430 Participant 21

Second, was when they used their ability to uncover patient problems and those in the clinical work environment, to both actively learn from those situations and turn that learning into meaningful action.

- Category: (C7) Constant Positive Presence

While participants generally had no management role, as senior nurses they generally had considerable experience of managing and leading and as leaders and influencers they were a considerable resource to the wider team. Both individually and collectively they had a grasp of their department and services that was largely unparalleled. As a constant presence the Advanced Nursing Practice teams provided a particular sense of continuity, using their interpersonal skills to collaborate and strengthen the wider teams within their respective services, building confidence and creating stability:

> *"…so I think **we can support and build confidence in the team whether it's a team, a constant team… or a team that's in or out**, but I think **it's nice now that we are more members of our own team because I think that will impact again on our role and teaching***
> *Alastair: "so erm…*[bringing] *stability, the constant of you being there?"*
> *"stability yeah… **I think stability is the biggest thing**….."*
>
> Case Study 1: Interview 7 Lines 401, 403-4, 6 Participant 16

A key difference between the case studies participants was where Advanced Nursing was strong within Advanced Nursing Practice. This was found mainly in Case Study 2, where participants both valued their nursing skills and sought to retain these as central to their activity. They held a unique role among the team in their ability to influence nursing practice but also act as connectors and collaborators between team members. They were described as the 'bridge', especially between the medical and nursing teams. This was highly valued by all, including medical staff as exemplified by this consultant surgeon participant:

> *"…the **ANP's were a useful bridge between the medical team and the consultant and the ward nurses** when the ward nurses weren't sure, they might not be encouraged to consult the consultant or the registrar, but **they would be happy to phone up the ANP."** (Alastair – yeah), "…and **the ANP would act as a bridge for the communication between the ward teams about the patient's relatives**" (Alastair – yeah) "**so that seemed to work quite well**."*
>
> Case Study 1: Interview 19 Lines 205-11 Participant 31

This notion of acting as a bridge was extended to the relationship between patients and clinical staff. As a constant presence and because of their unique role Advanced Nurse Practitioners were able to be effective advocates for their patients, speaking for them, empowering, enabling, and facilitating effective responses to their need using skills of advanced communication skills, empathy and negotiation (Rolfe 2014b).

Their constant presence fostered demonstration of a high standard of practice through role modelling the delivery of person centred/ therapeutic approaches, as exemplified in this extract:

> *"**I have just had a lady that has been in before so I know the whole care plan off by heart, so when I put my plan in place,** I'm going to ask for the ECG, the urine dip, the blood pressure, so that patient care is completed quickly, **whereas potentially a new junior or house officer might not do those bits because they have not seen the Care Plan like we, … like traditional nurses have.** We've used them and I think that it is important, how a drug is given, we know how that is done, so when we have had people who are fluid restricted and you have to give Gentamicin, which comes in a two hundred and fifty ml bag, you have to revaluate that, but that's because as nurses we used to giving those IV's (Alastair – hum …mm) **"…our nursing knowledge (skill) makes it easier to know how to plan our treatment for patients, how to talk to our patients, but also how to support the nurses…** because we do have newly qualified nurses, so it may be about, 'I've just prescribed this so I can't be the second checker, but if you look at Medusa* [medicines guide] *this is how we give it, and this is my evidence base,…', so that's a clinical role but actually I've just managed my patient, got the treatment done via a nurse, and educated that nurse so erm… yes good for both…"*
>
> Case Study 1: Interview 7 Lines 201-211 Participant 17

Influence was often exercised through education, and while this was generally focussed on staff within the service, medical staff were also included, as exemplified here:

> *"…**we have had a lot of staff coming and going,** **[lots of training needs]** **so I think our 'constant presence' enabled us to support medical staff and nurses…people find us, we can be approached easily for support**…I guess that's why we get pulled here there and everywhere which... I think that's the nice part of our job and it does actually make you feel that actually you are significant between the continual pressure to be clerking… clerking .... clerking….but in between, 'oh could you come and help us with this… or could you advise us how we do that… even if it's referrals to different specialities or how do we get a 'hot clinic' for this patient **so I think we have been that constant presence…we have knowledge in those sort of things where a new house officer's has no idea how, the consultant asked for it and the consultant doesn't know themselves but we can make it work."***
>
> Case Study 1: Interview 7 Lines 390-9 Participant 16

While a large part of the educator role was directed at colleagues, it also included patients, because of the 'therapeutic relationship' that had been established during the assessment phase and progressed through the patient management process:

> *".. because you know **some of my patients, I have known for twenty years** and you know it's because … we're not that formal with them that they do tell us the things that matter and you know we can sit there and say, stop! What actually what is the bottom Lines, what's really going on here?" (Alastair – hum mm) "then when they tell you, it's possible to explain the treatment and give information to answer their fears. Then they are happy!"*
>
> Case Study 2, Interview 5 Lines 244-247; Participant 14

- Category: (C8) Informing Practice with Knowledge

Knowledge acquisition and knowledge informing practice was important to the participants and was undoubtedly brought to bear on their practice. However, they readily acknowledged that research

was the one pillar that was least represented among the four, particularly in undertaking primary research (Kilpatrick 2023). Largely the focus for research activity was on reading for knowledge and application, and for evaluation and audit of outcome measures, data was important to ensure quality was monitored, outcomes were achieved, and services remained viable and efficient. consultant nurse participants from both case studies echoed the importance of assessing research before it was applied, one speaks here:

> *"**I think that's our role really as senior practitioners to try and influence the best practice…"** (Alastair – sure). "…not (accepting)… so just **because it's a guidelines doesn't mean to say it's right** it could be that **we may need to modify and adjust it and we need to be able to do that…"***
>
> Case Study 2: Interview 9 Lines 209-213 Participant 19

However, there was clear aspiration for undertaking research and research impacting practice, exemplified here by efficiencies gained in Case Study 2 regarding use of medicines to manage Parkinson's disease:

> ***"…so I'm doing a medication audit at the moment across the trust of all medications that have been missed or even that wasn't the best option in Parkinson's disease**. Its looking right from when they come to A&E to right when they are going out but idea is not just about the medication audit it's then about them if they have the medication appropriately could we then reduce the length of stays and bed stays…" (Alastair – it's the impact?)*
> *"…**it's the impact of that and sending that to the trust and that's very attractive and it's not wasted time** then **if you wanted to do some research from that I know I would be very interested doing you know some research around extended length of stay for patients in hospital with long term conditions** and that's how I feel and that's how it can be sold to management because there's a benefit to them." (Alastair – yes)*
>
> Case Study 2: Interview 5 Lines 500-512 Participant 13

Participants were keen to learn and advance their own practice, becoming an Advanced Nurse Practitioner appeared likened to being on a journey of life-long learning which was enabling them to grow in self- awareness, recognising their own potential and impact. Being or having been on the MSc Advanced Practice course was significant to them, not least in growing in confidence, which enabled them to articulate views and challenge practice with senior colleagues as indicated here:

> *Alastair "…let's just explore the academic level again… **what is the point of master's level?**"*
> *Participant 14 "**understanding the research and,… yeah interpreted and critiqued and then being able to articulate your views"** (P 13 reply "views") **"…yes, views, because you have to stand up to some powerful people to get what you want…"** (Alastair "hum mm")*
> *Participant 13 "….and **being able to analyse it, the information you know, information in a better way, that others would also understand, and then you can divulge to other people, and I don't think you do that quite as much at a lesser level…"***
>
> Case Study 2: Interview 5 Lines 546-547 Participant 13 and Participant 14

However, several participants pointed to limited access to ongoing continuing professional development (CPD) once they had completed the course. Moreover, what was provided focussed on clinical issues and not subjects that which would enable the other non- clinical pillars:

"don't know if it's nurse education as opposed to how medics are educated, I think medics assume that they have all of those skills, and you know that they don't need any more development. ***I think nurses are probably more aware that they need to develop their skills and they've probably got a better understanding of broader need, for example what makes up/ what are the skills that you need for an effective leader…"*** *(Alastair – hum mm…)."*

Case Study 1: Interview 2 Lines 534-537 Participant 6

5.2.1.3 Summary of the Comparison of Findings between Case Study 1 and 2

This section is a summary of the comparison of findings related to the first research question:

What are the Features and the Scope of Advanced Practice?

Following the process of comparing and contrasting data in relation to the two case studies, codes generated were reduced to generate **Concept 1 - Characteristics**

Case Study 1: Acute Services (Acute Medicine/Surgery)	**Case Study 2: Non-Acute Services (Gerontology/Medical Specialities /Pre-operative Assessment)**
Common Findings	
• Advanced Nursing Practice was defined as a level of practice, reflecting critical decision making and problem solving. • Participants were active learners, valuing their academic preparation. The MSc Advanced Practice degree course represented a significant part of their journey of personal and professional development. • While founded on direct clinical practice, role impact significantly benefitted from integrated four pillar activities. However, individual pillars were often utilised but in an 'add on' capacity as an adjunct to their main clinical role. • Undertaking research was a low priority, although audit of disease-centric activities and processes took a higher priority than patient-centric activity. • Autonomy of clinical role was represented when participants were supported 'to intervene more and escalate less'.	
Separate Case Findings	
• High value for the clinical pillar, and a disease-centric focus with the medical model dominating practice • Focus on 'seeing' patients through a medical lens* thereby restricting holistic practice • Clinical/physical skills central • Four pillar engagement a low priority • Emphasis on role being absorbed into medical team	• High emphasis on clinical pillar, but emphasis on mixed use of disease-centric/patient centric care according to patient need • Reliance on use of nursing lens* • Interpersonal skills paramount, high emphasis on therapeutic relationship • Four pillar engagement a high priority integrated within clinical practice • Emphasis on central co-ordinating role in the multi-disciplinary team • Emphasis on service improvement ***Definitions are in glossary, page xviii**

Table 21: Summary of the Comparison of Findings between Case Study 1 and 2 (Concept 1-Characteristics)

5.2.2 Constructing Concept 2: Advanced Nursing

Concept 2: Advanced Nursing, was constructed from the range of participant views and perspectives about what nursing and Advanced Nursing meant to them, their significance and consequences, and their actual and potential impact. Categories were generated from codes and these were reduced during the analytical process to form two Super Categories, SC3- Centrality of the Advanced Nursing Perspectives, and SC4- Advanced Nursing Activity. The findings are summarised in Table 21 and are discussed with examples from both case studies in detail after that.

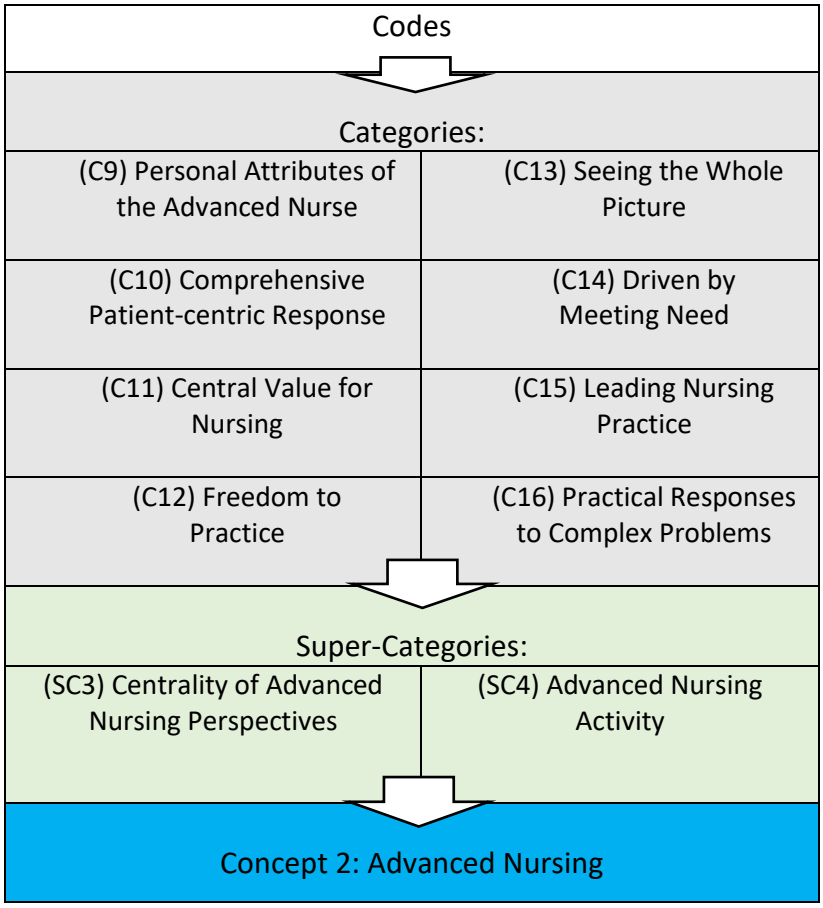


Table 22: Categories Analysed and Reduced to Form Super Categories, then Reduced to Construct Concept 2 - Advanced Nursing

At the end of this section, on page 157, Summary Table 23 compares and contrasts findings in relation to Case Study 1 and 2. This set of findings addressed the second research question, and led to the generation of Concept 2.

5.2.2.1 Super-Category (SC3) Centrality of the Nursing Lens

- Category: (C9) Personal Attributes of the Advanced Nurse

Personal attributes identified arose from who each individual Advanced Nurse Practitioner was, their personhood and their experiences. Together these played an important part in how they enacted their role. Reflexive and enquiring mindsets enabled participant proactivity with a high desire to innovate, however, they also expressed that this was challenging There were numerous obstacles to negotiate during their time as trainees which continued into the role itself. Participants found that to be successful, they had to be highly self- directed, determined to pursue their vision for Advanced Nursing Practice. However, it was not unusual to find participants experiences of their roles constrained by being overly disease-centric. This was a real challenge for number of participants to resist service pressures to be disease rather than patient-centric, particularly those working in Case Study 1 areas, as indicated next:

> *Participant 8: "…my perspective is, how* ***it all depends on, how you want your role to be,*** *you think whatever you are trying to define that role," (Alastair "yes") "…yourself." (Alastair "absolutely") "you don't want to go by being led, you don't want to go by being led by the leader,"*
> *Alastair: "…****are you suggesting that in his (Participant 9's) view, that (autonomy) is restricted by an operational need?"***
> ***P 8: "I would, and I would confront that, I would say no."*** *(Alastair "ok")* ***"…this is what my role is, this is how I want it to be," (Alastair "ok") "if you're not happy with it I am going to move on to somewhere that my role fits better…"***
>
> Case Study 1: Interview 3 Lines 787-798 Participant 8

- Category: (C10) Comprehensive Patient-centred Response

Consultant nurse participants from both case study groups emphasised that the main focus for Advanced Nursing Practice was providing a comprehensive response to patient need that went beyond a purely disease-centric response, but recognised difficulty in measuring and quantifying its impact since much was hidden, even taken for granted:

> *Participant 5 "…* ***they*** [senior management] ***were trying to measure, (how) effective, is that the word, erm how our team was being… how do you measure that?***
> *Participant 6 "well, it's very difficult to measure it by tasks…" Participant 7 "Yes, extremely"*
> *P 5* ***"they wanted at one point… how many patients a day that you are seeing****, (P6 "yes")*
> *P 5* ***"…so I could see five patients, and my colleague could see ten, but actually I've taken them (patient) to the toilet, I've looked at pressure areas, and done my nursing interventions…so that's not a measurement of, a true reflection…,"***
> *P 6* ***"of what are you able to give to the patient…experience, where a medic can't****….Just a little* ***anecdote, erm… my brother knows what I do and I talk about it a lot and he,… at his surgery, he said (to me) unprovoked, he'd rather see an ANP anytime over a doctor, because there is something extra you get…" (Alastair "yes") "erm… it's how you communicate and listen and how you assess the patient its all the…"***
> ***Participant 7 "recognising the significance of things…"***
>
> Case Study 1 and Case Study 2: Interview 2 Lines 866-880 Participant 5, 6 and 7

An important difference emerged between the two Case Study groups, in the degree to which comprehensive care was achieved. The consultant nurse participant in Case Study 2 Non-Acute (Gerontology) service, articulated the absolute link between Advanced Nursing and the sort of comprehensive service that older patients (Gerontology) patients required. Indeed, a very clear claim was articulated that older patients' problems were linked with nursing practice solutions:

> ***"A lot of those problems / risks can be related to nursing care and Advanced Nursing Practice will allay those risks to patients a lot of what happens falls issues around polypharmacy around medication problems erm…around skin hydration integrity nutrition the fundamental elements of nursing if you like…"'***
>
> Case Study 2: Interview 2 Lines 324-326 Participant 7

Another participant, speaking from his current role in Case Study 2 Non-Acute Service (Gerontology), recalled his time working in Case Study 1 Acute Services (Trauma and Orthopaedic Surgery). He commented that he carried a level of autonomy, and the patient journey was not fragmented, but despite efficiency in the processes he engaged in, it was not holistic in scope. It was medically led and, disease-centric. Consequently, the service offered to patients he suggested was limited, as described here:

> ***"… looking back I can definitely compare my role now to what I was then, (in Trauma Orthopaedics)*** *if I became an ANP there it would have been very different* ***because a lot of the role really was … very much consultant led and really you were more of a logistics expert*** *shall we put it that way,* ***the role really was more about how you know being able to actually facilitate the smoothest possible erm.. patient journey****, through the whole thing and that required right* ***from the assessment period, to the pre op, to the in hospital stay, to managing complications, to still seeing them in clinics*** *wound clinics and things -you get that rounded sort of approach for the patient* ***but it was very much consultant led and you know a lot of the decisions really could not be made without consultant input…"***
>
> Case Study 2: Interview 16 Lines 104-115 Participant 22

A significant point in his commentary lay in his experience of a discernible difference between two forms of direct clinical practice he experienced: the first, in Case Study 1 - Acute Services was disease-centric, directed by doctors; and the other was patient-centric, revealed by patient need and facilitated by Advanced Nurses in his current role, Case Study 2 Non- Acute Services (Gerontology). Other participants recognised that both forms of direct clinical practice were found within their experiences of Advanced Nursing Practice.

The impact of Advanced Nursing was reported in the totality of comprehensive clinical practice. Providing 'added value' to clinical practice was recognised as important, though was somewhat difficult to articulate. It was suggested that there was a hiddenness to elements of patient-centric

clinical care, but that it required a broader skill set than medical skills alone, including advanced communication and therapeutic use of self. Moreover, when present, these abilities were very much appreciated by patients, engendering trust and confidence in the Advanced Nurse Practitioners caring for and managing their conditions.

Similar communication skills were also employed with team members and colleagues, reported in both case studies, when participants acted as advocates and negotiators. This was reflective of engagement with the non-clinical pillars of practice, particularly leadership but also education and research. These aspects of the role revealed the Advanced Nurse Practitioners as trusted individuals within the team who enabled the wider team members to work together efficiently:

> *Participant 11: "…**they just want us there, they just feel comfortable with having you just provide, well you take the confusion away,** because there's always confusion there, even though they* [may have been] *the 'on call' people**, at times they do not know what they are meant to be doing. So, it's just providing, 'this is what you are doing… this is where you should be.', it's just taking the confusion away."***
> *Alastair: "so when you say taking the confusion is that from the F1's* [junior doctors]?"
> *Participant 11: **"No, it's the whole team."***
> *Alastair: "And that's because you know the system and are aware of what's happening with each of the patients?"*
> *Participant 11 **"Even the consultants, they don't even know what is happening when you're on call, so they just want you there and just ask what do I need to do?** Even on the ward rounds you have to lead them, **and if none of us are there they just panic, they don't know what they are supposed to be doing.** ALL: Laughing*
> *Participant 11: "and they don't know where to start."*
>
> Case Study 1: Interview 4 Lines 479-488 Participant 11

The centrality of the non-clinical pillars of Advanced Practice, was linked directly to the wider effectiveness of Advanced Nursing Practice as seen here:

> *"… but I do agree that **I don't think you could be an Advanced Practitioner without those four pillars**, that's the whole reason that we do masters, and that's why you do those elements of the masters **to make sure that you can achieve those elements in your job and your role."***
>
> Case Study 1: Interview 7 Lines 50-52 Participant 17

- Category: (C11) Central Value for Nursing

The importance of their identity as nurses was referred to by most of the participants across both case studies. Their current identity was regarded as being shaped by them being first and foremost nurses:

> *"… we're here to help them," (Alastair- hum mm) "…and we have the patients trust because we are still nurses…"*
>
> Case Study 1: Interview 4 Lines 196-7 Participant 12

The complexity of articulating what nursing and being a nurse meant became clearer when participants were asked how they would define nursing. My intention had been to see if it was possible to draw a contrast between 'baseline' or ordinary nursing, and Advanced Nursing. Some initially found it hard to articulate but as they tried, significant features emerged:

> ***"…I always say that I am an advanced NURSE practitioner,"*** *(Alastair "ok, why's that?)* ***"…I like my nursing title really erm.. it's difficult to explain, and in my head it's very different erm... I just feel we're broader, I can't explain it really…"***
> *Alastair: "You were saying* [earlier] *it was being responsive to patients, being 'driven' by patients, and erm.. that nursing really acknowledges that, but also has an engagement with patients that's different. Is that what you were saying?"*
> *Participant 21:* ***"yes, I think so. I had a year off work and the thing I missed the most from not being at work was not being able to help people,"*** *(Alastair "right")* ***and that sort of underpins everything for me it's about helping people, and whatever is needed.***
>
> Case Study 2: Interview 12 Lines 453-466 Participant 21

A common theme was 'helping', supporting, enabling and the provision of practical responses to patient need:

> ***"…. so for me Advanced Practitioner is what your patient needs it to be…"*** *(Alastair- erm…) "… if I think about what our gaps are, what our issues are, and what our challenges are, as far as patient care and delivering service provision…" (Alastair – hum mm..) "…A lot of those problems, risks, can be related to nursing care, and* ***Advanced Nursing Practice will allay those risks to patients****, a lot of what happens, falls, issues around polypharmacy, around medication problems erm…around skin hydration, integrity, nutrition****, the fundamental elements of nursing …"***
>
> Case Study 2: Interview 2 Lines 319-326 Participant 7

Indeed, it was when the focus was on patient need, rather than other things, that the therapeutic nature of the relationship between nurse and patient became clear, being a constant reassuring presence:

> ***"so it's about having your communication skills and awareness isn't it, emotional intelligence isn't it, really that's what you need to have….*** *I suppose is it people's perceptions of us really if you think of as nurse, the standard perception of a nurse I would say they're this lovely, caring person…always around."*
>
> Case Study 2: Interview 12 Lines 436-7 441-2 Participant 21.

However, while participants recognised the therapeutic significance of Advanced Nursing for patients, there was also an awareness that the value of this for others, including some nurses, was superseded by prioritising disease management. That perspective considered Advanced Nursing of lesser importance and of limited value, nurses who took this view appeared to regard their new medicalised practice as more glamourous and prestigious. The following extract explored this issue:

> ***"the activities of nursing that are task based, are glamorised to a point,*** *so let's say for example you're in surgery, so it's about wounds it's about you know post-op complications, so you are so good at that and you show it, if you are in ITU, the machines and all that, but actually when you look at it,* ***a lot of the quality work that nurses do in that high stress environment its nothing to do with those task based things,"*** *(Alastair "hum.mm") "…that stress part of the job because that is what your job is about to deliver the care (Alastair "hum.mm") "…****but a lot of the care quality comes in the communication****, it comes in the organisation, you know the care the knowing how to,* ***actually how to, actually to make this patient Journey as painless, as comfortable, as smooth as possible for the patient and the family*** *in the way that you have enveloped it in your effective communication…."*
>
> Case Study 2: Interview 16 Lines 425-435 Participant 22

Consultant Nurses from both case study groups expressed their concern where they recognised a lack of value for nursing among some of their team members:

> *Participant 7:* ***"…I've heard Advanced Practitioners say, 'you'll have to speak to one of the nurses', almost as though it's not their role anymore, and give that perception…"***
> *Participant 5: "Yes, I'm not that anymore.* ***It's almost going back to it's not my patient and that I'm not the nurse, that's the difficulty, isn't it?"*** *(P7: "Yes, yes") "Going back to something you said earlier if you don't mind…" (Alastair: "do do…")* ***"We were on about, I think there was an element of personality… the fact that some ANP's only want to do that medical role*** [the clinical practice pillar]***…"*** *(Participant 7: "Yes yeah")* ***"… there's two sets*** **[of ANPs],** ***there are people who want to do the job with all four pillars and complete the whole role,"*** *(Alastair: "hum mm")* ***"and you've got those others that actually, [Clinical practice] is all I want to do…"***
> *Participant 7:* ***"medic's by proxy almost…"*** *(Participant 5 -Yes hum…)*
>
> Case Study 1 and Case Study 2: Interview 2 Lines 655-665, Participants 5 (CS1) and 7 (CS2)

They also recognised their own need to provide leadership to their Advanced Nursing Practice colleagues, not least emphasising the role does not just have a clinical focus:

> *Participant 5****: "…And try to drag them back to the reality of you have these other pillars*** **[to engage in]…**
> *P 7****: "And so it's up to the leaders, people in this room who actually makes sure that doesn't happen"*** *(Alastair: "hum….")*
> *P 5: "and look at* ***what's worrying is how many services that don't have those leaders."***
> *P 7: "****exactly yes yes."***
> *P 5: "and therefore* ***there's no one there dragging them back to reality this is the role this is what your job is and these are the aspects…"***
>
> Case Study 1 and Case Study 2: Interview 2 Lines 663, 665-8, Participants 5 (CS1) and 7 (CS2)

It was reported that Advanced Nurse Practitioners who actively embraced medical substitution as the central part of their roles had little interest in addressing the other pillars, nor did they seek to act as nurse role model for junior nursing colleagues. In contrast, where the nursing identity was fully embraced by participants, they embraced providing holistic patient centred care and sought to integrate this with non-clinical pillar activity. This involved associating with the nursing workforce, offering and providing leadership and support for the nursing team, acting as a resource for them.

Moreover, Consultant Nurse participants, who had all been Advanced Nurse Practitioners previously, echoed that position:

> *"Yes, we are nurses, full stop." (Alastair "ok")* ***"…and I think we as nurses are here to support the nursing staff…"*** *(Alastair – "right") "…****we are there as a support to the medical need within our speciality, but we are also there to support nurses****, and I see the other part of our role would be having a big impact on quality of nursing. I see our band fives look up to us…"*
>
> Case Study 1: Interview 2 Lines 450-6 Participant 5

They recognised a huge untapped potential within nurses working as Advanced Nurse Practitioners to significantly influence their practice environments, although they also recognised that this was frequently restricted by senior managers whose priority was responding to the disease management clinical need of patients. These managers generally had overall power to decide the roles and deployment of staff. The importance of nursing identity was pronounced when attempts were made to replace the word 'nurse' from the role title, replacing it with 'Advanced Clinical Practitioner'. One participant explained it like this:

> *"I always feel* ***that it's down grading me to say that I am an advanced clinical practitioner*** *because erm… I mean… I feel that…* ***the patients say, so what is that then, so you're not a nurse you're not a doctor…?"***
>
> Case Study 1: Interview 7 Lines 504-5 Participant 16

This new title arose from Health Education England's work (HEE 2017) and was recognised as an umbrella title to include allied health professionals. However, participants suggested it had the unintended consequence of stifling advancement of each professions' individuality and individual characteristics. An alternative approach, suggested one participant, was to identify as an 'Advanced Practice-Nurse', as with the title used in the United States of America. Similarly, 'Advanced Practice-Physiotherapist' and so forth, depending on the individual's health profession background. One participant in recognising the growing prevalence of the ACP title argued as follows:

> *"…it's too broad, 'Advanced Clinical Practitioner'. I think that's (ACP) at the top and then you have got sub (underneath that), 'Nurse'…'Paramedic'… that's the I think it's just I don't want to say tars everyone with the same brush…* ***but actually (its) important that the patients know who they are being approached by what skill set do you have…"***
>
> Case Study 1: Interview 7 Lines 529-531 Participant 16

It emerged that Advanced Nurse Practitioner participants from both case studies, identified as nurses first, with nursing central to their identity and work as Advanced Nurse Practitioners. Moreover, an increasing distinction became clear between 'nursing' and 'Advanced Nursing'. The difference was explained simply as where each participant was positioned on a continuum where Advanced Nursing was the natural progression of what nursing already did, though this was at a

higher level of complexity, requiring a wider set of critical thinking, decision making and intervention skills:

> ***"…so advanced level nursing is understanding risks, the risks of clinical condition, of the interventions, of what it is that we're doing to them, their trajectory, their prognosis, all of that and managing that person.*** *So for Gerontology where it's all about…" (Alastair – hum mm...) "...about holism, and disease burden, risks of treatment, verses burdens of treatment, and prognosis…" (Alastair- yes hum…) "…of life expectancy that* [lends] *itself to advanced level practice because it's a natural progression of what nursing already does."*
>
> Case Study 2: Interview 2 Lines 333-341 Participant 7

This was more specifically reflected in terms of the level of practice, making of judgements and decision making, along with the breadth of, knowledge base, skill, expertise, and the scope of activity demonstrated by Advanced Nurse Practitioners in delivering safe patient centred care.

- Category: (C12) Freedom to Practice

It was clear that the point and purpose of autonomy for those Advanced Nurse Practitioners who held a high value for nursing practice, was primarily to use it to act as advocates for their patients, addressing obstructions or restrictions to their holistic management. However, autonomy was also a vexed issue for participants, as there were several factors which influenced their experience of autonomy in their everyday activity, not least who exercised oversight over them. They were proud of nursing as a profession and nursing's key role within Advanced Nursing Practice. Consultant Nurse participants made clear their role enabling and facilitating autonomy, as seen in this extract:

> *"And that's what I see, roles like ours do (Consultant Nurses), understanding it, and recognising it, and enabling, with the skill and giving them (Advanced Nurse Practitioners) permissions to say, yes this is my role, this is what it is…" (Alastair – "Yes") "…**and not to be dominated so much by medicine, (but) to have confidence and pride in nursing as a profession, yes.."***
>
> Case Study 2: Interview 2 Lines 604-7 Participant 7

Moreover, there was a growing sense of confidence that participants who identified as nurses wanted to assert the potential of their roles to maximise nursing and its influence within the clinical environment. However, they recognised that this was not easy to achieve. Those Advanced Nurse Practitioners who did not embrace the centrality of nursing within their practice and instead embraced the medical paradigm appeared content to submit to medical oversight and control, as seen in this extract:

> *Participant 5:* ***" … whilst medicine always dominates and assumes, 'well I'm the consultant, of course I'm the natural leader… will automatically tell everybody what to do, because this is what I do…', because nursing traditionally carries out medical orders, there's an automatic cultural subservience. Well, now we've got advanced clinical practitioners, who are nurses, that are saying, 'hang on a minute, nurses should have a voice, and we should be bringing nurses with us'…"*** *(Alastair – hum…)*
> *Participant 7: "…as opposed to that whole now,* ***'I've decided to become a medic,'*** *(Alastair "hum"),* ***"so, 'the fact that I'm a nurse is irrelevant'…"***
> *Participant 5: "*[No, not at all, rather…] *a big part of it* [Advanced Nursing Practice] *is around the influence on nursing, and the impact of what nursing has on patient outcomes and recognising…" (Alastair – hum) "…that sort of chain of development, and progression..."*
>
> Case Study 1: Interview 2 Lines 617-20 Participant 5 /Case Study 2: Interview 2 Lines 609-614 Participant 7

The distinction between the different approaches to Advanced Nursing Practice was emphasised when participants worked in Case Study 1 - Acute Services, where their roles were heavily clinically focussed, and the expectation was that they would carry out a disease centric/medical replacement role. This required them to report to senior medical staff, and therefore their accountability and reporting lines were transferred from senior nursing to consultant medical staff.

Perspectives participants held about where accountability for their practice lay, and who they were accountable to, differed from perspectives held by junior medical staff they were working closely with. Junior medical staff appeared to focus less on what they were accountable for and instead focussed on who they were accountable to. They believed that their medical consultant carried accountability for their actions. In the junior medical staff's minds, it followed that Advanced Nurse Practitioners acting in a quasi-medical role would also just 'join in' and operate 'under the consultant's wings'. One of the consultant nurse participants offered an example illustrating this, regarding prescribing practice,

> *"… we sometimes have drugs that come from left field and because we (ANPs) now manage a case load, the TTO's and the rewrites come to us. But, if those drugs are out of scope, the guys (ANPs) say, I can't prescribe them, so they will say to the junior (doctors) 'will you prescribe them, they're out of my scope?', …"*

The junior doctors responded, as follows:

> ***"…'can't you just write them up, if we watch them or they write it and we sign it?',… And I'm like 'oh my god', they don't understand the concept, I'll have to give them a talk on*** **[principles of]** ***independent prescribing*** *(Alastair – hum mm)* ***"…they see everything as under the supervision and direction of the consultant and so, you're just joining in, aren't you?*** *(Alastair -Yes..yeah****) "… you're a nurse that's becoming 'one of us'…"***
>
> Case Study 2: Interview 2 Lines 395-407 Participant 7

Responsiveness to service gaps revealed tensions and the need for ethical decision making and not infrequently advocacy, represented in intervening for patients, explaining and interpreting what was happening to those who were often confused and sometime frightened, unclear about what was happening to them:

> ***"…that's the old saying, the doctor tells you what's wrong with you and the nurse tells you what the doctor says*** **[means]…***(Participant 6: "exactly", Alastair – "yeah, yeah",* ***All: laughing****)*
> ***"I always say to my patients I'll come back give me five minutes and I'll go off and then come back and say 'did you understand?'. That, that's what they need…"***
>
> Case Study 1: Interview 2 Lines 930-936 Participant 5

This last extract was interesting with participants acting as 'go between' between doctor and patient, so common in many doctor patient encounters and reflected in the 'knowing' laughter of all taking part. However, participants from that case study recognised it went beyond relatively routine exchanges to those where participants referred to themselves being crucial links enabling communication and effective working between the different health professionals involved. This was in the context of staff depleted services, where former systems were no longer in place to connect colleagues, which hindered effective communication and working. This was an example of a significant 'gap' which participants filled but which drew on their strengths. The notion of 'gap filling' was also reported as a significant finding, and will be discussed further later in this chapter, see page 152. Participants provided stability and calm as described here:

> *Participant 11****: "When we say taking the confusion away, it's from the whole team."***
> *Participant 10: "and that's* ***because we know the system****… yes…" (Alastair: "right")* ***"this is what should be happening with this patient and with this consultant…."***
> *P 11: "even the consultants they don't know what is happening when you're on call so* ***they just want you there and just ask what do I need to do,*** *even on the ward rounds you have to lead them.* ***If none of us are there they just panic they don't know what they are supposed to be doing."*** *(ALL Laughing)*
>
> Case Study 1: Interview 4 Lines 540-550 Participants 10 and 11

5.2.2.2 Super-Category: (SC4) Advanced Nursing Activity

- Category: (C13) Seeing the Whole Picture

Participants reported another facet of Advanced Nursing as the ability to not just see their individual patients but look more broadly at groups of patients, the team, the speciality, the trust and beyond that too. In so doing participants used the nursing lens to utilise the non-clinical pillars of leadership, education and research to bring about changes and innovations.

In discussing this with participants, one shared his view that just as with the clinical pillar, the non-clinical pillars applied to all qualified nurses to a greater or lesser extent, and not just Advanced Nurse Practitioners. This suggestion immediately raised questions about what was the difference between ordinary nursing and Advanced Nursing? He went on to address this by pointing to difference in scope and distinguishing features of 'level' of practice, and particularly advanced clinical skills.

> *Participant 9: "… the features* [of Advanced Nursing Practice] *definitely coincides with the four pillars in advanced practice," (Alastair: "hum mm")* ***"but I'd say as a staff nurse you should be doing those as well, erm…"*** *(Alastair: "hum mm") "… so in terms of* ***the educational side as you develop as a staff nurse you should be educating others, you know you should be leading people as well…"*** *(Alastair: " sure") "and erm… you know I suppose* ***the emphasis on research…*** **[is challenging],** ***as a staff nurse, however I'd say as a staff nurse it's something that should be done…*****[**but **it]** ***is definitely a feature of advanced practice, I would say…"*** *(Alastair: "hum mm") "erm…* ***in terms of the scope [for Advanced Nursing Practice]*** *you are taking on extra responsibilities, you are you are primarily working at the* ***same kind of level [Clinically] as a doctor*** *I would say erm….and those responsibilities are there in terms of prescribing in terms of erm… the way you practice…there are* ***certain advanced practitioners who have the scope of [Advanced Skills]*** *doing lumber punctures, doing chest drains, doing acetic taps, and you know that is something that is not usually undertaken by a staff nurse as such so I would say* ***the scope is a lot broader."***
>
> Case Study 1: Interview 3 Lines 20-32 Participant 9

Other participants commented that the 'broader' scope of activity indicated in the last extract, went beyond advanced clinical skills that were largely disease-centric, and where non-clinical pillar activity was simply 'tacked on'. They reported that Advanced Nursing was revealed as a complex interaction between all four pillars which was integral to their everyday roles. Clinical practice itself involved high-level skills in risk assessment and management, using advanced judgement and decision making which revealed Advanced Nursing Practice as a level of practice. Moreover, the complex interplay of clinical and non-clinical pillar activity when fully engaged, could rightly be described not just as Advanced Practice but as Advancing Practice, the intent of this being to impact and improve the patient experience and their journey through a complex and often bewildering service.

- Category: (C14) Driven by Meeting Need

It was reported that not only did participants value their nursing identity but also the nursing practice which flowed from that. Moreover, they were clear that nurses and nursing were also important to patients, who had confidence in nurses, exemplified in these extracts:

> *"….**and I like to say Nurse Practitioner, because then the patients know where you have come from and they know my background they know I'm a nurse it doesn't confuse them** because you know are aware that roles change,* [but] *yes I am a nurse I wear a stethoscope but you know they understand from my job when I see them I clerk them or examine them …. **I feel strongly about being called an Advanced Nurse Practitioner I still think that when you approach a patient, they are quite keen to know are you a nurse**..."*
>
> Case Study 1: Interview 7 Lines 496-499 Participant 17

> *"… and **yes they will*** [tend to] ***see us as a doctor when we approach because we have a stethoscope on and we are wearing scrubs as opposed to a nurses uniform** but that is another reason that **I like to say that I am an Advanced Nurse Practitioner just to be clear to them…. "***
>
> Case Study 1: Interview 7 Lines 511-13 Participant 16

The importance of patient-centric values was at the heart of attitudes towards patients:

> ***"…regards nursing in Acute Medicine erm… I think erm…. for a patient satisfaction side of life, as a ANP I will go to the patient and do the whole of the work that I need to do for that patient** (Alastair – Hum mm) **"…so I think, you know for sure, that they get 'together care' rather than, one nurse say, 'I'll be with you in a minute, so and so will be here in a minute** to do that', you know…" (Alastair – yes) **"…it's easier to do my own things, I know it's done, in a timely manner and I can make a decision."** (Alastair – hum mm..) "…it's back to…gathering evidence, my clinical impression of the patient," (Alastair – hum mm…) **"…But for a patient, for a patient's view, 'at least I've been sorted by one person, not ten or twelve'."** (No 6 – "yes") (Alastair – so it's less fragmented essentially…?)*
> *Participant 5 "…**and that's probably part of the Advanced Practitioner role, and that's why it's here** (Alastair – hum mm…) **"an(important) element of it."***
>
> Case Study 1: Interview 2 Lines 420-435 Participant 5

The emphasis of Advanced Nurse Practitioners reflecting nursing values was demonstrated by their ability to communicate in a person-to-person manner. However, the value of these connections in enabling the delivery of unfragmented care and management was not always appreciated by fellow professionals:

> *"one of the things one of **my mentor*** **[said to me]** ***when I was doing my health assessment thing was that I was erm… 'too friendly'** I think was the term she used,… **with the patient. I think I called her by a first name term and things like that, but I actually disagree with that,"** (Alastair "hum mm") "…because you know **some of my patients, I have known for twenty years and you know it's because we have got that,… we're not that formal with them that they do tell us the things that matter, …"***
>
> Case Study 2: Interview 5 Lines 240-246 Participant 14

The kind of connection with patients described in the last extract was not universally admired. The apparent misunderstanding of its power was recognised by participants who nonetheless saw it as a distinguishing feature of Advanced Nursing, enabling all other aspects to be achieved, as seen here:

> *"… we might ask about, for example, a patient is perhaps falling, we will then assess them, for example bone protection, we would drill into those signs more than sometimes the medics do, we'll give perhaps a life style advice that goes with it we'd look at what the researchers you know… we often know what the researchers suggest to support that, and we can signpost them better about how to make improvements actual lifestyle, and that's where I think the research …and I think keeping up to date with those kinds of things and current is an additional value that we add to our consultations from the clinical side of things.* ***But … its mixing those other elements from Advanced Practice into the consultation…"*** *(Alastair "hum mm")* ***"…the personal nature of our consultations erm.. and you know the medic criticising number fourteen for being too friendly erm.. part of Advanced Practice is about you, you know the part, you bring yourself to the consultation, and that is important."***
>
> Case Study 2: Interview 5 Lines 248-260 Participant 13

Advanced Nursing was expressed in deliberately seeking to establish a therapeutic connection and not merely a utilitarian one. This was reported as an essential feature, especially in Case Study 2: Non-Acute Services, where the long-term conditions patients generally required a different level of connection. The aim was to ensure patient understanding, as seen here:

> *"…what was that? what's happening? what am I waiting for now? so I think we make…* ***I always do make a conscious decision when I've clerked a patient. I've said to them, this is what I think it is, or could be, this is what we need to do, this is what I foresee is going to happen, … you know it's you're tailoring what you are saying to them at the level*** **[suitable]** ***to them, what do they understand?*** *Obviously if they are a doctor you can use the terminology, but sometime there are lots of big words that baffle people, and* ***what they have said is, what they have said is, 'you explain everything nicely'."***
>
> Case Study 1: 1nterview 7 Lines 419-424 Participant 17

A high level of skill in communication was reported here with a human touch, alongside thorough assessment which led to effective problem-solving activity. The impact of Advanced Nursing is contrasted here with how a situation might have been managed previously:

> *"So for example if we were in primary assessment and we had somebody who came in that could be septic… " (Alastair – yes),* ***"…well, before*** **[previously]** ***we would have to wait for a doctor*** *to prescribe everything,* ***but now we can prescribe and so can get/ sort out things in a more timely manner…you don't have to wait for the doctor to prescribe you don't have to wait for anybody…"*** *(Alastair - right),* ***"…so their clinical care, there absolute direct clinical care is improved by Advanced Nursing."***
>
> Case Study 1: Interview 7 Lines 568-71 Participant 15

However, in assessing need, often service gaps were also revealed highlighting gaps in care delivery, participants reported that Advanced Nursing Practice when permitted addressed these as seen in this response:

> *"…erm…. so* ***for me Advanced Practice is what your patients' needs it to be***
> *(Alastair- erm…)* ***" if I think about what our gaps are, what our issues are, and what our challenges are, as far as patient care and delivering service provision…"***
>
> Case Study 2: Interview 2 Lines 319-322 Participant 7

- Category: (C15) Leading Nursing Practice

Participants recognised their previous roles as senior nurses included managing nurses and to a greater or lesser extent leading nursing practice. Now no longer managing nurses, participants recognised the scope for leading nursing was present as an enabling part of the Advanced Nursing aspect of their Advanced Nursing Practice roles. As one of the non-clinical pillars, leadership embraced several codes including, questioning, challenging, collaborating, connecting, pushing the boundaries, and enabling the clinical team. Leadership was also recognised to spring from their personal development journeys as they moved into the role they now held. Participants also drew a distinction between Advanced Nursing and the practice of other senior nurses which focused more on 'managing' than 'leading'. This was explained as noteworthy since it meant that rather than carrying organisational power from formal management posts, Advanced Nursing Practice participants had only their influence, based upon their experience, knowledge, and skills base, and their individual standing within the team. When optimal this placed Advanced Nurse Practitioners in a powerful position to influence and promote patient-centred care and service improvement.

As role models they demonstrated quality patient centred care and provided support of the nursing team through education, training and development. However, significantly this was not limited to the nursing team but included medical and allied health professional colleagues. Participants often reported having a unique place in the team, as permanent team members they acted as bridges between professional groups and team members. Acting as a central link and as a co-ordinator they enabled services to run by harnessing and guiding the team. A key aspect of this was that they frequently had a unique relationship with the senior medical staff, who held them in high regard and listened to what they said when problems arose, as indicated here:

> ***"…the beauty of ANP's is they give you something different, if you need an alternate view on things and as long as you are broad minded enough to embed them into the team and listen to them when they speak to you then they add to the standard of overall medical and nursing care don't they?"***
> *Alastair: "and so therefore really on the basis of their experience their background their training that all of that adds something really significant in terms of challenge and support …, would you agree with that?"*
> *"Yeah,* ***I think you have just got to embrace and bring them into the team identify what their skills are and let them flourish within the team find out what their skill set is then they can run as far as they can…"***
>
> Case Study 1: Interview 19 Lines 244-252 Participant 31

Communication and connecting skills were highly valued and their ability to explain, clarify and enable care processes to progress smoothly were much appreciated. Furthermore, they were

frequently seen as 'fixers' and the 'go-to' people, who act find innovative solutions to problems and enable the service to run well, as seen here in an example representing both case studies:

> *Participant 20:* ***"I think as individuals we can be victim of our own success sometimes and we can be seen as these 'fixers' of everything***
> *Participant 19: "absolutely"*
> *P20:* ***"…so whenever there is an issue with anything we are almost these 'go-to's'."***
> *Alastair: "right, and is that a good thing or is that a bad thing?"*
> *P19:* ***"So, I've been in the trust eleven weeks so I'd say my first day experience from being in this role was very much a case of, we're going to have to do an audit on the front door streaming, X, could you do that for us? So literally both feet in because I was like they saw me as the person that was overarching you know education, development…."*** *(Alastair: "yes") "I know you get that on a day to day basis, something won't be fixed* ***so they think that you are a 'fix it', person because you have a high level of experience, knowledge and you do have the ability to network with things perhaps that people won't have thought, because you are thinking globally all the time. So you tend to be that person that people say let's ask X could you just highlight it… could you just look at this for us?....."***
>
> Case Study 1: Interview 9, Lines 160-176 Participants 19 and 20

Participants reported their ability and appetite for networking built on their ability to have a 'global view' about their service, its problems, and potential solutions. There was a strong desire to innovate, and this was fuelled by their ability to identify limits on practice and propose workable solutions as demonstrated here:

> ***"…as a specialist nurse*** **[previously]** ***you might have done a memory test, but then as an Advanced Nurse might have questioned if that was this the most appropriate tool to use?***
> *Looking at if not, why not and you know, also what are other people doing with tools erm… what's* [happening in] *general practice? It's thinking about other things that feed into your service, and how you can improve services as well as an advanced practitioner …"*
> *Alastair: "… so it's bigger thinking?"*
> ***"… yeah, thinking outside the box and also collaboration erm… not just other areas, maybe other nurses outside of erm… the area where you work and bringing their practice back into your own practice, expanding on it erm****… for example driving advice, the consultants are simply all doing (just) tick boxes for patients to give them their driving licence back, whereas we have actually looked at, does a patient understand what this is for? Could we develop our own driving tool for our patients to do? Also, what else do other tools ask (patients) about their memory and sleepiness …plenty to evaluate"*
>
> Case Study 2: Interview 5, Lines 570-90 Participant 13

Examples of quality services were exemplified: first, when sufficient time was allocated for consultation; and second, when fragmentation was removed as in this example of a 'one-sStop shop' approach. These examples demonstrated the potential of what was possible where restrictions on the scope of Advanced Nursing were removed, and collaboration was allowed to flourish:

> ***Participant 14: "I look forward to my clinic on Friday morning, I fought to get forty-five minutes…"*** *(Alastair – hum mm),* ***"…which I eventually got because I tend to do everything in that clinic…"*** *(Alastair – yes), "…and* ***even if it's cognitive assessments full neuro exam whatever you know I'd sooner do everything in that one clinic, so much better for patients…"***
> ***Participant 13: "Yeah, similar to my therapy clinic that's started"*** *(Alastair – yeah)* ***"…its a one-stop shop for erm… people that are having certain treatments****, before they would go to the consultant, then the consultant would send them for various blood tests or for ECG's they might collaborate with gastro they might collaborate with respiratory radiology and* ***now I do it all in the one sort of advanced clinic…"*** *(Alastair – yes) "…and that is collaboration in itself, whereas we weren't doing all of those things before." (Alastair – right …)* ***"the collaboration with other areas and with other ANP's has increased."***
>
> Case Study 2: Interview 5 Lines 611-38 Participant 14 and Participant 13

- Category: (C16) Practical Responses to Complex Problems

The importance of the level of practice, considered earlier as a critical defining feature of Advancing Nursing Practice, was further explained with reference to providing practical responses to complex problems, making decisions, applying judgements, and managing risk. A clear contrast was drawn in attitudes, approaches and skills between Advanced Nursing and medicine. Advanced Nurse Practitioners spoke about the importance of the 'person' of the individual patient in relation to their condition, whereas by contrast doctors guided by the medical model tended to focus their attention on the patient's condition and how to manage that, rather than on the whole person.

Advanced Nurse Practitioners participants carried a very wide scope of skills, as discussed already, however, their high-level communication abilities and wider 'people' skills were utilised not only in the clinical pillar but throughout their broader non-clinical work. They built effective relationships, acting as effective collaborators within and without their teams. Participants pointed to the value of skills beyond traditional physical/technical skills, including negotiation and co-ordination skills which supported a personalised and flexible response to patient need. While to some extent these are nursing This broader skill set appeared more evident in Case Study 2: Non-Acute Service participants, which generally sought to provide patient-centred care as indicated here:

> *"but* ***a lot of the care quality comes in the communication, it comes in the organisation…*** **[of]** ***the care the knowing how to… make this patient's journey as painless as comfortable as smooth as possible for the patient and the family****, in the way that you have enveloped it in your effective communication," (Alastair "hum.mm")* ***"…so you straight away, intuitively know, I'm the link,*** *the physio knows about this, the OT knows about this, the pharmacist knows, and* ***you're almost like seamlessly, just do that, to know that's what is needed, and that's what nurses do, you literally, you know in the middle of that also juggling the other priorities could be the TTO's or whatever and we are just so good at that, art you know it is an art…"***
>
> Case Study 2: Interview 19 Lines 432-440 Participant 22

5.2.2.3 Summary of the Comparison of Findings Between Case Study 1 and 2

This section is a summary of the comparison of findings related to the second research question:

What is the contribution to Advanced Nursing Practice that comes from being a nurse?

Following the process of comparing and contrasting data in relation to the two case studies, which were the units of analysis for the study, codes generated were reduced to generate

Concept 2- Advanced Nursing

Case Study 1: Acute Services Acute Medicine/Surgery	**Case Study 2: Non-Acute Services**
Common Findings	
• Identity as a nurse was important to all nurse participants, including Consultant Nurses. • Emphasis of participants lay in holistic response to patient need, though this was obstructed where the emphasis of role was on medical substitution. • Being a constant presence, a connector and link between colleagues was important. • Participants carried the respect of medical staff, especially consultant medical staff, for their experience, knowledge and communication skills and for their practical responses to complex problems. They were often regarded as 'go to people'/'fixers'.	
Case Study 1: Acute Services Acute Medicine/Surgery	**Case Study 2: Non-Acute Services**
Separate Case Findings	
• Disease-centric role required use of the medical model limiting delivery of patient-centred care. • A narrow response to patient-need by seeing only part of the picture • No emphasis on unmet need • Nursing autonomy limited • No role in leading nursing	• Seeing patients through a 'nursing lens' and by using a nursing model key to delivering patient-centred care • A comprehensive response to patient need by actively seeing the whole picture • Focused on unmet need • Role in leading nursing, including input from consultant nurses • Significant role in leading nursing practice and developing nurses

Table 23: Summary of the Comparison of Findings Between Case Study 1 and 2

(Concept 2- Advanced Nursing)

5.2.3 Constructing Concept 3: Enablers

Concept 3: Enablers, was constructed from the range of participant views and perspectives about the actions and activities that led to the development of a culture that supported patient-centric Advanced Nurse Practitioner roles. Participants regarded these roles as dynamic, continually evolving and challenging practice, innovating and improving care. Categories were generated from codes, and during the analytical process were reduced to form two Super Categories, 'Making Advanced Nursing Practice Visible' and 'Making Advanced Nursing Practice Happen'. The findings are presented in Table 22 and are discussed with examples from both case studies in detail after that.

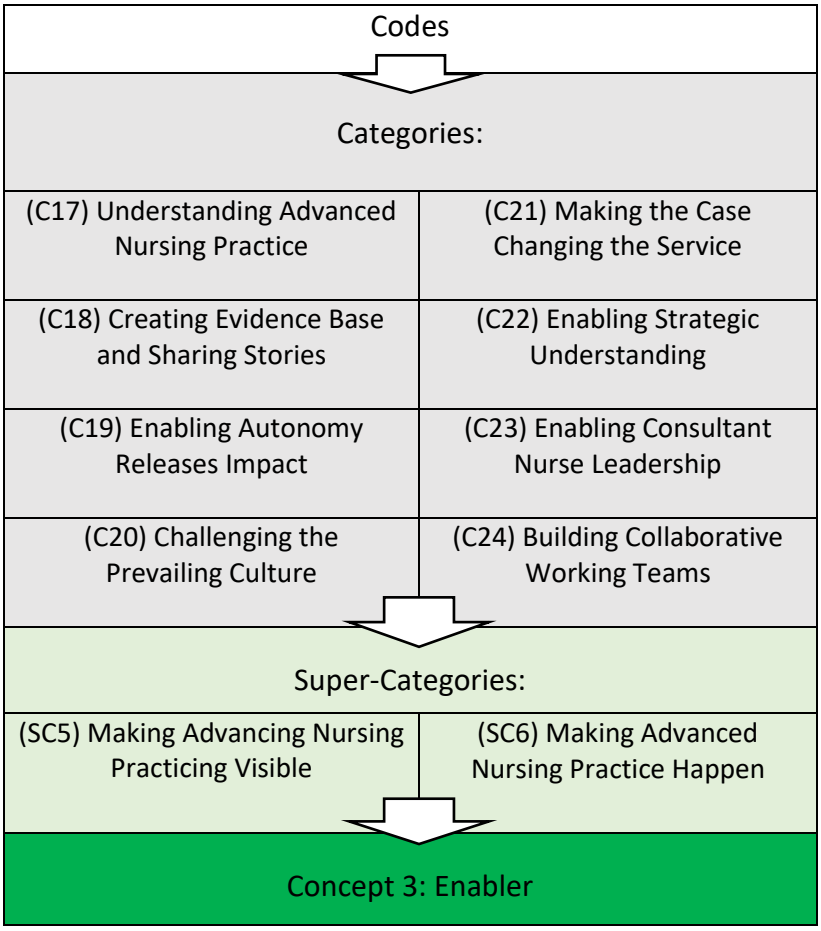


Table 24: Categories Analysed and Reduced to Form Super-Categories, then Reduced to Construct Concept 3 - Enablers

At the end of this section, on page 176 Summary Table 25 compares and contrasts findings in relation to Case Study 1 and 2. This set of findings addressed the third research question, and led to the generation of Concept 3.

5.2.3.1 Super-Category (SC5) Making Advanced Nursing Visible

- Category: (C17) Understanding Advanced Nursing Practice

The need to make the purpose and scope of Advanced Nursing Practice clear to colleagues was a high priority for participants. The prevailing participant view was that most colleagues, whoever they were either didn't understand Advanced Nursing Practice or had a very narrow view of what it was. In order to understand, participants reported that it was reduced to a notion they could recognise or to roles they were already familiar with. Consequently, a lot of time was spent explaining what the role was. It was particularly difficult to explain that there was not just one model, but that the numerous variations were normal, as commented here:

> ***"ok so I think the fact that people don't really know what we do,"*** *(Alastair "hum.mm")****"and I think it varies greatly what we do,"*** *(Alastair "yeah")* ***"and I think people tend to view it as a role … so they think we should all be the same and be able to do the same thing, but that isn't the case at all… we have like our foundation skills, and then we have ones specific to our clinical areas and what we are doing,*** [but] ***it's very different*** **[in different services]…"**
>
> Case Study 2: Interview 5 Lines 37-41 Participant 21

The predominant understanding was that it was a 'clinical' role, involving a high degree of 'disease-centric' activity. The challenge of trying to explain it did not always bring the clarity intended, as revealed in this extract:

> ***"…I think certainly within this trust some areas absolutely get what the role is about and the level of practice (Alastair "yes") "and some don't they haven't got a clue, ...they*** [senior management] ***are having to do a paper on it, to explain to our clinical director what it was although there are other ANP's / ACPs within that directorate."***
> *Alastair: "right, so why is that? …"*
> ***Participant 21: "…what, that it's misunderstood?*** *(Alastair "hum.mm")* ***"well, I think it's reasonably new…*** *in the big scheme of things …****the increasing numbers has made people more aware of it. They're aware of it but they're not really aware, they know they're out there, but they haven't got a clue what anybody does."*** *(Alastair "right") "…unless you work with one,* **[I was reminded of]** ***what an HCA said to me, 'does that mean you are one down from a doctor?'"*** *(Alastair – laughing …)* ***" I said no it doesn't, and she said, 'what are you then, one up from a nurse?', I said, no I am still a nurse it's just I've got you know I've got a bit more knowledge, so I can make different decisions about things…"***
>
> Case Study 2: Interview 5 Lines 49-61 Participant 21

This misunderstanding extended to participants too, especially during their initial training phase. The process of transformation and broadening of their understandings from the commonly held view, that Advanced Nursing Practice equated to disease-centric practice, to the view that it was about patient-centric practice, was expressed by this participant's experience during the Advanced Practice course:

> ***"…when I started I thought it was mainly going to be clinical,"*** *(Alastair "hum mm")* ***"…and I thought we would do a lot more on health assessment blood interpretation x-rays that sort of thing,"*** *(Alastair "sure") "…****that's the impression that I got from who was our nurse manager,*** *erm… which I* [now] *think is wrong* ***because having done the course it makes you realise that you just can't*** **[just]** ***focus on the clinical,*** *..its more than that." (Alastair "yes")*
>
> Case Study 2: Interview 5 Lines 37-42 Participant 14

The participant went on to speak about the personal conflict that her new realisations introduced to her practice because of the clash of expectations between herself and her managers, who perceived the role as very much disease-centric. She clearly contrasted the two types of Advanced Nursing Practice discussed so far:

> *Participant 14: "and…* ***well now I'm finding that I feel that I am just going around doing my job in a straightjacket because you've got the skills to do other things but I'm only required to do the clinical,"*** *(Alastair: "right.")*
> *"I've only witnessed* [Patient-centric Practice] *working in Gerontology (Case Study 2: Non-Acute Services),"*
> *Alastair: "right, so in Gerontology you see that or you perceive* [Patient-centric practice] *….?"*
> *Participant 14:* ***"yes, they're doing everything*** **[holistic care and management]**, *but* ***when I've, seen it in other areas like emergency department, cardio thoracic*** *(Case Study 1: Acute Services) whatever," (Alastair "yes")* ***"….it's ninety eight percent clinical*** *(Alastair "hum mm")* ***"…and it's all about who can put in the best chest drain, who can, you know, who can whatever,*** *… to me that isn't, I mean* ***before I did the course I thought that's what it was all about*** *(Alastair "sure")* ***"but it was only in year two you have the light bulb moment it actually clicked what it was all about…"***
>
> Case Study 2: Interview 5 Lines 49-61 Participant 14

Participant recognised that explaining Advanced Nursing Practice to new team members was essential in orientating them to effective roles and functioning relationships (Boulanger 2008). However, participants indicated that this required stamina, as the repetitiveness of undertaking this for each new cohort of junior medical staff was wearisome!

> ***"Every rotation*** **[Junior doctor changes]** ***for me, the longer I have been in this world of Advanced Practice, it is like swimming through treacle, because you say 'here we go again' you make progress and you do something and then you go here we go again, I'm having the same conversations I'm having to explain again….*** *some people* [Advanced Nurse Practitioners] *will get frustrated …and will move on and you get somebody else that's new and they've got to learn..."*
>
> Case Study 2: Interview 2 Lines 259-262 Participant 5

- Category: (C18) Creating Evidence Base and Sharing Stories

Participants recognised the importance of producing research evidence that could reveal what Advanced Nursing Practice was, and its impact when fully employed. They recognised satisfaction studies had been published (Corner 2003) and while acknowledging they indicated patient support for Advanced Nursing within Advanced Nursing Practice, they also recognised that they were limited. Other research drew comparisons between the clinical work of doctors and Advanced Nurse

Practitioners. However, Consultant Nurse participants were clear that not only more research was needed, but meaningful research and evaluation that connected innovation with clinical activity:

> *Participant 7: "… I think though (that) research projects are viewed as being a big thing and are going to take a lot of time, and* ***I think*** **[research revealing]** ***...being more innovative and looking at how you are working and looking at what isn't working why are we having you know why are our patients waiting for however long or whatever…"*** *(Alastair- hum mm..) "… I think it's about challenging the way we work and I know that's not 'research' but I think working in that way you're looking at… oh I can't think of the word…"*
> *Participant 6: "With objective eyes."*
> *Participant 7: "Exactly, you're challenging… yes, I think that ticks that box in a way*
>
> Case Study 2: Interview 2 Lines 859-869 Participant 7 and 6.

The research need expressed was narrowed to studies: which 'made the case', illustrating what Advanced Nursing could achieve when it was effectively recognised and supported; and the range of Advanced Nursing skills which participants claimed made as much a critical impact as physical skills applied to disease-centric practice. The research methodology was also discussed with regard to making findings visible as indicated in this exchange:

> *"I think it's how you communicate and listen and how you assess the patient,* ***it's recognising the significance of the things you are able to give that medics on their own can't give. It's all of those things and I think it's that, that you need to measure, it's got to be qualitive data,*** **[that will reveal]** ***what you are able to give…*** *and that's not taking away from what they* [doctors] *do,* ***but it's what we add to it …the nursing element that the doctors don't have …***
>
> Case Study 1: Interview 2 Lines 883-886 Participant 5

Most participants reported limited active involvement in active research, which appeared to be due to work pressures, but also lack of ongoing continuing professional development opportunities. Where development opportunities existed, they largely focussed on clinical subjects, not developing research skills. Most were involved in audit activity, and one specific example was of a participant in Case Study 2, who led clinical audit within her speciality, focussing on why patients weren't engaging with taking medication consistently. The audit led by her was ambitious and had notable impact on improving the uptake of medications prescribed taken by her patients:

> *"so, for example* ***I'm doing a medication audit at the moment across the trust of all medications that have been missed or drugs that shouldn't have been prescribed in Parkinson's. Its looking right from when they come in to A&E to right when they are going out, but idea is not just about the medication audit, it's then about them and if they had the medication appropriately, could we then reduce the length of stays and bed stays."***
> *Alastair: "so it's the impact?"*
> *"[Yes} it's the impact of that, and sending that to the trust….and that's very attractive and it's not wasted time then if you wanted to do some research from that. I know I would be very interested, doing you know some research around extended length of stay for patients in hospital with long term conditions. … that's how it can be sold to management … there's benefit to them!"*
>
> Case Study 2: Interview 5 Lines 500-512 Participant 13

Along with undertaking research discussed so far, the repeated sharing and telling of stories to illustrate the nature and impact of Advanced Nursing Practice was highlighted as a productive way of explaining and showcasing Advanced Nursing Practice to colleagues and others (Attenborough and Abbott 2020):

> *"…but* ***it's also about challenging people's understanding of our role, and although we do that and say what we do*** [it's still not well understood]. ***Today I was preparing a story board for a conference that we went to, so it's technically feeding back to the team what we did at this conference. But outside they say oh they are 'just in the office',"***
> *(Alastair – Hum..mmm)*
> ***The key thing is it's sometimes just reminding them what we have to do, to achieve those other pillars…. because we don't want to lose any of that…"***
>
> Case Study 1: Interview 7 Lines 100-101 Participant 15

In terms of what the stories should consist of it was suggested that they must clearly point to key characteristics and the benefits of demonstrating holistic, unfragmented care. The following extract is of a story revealing the power of holistic care, was of an encounter between a patient, the Advanced Nurse Practitioner caring for him, the chief executive of the Trust, as witnessed by a Consultant Nurse participant:

> *"…the chief executive came in and* ***he*** **[the patient]** ***said that he hadn't been, 'more thoroughly looked after in his whole life', he was confident…. he was clear and understood what we were doing, he knew where he was going, he was happy to go home, we'd done everything to explain and done all of his meds those additional bits*** **[treating him]** ***as a person rather than diagnostics or interventions…*** [then also] ***asking him, are you happy with this? do you know why we are doing that?***
>
> Case Study 2: Interview 2 Lines 895-918 Participant 7

The contrast between Advanced Nursing, providing comprehensive care, and the somewhat limited alternative of a disease-centric response, was reflected in this:

> *… that's not just clinically…. 'your bloods are much better', that's psychologically, emotionally, socially, (Alastair – yes) …* [the patient went on to say] ***'I'm prepared for this well, you did say that was happening, so I'm alright with that'.*** *Rather than* [an alternative approach] *saying well you're medically fit now, off you pop, yeah, lovely …. Bye-bye, see your GP if it doesn't settle..."*
>
> Case Study 2: Interview 2 Lines 895-918 Participant 7

Stories were also seen as useful in revealing the broad knowledge base Advanced Nurse Practitioners used, including both nursing, medical and other knowledge, but specifically selected based upon what was needed and how this was carried out to support the response the patient needed (Rolfe 2014b):

> ***'it's not what you do it's the way that you do it,'***
>
> Case Study 2: Interview 11 Line 76 Participant 7

The approach of Advanced Nursing within Advanced Nursing Practice was regarded as unique among the health professions, with flexibility and adaptability demonstrated consistently and regarded among essential distinguishing features. Certain stories revealed insight into how services developed and offered explanations as to why Advanced Nursing Practice was perceived as a solution to problems in those services. Indeed, it was reported that Advanced Nursing Practice had been proposed to 'see if it would work', rather than with a clear business case. This was exemplified here in an exchange between medical and nurse consultants:

> *"…I have had a number of* [Medical] *consultants come and speak to me and say* ***'we want some of those ANP's… and I've got some you know who I think would be great, and have got some money' But the first thing I say to them is what's your problem? What's your issue? What do you want them to do what are you trying to achieve by implementing Advanced Practice here because if it's not linked to service improvement or development or workforce design you're off on a back foot…"***
>
> Case Study 2: Interview 11 Lines 131-6 Participant 7

The power of stories was further exemplified in the transformation of thinking of one of the consultant medical staff participants, when speaking of his own journey of learning that led to his view that Advanced Nursing Practice had for him now become irreplaceable. This had not always been his view:

> *"…and as you move through your career whether it just that you become more used to it as a consultant,* ***you see the value of ANP's erm… I think certainly the way it works in this Trust… I think that they are irreplaceable."***
>
> Case Study 1: Interview 19 Lines 73-75 Participant 31

- Category: (C19) Enabling Autonomy Releases Impact

Where autonomy was enabled, participants' practice flourished, and job satisfaction improved, but when it was restricted the range of practice was narrow and this was frustrating:

> ***"… You know I remember an ANP saying to me once, "I am going to be an SHO for the rest of my life"…"*** *(Alastair "laughing …") "…because* ***that was her perception, you clerk your patients, you discharge your patients, you do your TTO's, and its very task focused its advanced level tasks but it is still tasks isn't it?*** *Nonetheless* ***if you look back on a service and five years later and it's still doing the same things, you haven't advanced anything so what was that purpose of that role other than being a replacement?***
>
> Case Study 1: Interview 11 Lines 59-65 Participant 7

Another participant noted that autonomy was associated with a mindset of 'pushing the boundaries of practice', but that this was not limited to those titled Advanced Nurse Practitioners, it was also seen in experienced nurses who had a broad range of skills, personal and professional values, and a vision for patient-centric practice, which they advocated and pursued in their daily work.

However, not infrequently participants attempting to develop their autonomy were restricted, leading to feelings of disempowerment, limiting their wider impact on, improving patient care, developing their teams, and the wider service.

Category: (C20) Challenging the Culture

Participants reported ignorance about Advanced Nursing Practice among leaders and commissioners of services they were involved in. This appeared especially true among Case Study 1: Acute Services, where the prevailing culture among the management of those services appeared at best to be ambivalent, and at worst hostile to the concept. Moreover, where Advanced Nurse Practitioners deviated from the perceived central purpose of providing a medical replacement/ disease centric function, this was obstructed. While participants commented on their developing clarity about the breadth of the role from the outset, they also revealed limited confidence in expressing their developing thoughts about their role as their knowledge and experience grew:

> ***"… I wasn't proactive at the beginning and I hadn't really got a vision for myself, what my role would look like at the end of the course…"*** *(Alastair: "right")* ***"…but now I have got a vision of what it looks like, well, I'm doing it (laughing) I'm doing it!"***
> *Alastair: "So, what is stopping you now…?"*
> *P 13: "… I'm putting the case to them so it's in process now (Alastair: "ok I see")* ***"but I don't think you can just…I think you need to [grow] and I don't know if I would have been able to argue the point enough at the start of the course."***
>
> Case Study 2: Interview 5 Lines 400-410 Participant 13.

However, where participants persevered with explaining the potential of Advanced Nursing to colleagues, and took risks demonstrating their potential, they were often rewarded with further influence. Participants in Case Study 1: Acute Services - Surgery, reported how their role initially had been to fill the gaps left by missing medical staff, however, over time as their consultant surgeon supervisors became confident in their developing skills they were entrusted with more and more responsibility. They in turn used this to widen their role from being medical assistants, using their enhanced autonomy to impact every area of the service to deliver a less fragmented service, as captured in this snapshot:

> ***"…my experience last week I was seeing a patient in clinic.*** [When] *I do a clinic, I do the consenting and all for theatre and then of course they come* ***on the morning of their operation I'll be there*** *reconfirming their consent and they knew that I'll be in the theatre to assist the surgeon* ***then post op when you go and see them in the ward*** *instead of seeing someone else you've gained their trust already just speaking to them before the surgery…" (Alastair: " sure")* ***…they*** **[Consultants]** ***trust you will look after the surgery aftercare*** *and you will do all the letters for them to go home so* ***you already have that bond between a nurse and a patient and you have the trust of the surgeons who's done the operation…*** *(Alastair: "sure")* ***"… so it works well with the patient journey…"***
>
> Case Study 1: Interview 4 Lines 178-188 Participant 11.

Participants became established as a continuing presence for patients, who saw them at every stage of their journey. They clearly valued their distinctiveness first as nurses, using nursing skills as key communicators, becoming consistent reference points enabling continuity for all members of the multidisciplinary team. As their influence grew so they became regarded as significant and indispensable to the effectiveness of the service:

> *Participant 11: "…there are other things that doctors only do which we can't do* ***and thing's that nurses can do that doctors cannot do, we come in the middle*** **[influencing patient care]** ***… because we understand how to talk to the patients, we understand how to listen to them as well because the consultants, some of them haven't got the communication they don't know how to talk to patients… so I see myself as a nurse*** **[primarily]…"**
> *Participant 10: "… with what number eleven said it's a nice position in the middle ground* ***we are in the middle, as we call ourselves, because as she said earlier on we are the patients voice because sometimes we reason with the consultants this is what the patients saying and sometimes the patients can't understand and what the consultant wanted to convey so you are the ones giving them*** [patients] ***understanding too…."***
>
> Case Study 1: Interview 4 Lines 716-723 Participant 11 and 759-762 Participant 10.

Direct patient interaction was also supplemented by integrated expressions of four pillar activity, including providing support and education for the nursing team, which in turn improved nursing care:

> *Participant 12: "… because we are part of surgical team* ***we go around the hospital all the surgical wards It's not only one ward and we can see when is there which ward which nurses lack of some maybe information or they need teaching****…* [so, then we go to] *one specific ward maybe lunchtime, maybe take poster or board with us and do quick fifteen minutes ten minutes presentation or something that's important for the specific ward. "*
> *Participant 10: "…if they need teaching you have to give that teaching you have to feed that hunger so you can all work together" (Alastair: "sure")*
> *Participant 12:* ***".. you have to realise how important it is teaching educating all nursing staff [including] student nurses…this is very important, and is part of our role."***
>
> Case Study 1: Interview 4 Lines 410-415, 443-447 Participant 12 and 10

One of the consultant nurse participants, from Case Study 2: Non-Acute Services (Gerontology), spoke of her previous experience as a modern matron in influencing her service's clinical director to support development of a comprehensive Advanced Nurse Practitioner service. This led to establishing a consultant nurse role, introducing governance arrangements, including sound policies, job plans and job descriptions, reflecting the full scope of Advanced Nursing Practice:

> ***"…, I had to move out of an Advanced Practice role into a nurse management role to implement a service, to try and influence what they would do, and then I was in a position to then influence the CD*** [Clinical Director]***to say we need to do this this and this…****, then when he said 'great, can you do that?', I said absolutely not, that's not the role of the matron,* ***it's the role of a Consultant Nurse'.*** ***'*****[He said…]** ***…well we need one of those then, don't we?'*** *It was almost like taking one for the team, one for Advanced Practice and that's the interesting question I had when we had that conference, somebody said to me, 'do you think you would have got where you are if you hadn't been a matron?' I probably would have done but* ***maybe the desire for that role wouldn't have been there if I hadn't been influential managerially…" (Alastair Hum mm…) "..and the difficulty*** [for other Advanced Nurse Practitioner services] ***is whilst they don't have the influence managerially, they won't have the input to shape the service, reflective of what it should be…."***
>
> Case Study 2: Interview 2 Lines 731-743 Participant 7

5.2.3.2 Super-Category: (SC6) Making Advanced Nursing Practice Happen

- Category: (C21) Making the Case, Changing the Service

The major issue referred to repeatedly by participants was a widespread and persistent lack of understanding and clarity about the role, it's scope and purpose for all concerned. This was often also true of participants as they started in their roles. Interestingly this spoke of the personal and professional journey thy were on which they recognised in how views and perspectives changed throughout the course. Case study examples and stories were an essential means of making the argument for the Advanced Nursing element to be supported and promoted within Advanced Nursing Practice. The following are examples of roles shaped initially by a medical replacement/disease-centric mandate:

> *Participant 11:* ***"…when we came into this job it wasn't structured*** *so that frustrated other people that they had to leave the job because it wasn't structured…" (Alastair: "right")* ***"…so you have to have the perseverance to see… where you want to go…to see that we get to the level.*** [At the beginning the consultants] ***they just say that this is the job we want you to do but it's up to you to build the job to build the role to make it what you want it to be…"***
> *Alastair: "So they were giving you autonomy?*
> *P 11:* ***"Yes, I think it is autonomy, because if I look back from where we started we thought our job was to do cannulas to take bloods just do the small things, now that I have new skills and when I go to work I don't take bloods I don't even do cannulas, but I am doing a different a totally different job, so it is a vision if you have a vision to what you want, you can shape it to what you want it to be so the role is what you want***
> *Participant 10: "…it's a bit different in surgery because in the hospital you've got the medical team* [Acute Services] *who have got the* [Advanced Nursing Practice service] *structure already* ***we are the first one we have five of us started the job and two left…" (****All: Laughing) "… because there was no structure, we were thrown in at the deep end at first … that's what we are thinking and when they have thrown us on the job we are with FY's* [Foundation Year doctors] *What does FY's do? Just follow what the SHO or the registrar does…" (Alastair: "hum mm")* ***"…and then we were sent to uni*** [MSc Advanced Practice Course] ***and then step by step in time we have developed the role and now after three years we have started to have a structure. We have also started to recruit more colleagues, …from three to five to, now we're twelve…"***
>
> Case Study 1: Interview 4 Lines 818-843

Over time the personal and professional development these participants experienced led to an increased sense of what their role could be, and the influence that they as Advanced Nurses could have. No matter what other agenda colleagues had, these participants felt able to pursue their vision:

> *"yeah **it's highly medically related isn't it, that's why they** [senior managers] **bought into it…the operational department brought in having ANP's, because they wanted assistants with the medical bit,** [BUT] **we bought in with it because we wanted to utilise our nursing knowledge and expand on that…***
>
> Case Study 1: Interview 7 Lines 618-20 Participant 17

- Category: (C22) Enabling Strategic Understanding

Where understanding of the relevance of Advanced Nursing grew, and where it carried the support of service managers, so its influence grew. This was particularly so where managers also had a key role in initiating the service. Continuing positive and passionate leadership was significant in enabling an ongoing strategy to embed the role, and so build and empower what were initially, emergent teams.

Participants commented that the Trust lacked clear vision for Advanced Nursing Practice. Central leadership was reported as limited following the departure of the former chief nurse, at the outset of this study, who had heavily backed development of the role. Indeed, their influence led to the appointment of several Advanced Nurse Practitioners, subsequently recruited as participants in this study. Nonetheless, lack of understanding among senior managerial and clinical leaders in the trust was widespread, and inaccurate or confused thinking frequently hindered both development and operationalisation of the role. The desire by participants for central leadership was evident, and it was proposed that the appointment of a Trust Strategic Lead role would make a considerable difference. During the latter period of the study, several participants pointed to the promotion of a senior nurse, who had come from a consultant nurse, matron and Advanced Nurse Practitioner background, of whom they were expectant would make a difference to strategic direction of Advanced Nursing Practice in the Trust over time. As a participant in the study, she commented on her own expectations:

> *"it's almost this evolving, **we aren't there** [yet, it...] **is an ever- growing workforce, but whilst you've got pockets of this, that and the other, and indifference….** [This is…] **the reason that I've taken the job that I have done, it is to influence trust-wide..."** (Alastair – hum……) "…**that's what I am doing, it's an entire trust wide review of advanced practice,** yeah, who have we got, what do they do, who are they managed by, who shapes them, yeah, who develops them, what banding, what's their service doing so we'll know…" (Alastair "yes") "Yeah, **what do we mean by** [defining] **Advanced Practice…where do we need to raise the bar?"***
>
> Case Study 2: Interview 2 Lines 264-278 Participant 7

Meanwhile, individual participants who made the transition from a 'clinical only' focus to embrace the breadth and depth of Advanced Nursing, included leadership, role modelling and innovation and recognised the significance and potential of consultant nurse s in supporting their roles. They saw this as a critical part of establishing and embedding Advanced Nursing within Advanced Nursing Practice.

Indeed, participant Consultant Nurses were active, having a significant impact in shaping and developing Advanced Nurse Practitioners, as well as the services they worked in. However, the Consultant Nurses were not themselves well supported by the trust senior nursing community nor effectively connected into existing senior nurse structures within the Trust. This will be revisited in the 'Concept 4 Restrictors' section from page 178. They were clear that wider support was needed throughout the senior nursing structure, up to the most senior level:

> *Alastair "hum…. you seem to have identified that nurse managers don't understand about the role of Advanced Practice or Consultant Nurses. Clinical Directors don't, medics don't, administrators don't. Seems that there's a massive educational issue here of trying to explain what it is?*
> ***Participant 7: "Yes, I think it has to come from the top, the chief nurse needs to…"***
> ***Participant 6: "… I think it has to come from that level, or as you* [Participant 7] *did, you almost created it yourself …"*** *(Alastair "right")* ***"I think it needs to come from the nursing directorate level and I think the difficulty that we have all experienced is that we are really quite separate from the overall nursing umbrella (within this trust), we don't sit under any, you know we don't have an ADN (Assistant Director of Nursing) that we can, that we report to, or we're not a part, we're not a matron, so we're not part of that set up,*** *you don't hear the nursing issues erm…it's quite erm…..a separate role, we're not part of the operational things so you miss out on a lot of operational things*
> ***Participant 7 "I think that's it, it takes you to fight, the fight doesn't it…"*** *(Alastair – hum mm…)*
> ***"…as on the ground you're fighting the ACP fight, to get junior doctors and nurses and managers and people to understand what you should be doing, you have to still fight the higher up you get…"***
>
> Case Study 1 and 2: Interview 2 Lines 747-778 Participant 6 (CS1) and 7 (CS2)

These contrasting experiences indicate that where support from senior medical staff was present it often took time to come but was welcome where it existed, and did make a real difference as also indicated here and elsewhere (see page 190 and 192):

> *Participant 14: "…a real hindrance for me came from a lack of vision from management and lack of understanding of the role…" (Alastair: "I see") "… it's the team that I work with that have no idea the line manager and the consultants.* ***I've lost count of the number of times that I've been in the room that they've said when they have had new reg's, 'she's training to be a mini doctor'*** *laughing." (Alastair: "right").*
> *Participant 13:* ***"I think that if they* [can see it]*… my consultants that I work with they're very different , I have got very forward thinking pro-active consultants and I think they have been on the Advanced Practice journey with me and by the end of the course I think they understand what Advanced Practice is…"*** *(Alastair: "right") "…yes, I think they do*
>
> Case Study 2: Interview 5 Lines 376-391 Participants 14 and 13

- Category: (C23) Enabling Consultant Nurse Leadership

Participants referred to the need for strategic leadership to be in place for the role to flourish, and consultant nurse participants in picking this theme up, discussed their own roles as strategic leaders. This led to a realisation that, as was the case with Advanced Nursing Practice, there was also a wide lack of understanding about, and recognition of, the Consultant Nurse role. When colleagues tried to understand the role, it was frequently compared with what people knew already, the consultant medical staff role (Doody 2014). However, the Consultant Nurse was a different role, not readily comparable with anything already existing. Consequently, the Consultant Nurse body appeared to be an irrelevance for many, as described here:

> *"Well, before you address it* [lack of Consultant Nurses] ***I think really the problem, again people don't understand the role of the Consultant Nurse, particularly clinical directors.*** *You know they just don't understand about it,* ***so why would they actually need one?*** *And* ***the matrons don't really understand it, so there's no push there, the managers don't really understand it so why would we need one of these?"***
>
> Case Study 1: Interview 2 Lines 716-21 Participant 6

The Consultant Nurses also experienced being hindered in exercising strategic leadership. In seeking the authority and power that was equivalent to line managerial authority to make the differences required and implicit within the role they were often treated with indifference, reflected in largely being excluded from the existing senior nurse structure:

> ***"I think it needs to come from the nursing directorate level and I think the difficulty that we have all experienced is that we are really quite separate from the overall nursing umbrella at*** [the Trust] *… we're not part of that set up you don't hear… we're not part of the operational things so you miss out on a lot of operational things."*
>
> Case Study 1: Interview 2 Lines 767-774 797 Participant 6

They went on to speak about an existing Advanced Practice group, a trust-wide body representing Advanced Nurse Practitioners and Clinical Nurse Specialists. They felt that it failed to carry the influence that it could have if more motivated and focussed:

> *Participant 5 "and if you think about the Advanced Practice Group, what does that mean? (P7 "well exactly")* ***"…it doesn't shape or influence anything, so it's almost within our gift to them this is the thing we should be leading…"*** *(P7 "yes")*
> *Participant 5 "this is to say actually* ***this should be the voice of Advanced Practice*** [in the Trust.]*"*
> *Participant 7* ***"yes….to have influence and input.*** *Because you know I sit on the Nursing and Midwifery Committee which is at board level…" (P5 "yes") "and the Nursing Board, and* ***when we get the report*** **[from the AP group*****, it's like, 'somebody came to talk to us about this and somebody came to talk to us about'...but, what's that got to do with anything significant…?"***
>
> Case Study 2: Interview 2 Lines 798-814 Participants 5 and 7

An interesting argument emerged for a consultant nurse to be appointed into post to establish an Advanced Nurse Practitioner service first, before recruiting Advanced Nurse Practitioners:

> *"…**there's an argument for putting the Consultant Nurse role in first to say actually what would advanced practice do, what would it look like how would it be shaped** erm… **what are the benefits what would be their non-clinical role what influence would they have so you have got that strategic level thinking and influence to be able to say I have got a vision for you…***
>
> Case Study 2: Interview 11 Lines 119-122 Participant 7

This was reflected in what another Consultant Nurse participant, from Case Study 2: Non- Acute Pre-Operative Assessment Service had achieved. She recognised and promoted nursing as central to her vision for excellent patient-centric care and management. She spoke of the importance of promoting patient-centric care and the four pillars, and consequently the Advanced Nurse Practitioners in that service, also participants in this study, described their roles as integrating four pillar activity within their everyday roles. They had a very active clinical role, carried a high degree of autonomy for decision making, and were heavily involved in education, team building and innovation. She noted the need to recognise two very significant issues: first, why each service had been set up; and, second, where it was in its development journey:

> *"sort of leading on from that I think it can be variable, **so there should be the four pillars,*** [but**] *I think that can vary depending on the specialty but also the point in time of that speciality or service,… those pillars can flux and the weight of each of them can depend on what's going on. So for example in my service erm.. in the last four years is that we have had a lot of service development,** so I know like in your* [refers to another participant's] *service, you say a lot of your practitioners are weighted quite clinically and they struggle with the other ones. So **my girls have had the opportunity to do a lot of the leadership and the other pillars but they'll be other times where the demands of the everyday service is to just see patients…."***
>
> Case Study 2: Interview 2 Lines 25-31 Participant 20

What was significant about this Consultant Nurse was that she carried service management responsibility. This was interesting because participants generally reported that it was service managers who limited support for Advanced Nursing activity and supported medical replacement/ disease-centric emphasis instead. The difference in this instance was that she understood Advanced Nursing Practice and supported it. Another participant emphasised that origins and set up were key to what sort of service would emerge:

> *"I agree with you, where it comes from… speciality wise…*[dictates the focus]… ***for our service we try and do all four pillars of Advanced Practice, however I am aware that there are areas within this and other organisations*** [Trusts] ***where predominantly there is one pillar which is more prevalent than others, which is clinical, because it depends where the premise for the role comes from…"***
>
> Case Study 2: Interview 2 Lines 17-20 Participant 18

Participants recognised that the significance of Consultant Nurses was a low priority for Trust managers. However, they argued that strategically appointed Consultant Nurse roles would provide the necessary strategic service leadership that would facilitate fully enabled Advanced Nurse Practitioner roles and that both should be included in workforce plans. These Consultant Nurse participants recognised their role in providing leadership for Advanced Nursing Practice where it did not exist:

> *Participant 5: "…there's two sets, there are people* [Advanced Nurse Practitioners] ***who want to do the job with all four pillars and complete the whole role…"*** *(Alastair: "hum mm…")* ***…"*****and you've got those others that actually 'that's all I want to do…"**
> *Participant 7:* ***"…medic's by proxy almost.."*** *(P 5: "Yes, hum…")*
> *P 7:* ***"And that is up to the leaders, people in this room,*** **[Consultant Nurses]** ***to actually make sure that doesn't happen"*** *(Alastair: "hum….")*
> *P 5:* ***"and look at… what's worrying is how many services don't have those leaders***
> *P 7: "exactly yes, yes"*
> *P 5:* ***"and therefore there's no one there dragging them back to reality, 'this is the role this is what your job is, and these are the aspects*** [Pillars]***…"*** *and also within our groups* [Services] *that person* [the Consultant Nurse] *is battling away with, you know, the pressures of a medical rota…* [Service managers insisting…] '*actually you are a medic, so you will do'…"*
>
> Case Study 2: Interview 2 Lines 661-673 Participant 5 and 7

The Consultant Nurse participants felt that lack of senior trust managerial and medical support directly contributed to the limited impact of their roles, which also restricted their impact through the clinical leadership that they could otherwise have provided:

> *Participant 6:* ***"you know we need to move away from the medic's defining what*** [we] ***really what we do erm… and until there's*** [policy] ***documentation around that, of people at this clinical level …*** *for a trust our size* ***four consultant nurse posts it's not big enough and not influential enough****. We need people to rise out of this and say ok let's influence it out of all these 'pockets'* [Services]. (Actually***…"there's only three consultant nurses in post now*** *don't forget, whether they will have a second one in acute medicine who knows?"*
> *Participant 7 "yeah and look where we've got areas of large teams* [of Advanced Nurse Practitioners] *… in surgery, ED…"*
> *P 6:* ***"and they're currently being managed by a consultant medic…"***
> *P 7: "it's very worrying…"*
> *P 6:* ***"…yes, it's very worrying because they*** [Advanced Nurse Practitioners will tend] ***to go down that medical model route erm…"***
>
> Case Study 2: Interview 2 Lines 298-300 Participants 6 and 7

The limited number of Consultant Nurse posts was unhelpful, more were needed to achieve the critical mass that would help develop momentum and impact for Advanced Nursing within Advanced Nursing Practice, importantly it was noted this could not happen overnight and would take time (Pottle 2018). Participant 6 identified the risk of Advanced Nurse Practitioners not achieving their potential as Advanced Nurses in the absence of supportive leadership and in the face of overwhelming pressures to settle for disease-centric medical substitution practice.

- Category: (C24) Building Collaborative Working Teams

Participants reported that service leads and managers tended to be narrow in their interpretation of the focus for the Advanced Nursing Practice, essentially supporting gaps in the service and getting patients through the system as quickly as possible:

> *Participant 15**: "I think there is still a lack of knowledge about of what are the whole areas of our roles…"** Participant 16: **"yes definitely…"***
> *Participant 17: **"whenever there's a queue, whether there's a queue for anything… The first thing that's said*** [by THEM is] ***where are the Advanced Nurse Practitioners? What are the Advanced Nurse Practitioners doing? Why are they in the office?"*** *No 16 – yes ...*
> *Participant 17: **"… we have undertaken teaching…audits…service development*** **[but]** ***when the poop hits the fan, its…. 'Where are the Advanced Nurse Practitioners?' that's what we are here... we're here to cover the juniors…there is a heavy reliance on clinical."***
>
> Case Study 1: Interview 7 Lines 86-96 Participants 15,16 and 17

On asking who 'THEM' were, participants referred to senior nurses and service managers, who variously interacted with and directed Advanced Nurse Practitioners activity toward disease-centric practice. Participants felt managers did not see the bigger picture of the Advanced Nursing Practice role: the potential for delivering patient-centred and not just disease-centred care; nor of the need for strategic leadership and co-ordination of team activity, facilitating team development and communication. Participants were clear that building more effective teams and using the range of skills available would lead to improvement in the overall patient journey. However, service managers actions and decisions appeared overly constrained by Trust priorities and immediate concerns about the patient journey:

> ***"…one of the things that I am noticing because we were involved in setting the service and now that we are up and running, one of the things that is a constant struggle, I think it is common any way anywhere*** [across the Trust], ***I think the struggle is actually translation of the clinical priorities and the service provision priorities and the sort of corporate stuff that happens in delivering the hospital*** [Trust agenda] *as a whole"* [Alastair "sure"] ***"… because in our area discharges…*** [are] ***focused*** [on] ***as the holy grail as it were, you know, and I hate to say it,*** [but] ***at the expense sometimes of the quality of how you deliver the service and I think where we could make improvements and*** [this is] ***where our leadership would probably come in is our involvement actually in the strategic side of the service***
>
> Case Study 2: Interview 10 Lines 219-227 Participant 22

Participants had ambition to achieve more and bring meaningful contributions to decision making, innovation and problem solving, but were hampered when managers and service leads adopted a reactive rather than proactive stance, deploying Advanced Nurse Practitioners to meet only immediate service needs. Interestingly this was in contradiction to the espoused view of some:

> ***"I would say that, yes, we are being made into mini doctors I would say the prime example you know we are there to fill short comings in terms of the medical workforce the majority of the time, although our lines managers would say no you are not you are there to educate and to carry out research to lead people…"***
>
> Case Study 1: Interview 3 Lines 778-779 Participant 9

Participants suggested better service and workforce planning would support better skill mix of staff. One of the experienced Consultant Nurses emphasised that a detailed workforce plan was critical to ensure all aspects of Advanced Nursing Practice were included in their service delivery:

> *" (it's about)…* ***a model of service planning that… because if*** [Advanced Nursing] ***is not built into your work force plan and your coverage of service your delivery of service will all be about how many people on the shop floor clerking patients*** *(Participant 6: "yes")* ***"…demand outweighs your capacity, …overwhelms your capacity, so you fire fight all day just to get through demand, and if you don't have any breathing space, head space you don't have the time to think of the other pillars and of how you can develop (them)…. you do it, but it's a bit lip service*** *…"*
>
> Case Study 2: Interview 2 Lines 475-492 Participant 7

The consequence of a lack of thorough workforce planning and collaborative working was at the root of 'gap filling' and relative 'quick fixes', rather than carefully and skilfully building teams to meet patient needs and improve services. It was concerning for participants that limitations on the kind of service that was provided arose from flawed service design, and models of service delivery not fit for purpose, since they were not sufficiently focussed on patient's holistic needs. An alternative was proposed:

> ***"…but if you think of designing Advanced Practice, it should say"*** *(Alastair – hum.mm) "****right, take everybody out, put your patients back…"*** *(Alastair: "hum.mm"). "*[Then ask] ***what do they need? Do they need it? What skills, what knowledge what ability, what time of day, what's the service delivery model, what does it need to look like, who can deliver that who should be doing that, what are the skill set of your nursing team, what does that make up look like?"*** *(Alastair: "hum. hum")* ***"Why wouldn't there then be a role for Advanced Nursing in that, because you have got CNS's*** [Clinical Nurse Specialists] ***and Advanced Nurse Practitioner skills without medicalising it…."***
>
> Case Study 2: Interview 11 Lines 308-313 Participant 7

The main thrust of participants' comments emphasised the need for Advanced Nursing in service delivery, because it supported unfragmented, holistic care and management. This extract reveals insight into the team development journey of the Case Study 2 - Non-acute Gerontology team, formed with a patient-centric emphasis:

> ***"…we didn't really start out as a team that was supposed to be medical replacement, that wasn't the rational for our existence, it was very much about we wanted to set up a team which was nursing led, autonomous and a key partner in service improvement, you know for care of the elderly that really was the vision…"*** *(Alastair: "yeah")* ***"…and because it started out like that then… we went through thick and thin we went through all the storming and norming and all that but because we've managed to come out of it as a separate entity of autonomous nurses we've managed to actual retain that brand…"***
>
> Case Study 2: Interview 16, Lines 577-584 Participant 22

Having established their team based upon the principles of Advanced Nursing, an interesting observation came from a participant working in Case Study 1 - Acute Services - Acute Medicine. He criticised his fellow Advanced Nurse Practitioners for not sufficiently building their medical knowledge and skills to enable them to confidently address disease processes for their patients:

> *"I work as a band five staff nurse over in a hospital which has ANP's working with doctors, I see first-hand as a band five staff nurse doing a bank shift,* ***the Gerontology ANP's just see medically fit patients, whereas*** [in my ANP role in Acute Medicine] ***I pick up and take over a patient who has been seen by a doctor and I will see in my*** [assessment] ***work that this patient is septic and you know… why hasn't this been brought up picked up by the actual doctor?*** *So you know* ***I would say that the ACP/ ANP Gerontology should be seeing medically and non-medically fit patients because I think care could be better…"***
>
> Case Study 1: Interview 3 Lines 723-728 Participant 9

This was a relevant point since not being able to deliver appropriate medical care within their scope, was just as limiting for patients, as it was where Advanced Nurse Practitioners were not enabled to deliver Advanced Nursing input where that was needed. Both types of the clinical pillar, disease-centric and patient-centric care and management were needed.

Moreover, participants working in Case Study 2 - Non-acute Gerontology, recognised that not only did patients need a blend of both disease-centred and patient-centred clinical responses, but it was also inappropriate to ignore the nature of hospital services as predominantly doctor led. Consequently, there was a development journey occurring of finding a different way of working collaboratively with both the medical staff and other health professionals to promote delivery of patient centred care:

> ***"…so that leads me to the biomedical model, we had to face*** [the fact] ***when we joined the team that that is how hospitals work. There's no two ways about it, you know a lot of the higher things that happen in hospitals are doctor led, consultant led, and I think only now we're realising we need to sort of like stop thinking like that,*** [being controlled by biomedical model thinking] ***and probably do more lateral thinking, out of the box, actually appreciate it and the input of other professions.*** *I do think that's changing,* ***most certainly changing especially here in our speciality because a lot of our problems are multifactorial because you do need different specialities to come to the floor together and sort this bit out,*** *you need to refer to many sources to get one problem sorted…* ***because that is what how we think I think there is a change for this department they are listening more to our point of view I suppose"*** *(Alastair: "right") "…but in the beginning it was it was not like that it was really like you prove your worth you need to show us you are equally capable shall we say…"*
>
> Case Study 2: Interview 16 Lines 591-602 Participant 22

.

As they demonstrated effectiveness and built relationships, so they found a new level of collaborative team working, where their voice was heard, and their contribution valued. A consultant physician in their team made the following comment about Advanced Nurse Practitioners working collaboratively between nursing and medicine:

> ***"****erm.. well they*[ANPs] ***have got a better handle I think of how to manage patients with long term conditions erm.. they understand the nature of chronic conditions they understand that patients can deteriorate and the ways that they can deteriorate, so can be quite good in spotting early signs of deterioration of patients that are sitting on the wards,…and there often the things the doctors ignore because their more focused on the acute exacerbation of COPD they forget about the bowels and the water works and that sort of stuff so again the ANP's seem to be better at picking up on that erm...*** *There was a debate when we started with ANP's what were they going to be, were they going to be super nurses or erm…replacement junior doctors? (Alastair:* ***"****hum.mm")* ***"****Laughing…I am not sure that's necessarily been answered and* ***I think they are a bit of both to be quite honest…"***
>
> Case Study 2: Interview 17 Lines 84-87, 106-110 Participant 29

5.2.3.3 Summary of the Comparison of Findings Between Case Study 1 and 2

This section is a **summary** of the comparison of findings related to the third research question:

What helps nursing to develop and be expressed within Advanced Nursing Practice?

Following the process of comparing and contrasting data in relation to the two case studies, which were the units of analysis for the study, codes generated were reduced to establish:

Concept 3 - Enablers

Case Study 1: Acute Services Acute Medicine/Surgery	**Case Study 2: Non-Acute Services**
Common Findings	
• The need to explain Advanced Nursing Practice was necessary, but was laborious to break through preconceived ideas • There was need for qualitative research and clear examples of Advanced Nursing Practice to demonstrate and reveal its potential • Advanced Nursing Practice was associated with being a 'constant' positive presence. This was important in enabling efficient service flow, through expert communication skills, support, education, challenge and promotion of innovation, all of which were characteristic of Advanced Nursing. • Why Advanced Nursing Practice Services were set up dictated its character • Where services were placed in their developmental journey was significant for the type of Advanced Nursing Practice that was demonstrated • Better workforce planning was needed to ensure effective Advanced Nursing Practice was found in service delivery.	
Separate Case Findings	
• Set up as medical replacement/ disease-centric services • Had a restricted vision for role, majoring on clinical pillar and gap filling. • This type of role (Type 1 Advanced Nursing Practice) supports existing culture rather than challenges it • Stories about the role emphasise disease-centric, not patient-centric practice • Participants proving effectiveness or 'worth' was important (surgical service) in gaining support for inclusion of Advanced Nursing.	• Typically set up as an Advanced Nursing service. • Broad vision for role, beyond just clinical pillar • This type of role (Type 2 Advanced Nursing Practice) challenges existing culture • Autonomy was associated with clear vision and proactive mindset • Stories about the role emphasise holistic benefits of Advanced Nursing • Consultant Nurse leadership needed to establish service on right footing from outset • Medical Consultant support significant

Table 25: Summary of the Comparison of Findings Between Case Study 1 and 2 (Concept 3 - Enablers)

5.2.4 Constructing Concept 4: Restrictors of Advanced Nursing Practice/Advanced Nurse Practitioners

Concept 4 - Restrictors, was constructed from the range of participant views and perspectives about actions and activities that hindered the development of a culture that supported patient-centric Advanced Nurse Practitioner roles. Participants regarded these roles as dynamic, continually evolving and challenging practice, innovating and improving patient care. Categories, generated from codes, were reduced to form two Super-Categories, 'Concept Polarisation' and 'System Restrictions'. The findings are presented in Table 26 below and discussed in detail after that.

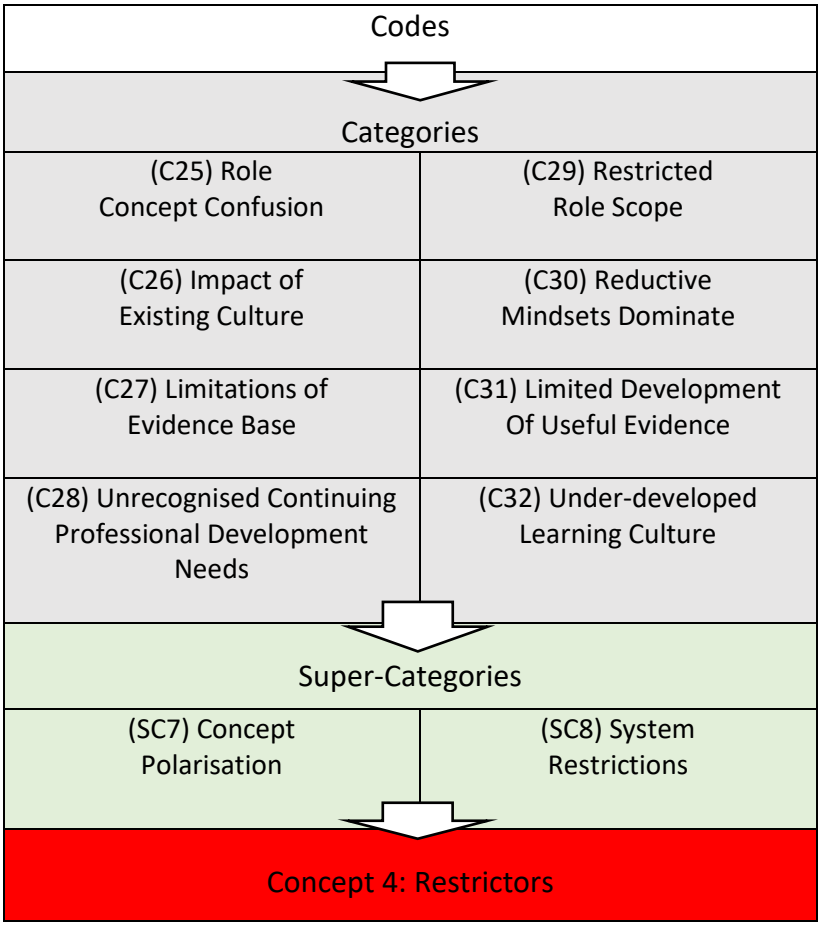


Table 26: Categories Analysed and Reduced to form Super Categories, then Reduced to Construct Concept 4 – Restrictors

At the end of this section, on page 197, Summary Table 27 compares and contrasts findings in relation to Case Study 1 and 2. This set of findings addressed the fourth research question, and led to the generation of Concept 4.

5.2.4.1 Super-Category: (SC7) Concept Restriction

- Category: (C25) Role Concept Confusion

A real conflict for participants was revealed at the heart of their activity and focused on this issue: was Advanced Nursing Practice a medical role, a nursing role or a mixture of the two? All participants who expressed a view valued nursing and their role as nurses and wanted to use and develop this within their work. However, defending where the role of nursing sat within Advanced Nursing Practice was challenging for them, especially at the outset of their roles, as they were of necessity focussed on learning medical skills and practices to support the Type 1 Advanced Nursing Practice that they were generally required to do. This applied most commonly in Case Study 1 :- Acute Services, but to a lesser extent in Case Study 2 : Non-Acute Services. Their relative inexperience at that level coupled with service pressures led to limited confidence in promoting 'Advanced Nursing', (see glossary page xviii), especially when the prevailing view by those leading and managing services was that Advanced Nursing Practice was largely, if not overwhelmingly perceived as a medical substitution role governed by a disease-centric approach.

Participants noted that in their experience there were a minority of Advanced Nurse Practitioner colleagues who had a limited value for nursing, and were content to downplay its application within their practice. One new member in the Non-Acute Service Gerontology team had been educated elsewhere and had worked in another trust where she was rostered as a member of the medical team. It was clear she intended to work in a medical substitute capacity in this service and was not interested in working in a patient-centric manner:

> ***Participant 25: "…she was introduced to Advanced Practice as a medical role, as a medical doctrine*** [mindset] ***and that's the difference. I think because we are nurses and our exposure*** [experience] ***has been led by nurses***, [it's been very different]*and I think* ***she's had a very different start … they were brought in as medical replacements so they were included straight off, this is at a different trust…"*** *(Alastair – "hum.mm")* ***"… they were included straight off on medical rotas and things like that and that's how the job was sold that they were going to be the medical replacement and a different approach***
> *Alastair: "ok so in your experience are you saying from that, that the socialisation even the educational course is significant in the shape of the role?"*
> *P 25:* ***"yes definitely I would say it was."***
>
> Case Study 2: Interview 16 Lines 376-386 Participant 25

This colleague posed a challenge for the existing team, who were unclear how in a service with a patient-centric ethos this would work. Nonetheless, participants both in this service and others located in the study felt it important to promote Nursing and retain their identity as nurses. They

expressed concern over the risk of losing the influence and impact of nursing if patient-centric practice was diluted. The majority of Advanced Nurse Practitioner participants felt their nursing skill set was undervalued and underutilised, and in others' eyes was superseded by more 'glamorous' medical skills and activities, embraced within 'Type 1 Advanced Nursing Practice' (see Chapter 2 page 37) with its disease-centric emphasis:

> ***"…the Activities of Nursing that are task based*** **[Medicalised]** ***are glamorised to a point, …****for example in surgery, so it's about wounds it's about you know post-op complications, so, you are so good at that and you show it, if you are in ITU, the machines and all that,* ***but actually when you look at it, a lot of the quality work that nurses do in that high stress environment, its nothing to do with those task-based things…"*** *(Alastair: "hum.mm") "because* ***your job is about delivering care…"*** *(Alastair: "hum.mm")* ***"..and a lot of the care quality comes in the communication, it comes in the organisation …. the knowing how to actually make this patient journey as painless as comfortable as smooth as possible for the patient and the family in the way that you have enveloped it in your effective communication…"*** *(Alastair: "hum.mm")* ***"…so you straight away intuitively know I'm the link…*** *the physio knows about this, the OT knows about that, the pharmacist knows…. and you seamlessly just do that… to know that's what is needed.* ***That's what nurses do, you literally you know in the middle of that, also juggling the other priorities, could be the TTL's or whatever, and we are just so good at that art you know it is an art…"***
>
> Case Study 2: Interview 16 Lines 425-435 Participant 22

Moreover, participants noted there was a degree of passivity towards challenging the prevailing disease-centric emphasis practiced by some nurses, even to the point on occasions of colluding rather than challenging reductive attitudes. This was reflected in passive acceptance of the status quo, showing undue 'understanding' of managers' ignorance of the wider scope and purpose of Advanced Nursing Practice rather than challenging it. Participants speculated about the reasons for this but included: externally, the continuing influence of disease-centric culture and hierarchical structures; and internally, nurses' inexperience and lack of confidence, and subservient mindsets borne from weak professional socialisation. Overall, it was attributed to the relative junior stage that had been reached by some in their journey of becoming Advanced Nurse Practitioners:

> *Participant 15: "…I feel like, yes, that they* [managers**]** ***think we should be out there seeing patients all the time, you*** [then start to] ***feel that you should be doing that****... you are getting a knock on the door 'oh are you covering here today?' so even if you were to be doing one of your other elements* [Pillars] ***then it's the other persons expectations…"*** *(Alastair: "yeah")*
> *"Participant 16:* ***"but also I think it's not just erm…about professionally what people think you should be doing, but personally for me having been on maternity leave I feel actually that what I mainly want to do at the moment is clinical, because I had a year off work and I wanted to get back to where I was…"*** *(Alastair: "Hum..mmm")*
> *Participant 15:* ***"…there is still a lack of knowledge about of what … our roles*** [are about]… ***whenever there's a queue whether there's a queue for anything, or whether we are short on the primary assessment, the first thing that's said*** [is] ***'Where are the ANP's? What are the ANP's doing? Why are they in the office?'***
>
> Case Study 1: Interview 7 Lines 73-89 Participant 15 and 16

Participants recognised contention about the concept of Advanced Nursing Practice, its purpose and scope, was ever present and had huge implications for everyone involved. This included Advanced Nurse Practitioners themselves, especially when they were new in their development journey. The understandings of the role appeared to be diametrically opposed to one another. Medical staff mainly, though not universally, held the perspective that the role was disease-centric, therefore providing a medical substitution role. Service managers mainly concurred with this recognising Advanced Nurse Practitioners as brought in to help with patient journey flow issues and filling 'gaps' in service provision. There was no shortage of people opining what Advanced Nursing Practice was and claiming a share of those same Advanced Nurse practitioners to solve their particular problems:

> *Participant 7:* ***"… I don't know about acute medicine is but for Gerontology there's lots of other people that would like to tell us what they think our ANP's should be doing, especially medical staff and nursing management, 'Can your ANP do this?*** *(Participant 6: "Exactly…")* ***"…and there's lots of… we've got a gap, can you fill it? So you become almost this fluid, we used to call ourselves the anything Nurse Practitioners***
> *Participant 6: "yeah, anything...anything anybody can think of…"*
> *Participant 7:* ***"Yes you can, but it doesn't necessarily mean you should…"***
> *Participant 5:* ***"And that's a lack of understanding of those people's perception of the role….***
>
> Case Study 1: Interview 2 Lines 198-214 Participants 5, 6, 7

While participants reported that Advanced Nurse Practitioners generally recognised the importance of a patient-centred emphasis as central to Advanced Nursing Practice, reaching this viewpoint was not always achieved at the start of their developmental journey. This position often took time to develop and therefore impact their thinking and their activity. This was not helped by the prevailing culture pointing so strongly to medical substitution and a disease centric focus:

> *Participant 7:* ***"… with my staff and my team I can see them, maybe it happens around twelve months post qualification,*** *that they've got that bit of breathing space, that bit of time, and go* ***'ok I get what you mean now' or 'I'm getting it, I'm seeing this, we need to think about that don't we?' …they start pulling the other pillars in*** *and see how it will all work* ***but it's very difficult to then say that they should have had that from the beginning…"*** *(Alastair: "right")* ***because I don't think they have the experience or…"***
> *Participant 6:* ***"About them being confident in their role as well and understand what they want to do****, where they want to go with it next…"*
>
> Case Study 1: Interview 2 Lines 214-225 Participants 6 and 7

The trust had no central standard or definition and participants discussed how the role was interpreted very differently in different services, many saw it narrowly as disease-centric while others took a broader patient-centric view:

> *Alastair: "…you seem to be implying that the lack of vision among management includes lack of understanding* [about the nature of the role]*?*
> *Participant 14:* ***"…oh totally"***
> *Participant 13:* ***"But, you've*** [P14] ***got very different consultants to me… I think that*** **if they** [begin to understand] ***it… I think my consultants, those I work with, are very forward thinking, pro-active consultants and I think they have been on the advanced practice journey with me and by the end of the course I think they understand what Advanced Practice is…"***
>
> Case Study 2: Interview 5 Lines 388-389 Participant 14

The last participant spoke directly of the notion of a developmental journey, referring to both hers and her consultant physician colleagues journeys of development of understanding. This notion was more broadly found within the wider findings, underpinning participants and services experiences of developing understandings about the value of Advanced Nursing Practice and its different facets.

It was also clear that participants initially found difficulty in explaining the breadth of Advanced Nursing Practice beyond the clinical pillar. One participant observed how a senior medical colleague she respected and thought would be able to grasp Advanced Nursing Practice struggled with it:

> *Participant 6:* ***"we're not very clear certainly at this Trust, within different groups*** [Services] ***we've got ANP's working differently…"*** *(Alastair "Yes")* ***"…so it's very unclear what the role of the ANP is, you know it can be 'this' in one area, and 'that' in another area, so I think there is a lack of clarity about and a lack of understanding of what ANP's are because they are not like regular nurses, they're not like doctors, but something in between …"***
> *Participant 5: "the* ***medical staff and the hospital management staff don't really get it still… I really don't know how to make them understand… I've come back and I've met a new registrar who said (to me) 'oh hello*** [Participant 5] ***I don't get ANP's?'*** *(but)* ***he was a very switched-on registrar, and I thought… 'he said, 'so what's it all about?' that was really shocking for me…"***
>
> Case Study 1: Interview 2 Lines 245, 247-249 Participants 5 and 6

Participants narrowed role confusion down to two features about the role they had experienced and observed: first, definitions lacked precision and tended to be generic, rather than bringing clarity, this made it difficult for interested colleagues to apply the definition to their contexts; second, roles varied in their features as they were shaped by attempting to meet their specific patient needs. This tended to confuse, as described here:

> *"… ok so I think the fact that people don't really know what we do…" (Alastair: "hum.mm")*
> ***"… and I think it varies greatly what we do.*** *I think people tend to view it as a role if they don't know what it is* ***so they think we should all be the same and be able to do the same thing but that isn't the case at all*** *I think* ***what it is for me I could go to somewhere else and assess a patient you know a head-to-toe assessment but I wouldn't be as good as someone who works at A&E at it but you know I think we have like our foundations skills and then we have ones specific to our clinical areas and what we are doing*** *so you know* ***an ANP in ED would be all about getting that patient moved through diagnosing, der-di-der but that's not me, I'm about making sure that that patient is safe for their anaesthetic."*** *(Alastair: "right")*
> *"So I think it's very different so I think it's more I know it's dead cliché* ***it's a more level of practice*** *it's about* ***your decision making*** *…and I don't think people necessarily get that…"*
>
> Case Study 2: Interview 12 Lines 481-494 Participants 21

Several participants spoke of the new title, 'Advanced Clinical Practitioner', introduced nationally by Health Education England (HEE 2017). This title was designed to be inclusive of not only nurses but allied health professionals and others, but it was considered that this added to the existing role confusion. Concerns were also expressed about displacement of the title 'nurse' and 'nursing' from this new title. As indicated earlier, it was clear that most participants wanted to retain the descriptor 'nurse' in their job title. They regarded it as important in making clear their professional identity to patients, so it was clear who they were and what could be expected of them:

> *Participant 16* ***"I always feel that it's down grading me to say that I am an Advanced Clinical Practitioner because erm… I mean I feel that the patients say, 'so what is that then, so you're not a nurse, you're not a doctor***…[what are you]***?' ,"*** *(Alastair "hum…mm")*
> *Participant 17 "that's how I, 'so you don't really know what you are talking about!', is almost the feeling* [you get] *sometimes, but that may be* [because] ***I feel strongly about being called an Advanced Nurse Practitioner I still think that when you approach a patient, they are quite keen to know are you a nurse …"***
>
> Case Study 1: Interview 7 Lines 504-9 Participant 16 and 17

Participants expressed continuing concerns about the distinctive contribution of nursing being obscured by the generic title, Advanced Clinical Practitioner, and that this perceived risk to nursing was in fact a risk to the promotion of expert holistic nursing interventions for patients.

- Category: (C26) Impact of Existing Culture

Participants reported imbalance between the dominant professional groups of medicine and nursing, reflected in who controlled what Advanced Nurse Practitioners could and should do. Participants regarded personal and professional autonomy as an essential dimension to enable Advanced Nursing, yet noted that their autonomy in relation to their clinical activity was often limited by medical oversight and direction, and non-clinical pillar activity was restricted by a lack of support for engaging in it. The contrast in cultural mindsets between medicine and nursing was therefore marked. Medical staff were regarded by participants as having a very focussed approach to their activity, perceiving their patients through a 'medical lens', indicative of reductionist thinking, the product of the medical model. As discussed already some nurses gravitated to that mindset, particularly where their role was largely Type 1 - Advanced Nursing Practice, (see Glossary page xviii) and medical substitutionary in emphasis. This led participants to function primarily as a doctor would and was disease-centric rather than patient-centric:

> ***"… I think what happens is there is so much emphasis*** [by service managers, on patient] ***flow…they see a group of practitioners*** [Advanced Nurse Practitioners] ***who have been*** [learning and gaining advanced] ***skills, the more that they see them, the more that they get used to them, they expect them to medically clerk*** [patients]***…"*** ***(****Alastair – yeah") "…for admission, so it frees up the space so the SHO's and the clinical fellows, so they can go for teaching…"*

Case Study 1: Interview 9 Lines 152-156, Participant 19

Moreover, participants mainly in Case Study 1, were required to support the prioritisation of junior medical staff development by fulfilling their work so they could receive teaching. This was one sided and was not reciprocated, while their own development was restricted. Participants recognised not only were they fulfilling primarily a medical not nursing role, but they were also 'gap-filling'. There were implications for doing this, since they became increasingly seen as only clinically facing, and there was no appreciation nor expectation that they would do anything beyond what a junior doctor/Senior House Officer (SHO) would do:

> ***"I think it's as management, as the beast of management, whoever they are, don't understand. They will see them*** [Advanced Nurse Practitioners] ***as significant as an SHO*** *(Senior House Officer),* ***so, that what we need them for, so that's their role….!"***

Case Study 2: Interview 2 Lines 500-1 Participant 7

Participants in those situations inevitably had a restricted scope and a reductionist brief for their activity, and for some medical consultants this was the intended outcome:

> ***"…some*** [medical] ***consultants just won't have it…*** [Advanced Nursing Practice] ***rather they say…'this is what I want you to do…', and I have been in a situation where a consultant has said 'I don't want any of that nursing stuff I want somebody who can clerk patients and write TTO's, end of story', and that's what they want…."***

Case Study 2: Interview 11 Lines 727-9 Participant 7

Consultant Nurse participants in the face of this raised the need for Advanced Nurse Practitioners to remain ambitious for Advanced Nursing:

> *Participant 6:* ***"I think…. it's very easy for ANP's to fall into what the service requires rather what the patients actually needs*** *and there's rather a lot of pressure too obviously put on them to meet the requirements, perceived requirements… so if it's on one day* ***it could be you haven't got enough junior doctors, so can you go to ED and clerk patients, and another day it could be that we haven't got enough nurses so can you coordinate the shift or err….."***
> *Participant 5:* ***"I agree, yes, I agree, and the reason is if you don't set a programme or a rota that can assist the other elements or pillars then they're never going to happen…"***

Case Study 2: Interview 2 Lines 179-188 Participants 5 and 6

One of the Consultant Nurse participants recognised that developing into new roles took time and that recognising the stage of their developmental journey for each Advanced Nurse Practitioner was

important for those leading them. She also pointed to the fact that that development journeys could stall and that Advanced Nurse Practitioners could effectively get stuck:

> ***"….I think it*** [the role] ***evolves over time, so when people start in the post they're rightly consumed with those skills and knowledge that you need to learn, the ability to prescribe, to be comfortable and confident and to act as a clinician…"*** *(Alastair: "Yeah")* ***"…***[however, if ***that's becomes all that they know then that's what the job is because 'that's what I've done for the last two years'…***
>
> Case Study 2: Interview 2 Lines 189-190 Participant 7

Even participants in the Case Study 2: Non-Acute (Gerontology) setting were clear that for them the full extent of Advanced Nursing Practice, in what was otherwise seen as a patient centred service, had been hindered because the common assumption that their primary role was to provide a medical replacement service:

> ***"…I think advancing practice needs to come back to nursing****, so* ***we spend too long being compared to medical placement,*** *…* ***that's not what we are, we are nurses and we should be seen alongside medical replacement, because we have got so much more, we've got different things to offer we've got a different perspective and in line with medics, and we have a good contribution to make…"***
>
> Case Study 2: Interview 10 Lines 242-247 Participant 23

Indeed, the ability to influence and shape services was limited by inescapable clinical demands at that point in their service's developmental journey:

> ***"… unfortunately we are not there (yet) …..you can't innovate while you are… in the microcosmic world that you are in, because*** [Clinical] ***that's the key focus of our activity at the moment,*** *and it has to be because you can't,… you have to sort out whatever clinical issues you're sorting out….****but in terms of stepping back and being part of the strategy from a bigger picture point of view, we're not really able to do that yet,*** *and I think it's a source of frustration* ***but it's something that we have to crack I think at some point as a team…'***
>
> Case Study 2: Interview 10 Lines 236-240 Participant 7

Participants regarded filling the medical gap as a simplistic reaction to what they acknowledged was a real problem, but without adequately thinking through the consequences or costs of that quick fix strategy. It missed the opportunity to design and provide a comprehensive and appropriate response to service pressure, that would not only mitigate loss of medical staff but also provide a more holistic response including more detailed and comprehensive assessment, supported by effective communication.

- Category: (C27) Evidence Base Limited

Participants believed that producing good quality research was the gold standard for supporting and making a case for change, yet research into the impact of all levels of nursing was relatively limited,

and for Advanced Nursing Practice very limited. It was generally not regarded as a priority, was underdeveloped and had previously focussed on assessment of patient satisfaction, or on drawing comparisons with doctors. Little research existed that revealed the broad nature and impact of Advanced Nursing within Advanced Nursing Practice (Kilpatrick 2023). Whilst it remained an objective for participants to undertake research into their roles and activities, few participants had active involvement with it in their current roles, because of the demands on their time and under-development of research skills.

Audits were more common, but often did not focus on patient issues in relation to nursing practice. However, an example referred to earlier, of efficiencies gained in the use of medicines to manage Parkinson's disease was significant because it was an Advanced Nurse Practitioner who undertook and led the research. Moreover, it developed because of the participant 'seeing' and using a nursing-lens to examine clinical problems she had uncovered from her practice with her patients. She autonomously generated the solution and led the innovation that resulted. Her thoughts on the importance of collecting data to demonstrate, explain and justify the service and support selling her innovations to an often sceptical and currently unconvinced audience follow:

> *Participant 13:* ***"…when you are evaluating a service that you provide to a patient erm.. you can either devise your own tool or there is a variety of ways it's not always easy to capture it all and some of it is quite subjective…"*** *(Alastair: "sure") "…but yes I think you can measure it."*
> *Alastair: "Is it important to measure it…?"*
> *P 13: "I think data is important."*
> *Alastair: "why is that?"*
> *P 13:* ***"because if you've got data, it's more powerful to be able to talk to service managers if you wanted to enhance your service, data can turn into money, money talks in the NHS. There's no new money… and also I think it's important for bench marking and auditing your service when you're thinking about measuring it and how did we compare to somewhere else…"***
>
> Case Study 2: Interview 6 Lines 298-308 Participant 13

Participants felt that research was needed to ask questions about the practice of Advanced Nursing, its character, processes, the nature of nurse-patient interactions, including impact on service change and innovation. Participant were clear that undertaking qualitative research would help reveal the value of Advanced Nursing:

> *Participant 6:* ***"it's all of those things, and I think it's that, that you need to measure, it's got to be qualitive data, what you are able to give that a medic on their own can't give,*** *and that's not taking away from what they do, it's what we add to it*
> *Participant 5: "****it's the nursing element to our job that the doctors don't have, because they're not nurses.***
> *Participant 7:* ***"but it seen by the medics as, .. but it's seen as soft and not so important and fluffy… but the patients, the patients don't see it like that, they see that it's totally valuable…***
>
> Case Study 1: Interview 2 Lines 885-890 Participant 5, 6, and 7 (Case Study 2)

Alongside research evidence, participants also referred to anecdotes and stories having the ability to explain and 'capture hearts and minds'. Indeed, examples of the benefit and impact of Advanced Nursing provided real opportunities to persuade and influence those who had only previously had a partial view of what Advanced Nursing Practice was and what it could achieve. A participant consultant surgeon pointed to such an example in his observation of the effective work an Advanced Nurse Practitioner in an associated service was doing and of its likely impact:

> *"there's an Advanced Nurse at* [my current workplace] *that is fantastic, called* [Simon (name changed)] *and essentially he's much more interested in the other* [Non-Clinical] *aspects, so he can do the clinical**, but he sees his role as to educate the ward staff to try to increase the overall skill level of the staffing base so we can improve our cancer outcomes…"***
>
> Case Study 1: Interview 19 Lines 383-6 Participant 31

- Category: (C28) Continuing Professional Development Needs Unrecognised

Participants pointed to limited opportunities for continuing professional development (CPD) following completion of their Master of Science degree course. They recognised their need to consolidate the course but also to the need to continue their learning if they were to remain current and relevant. However, this was felt to be largely not recognised by service managers, who believed they had 'completed their training' so there was no longer need for further education nor protected time for learning. In one Case Study 1: Acute Services location, managers actively stopped scheduled teaching because it interfered with participants being used to fill service gaps:

> ***"… we used to have teaching on a Monday and several times when we had teaching…*** [we were interrupted]. [On one occasion] ….***my bleep went off several times even though we had an hour's scheduled teaching with other Advanced Nurse Practitioners, so a group collaborative, there were ten of us*** [Advanced Nurse Practitioners] ***…one of the registrars was doing teaching.*** … [I went to find out why I was being bleeped] ***the operational managers were in the corridor saying 'we have been bleeping you, you can't have teaching'… and our teaching stopped…".***
>
> Case Study 1: Interview 7 Lines 125-131 Participant 16

This extract provides further context:

> ***"…quite early on having …. gone into the role as a trainee I don't think it was long before the teaching was knocked on the head erm… obviously*** **[we were]** ***still doing our Advancing Practice master's but sort of our erm… time out of the role to have that was quite quickly phased out and I think it was because there was a lot of pressure on our manager to show what we were doing, what we could be, covering all this other stuff so other people could do…*** [Junior medical staff could receive their training] ***but actually I feel that I was just to prove that we were there and we could be there all the time,*** *so then we lost out and I think it's sort of just never really got back up….so, now we need to prove that we need the teaching."*
>
> Case Study 1: Interview 7 Lines 245-252 Participant 16

Where education was available, it focussed on clinical subjects and skills and ignored development of non-clinical pillar knowledge and skills, which participants felt was their main need. One clear example of this was in developing research skills, which participants acknowledged had been taught on their Master of Science degree course, but which needed to be developed into living skills within their service environments.

5.2.4.2 Super-Category: (SC8) Service Restrictions

- Category: (C29) Role Scope Restricted

Participants observed that the scope of their roles was often restricted from their outset. The process of introducing Advanced Nursing Practice to a service was challenging for everyone involved, and it was at the point of introduction that the seeds for success or otherwise were sown. Typically, proposals that included major Advanced Nursing elements challenged existing norms and values about how professionals operated and related to each other in relation to professional boundaries of practice. These required a wider culture transformation for them to be able to succeed.

Participants observed that senior managers in the trust appeared committed to supporting the widespread belief that Advanced Nursing Practice was there to provide a medical substitution service. However, participants felt the attitude and approach of managers was often muddled, with initiation and set up representing a lack of clarity about what was wanted and therefore what both trainees and completed Advanced Nurse Practitioners should be able to deliver. This had a particular impact on medical staff working with the Advanced Nurse Practitioners, not sure what to expect from them and at what clinical level they were working:

> *"*[In this hospital} ***it's a very different service, it's really new and they're very junior so they've not got their feet really ready yet. I think that's because the ED medical clinicians aren't really sure what they can and can't do…"*** *(Alastair: "hum.mm") "…* ***so there's a bit of flux between very ambitious Advanced Practitioners wanting to get on, and finding a bit of a stumbling block because the doctors don't real know exactly what they can or can't do…"*** *(Alastair: "right")*
>
> Case Study 1: Interview 9 Lines 79-81 Participant 19

Because Advanced Nurse Practitioners worked in different ways in different specialities, this created a certain anxiety for doctors unsure what to expect from Advanced Nurse Practitioners when they moved to another service:

> *Participant 18: "…from a clarity point of view, and* [regarding] *professional boundaries* ***I think from a medic point of view there is some uncertainty of what the role can do. They're used to working with you in practice, in your speciality,*** *but… their roles are different wherever you work, my role is different to your role,* [which] *is different to your role…****Advanced Practitioners do*** [provide] ***different roles."*** *(Alastair "right")* ***"therefore when you have a rotation of medics who have worked with ACP's in TNO*** [Trauma] ***and they come to Gerontology they assume certain expectations, '…well they*** [Advanced Nurse Practitioners in Trauma] ***do this there, they work as a medical replacement, why aren't you doing that?***
> *Participant 20: "Yes and until they get to know the individuals, well they don't know how long they have been Advanced Practitioners? (Alastair "Yeah … hum…")*
> *Participant 18:* ***"…from an organisational point of view it's not surprising that they don't understand the role when there's a variation within our own organisation let alone externally."***
>
> Case Study 1: Interview 9 Lines 98-105 Participant 18 and 20

Participants observed that managers, driven by service imperatives, were focused on service delivery. They appeared rule driven, lacked flexibility, and were resistant to any deviation from supporting medical interventions to move the patient journey forward. Advanced Nurse Practitioners were judged significant only in so far as they provided the service a junior doctor would. This was particularly so in Case 1: Acute Services as follows:

> *"…* ***what other people*** [managers] ***think, what we should be doing…they think we should be out there seeing patients all the time,*** [then] ***you*** [start to] ***feel that you should be doing that too!...*** *you get a knock on the* [office] *door, 'oh are you covering here* [the department] *today?'* ***So even if you were*** [scheduled] ***to be doing one of the…trying to achieve one of your other elements*** [Four pillar activities] ***then it's the other person's*** [manager's] ***expectation***…[that wins]"
>
> Case Study 1: Interview 17, Lines 70-75, Participant 16

The reality according to participants was that services were culturally unready for Advanced Nursing Practice at multiple levels. A lack of preparedness, limited governance arrangements and risk adverse culture all had a restricting effect on moving the Advanced Nursing agenda forward. It was pointed out that anomalies of autonomy were often location dependant which raised issues for central policies to maximise autonomy and minimise inappropriate restrictions:

> *Participant 9:* ***"…other organisations/ trusts have their ACP's/ ANP's requesting CT head MRI's, it's very much entirely up to the trust and from a prescribing and from a radiology point of view I think yeah I think it's open for discussion*** *and you know meeting up with these departments…"*
> *Alastair: "hum mm, so is it about making a case then for why you should be doing that then are you suggesting that?"*
> *Participant 9: " yes".*
> *Participant 8: "****yes, and obviously giving us that training and understanding why… what's the difference? why can't we request a CT or MRI what is that we don't have in terms of skill experience and we don't understand???..."*** *(Alastair: "sure") "… and even the doctors in the foundation year can do this…"*
>
> Case Study 1: Interview 3 Lines 639-647 Participant 8 and 9

Interestingly, this last example arose for Case Study 1: Acute Service, where disease-centred roles were the norm and yet even in those roles the autonomy required to efficiently perform their disease focused functions was frustratingly restricted by having to seek medical permission to progress with tasks they were well able to perform. This raised serious questions for participants about the level of their autonomy when they were acting under the auspices of medical not nursing line of accountability:

> ***"***[We are…] ***only allowed to request certain x-rays we're not allowed to request CT head scans we're not allowed to request MRI's, so are we really that autonomous? We have to ask a doctor to do it for us or a foundation year one doctor newly out of erm… medical school to do it for us???"***
>
> Case Study 1: Interview 3 Lines 630-4 Participant 9

Organisational unreadiness was further reflected in a lack of balance between supporting disease-centric medical substitution roles, versus patient-centric Advanced Nursing roles. There was an absence of thinking through the implications of not supporting Advanced Nursing in Advanced Nursing Practice roles and a complete lack of acknowledgement of the value of Consultant Nurse leadership in supporting the aspirations of Advanced Nurses.

Indeed, in considering the value and place of the Consultant Nurse once more in the service structure, as suitable leaders of Advanced Nursing Practice services, a Consultant Nurse participant who was recognised by senior trust manages as an expert on Advanced Nursing Practice was asked the following question:

> ***"…'So, we*** [Senior Trust Managers] ***want to know…can they do this? or can they do that? are they allowed to do this?'… you know those sorts of restrictions*** *over* [important aspects of Advanced Practice]***…. I did a piece of work for the Chief Nurse previously about whether a Consultant Nurse could be without medical oversite, and … the levels of restriction on legality, professional, and what was the equivalence*** [with medical counterparts.] ***…internal politics and whether you were organisationally set up***. [Actually] ***it doesn't matter who does it, if they have got the skills, ability and the knowledge***. ***So, organisational readiness and acceptance of service delivery these are some of the barriers…it's people's lack of understanding.***"
>
> Case Study 2: Interview 11 Lines 698 -705 Participant 7

Participants reported that daily service challenges drove management priorities, with the pressure of workload compelling them to focus on moving patients through the system. While this enabled disease-centric medical substitution practice, it weakened patient-centred holistic practice, revealing that this was not the priority for service managers. The inevitable focus on 'tasks' was hugely demotivating as participants wanted to do more. The problem was magnified as this became the

norm. It was particularly true for participants working in Case 1: Acute Services, where they were working largely as doctor substitutes:

> ***"I would say that yes, we are being made into mini doctors, I would say the prime example you know we are there to fill short comings in terms of the medical workforce the majority of the time, although our line managers would say, 'no, you are not, you are there to educate and to carry out research to lead people.' An example, on Friday they were two doctors short on a certain ward I was made to go and work as a doctor on that ward and undertake doctor's jobs and that was my responsibility for that shift for that twelve-hour shift, I was there*** [effectively working] ***as an SHO*** [junior doctor]."

Case Study 1: Interview 3 Lines 778-783 Participant 9

However, a consultant medical participant from Case 2: Non-Acute Services pointed to the quality of clinical care and management that Advanced Nurse Practitioner in the Gerontology Service demonstrated, with clear evidence that they delivered at least the same standard as medical colleagues, but delivered better since they invariably brought something extra to their encounters:

> *"...**they*** [Advanced Nurse Practitioners] ***have got a better handle I think of how to manage patients with long-term conditions erm.. they understand the nature of chronic conditions they understand that patients can deteriorate, and the ways that they can deteriorate and so can be quite good in spotting early signs of deterioration of patients sitting on the wards …"*** *(Alastair – Hum.mm) "**and they are often the things the doctors ignore because they are more focused on the acute exacerbation of COPD they forget about the bowels and the water works and that sort of stuff, so again the ANP's seem to be better at picking up on that** erm.. there's been many patients where that's happened so you know the doctors have done the treatment for the medical problem the nurses have done their bit, then you know **it's taken the ANP's to notice they are constipated."***

Case Study 2: Interview 17 Lines 84-88, 95-99 Participant 29

While this feedback was positive, and did reveal more patient-centric rather than disease-centric practice, it was still primarily focussed on the clinical pillar, and participants lamented limited opportunity to engage with non-clinical pillar activity. At the time the data collection for this study, there were a large number of Advanced Nurse Practitioners employed in the trust, beyond the two case studies services that were the subject of this study. Participants were concerned that despite a numerical 'critical mass' of Advanced Nurse Practitioners, only a few were operating beyond the clinical pillar, most were not significantly effecting change or transformation within their services.

The reason for this according to participants was that they were swamped with clinical demand as indicated here:

> ***"…so if the demand overwhelms your capacity, so you 'fire fight' all day just to get through demand, and if you don't have any breathing space/ head space you don't have the time to think of the other pillars and of how you can develop those…. it's a bit lip service, 'so come with me, and I'll teach you this whilst I'm doing that'…because I have got to move on because I have got four more people to clerk and I've got that and there's three sets of*** TTO's [To Take Out medicines] ***to do, it becomes the tasks that you've got to undertake…"***
>
> Case Study 2: Interview 2 Lines 480-484 Participant 7

While in this example participants were addressing disease-centric needs, they were unable to contribute adequately to meeting patient-centred ones, and their Advanced Nursing abilities were underutilised. Consequently, they felt ineffective as senior nursing role models and leaders of nursing practice. The overriding clinical focus for their activity also effectively squeezed out non-clinical aspects of four pillar activity. It was reported that despite the ambition to do more participants found it difficult to challenge the status quo, their level of experience, maturity, personal confidence, all reflected in where they were found on their personal development journey, dictated how well they were able to navigate these restrictions and pursue patient-centric outcomes for their patients. It was also an indicator of the level of personal autonomy they had achieved. The following extract by a consultant nurse participant in Case Study 2: Non-Acute Services spoke about the fragility of autonomy for Advanced Nurse Practitioners in this way:

> ***"I think*** [autonomy] ***it's there but it needs empowering and building"*** *(Participant 5 – yes)* ***"and that's what I see, roles like ours doing, understanding it and recognising it and enabling with the skill and giving them permissions to say yes this is my role this is what it is…"*** *(Alastair – Yes)* ***"… and not to be dominated so much by medicine to have confidence and pride in nursing as a profession…."***
>
> Case Study 2: Interview 2 Lines 609-614 Participant 7

This participant went on to describe a wider autonomy problem among senior nurses/matrons in post to lead nurses and nursing practice. On a particular day an instruction was sent out to matrons to attend an urgent meeting. Rather than challenging what turned out to be an inappropriate summons they simply acquiesced, in contrast to senior medical staff who had ignored the instruction to attend:

> ***"…and you know nurses*** [attitudes] ***well, this was an interesting observation. When I was a matron we were called to ops*** [Operations Centre] ***and, ' it was all terrible, and everything was horrendous'…, and they*** [Senior Managers] ***were going on about, they needed more TTO's*** [To Take Out -patient discharge medications]. [This was said to…] ***a group of matrons. Now matrons don't make discharge decisions and they don't write TTO's, so somebody asked, 'why are you asking us, why are we here? You need clinical representation, you need medical representation?*** *(The reply was****)… oh we've asked the doctors but they haven't come, so we've gone back to the matrons because nurses do as they are told.*** *(Alastair – laughs.. right)*
>
> Case Study 2: Interview 2 Lines 609-614 Participant 7

This account indicated how matrons, as senior nurses in the trust were regarded by their senior managers, in a system that reflected a hierarchical structure that had little regard for the autonomy of professional nursing. Matrons were called to the meeting, they came, but there was no value in their attendance since they had not control over the clinical issues and actions that might reasonably have made a difference in that situation.

This participant pointed to an important cultural issue within the trust, namely that managements attitude maintained the status quo by a hierarchical structure that felt dominated by medicine and medical practice. It was suggested that the effect was to weaken expectations about nursing autonomy and that this would weaken rather than strengthen fledgling Advanced Nurse Practitioners developing the role and scope of Advanced Nursing.

- Category: (C30) Reductive Mindsets Dominate

As suggested already, participants regularly observed the restrictive impact of management and medical hierarchies, where management was both bureaucratic and controlling, and reductive/ reductionist mindsets associated with medicine dominated clinical practice. The effect of these was to limit and control Advanced Nursing Practice scope and activity:

> ***"… medicine always dominates and assumes, 'Well I'm the consultant, of course I'm the natural leader, will automatically tell everybody what to do because this is what I do because nursing traditionally carries out medical orders there's an automatic cultural subservience' …."***
>
> Case Study 1: Interview 2 Lines 619-623 Participant 5

Again, this time from one of the consultant medical participants regarding his disposition and his view of fellow doctors towards their work and towards colleagues:

> *".. I think one thing is…* ***my personal view is that I think that doctors are extremely selfish more selfish than nurses, and possibly more obviously generalising but if you generalize they would say that the average doctor is more of the type A personality than the average nurse ..."***
>
> Case Study 1: Interview 19 Lines 44-46 Participant 31

Medical staff were often seen to be very single minded and determined in addressing their goals of managing patient illness and largely other staff were seen as merely present to support that aim. The perceived usefulness of Advanced Nursing Practice and Advanced Nurse Practitioners in that context was described by participants, on more than one occasion, as dependent on whether or not they met doctors' expectations in serving their needs. This was in complete contrast to participants expectations that they were there to serve patient's needs:

> *" and I think* [lack of understanding about the role] *promotes this idea* ***'oh good, she's a good ANP because she does all the TTO's*** *[To Take Out medications]…" (Alastair: " yes")* ***"…you know we need to move away from the medic's defining*** [what our role is]**."**
>
> Case Study 1: Interview 2 Lines 229-331 Participant 6.

However, participants raised concerns that medical domination of the agenda in their hospital meant that services were insufficient to fully meet the complexity of patient need. However, it also appeared to participants that expansion and development of nursing roles, rather than delivering more patient-centric care was subverted into 'filling gaps' in the service supporting medical substitution roles addressing disease-centric problems.

An interesting additional finding was that participants noted that some colleagues were willing to collude with this situation, in effect supporting rather than challenging the cultural hierarchy and the status quo. Insight into this came from how a group of participants from Case Study 2: Non-Acute Services (Gerontology), described ward based nurses within their service, reluctant to take responsibility for difficult aspects of clinical practice. Those colleagues sought to pass problems upward, rather than address problems themselves, which they could easily have done. It appeared that their confidence as nurses to assess, make decisions, plan and act on their own initiative was very limited:

> ***"…I think we are seen as the… 'go to people' most of the time****…[but…]* ***not always in a good way. Sometimes I think it takes away the erm… the skills the nursing staff have, because if there is something that they don't particularly want to do they will see it as our job to do it…"*** *(Alastair: "ok") "So for example talking to families (Alastair: "ok")* ***… if a family are asking for an update on their relative, as a nurse you would do that,*** **[but]** ***the nursing staff on the wards tend to try and deflect that onto us.*** *I usually ask what the reasons why they're not able to provide an update and if there is anything specific any medical questions that the relatives that they can't answer then I would be happy to have the conversation…" (Alastair – hum.mm)* ***"but on a day-to-day basis I would just challenge and say why is it that you feel that I have to speak to the family why is it that you feel that you can't so... I guess it's about gaining an understanding of what their reluctance is…"***
>
> Case Study 2: Interview 10 Lines 77-113 Participant 25

Participants pointed to the prevailing culture that appeared to have a particularly unhelpful impact on expectations and confidence of nurses who, rather than rising to challenges to act for their patients seemed content to be passive. Participant were keen to challenge this passivity seeking to provide challenge and leadership.

- Category: (C31) Limited Development of Useful Evidence

Participants were clear that evidence, be it in the form of research findings or stories displaying the work of Advanced Nurse Practitioners was needed to challenge the prevailing culture of medical dominance. Positive stories and anecdotes presented clearly were regarded as powerful in their ability to explain and reveal the heart of Advanced Nursing. However, other less positive stories and anecdotes could also be helpful but in a different way. The following example revealed pitfalls resulting from poorly planned initiatives, this supported the call for better workforce planning. In this example a medical participant reflected on the sending of a nurse to complete doctoral studies to become an Advanced Nurse Practitioner. It failed because she was not provided with a clear role, nor had she been properly prepared to contribute to clinical work:

> ***"One of the first Advanced Practitioners that I worked with was when I did plastic surgery and she had gone off an done a PhD*** *for two or three years,* **[when]** ***she came back… they had not thought of a role for her*** *she would just follow me round and the on call SHO for the six months that I was there… but in terms of service delivered for the amount of time that she had been doing her course and she's back doing clinical work…" (Alastair: "yeah hum.mm")* ***"…but she just didn't deliver anything back."*** *(Alastair: "right")* ***"…looking back now as a consultant I think that job hadn't been thought out properly. The best Nurse Practitioner roles I have seen have got a relatively clear need within the hospital and that would be the role works best.*** *For example, theatre practitioners work well, endoscopy practitioners are fantastic and they are up to doing say eight lists a week which is more than the doctors were doing!*
>
> Case Study 1, Interview 19, Lines 97-117, Participant 31

However, stories also had the potential to act negatively and confuse. One of the consultant nurse participants introduced the notion of 'touchpoints' to explain why individuals might or might not understand Advanced Nursing Practice. She suggested 'touchpoints' were key visible attributes of a fellow health professional as observed by other health professionals or students, see Glossary page xvii.

What observers 'saw' either brought clarity or confusion. For example, where Advanced Nurse Practitioners were observed to be working as senior house officers (SHOs), and that was all they were seen to do, then that tended to define them as medical replacements. This explained why observers were confused about the scope and purpose of Advanced Nursing Practice, when all they observed were individuals performing a doctor's role.

Participants also noted the reactions of junior medical staff who interpreted Advanced Nursing Practice as a medical substitution role because that was their 'touchpoint' with those colleagues, it was what they 'saw', they had no idea what other things the Advanced Nurse Practitioners were engaged in. A consultant medical participant remembered his own previous experience and thoughts as a junior and compared them with his current junior medical colleagues' suspicious reactions. They saw the Advanced Nurse Practitioners as competing with them for clinical experiences, that they needed to progress. The same medical consultant in his current role referred to the same Advanced Nurse Practitioners as irreplaceable, helping him to 'get the job done':

> ***"I was originally sceptical… I think partly it depends on what stage of your career you're at because I was an SHO when ANP's first came in…"*** *(Alastair: "ok")* ***"…I just couldn't see the point of*** [ANPs] ***but I think as time has gone on you see that there is a fine line in the number of doctors and I don't think there is any choice….*** *the other thing is that core trainees are in direct competition* [with ANP's] *in theatre…" (Alastair: "hum.mm") "…and so if ANP's are going to go into theatre and the SHO's probably waited two hours for the case to finish to close the wound then the ANP does it and I think there will always be a little bit of a difficult relationship between SHO's and surgical practitioners* [ANPs] *I think that's going to be inevitable…"(Alastair: "yeah")* ***"…and as you move through your career whether it just that you become more used to it as a consultant you see the value of ANP's erm…I think certainly the way it works in*** **[this hospital]** ***I think that they are irreplaceable...in so many ways…and in… in getting the job done"***
>
> Case Study 1: Interview 19 Lines 61-75, 628 Participant 31

- Category: (C32) Underdeveloped Learning Culture

Participants reported a lack of awareness by their managers for the need for continuing professional development (CPD) which revealed a lack of appreciation that what they had learned on their MSc course needed further mentoring, refining and developing further for it to be effectively utilised:

> *Participant 16:* ***"but the band aid is, we are 'the Advanced Nurse Practitioners', … when the role came out what we've learnt is that it was to help with the shortages of medical staff as a band aid x,y,z*** *but because we are full time staff that work here we are not on training programmes we are not associated to the deanery you know* ***we have finished our masters most of us, we should be able to do the job. what do we need teaching for? It's kind of the outlook /point of view, isn't it? 'What do you need teaching for, you're qualified now?'."*** *Participant 15:* ***"it's not seen that teaching is priority for us at all whereas the medical [staff are treated differently]".***
>
> Case Study 1: Interview 7 Lines 145-149 Participant 16; Lines 150 Participant 15

The notion that participants saw themselves being on an ongoing learning journey was evident, and the recognition that acquiring new skills, in particular, related to project management, research and innovation were necessary. Managers had little appreciation of this or indeed sympathy for supporting this need. Despite this lack of support, participants demonstrated self-direction in their learning:

"…well the service that I'm in is firefighting at the moment, it's probably ninety five present clinical and anything else I do…I do a lot of research [study/learning] ***but I do it in my own time you know I erm… always try and learn at least one thing, one thing new a week that's not my subject area I've always done that…"***
Alastair: "So you're saying that's your standard, you have set that?
"Yes, I've done that for as long as I can remember, so I know absolutely nothing about … HRT or something…and I'll spend an hour…learning about that subject" *(Alastair: "hum mm")*
"…it's amazing because sometimes you will be in clinic, you'll say something and you'll say where did that come from? I didn't even know I knew that…"

Case Study 2: Interview 5 Lines 334-344 Participant 14

5.2.4.3 Summary of the Comparison of Findings Between Case Study 1 and 2

This section is a summary of the comparison of findings related to the fourth research question: What barriers exist that hinder or limit the expression of nursing within Advanced Nursing Practice? Following the process of comparing and contrasting data in relation to the two case studies, which were the units of analysis for the study, codes generated were reduced to establish: **Concept 4- Restrictors**.

<table>
<tr><th colspan="2">Case Study 1: Acute Services
Acute Medicine/Surgery</th><th>Case Study 2: Non-Acute Services</th></tr>
<tr><td colspan="3">Common Findings</td></tr>
<tr><td colspan="3">• Two types of Advanced Nursing Practice were evident: Type 1: disease-centric, which dominated the clinical scene, and Type 2: patient-centric
• While four pillars of activity were associated with Advanced Nursing Practice, the clinical pillar was pre-eminent.
• Two versions of the clinical pillar existed: disease-centric, which tended to dominate, and patient centric.
• Clinical workload, particularly managing disease, restricted available time for patient-centred care and Advanced Nursing, and there was limited opportunity to develop non-clinical pillar activity
• The personal and professional development journey for participants often began with a lack of clarity about the scope of Advanced Nursing Practice. Most initially felt it was a medical substitution role
• The presence of a journey of development was evident for both participants, and their teams and services, however restricted learning /continuing professional development (CPD) was the norm
• There was limited vision / support for Consultant Nurses and lack of recognition of their role in supporting the development of Advanced Nursing with Advanced Nursing Practice
• Role /concept confusion was prevalent. It was suggested that this was because of: lack of definition; multiple different expressions of the role; the advent of the Advanced Clinical Practice title
• Risk was perceived to the promotion of patient centred practice by removal of the ‘nurse’ descriptor from the Advanced Clinical Practice title. Similarly, risk perceived of over promotion of the clinical pillar by inclusion of the ‘clinical’ descriptor in the Advanced Practice title</td></tr>
<tr><td colspan="3">Separate Case Findings</td></tr>
<tr><td colspan="2">• Set up as disease-centric role.
• Disease-centric priority forces substitution role.
• Clinical pillar dominates activity, limited scope for non-clinical pillar activity
• Role restrictions initially by need to prove clinical ability and worth.
• Turnover present, and frustration in role present because of restricted nursing input. One participant moved to Case Study 2: Service.
• Restricted learning /continuing professional development (CPD).</td><td>• Set up as patient-centred role.
• Patient centred focus promotes Advanced Nursing role.
• Clinical pillar preeminent but scope for non-clinical pillar activity for those willing to prioritise it.
• Restrictions present but less about scope, more on issues of growth and development, team instability/ relative team immaturity.
• Turnover of team hindered cohesion.
• Continuing professional development (CPD) supported to some degree, including non-clinical content.</td></tr>
</table>

• Consultant Nurse leadership distracted with attention on service management. • Autonomy restricted in medical substitution role. Supervised by / accountable to senior doctors- professional challenge here. • Difficult to fulfil four pillars.	• Consultant Nurse leadership supportive, some distraction with service management and role limitations. • Autonomy variable but generally enhanced. Supervised by senior nurses for nursing functions, doctors for medical components. • Able to fulfil non-clinical pillars, though limited with research.

Table 27: Summary of the Comparison of Findings Between Case Study 1 and 2 (Concept 4 - Restrictors)

5.3 Summary - Concept Reduction to Establish the Core Concept

This section represents a summary of the reduction of each of the four concepts to form the Core Concept which will be developed and explained in Chapter 6.

5.3.1 Concept 1: Characteristics

This was constructed from the process of generating categories developed from initial coding, created from participant data about 'Features' and 'Scope'. These were generated from individual participant's experiences of the 'Features' of Advanced Nursing Practice, including their significance and potential, and the 'Scope' of its expression towards patients, taking note of colleagues' involvement, the service in which they were situated, and the prevailing Trust/service culture. The final stage was to creatively reduce categories to form Super- Categories. Collectively this is summarised in Table 28 below.

The analysis producing concept 1 was continued to result in its contribution to construct the Core Concept. This is illustrated below in Table 28, as the additional column on the right.

Codes		
Categories		**Reduced Categories**
(C1) Level of Practice	(C5) Situationally Aware	(RC1) Strengthening Level and Increasing Awareness
(C2) Patient-centric Practice	(C6) Case Manager	(RC2) Pursuing Comprehensive Care and Management
(C3) Integrated Four Pillar Activity	(C7) Constant Influencing Presence	(RC3) Modelling Excellent Nursing
(C4) Enquiring, Dynamic and Evolving Practitioner	(C8) Informing Practice with Knowledge	(RC4) Continuing Learning and Growing
Super Categories		**Reduced Super Category**
(SC1) Features	(SC2) Scope	(RSC1) **Ensuring Patients First**
Concept 1- Characteristics		Concept contribution to Core Concept – Advanced Nursing Practice is a Personal and Professional Journey not an End Point.

Table 28: The Contribution from Concept 1 - Characteristics, to Construct the Core Concept- Advanced Nursing Practice is a Personal and Professional Journey not an End Point

5.3.2 Concept 2: Advanced Nursing

This was constructed from the process of generating categories developed from initial coding, created from participant data about 'centrality of the nursing lens' and 'Advanced Nursing' activity. This identified factors that they believed supported the implementation of effective and dynamic Advanced Nursing within Advanced Nursing Practice roles delivering comprehensive care and management of patients, supported colleagues, and improved the service in which they were situated, as well as positively influencing prevailing Trust/service culture. The final stage creatively reduced categories to form Super- Categories. Collectively this is summarised in Table 29 below.

The analysis producing concept 2 was further developed to make its contribution, along with the products of the other three concepts, to construct the Core Concept. This is also seen illustrated below in Table 29, as the additional column to the right.

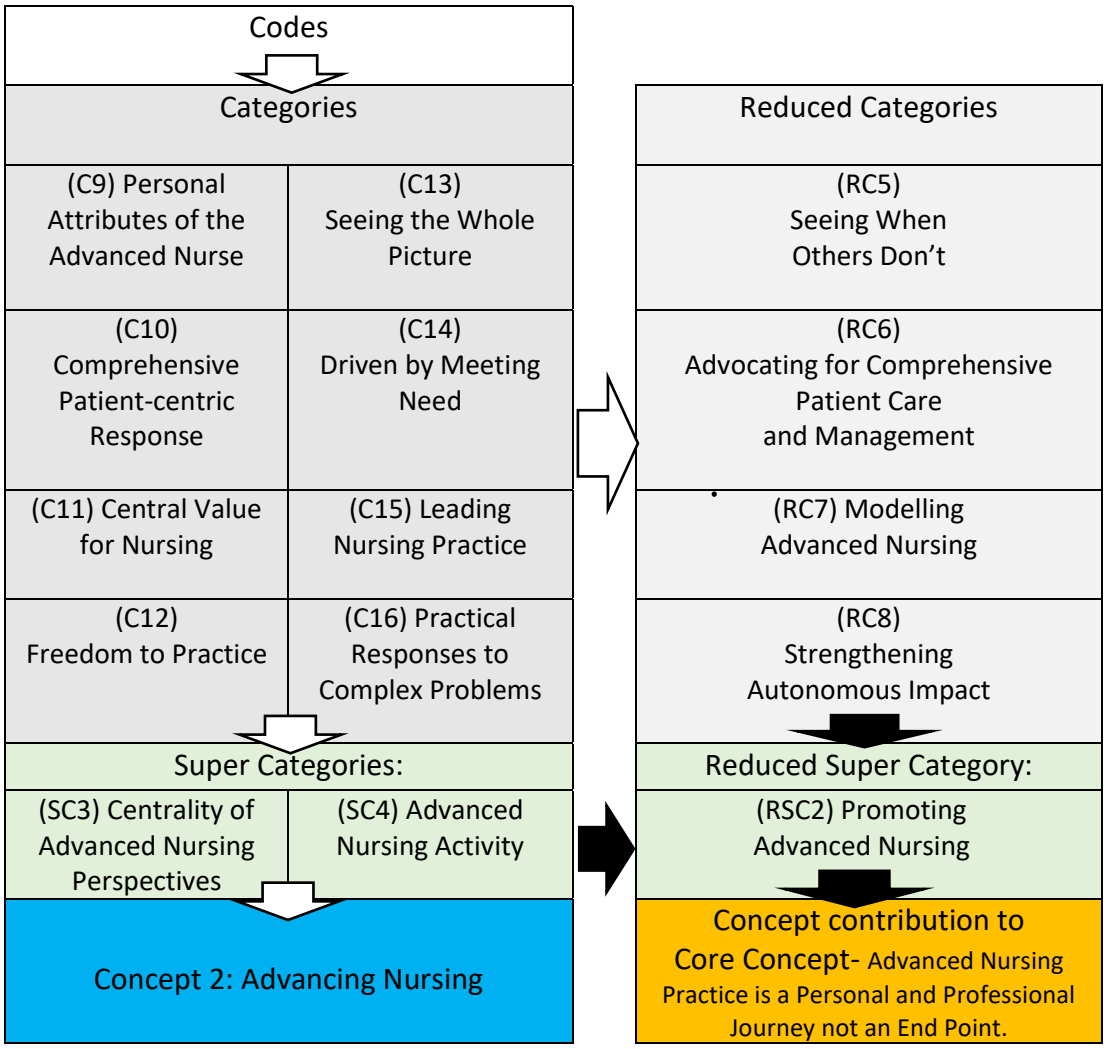


Table 29: The Contribution of Concept 2 - Advanced Nursing to Construct the Core Concept - Advanced Nursing Practice is a Personal and Professional Journey not an End Point.

5.3.3 Concept 3: Enablers

This was constructed from the process of generating categories developed from initial coding, created from participant data about 'Making Advanced Nursing Visible' and 'Making Advanced Nursing Happen', derived from factors that participants believed enabled implementation of effective and dynamic Advanced Nursing within Advanced Nursing Practice roles delivering effective comprehensive care and management of patients, supported colleagues, and improved the service in which they were situated as well as positively influencing prevailing Trust/service culture. The final stage creatively reduced categories to form Super- Categories. Collectively this is summarised in Table 30.

The analysis producing concept 3 was further developed to make its contribution, along with the products of the other three concepts, to construct the Core Concept. This is also seen illustrated below in Table 30, as the additional column of the right.

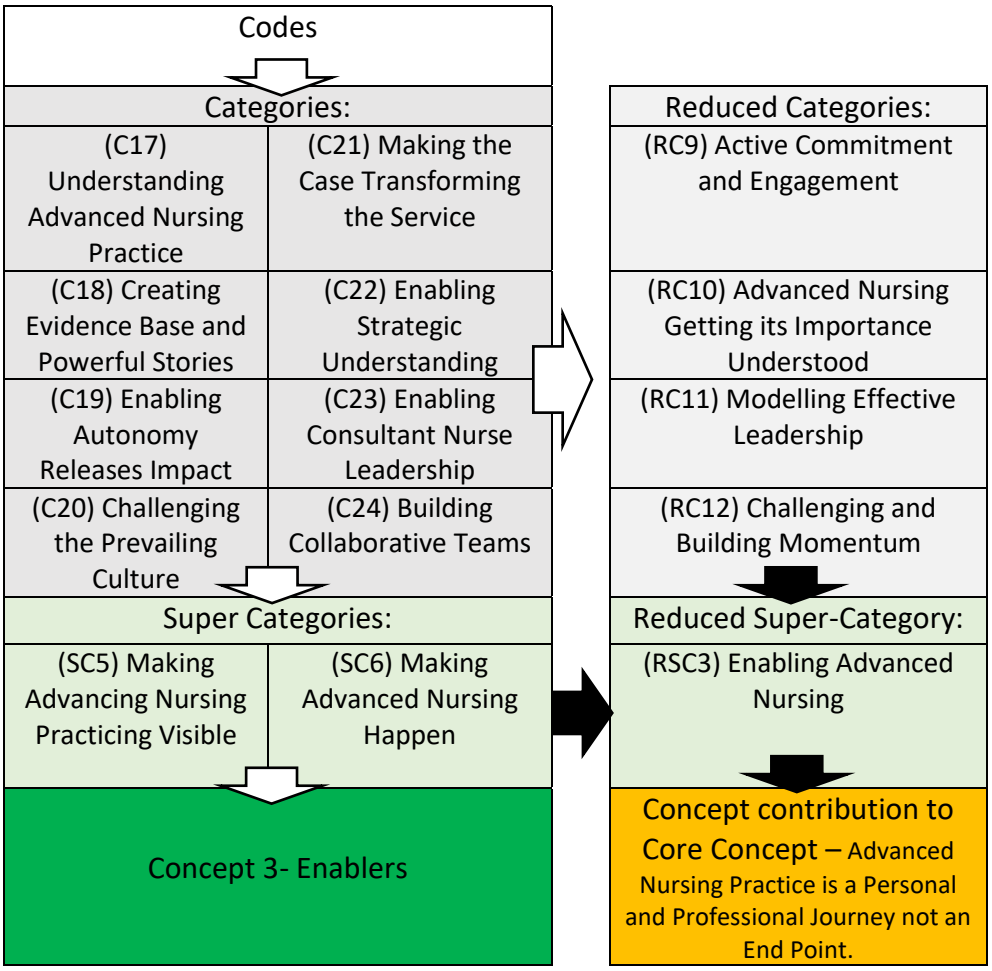


Table 30: The Contribution of Concept 3 - Enablers to Form the Core Concept - Advanced Nursing Practice is a Personal and Professional Journey not an End Point.

5.3.4 Concept 4: Restrictors

This was constructed from the process of generating categories developed from initial coding, created from participant data about 'Concept Polarisation' and 'System Restrictions'. All elements were generated from participants experience of factors restricting the expression and implementation of Advanced Nursing withing Advanced Nursing Practice. They included: issues for the Advanced Nurse Practitioners themselves regarding confidence in their identity, and the resilience to act autonomously creating space for their new roles; clarity around the concept of Advanced Nursing Practice and how to secure understanding of this; cultural and structural issues within the service and the Trust, which served to promote power imbalances and very restricted models of care and management that resulted in a restricted service. The final stage creatively reduced categories to form Super- Categories. Collectively this is summarised in Table 31.

The analysis producing Concept 4 was further developed to make its contribution, along with the products of the other three concepts, to construct the Core Concept. This is also seen illustrated below in Table 31, as the additional column of the right.

Codes		
Categories:		Reduced Categories:
(C25) Role Concept Confusion	(C29) Restricted Role Scope	(RC13) Explaining the Scope of Advanced Nursing
(C26) Impact of Existing Culture	(C30) Reductive Mindsets Dominate	(RC14) Promoting Patient-centric Practice
(C27) Limitations of Evidence Base	(C31) Limited Development Of Useful Evidence	(RC15) Producing Powerful Evidence
(C28) Unrecognised Continuing Professional Development Needs	(C32) Under-investment In Learning Culture	(RC16) Establishing an Inclusive Learning Culture
Super Categories:		Reduced Super-Category:
(SC7) Concept Polarisation	(SC8) System Restrictions	(RSC3) Removing Restrictions on Advancing Nursing
Concept 4- Restrictors		Concept contribution to Core Concept – Advanced Nursing Practice is a Personal and Professional Journey not an End Point.

Table 31: The Contribution of Concept 4 - Restrictors, to Construct the Core Concept - Advanced Nursing Practice is a Personal and Professional Journey not an End Point

5.4 Chapter Summary

This chapter has presented the findings constructed from the rich data set generated from participant interviews conducted in this study. It has illustrated how the data were analytically reduced to construct the four concepts: 'Characteristics', 'Advanced Nursing', 'Enablers', and 'Restrictors', and how the elements of each of these were in turn reduced to contribute to constructing the Core Concept. This was enabled by the realisation during the process of analysis of the repeated appearance throughout the data of the theme of 'Journey'.

While Advanced Nurse Practitioner, Consultant Nurse and consultant medical staff participants were involved in the process of data generation, the data analysis did not focus on the contributions of individual participants per se, but sought to compare and contrast data which represented each case study. During the analytical process, Charmaz's (2014) 'initial' and 'focused' coding phases were utilised to advance the process and this led to a shift in emphasis from attention on static and fixed codes, that had been of immediate interest, to more dynamic events and incidents that participants referred to. These uncovered the 'actions' involved in participants experience of Advanced Nursing Practice in their daily work (Charmaz 2014). These actions were reflected in the categories and super-categories that were generated, which ultimately fed into the formation of the four concepts: Characteristics, Advanced Nursing, Enablers, and Restrictors. This process supported not just description of what has been shared by the participants, but more of an explanatory account which enabled the construction of the Core Concept, the building block for the grounded theory (Strauss and Corbin 1998). The Core Concept and the construction of the grounded theory will be considered in the next chapter.

Chapter 6 Synthesis of Findings and Presentation of Grounded Theory

6.1 Introduction

This chapter builds directly on the findings of the study presented in the last chapter. It will explain and illustrate how the four concepts generated from the data supported the construction of the Core Concept: 'Advanced Nursing Practice is a Personal and Professional Journey not an End Point', and how this Core Concept contributed to the construction of the grounded theory, the culmination of the study (Birks and Mills 2015).

6.2 Constructing the Core Concept: Advanced Nursing Practice is a Personal and Professional Journey not an End Point

The concepts including the Core Concept were constructed mindful of the need to respond to and address the study research questions, aim and objectives, (see Chapter 4 page 70)**.** The aim was to:

> Explore the features, scope and activity of Advanced Nursing Practice, and explain the relevance and significance of nursing within this role, as experienced by two groups of nurses recognised as Advanced Nurse Practitioners, and the Consultant Nurses and consultant medical staff who work with them, in a local university hospital NHS trust.

The study objectives were encompassed and expressed through the four research questions, and these were addressed through the construction of these four concepts (Birks and Mills 2015):

1. What are the features and the scope of Advanced Practice? This led to the construction of Concept 1: Characteristics
2. What is the contribution to Advanced Nursing Practice that comes from being a nurse? This led to the construction of Concept 2: Advanced Nursing
3. What helps nursing to develop and be expressed within Advanced Nursing Practice? This led to the construction of Concept 3: Enablers.
4. What barriers exist that hinder or limit the expression of nursing within Advanced Nursing Practice? This led to the construction of Concept 4: Restrictors.

As data was compared and contrasted during the analytical process, the aim was to develop analysis beyond description to achieve theorising through conceptual abstraction (Birks and Mills 2015). I was mindful that different grounded theorists had suggested different approaches to coding, Strauss

and Corbin originally had three coding stages (1998) though these were effectively reduced later to two, as Corbin and Strauss (2008) dispensed with their middle 'selective coding' stage placing emphasis instead on 'theoretical coding', to support theoretical integration. Charmaz also identified three stages (Birks and Mills 2015) but asserted that most projects could be adequately completed using her first two stages, 'initial' and 'focussed' coding (Charmaz 2014). As considered in Chapter 4, this two-stage approach was adopted to progress my analysis and so construct my grounded theory. The analytical process discussed and illustrated in Chapter 4, page 76 is extended here to provide further detail in relation to the end stages of the process and the construction of the Core Concept and grounded theory. The illustration begins at data generation and progresses through its stages to the construction of the grounded theory, (see Figure 16, page 206).

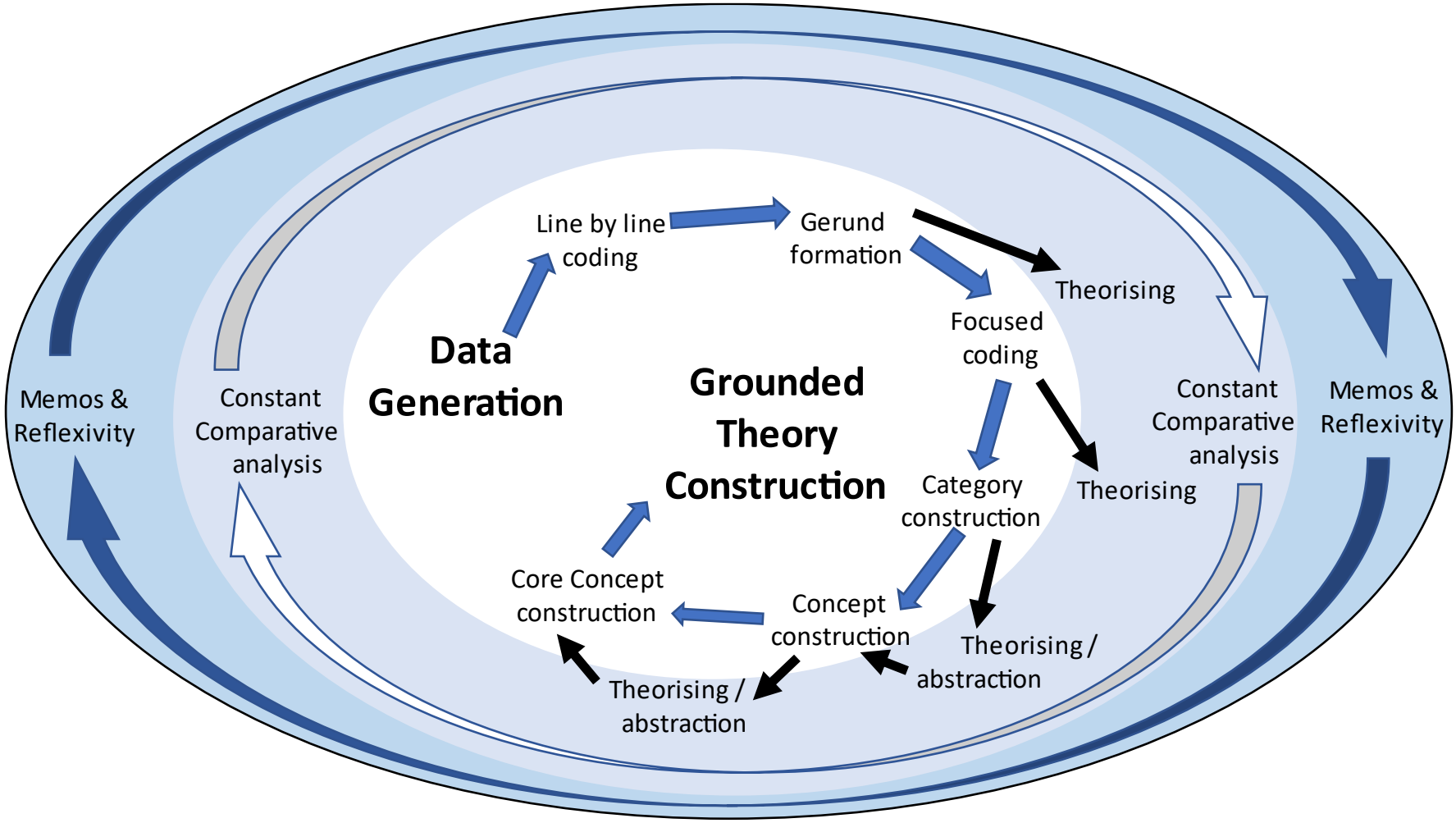


Figure 16: The Strategy and Process for Carrying out Simultaneous Collection, Generation and Analysis of Data in this Study

6.2.1 Establishing Journey as the Central Idea Underpinning the Core Concept

Throughout the process of analysis and abstraction leading to the construction of each of the four concepts, progressive reduction of the categories revealed new understandings about aspects of participants' development as Advanced Nurses. Conceptual abstraction of these understandings generated ideas about the centrality of the notion of 'journey', the process which underpinned becoming and being an Advanced Nurse. This notion was extended further since it was also recognised that completing a Master of Science degree course of preparation, so 'qualifying' participants for an Advanced Practitioner title, did not actually represent the end point of participants development. Certainly the 'qualifying' point was a landmark, titles were changed, from trainee Advanced Nurse Practitioner to Advanced Nurse Practitioner, service privileges were granted, and grades were changed, typically from Agenda for Change, Band 7 to Band 8a (National Health Service Staff Council 2023; Snaith et al 2023). However, acquiring the title was in some ways misleading since it was not uncommon for participants to feel unequal to the title, particularly when their autonomy had been restricted during their training. The notion of 'imposter syndrome' (Murphy and Mortimore 2020) was referred to by participants. Nonetheless participants recognised that to achieve their potential, it was essential that their development continued.

Explanation of what was happening with regards to participants' experience of becoming and being Advanced Nurse Practitioners became evident as the notion of 'journey' was generated from the data. Two memos captured my developing thoughts as I examined the data and considered its meanings:

> *'Throughout the data the concept of stages on a journey was emerging. It felt like a higher level of abstraction had occurred for me on the realisation that **JOURNEY** was becoming the recurrent and overarching concept, and a clear focus for 'what is happening here?'. Moreover, I realised that this concept applied in several different ways to development and growth or alternatively obstruction and restriction: first, to each Advanced Nurse Practitioner; second, to the team in which they serve; third, to the service in which they work; and fourth to the Trust where they are employed. As I considered when the journey began, it dawned on me that for the individual practitioner, the professional self is initiated in the pre-registration period. That is where socialisation begins, and professional values are taken up. For nursing the central focus of the patient as first is pre-eminent. The lens through which patients are seen is holistic and the aim is a comprehensive and unfragmented response to patient need. It seems to me then that a successful journey enables ultimately the experienced, autonomous, assertive practitioner, the challenger of practice and the advocate for patients.'*
>
> Memo 6: Journey

This second memo, six months later, revealed awareness of not only the Advanced Nurse Practitioner journey, but that several others were also taking place at the same time:

> *'In considering all the categories, super-categories and concepts, collectively there was the sense of a dynamic, organic, process of growth, change, development of self (The Advanced Nurse Practitioner) but also colleagues, the service and others beyond that! The positive result of that all coming together was a significant impact on the well-being of patients, and carers, moving them through their journey of healing and restoration.*
> *Advanced Nursing Practice therefore is a journey not an end point, punctuated by key moments of revelation (lightbulb moments), movement, encounter and relationships.'*
>
> Memo 7: Multiple Journeys

Continuing to reflect on and progress my understanding of participants undergoing a continuing journey of growth, it was participants 'personal' and 'professional' experiences of their journey to become and be Advanced Nurse Practitioners that stood out. Their clear repeated aspiration, where it was not already a reality, was to practice Advanced Nursing and so consistently deliver patient-centred care. Alongside this was a strong desire by participants to demonstrate impact through integrated non-clinical pillar activity, using also their personal influence to improve their services.

6.3 The Explanatory Frameworks: The Process of Generating the Core Concept Leading to the Process of Constructing the Grounded Theory

Reviewing literature during the study had played an important part in developing theoretical sensitivity as data analysis was undertaken. While this applied to subject literature, it extended also to research literature related to constructivist perspectives, and so the usefulness of an illustrative framework was considered to aid the explanatory effort. Though for some researchers this approach was contentious, Birks and Mills (2015) reported benefits of this in supporting explanatory efforts.

6.3.1 Development of the Explanatory Framework

I formulated an illustrative framework in two parts:

- First, 'The Explanatory Framework for the Process of Generating the Core Concept', (see Figure 18, page 209);
- Second, 'The Explanatory Framework for the Process of Generating the Grounded Theory', (see Figure 22, page 222).

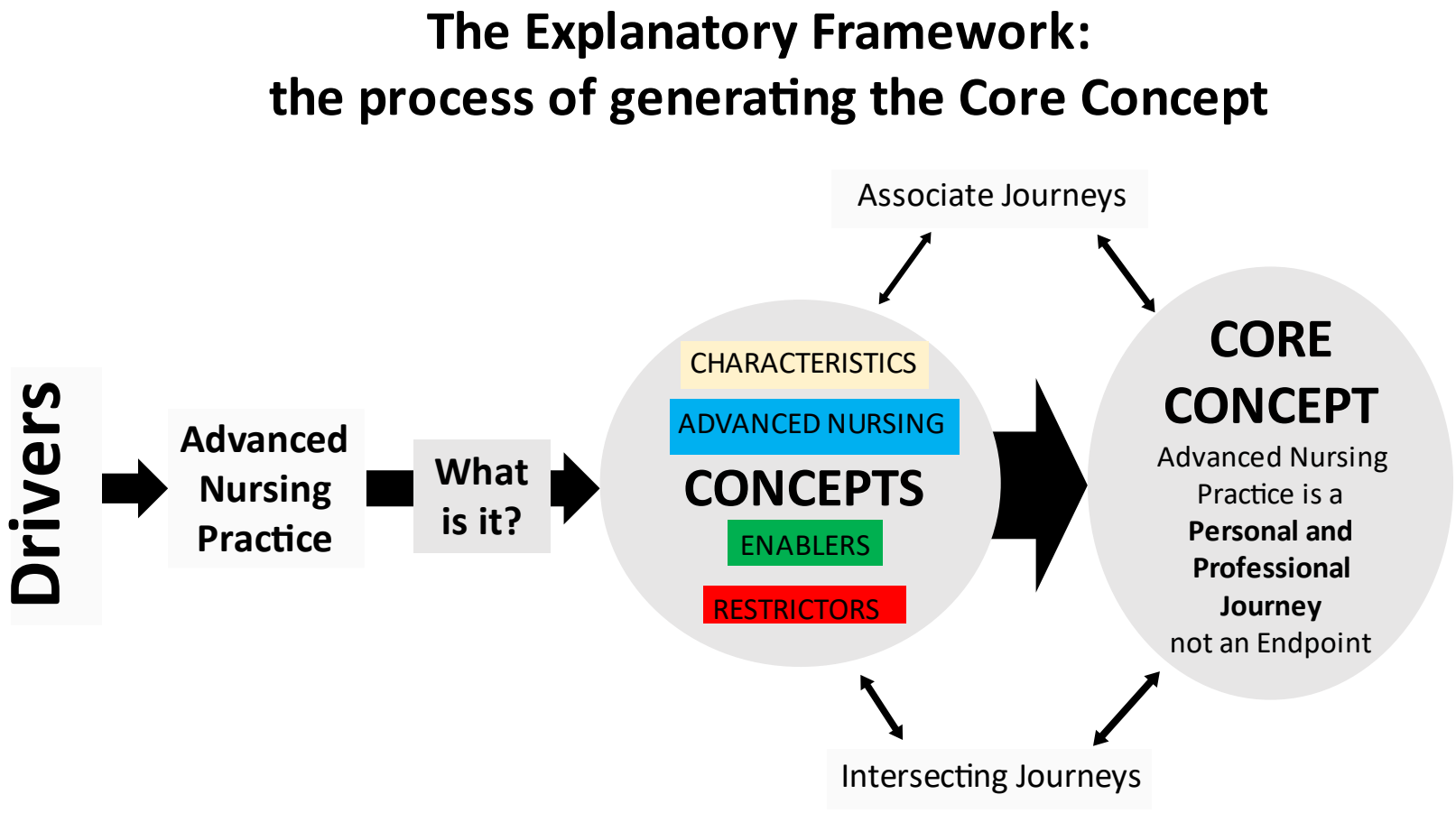


Figure 18: The Explanatory Framework: the Process of Generating the Core Concept

These explanatory frameworks were developed as a progressive method of illustrating explanation of the findings of this study. The first stage of this was focused on answering the central research questions at the heart of the study: what were participants understanding of their role as Advanced Nurses; what was Advanced Nursing; what helped its development; and, what hindered its development and implementation? This stream of activity ran alongside the ongoing process of constant comparison of data and was congruent with my intention from the outset to avoid predetermining and imposing concepts on the data (Glaser, 1978) but rather constructing concepts grounded in the data, and then developing them through higher level abstraction to form the Core Concept.

The discussion will now consider and explain each of the elements of the explanatory framework the process of generating the Core Concept, figure 18.

6.3.2 Drivers

This element initiated the explanatory framework, identifying drivers, which were the precursors for the Advanced Nursing Practice role experienced by participants located within each of the two case studies, the units of analysis for this study:

- Increased demands on NHS
- Insufficient key health workers
- Lack of assessment and decision- making capacity in patient clinical management
- Increased unmet patient complex care needs
- Professional ambition of nurses to do more for patients

These drivers were narrowed down in Chapter 2 to form two major drivers for Advanced Nursing Practice roles in the United Kingdom: first, the need to respond to medical staff shortages; and second, the need for a purposeful response to the rise in chronic and long-term conditions. Advanced Nursing Practice emerged as the key professional response to both drivers (Gray 2016), born out in data generated from this study. Advanced Nurse Practitioners were able to effectively address the assessment and decision-making need in clinical management, including the medical domain and so were well able to support the disease-centric model of care. However, where supported and having the freedom to do so, they were at least equally suited to address unmet complex patient care needs arising from chronic disease processes through the use of Advanced Nursing, delivering patient-centric care. The professional ambition of nurses to do more for patients

was however often limited and restricted by employer led demands to focus on primarily addressing the medical shortfall. This was a recurrent participant concern.

6.3.3 Advanced Nursing Practice

The drivers identified led to the emergence of Advanced Nursing Practice. However, what that title meant and how it was expressed in the clinical world was varied. Multiple examples emerged nationwide which led to much confusion. Indeed, from early in the development of these new roles, questions were raised as to whether these roles advanced the nursing contribution to healthcare, as the name implied, or were drawn instead into a medical substitution / replacement function. The contextual literature presented in Chapter 2 highlighted this as an ongoing concern, and was found to be a consistent concern within data arising from participant comments in this study.

Two types of Advanced Nursing Practice were proposed in Chapter 2 (see Figure 4 page 26), repeated here, described at polar extremes to each other. The findings subsequently recognized these types as present within participant comments in describing their clinical and wider activity within their case study services.

Four pillars* represent Clinical Practice, Leadership, Education and Research dimensions of Advanced Nursing Practice DoH 2010

Figure 4: Two Contrasting Examples of Advanced Nursing Practice

The findings revealed that participants in Case Study 1: Acute Services tended towards Type 1 roles (See Figure 4, page 211), where patients frequently had urgent medical needs and a disease-focused approach was judged the appropriate response. The driver for those Advanced Nursing Practice roles was explained as the need to fill gaps in medical staffing. In contrast, Case Study 2 participants tended in the opposite direction with roles similar to Type 2 (See Figure 4 page 211). This was explained by the fact that patients in these Case Study 2: Non-acute Services had long term conditions with multiple pathological problems. These required a much more complex set of solutions, broader and personalised responses associated with a different set of skills, drawing heavily on Advanced Nursing knowledge and skills.

However, the findings revealed that while the polar extremes did exist as described, participants generally found themselves instead positioned somewhere along a continuum between the two, along which most could and did move to achieve, at least in part, their aspirations for Advanced Nursing. This process strongly concurred with their experience of being on a developmental journey. Consequently, they were, at least theoretically, at different places along this continuum as their personal perspectives and situation dictated. The following diagram illustrates this:

Four pillars* represent Clinical Practice, Leadership, Education and Research dimensions of Advanced Nursing Practice DoH 2010

Figure 19: Developmental Continuum for Advanced Nursing Practice

6.3.4 Generating the Four Concepts

- Concept 1: Characteristics
- Concept 2: Advanced Nursing
- Concept 3: Enablers
- Concept 4: Restrictors

These concepts were constructed via the following process. Codes were developed from participant data, and were reduced to generate categories. Through constant comparative analysis three reductive cycles took place whereby super categories, reduced categories and from those finally a reduced super category was generated. Throughout this dynamic generative process attention was paid to the fundamental need to address the study research questions, aim and objectives. The process of forming each concept and then the Core Concept is exemplified using Concept 1: Characteristics in Table 32. Note this table is an expanded version of Table 28 on page 199 and provides more detail of the process.

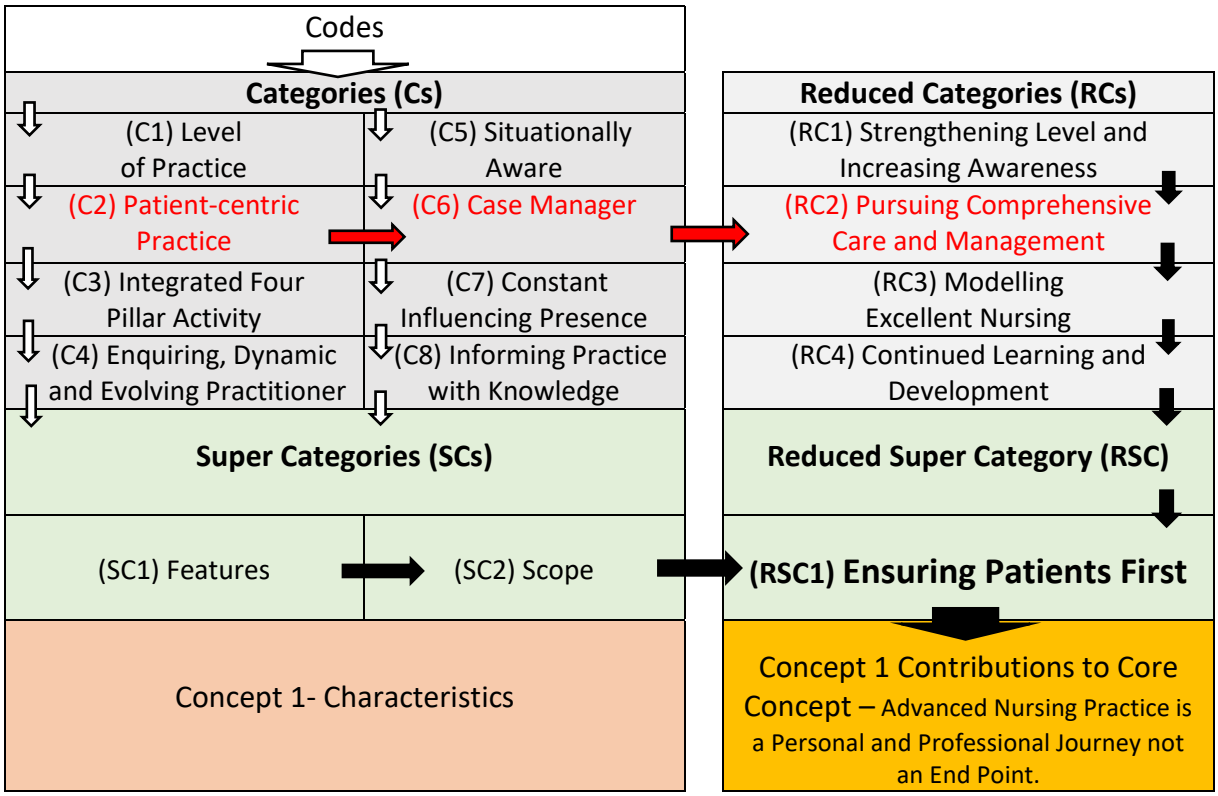


Table 32: Contribution of Concept 1- Characteristics, to Construct the Core Concept- Advanced Nursing Practice is a Personal and Professional Journey not an End Point

This dynamic process involving progressive theoretical abstraction continued through three cycles:

- Cycle 1: demonstrated by following the white arrows in the left-hand block (codes to categories), where the two columns of categories (C1-4 and C5-8), progressed to form the Super Categories- (SC1) Features and (SC2) Scope, from which Concept 1: Characteristics was generated.

- Cycle 2: As the process progressed, exemplified here by following the red arrows, C2 and C6 from left to right-hand block (reduced categories) to form RC2. This reflected the process of data reduction commensurate with the 'focused' stage of advanced coding and abstraction (Charmaz 2014). Here each row of categories (Cs) was reduced to form a Reduced Category (RC) as seen in RC 1 to RC 4;

- Cycle 3: where the Super- Categories (SCs), Features (SC1) and Scope (SC2) and Reduced Categories (RCs), RC 1-4 were reduced to form the Reduced Super Category (RSC) ensuring patients first (RSC 1). This became the reduced contribution of concept 1 to generate the Core Concept.

Though presented here for illustrative purposes as a neat linear progression, in reality the analytical effort was complex and 'messy' (Ward, Gott, and Hoare 2017). However, it was necessary to go through this to tease out meanings and understandings which were grounded in participant experiences. In comparing and contrasting these elements of data, a higher level of abstraction was achieved which enabled construction of this concept, and thereafter its contribution to generate the Core Concept. The same process described here was conducted for the other three concepts, illustrated in Tables 29, 30 and 31, see pages 200-202, in Chapter 5.

6.4 Generating the Core Concept

How the contributions of all four concepts were reduced is demonstrated in Table 33, page 215, illustrating contributions to construct the Core Concept. Once again, three cycles took place:

- Cycle 1: is demonstrated by following the white arrows in the left-hand block where the four columns of reduced categories (RC1-16) formed four reduced super categories: Ensuring Patients First (RSC1), Promoting Advanced Nursing (RSC2), Enabling Nursing to Advanced (RSC3) and Removing Restriction on Advanced Nursing (RSC4).
- Cycle 2: is demonstrated by following the red arrows, to the right-hand block where each row of reduced categories (RCs) was reduced to form a final category (FC). This is exemplified by RC2, RC6, RC10 and RC14 forming FC2, Promoting Patient-centric Services.

- Cycle 3: is demonstrated by following the black arrows in two stages: 1) the Reduced Super Categories (RSCs) RSCs 1-4, and 2) the Final Categories (FC) FCs 1-4, were both reduced and together contributed to generate the Final Super Category (RSC) Enabling Powerful and Dynamic Journeys (FSC 1). This process enabled the construction of the Core Concept.

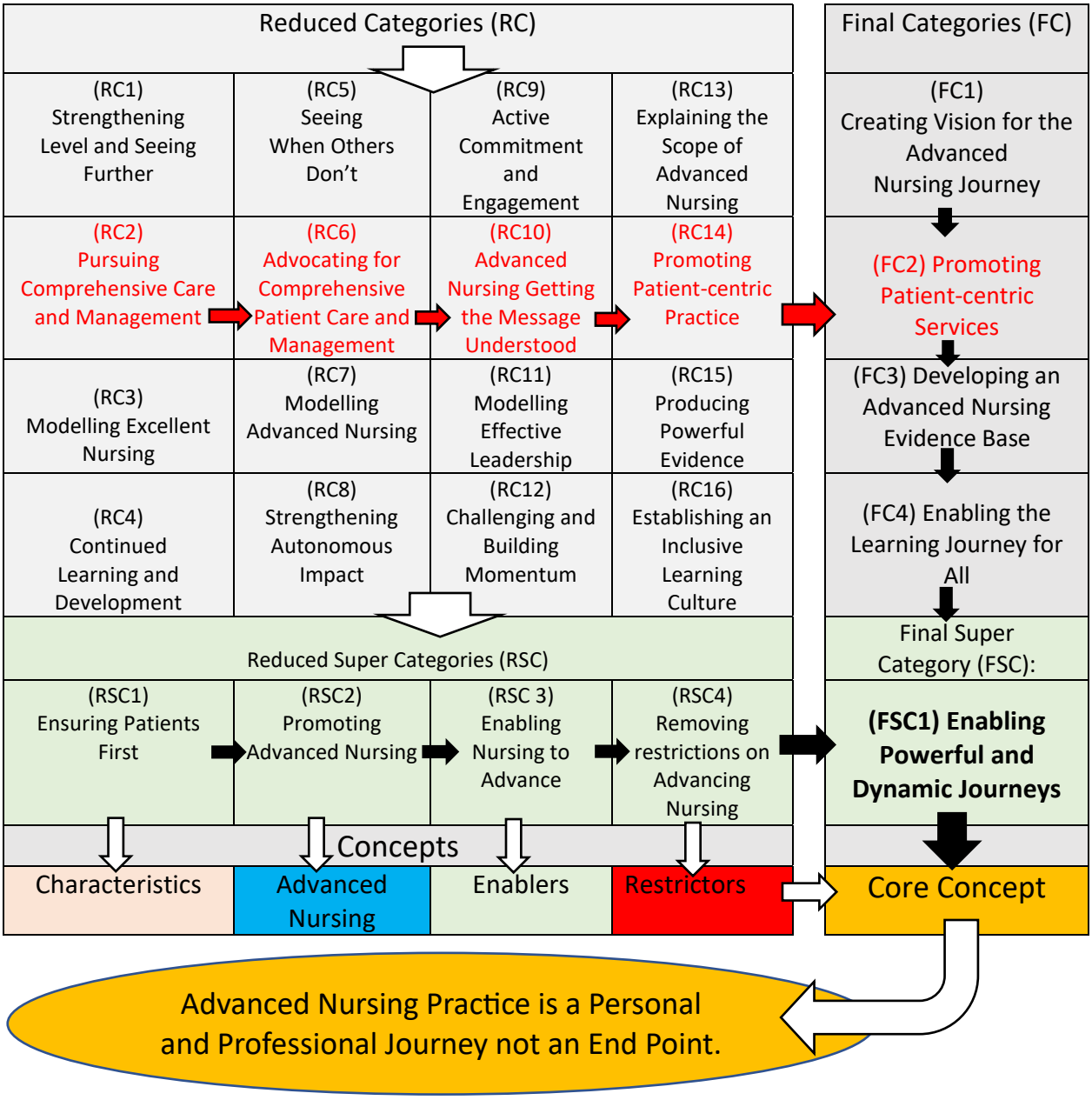


Table 33: Contribution of Concept Elements to Construct the Core Concept

6.4.1 The Personal and Professional Journey

The participants' journey was divided into two constituent elements:

First, the **Personal journey,** which focused on the extent of participants' personal growth and acquisition of personal attributes, including for example; carrying compassion for people, and having broad awareness beyond themselves and their patients to their colleagues and their service. It also addressed negative experiences and influences, and fostering development of coping mechanisms, resilience, and confidence.

Second, the **Professional journey**, which focused on the development of professional identity, and commitment to it; recognition and adherence to nursing values and beliefs; appropriate competence and skill set; range and depth of professional experience; speciality understanding, underpinned by depth and breadth of knowledge base; a firm foundation in problem solving skills and abilities, along with effective critical thinking and decision-making skills.

6.4.1.1 Internal and External Factors Effecting the Personal and the Professional Journey

The presence or absence of particular factors, represented in the findings and located within the personal and the professional journey, proved to be very significant for participants in terms of success or not in expressing Advanced Nursing within Advanced Nursing Practice. The personal and professional journey was much more demanding for participants where support was limited, since they had to draw upon their own reserves including courage and resilience to progress. The latter were examples of 'internal' factors discussed by participants, while other factors 'external' to them were located in their teams and the service they worked in. These factors acted either as accelerants or brakes on the development and progress of the journey that participants experienced.

- **Internal factors**
  - Level of individual professional maturity and grasp of professional identity as a nurse.
  - Attainment of personal characteristics, including empathy, compassion, professional confidence, resilience, persistence and courage.
  - Grasp of the central importance of recognising and addressing 'patient need' in all they did.
  - Achievement of education and preparation for the role, supported by the availability of broad-based effective mentorship, coaching and continuing professional development.
  - Commitment to advance nursing and nursing practice.
  - Clarity of personal vision for the Advanced Nurse Practitioner role.
  - A high level of personal* autonomy in their role as Advanced Nurse Practitioners.

- **External factors**
  - Support of positive leaders, influencers, mentors and role models within the workplace.
  - Clarity of vision, understanding, belief and active support for the role of Advanced Nursing Practice, by senior service, medical, and nurse leaders, representing the Trust at all levels.
  - A high level of structural* autonomy supported in their role as Advanced Nurse Practitioners.

    Note - *see Glossary page xvi

The continuing back and forth of constant comparison of the data, while a 'messy process' (Birks and Mills 2015) continued to generate new understandings about the concept of journey that were different from the Personal and Professional at the centre of the Core Concept. Further abstraction of the notion of journey led to an appreciation of other journeys which interacted with the principal Personal and Professional Journey, these were identified as 'Intersecting' and 'Associate' Journeys.

6.5 Interconnecting Journeys

In developing understanding and explanation of the Core Concept of Journey, complex relationships were revealed between the principal 'Personal' and 'Professional' Journey and two other Interconnecting Journeys. These will be considered in this section.

- the 'Intersecting' Journeys of the 'Advanced Practice Team', 'Clinical Service' and 'Trust'; together with,
- the 'Associate' Journeys of the 'National Health Service' and 'Nursing Profession'.

The interconnections of these Journeys are presented diagrammatically in Figure 20 (see page 218).

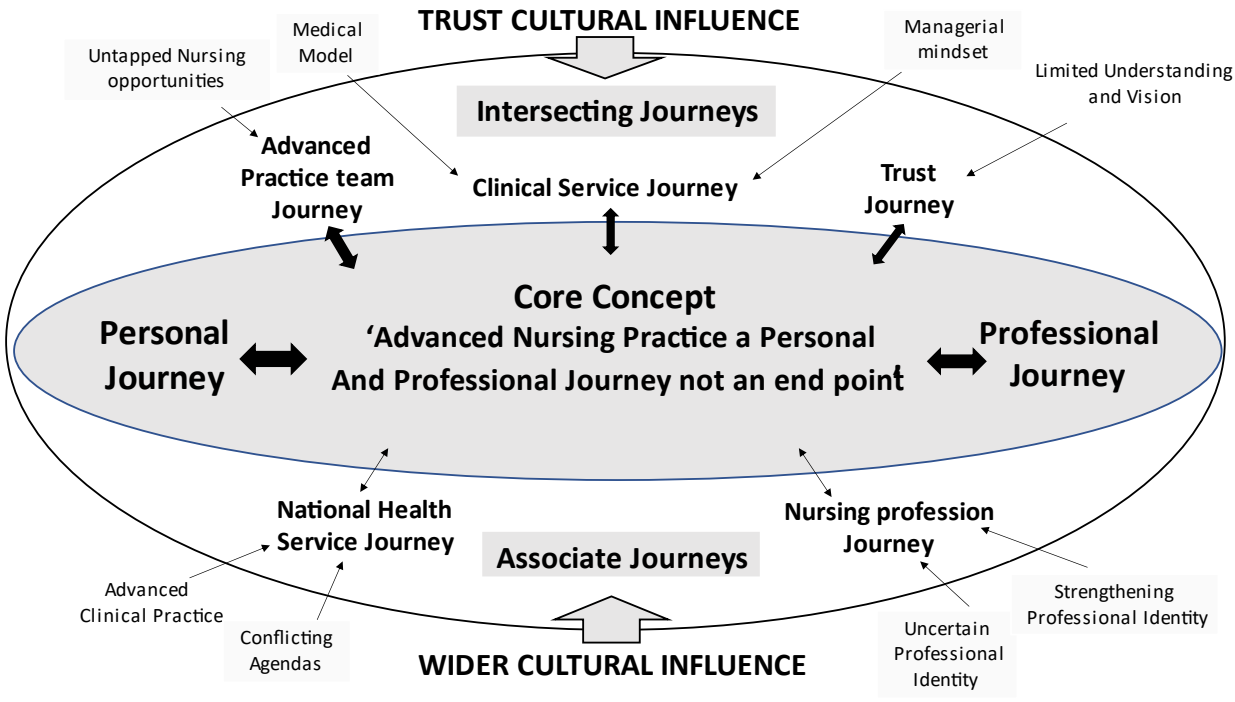


Figure 20: Relationships between the Core Concept, Advanced Nursing Practice is a Personal and Professional Journey not an End Point, and Intersecting and Associate Journeys

6.5.1 Intersecting Journeys

The following were labelled 'Intersecting Journeys', because they interacted with each other, and particularly because they had a direct bearing and influence on the ability of the Advanced Nurse Practitioner participants to reach their potential or not:

6.5.1.1 the Advanced Nurse Practitioner Team Journey.

In both Case Studies, most participants (n = 18/20) worked in teams of Advanced Nurse Practitioners. This was not always a straightforward experience. Creating and retaining a shared vision for the service demanded effort. Teams were not always stable, so team building was an ongoing issue. Supporting new members distracted from putting effort into innovation. Nonetheless working and collaborating with other health professionals, was seen as increasingly important and nurses were regarded as particularly effective in this. The presence of empowering leadership, including from Nurse Consultants, supported healthy team working and collaborative practice.

6.5.1.2 The Clinical Service Journey.

This was reported by participants as often undeveloped in terms of strategic direction and service leadership supporting new roles. Participants reported clarity was needed around: 1) the role and purpose of Advanced Nursing Practice; 2) a local vision for Advanced Nursing Practice; 3) establishing a strategic leadership culture, less orientated to 'firefighting' but looking more purposefully to progress future service improvements; 4) the development of service business plans that incorporated Advanced Nursing Practice in a strategic way; 5) a clear workforce skill mix strategy, alongside a workforce skill mix plan which considered the benefits of a mixed economy of clinicians.

6.5.1.3 The Trust Journey.

The Trust appeared to have been beset, prior to the period of this study, by an ambivalent and reactive attitude to Advanced Nursing Practice. There was a reliance upon individual services, and service leads to introduce and use Advanced Nursing Practice, or not, as they wished. There was little infrastructure to support the role centrally or any driving force to lead it. There appeared much to be done to embed Advanced Nursing Practice, though participants were encouraged that a senior nurse with a reputation for being an active supporter of Advanced Nursing Practice had been recently appointed with a mandate to bring change.

6.5.2 Associate Journeys

Alongside the 'Intersecting Journeys', 'Associate Journeys' were also located and though these journeys appeared tangential at first, it became clear they had far-reaching impact on the local situation of the trust where the study was carried out.

6.5.2.1 The National Health Service Journey

Two recurring and connected themes were expressed with reference to this Journey:

- First, concern over the prevalence of medical hegemony throughout the NHS, and experienced by participants within this rust and its services. Medicine was experienced as exerting disproportionate influence over the way services were delivered, what the service priorities were, other health professionals, and the way in which services were developing.
- Second, questions about whether the current models of delivery, largely led by the medical model, remained appropriate for meeting the growing complexity of patients' needs. Needs that often went beyond the scope of disease-centric responses.

6.5.2.2 The Nursing Profession Journey.

While exploring 'nursing' had not been the main focus for this study, Advanced Nursing was, and discussion of both became a recurrent theme within participants' commentary. There was evidently a broader 'nursing profession' journey in which nurses were re-evaluating what nursing was for and what nurses should be doing. Participants regularly stated nursing was of high importance, and important to them personally, but initially struggled to articulate a vision for Advanced Nursing. It became apparent that their position was frequently associated with where they were on their own developmental journey. However, participants recognised from their own experience a number of their fellow Advanced Nurse Practitioners had been content to be diverted into quasi-medical roles. They appeared to be pursuing a particular agenda which lacked ambition for advancing nursing, nor for themselves in promoting nursing. However, for most participants as they developed in their Personal and Professional Journeys, they worked through questions of professional identity and grew in their confidence to articulate and promote the delivery of Advanced Nursing, working with their colleagues to promote services which delivered patient-centred care.

While the concepts were constructed, participants' experiences of, and reflections on, the two types of Advanced Nursing Practice were a recurrent feature. They were distinguished by tensions which arose where participants experienced resistance to incorporating levels of patient-centredness into their practice. This resistance restricted the fullest expression of Advanced Nursing within Advanced Nursing Practice. While experienced in both case study services, it was particularly so in Case Study 1: Acute Services. The following figure contrasts the different emphasis placed on the clinical pillar and the kind of clinical practice that was demonstrated in each type. The presence and level of integration of the non-clinical pillars is also demonstrated:

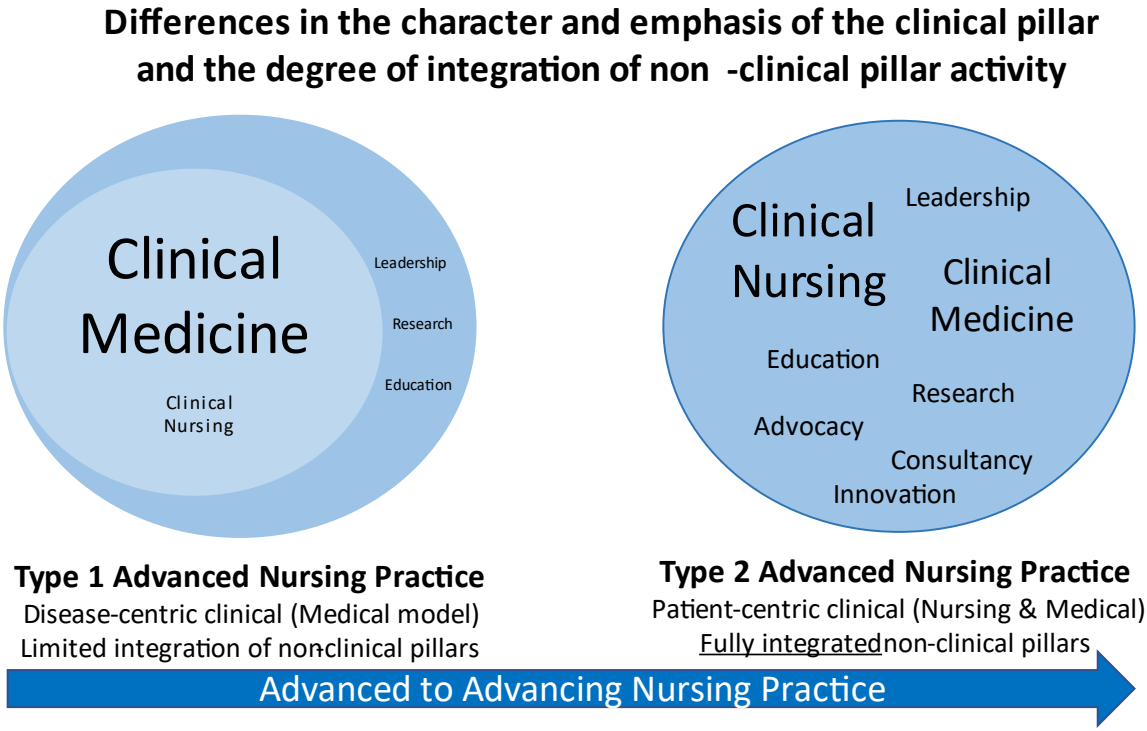


Figure 21: Differences in the Character and Emphasis of the Clinical Pillar between Types, and the Degree of Integration of Non-Clinical Pillar Activity

The clinical pillar was strongly represented in Type 1 and largely represented a disease-centric focus, with limited scope for Advanced Nursing interventions. Non-clinical pillar activity was minimal and little integrated. In contrast, Type 2, which also including a strong emphasis on the clinical pillar, instead characterised that clinical work as a deliberate integration of both medical model/disease-centric and nursing model/patient-centric input, which resulted in a less fragmented and more comprehensive response to patients' needs. Moreover, non-clinical pillar engagement was integrated as a continuous aspect of this type of Advanced Nurse Practitioner role. Associated capabilities of advocacy and consultancy are also included in this illustration as further examples of the wide range of features that have been evident in expressions of Type 2 roles as reported by participants and used to support the impact of this role for patients and services.

6.6 The Explanatory Frameworks: The Process of Constructing the Grounded Theory

The second phase of the explanatory framework supported the process of illustrating the construction of the grounded theory as the end point of the study, see Figure 22 page 222:

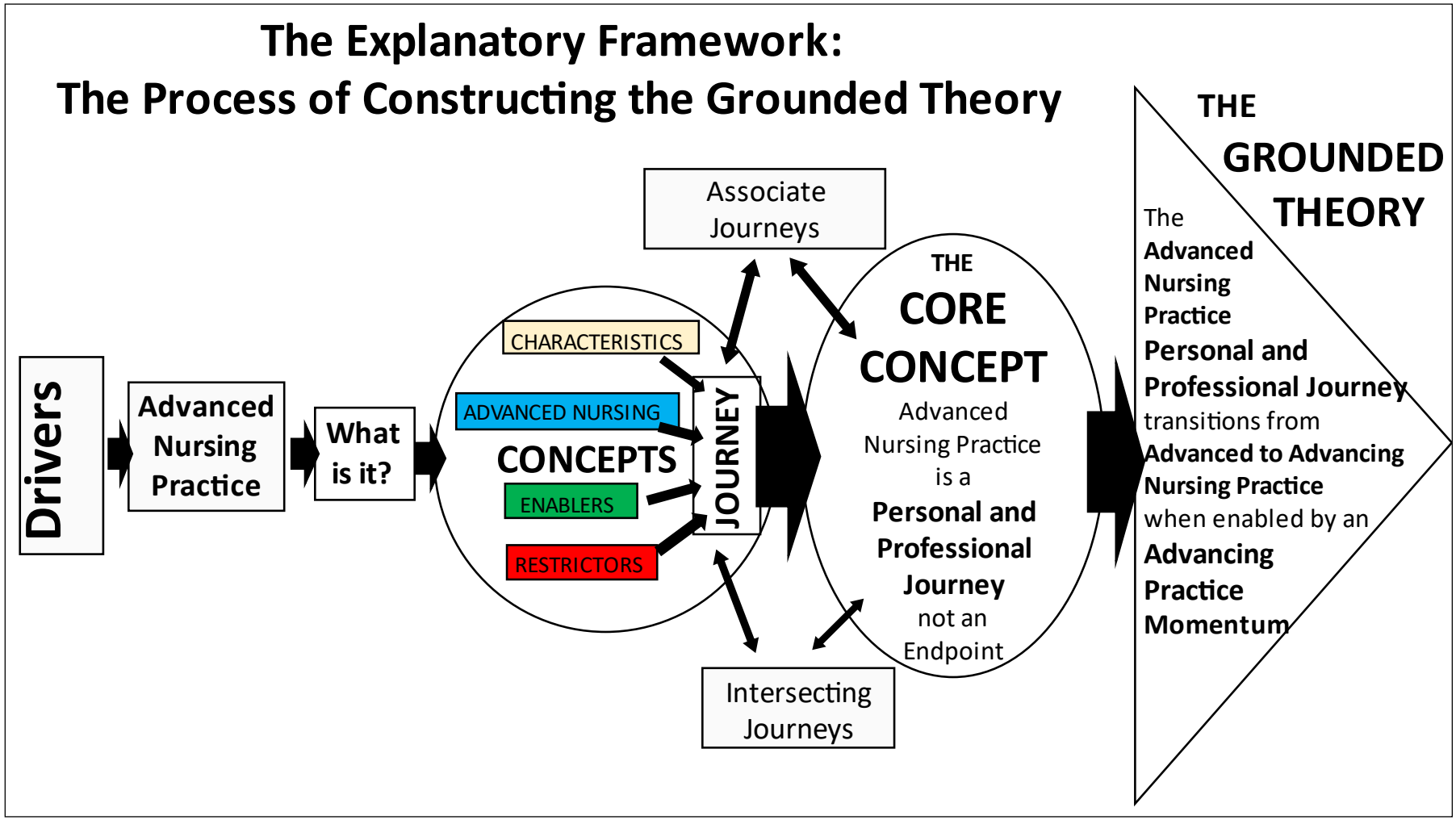


Figure 22: The Explanatory Framework: The Process of Generating the Grounded Theory

6.7 The Grounded Theory: 'The Advanced Nursing Practice Journey Transitions from Advanced to Advancing Nursing Practice when Enabled by an Advancing Practice Momentum'

The strongest and therefore the principal finding in this study was the presence of 'journey', which wove its way through participants experience of becoming and being Advanced Nurse Practitioners. Moreover, this journey consisted of two parts, Personal and Professional. Figure 23, illustrates some of the element of what the Personal and Professional Journey looked like in moving from being experienced nurses to becoming Advanced Nurses.

When this Journey had consistent support, a momentum grew that transformed Advanced Nursing Practice into Advancing Nursing Practice. The experience and influence of Intersecting and Associate Journeys variously helped or hindered this principal Journey.

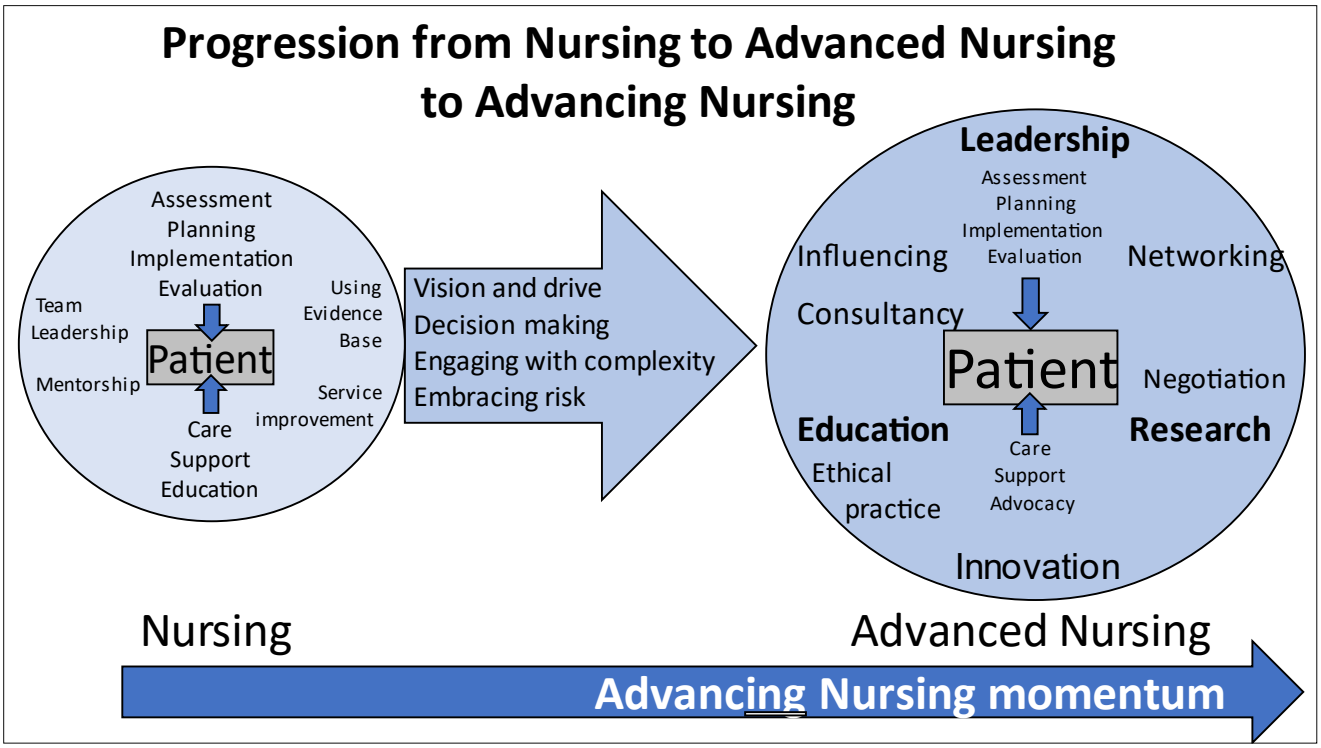


Figure 23: The progression of Nursing to Advanced Nursing

The key to developing Advanced Nursing Practice to achieve its full potential was explained in the notion of the presence of momentum. Momentum implies continuous, energetic forward movement, and this captured the essence of the key ingredient that enabled Advanced Nursing Practice to be transformed from Advanced into Advancing Nursing Practice. This dynamic was present when various factors, including those identified on page 195, both internal to, and external

to, the individual Advanced Nurse Practitioner came together in an integrated way and acted to initiate, propel, and sustain forward movement.

When this momentum was present Personal and Professional growth was continuous and this positively influenced, shaped, and impacted all aspects of clinical and professional practice. Conversely where the momentum was interrupted or hindered then that positive potential was difficult to achieve. Momentum in the sense described here was everything, and as such justified the status of enabler for the shift from Advanced to Advancing Practice.

6.7 Chapter Summary

This chapter has synthesised the findings presented in Chapter 5 and in so doing has addressed the Research Questions, Aim and Objectives, answering these through the construction of the Concepts and the Core Concept:

'Advanced Nursing Practice is a Personal and Professional Journey not an End Point'.

The Core Concept was presented and considered in detail, explaining the principal Personal and Professional Journey, while also explaining the Associate and Intersecting Journeys that related to the principal Journey. This was aided by the presentation of the first of two illustrative diagrams, 'The Explanatory Framework for the Process of Constructing the Core Concept'. The chapter then progressed to present the second illustrative diagram, 'the Explanatory Framework for the Process of Constructing the Grounded Theory' which prepared the way for the introduction of the grounded theory:

'The Advanced Nursing Practice Journey transitions from Advanced to Advancing Nursing Practice when enabled by an Advancing Practice Momentum'

Chapter 7. Discussion and Conclusions

7.1 Chapter Introduction

This chapter draws the thesis to a close and provides a critical discussion of how the research questions, aims and objectives of the study (see Chapter 4, page 70) were met. It is divided into four main sections:

- First, discussion and contextualisation of the key findings and how they relate to what is currently known about Advanced Nursing Practice as revealed in the literature, research and policy evidence base;
- Second, an evaluation of the merits of the study;
- Third, consideration of the implications of the findings and recommendations for policy and practice, education and research; and
- Fourth, presentation of the study's unique contribution to the science base of Advanced Nursing Practice and its originality claim. Broad, relevant and current literature will be included in this chapter to support the critical discussion and complete the process of ensuring literature referred to in the study overall is relevant and comprehensive. Final comments will draw the chapter and thesis to a close and provide the answer to the study's title question:

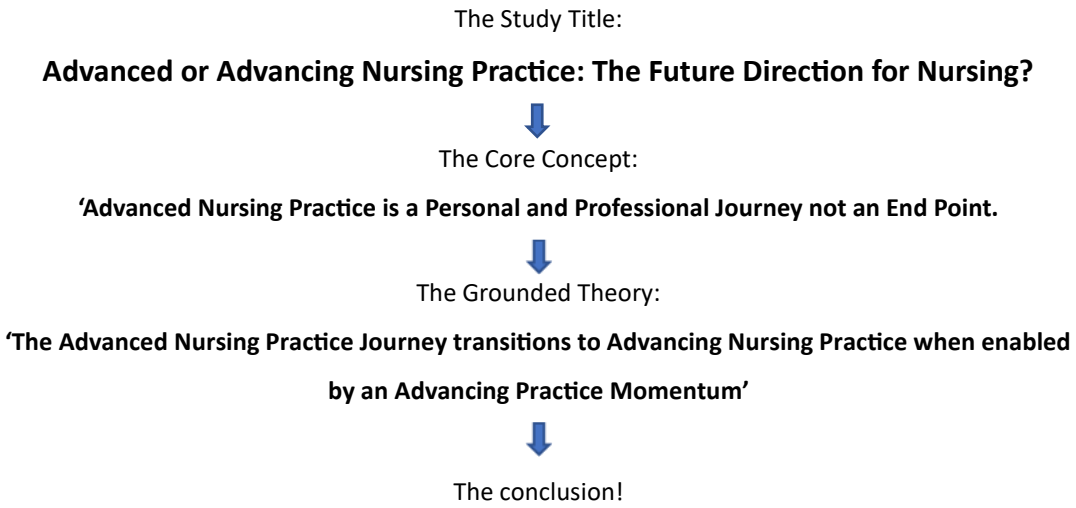


Figure 24: Key Statements from the Study

7.2 Discussion

This study came about because as an experienced academic and course director, I was concerned that many of my former Advanced Nursing Practice students, now in substantive posts, were not fulfilling the full scope of the role they had been prepared for. The expectations of their managers were limited to disease-centric use of the clinical pillar, with limited engagement with non-clinical pillars (HEE 2017). Moreover, my former students appeared to have reduced expectations of themselves, functioning in a limited capacity when compared with the full scope of Advanced Nursing Practice that they had been exposed to during their Master of Science Advanced Practice Course. One apparently demoralised practitioner working in a Type 1 service bemoaned her situation to one of the study participants, saying that she was restricted to practicing as, "an SHO [-junior doctor] for rest of my life." (See Chapter 5, page 163). This perspective echoed with me and reinforced my earlier decision to undertake this study.

The critical discussion hereafter will be framed with reference to examining how the study findings, expressed through the main categories, the reduced super categories and the final categories (see Chapter 6 pages 215), from which were generated the four concepts, the Core Concept, and the grounded theory, demonstrated achievement of the study research questions, aim and objectives.

The aim of the study (see Chapter 4, page 70) was to:

> Explore the features, scope and activity of Advanced Nursing Practice, and explain the relevance and significance of nursing within this role, as experienced by two groups of nurses recognised as Advanced Nurse Practitioners, and the Consultant Nurses and consultant medical staff who work with them, in a local university hospital NHS trust.

The 'two groups of nurses' referred to in the aim became Case Study 1 and 2, to which participants were allocated. Similarities and differences between these two case studies were an important aspect of the findings because they directly revealed participants experiences of Advanced Nursing Practice.

The two study objectives (see Chapter 4, page 70) arose from the study aim. The first objective also addressed the four research questions through four sub-objectives. Each of these four sub-objectives led to the construction of one of the four concepts. The concepts led to the construction of the Core Concept which in turn led to achievement of objective 2, the construction of the grounded theory.

7.2.1 Concept 1- Characteristics of Advanced Nursing Practice

Table 21 reflects common and separate findings between Case Study 1 and 2, for Concept 1: Characteristics of Advanced Nursing Practice:

Case Study 1: Acute Services (Acute Medicine/Surgery)	**Case Study 2: Non-Acute Services (Gerontology/Medical Specialities / Pre- operative Assessment)**
Common Findings	
• Advanced Nursing Practice was defined as a level of practice, reflecting critical decision making and problem solving. • Participants were active learners, valuing their academic preparation. The MSc Advanced Practice degree course represented a significant part of their journey of personal and professional development. • While founded on direct clinical practice, role impact significantly benefitted from integrated four pillar activities. However, individual pillars were often utilised but in an 'add on' capacity as an adjunct to their main clinical role. • Undertaking research was a low priority, although audit of disease-centric activities and processes took a higher priority than patient-centric activity. • Autonomy of clinical role was represented when participants were supported 'to intervene more and escalate less'.	
Separate Case Findings	
• High value for the clinical pillar, and a disease-centric focus with the medical model dominating practice • Focus on 'seeing' patients through a medical lens***** • Clinical/physical skills central • Four pillar engagement a low priority • Emphasis on role being absorbed into medical team	• High emphasis on clinical pillar, but emphasis on mixed use of disease-centric/patient centric care according to patient need • Reliance on use of nursing lens***** • Interpersonal skills paramount, high emphasis on therapeutic relationship • Four pillar engagement a high priority integrated within clinical practice • Emphasis on central co-ordinating role in the multi-disciplinary team • Emphasis on service improvement ***Definitions is Glossary, page xviii**

Table 21: Summary of the Comparison of Findings between the Two Case Studies (Concept 1: Characteristics of Advanced Nursing Practice)

While the literature has repeatedly suggested that the notion of Advanced Practice is unclear (Hardy et al 2021, Gardner et al 2013; Duffield et al 2009) participants did not readily identify with this, instead recognising a variety of expressions, broadly aligning with one or other of the two types identified in Chapter 2 (see page 37) and discussed throughout this study. Participant reported that the focus for them was clear, its scope directed by a nursing perspective viewed through a nursing lens (Disch 2012), (see Glossary page xiv). However, this position became problematic when some of those practitioners were required to use the biomedical reductionist model (Beresford 2010), which

required them to respond to their patient through primarily a medical rather a nursing lens (Disch 2012), (see Glossary page xiv), so medical substitution roles emerged. The medical lens tended to distort by narrowing the view of the patient and their needs, reducing them to the condition or issue they were facing currently, a partial view. Participants in Leary's (2019) workforce modelling project noted the same two types of foci for Advanced Practice, which has developed into two principal forms concurring broadly with Type 1 and Type 2 Advanced Practice proposed in this study.

7.2.1.2 Ensuring Patients First (Reduced Super Category [RSC1])

Participants in this study noted, along with many services in the United Kingdom, significant medical shortages required alternative resources to be developed to meet demand, and this has remained a continuing issue (Morgan 2022). Participants reported that, as nurses, they were called on to meet the gap, and as experienced nurses were a suitable fit. The transfer of these nurses, however, was not free of problems for the nursing team, since removing them depleted further a generally under-resourced nursing workforce. This might have been mitigated had they been supported to continue using their experienced nursing abilities in these roles, but this generally this was not reported as happening. Moreover, non-clinical pillar activity was limited, to the detriment of patients, services and development of staff.

Participants in both case studies noted that in their experience when Advanced Nursing Practice was directed towards addressing disease-centric problems only, it was not able to address the full breadth of patient problems, and reflected a fragmented and disjointed approach. This appeared to be mirrored throughout NHS services and systems participants experienced in their daily work (Ham, Charles and Wellings 2018). It was clear from the study findings that where there was an emphasis on disease-centric practice, medical substitution typically defined the scope of Advanced Nursing Practice. This was particularly the case for those working in acute services settings (Case Study 1). The result was that a reductionist and disease-centric approach to assessment and management of presenting problems was the norm (Krishnan 2018; Beresford 2010). By contrast, the experience in non-acute services was the tendency, arising from primarily a patient-centric focus, to embrace and integrate non-clinical pillar activity into their clinical work. Moreover, participants actively looked for opportunities to educate, innovate, study and lead.

7.2.1.3 Promoting Patient-centric Services (Final Category FC2)

One of the recurrent themes within the study was of participants observations of the 'patient journey', also described as the patient pathway, which reflected how patients progressed through their experience of the health service. In recent years the National Health Service overall has been undergoing probably it's most radical changes in its history (Ham, Charles and Wellings 2018), focusing on the need to broaden the emphasis from hospital-based services directed at disease-centric acute care needs, to one grappling with how to respond to growing numbers of patients with chronic disease in the community. Not an entirely new problem, as far back as 2014 chronic disease required 70% of the total health service budget (DoH 2014: 6). The need for new responses has not abated since the Covid Pandemic, which resulted in the phenomenon known as 'Long Covid', magnifying and adding to that burden (Maxwell and Radford 2021). These collective pressures have and are requiring the urgent development of different ways of thinking and working to ensure patient needs come first.

However, amidst positive participant experiences, there were also stories of obstacles and difficulties in delivering comprehensive care. This reiterated arguments for active promotion of holistic and patient-centred care; adjustment of approaches taken towards patients, moving from professional-centred to person-centred (Health Education England, Skills for Health, and Skill for Care 2017; McCormack et al 2015); and moving from services led by the biomedical model, to multi-professional teams and collaborative care (HEE 2017). While new roles have emerged in response to both existing and 'new' problems, and participants exemplified this in some instances, the demand for changes of this scale have been very challenging for health professionals used to working and relating in traditional ways. Participants experienced resistance when seeking to deliver patient-centric rather than disease-centric care in acute services. The argument presented to them was that existing acute demands had not abated, but increased and that was the service priority. While there is evidence that services across the NHS are changing (DHSC 2019) resources are stretched to accommodate the new demands while still responding to existing ones (Toner et al 2019).

Advanced Nursing Practice, as experienced by participants in this study, presented real challenges to their professional identity. Type 1: Advanced Nursing Practice roles, (see page 37) typically focused on the demands of the biomedical model with its disease-centric priorities. Participants in this study successfully filled the 'medical gap' contributing to this significantly, particularly in acute services (Toner et al 2019). While these roles were and remain widely recognised and supported, the identity challenge for nurses was that they had limited time and scope to address patient-centred clinical

need, or make contributions to improving services. Immediate workload challenges drove them to focus on skills and tasks shaped by reductionist approaches. Interestingly this focus was observed in the general nursing workforce too, where participants observed shortages of nursing staff (Duffield et all 2009). This led to an inevitable focus on 'tasks' as the most practical use of limited resources (Jackson et al 2020) but the consequence was recognised as hugely demotivating for nurses and for participants as they were hindered from doing more for their fellow nurses through leadership, role modelling and education, but were unable to achieve this because of workplace pressures (Pearce and Breen 2018).

Some participants were aware of efforts in their services to revise the skill mix and they benefitted from this through time released to pursue service innovations enabling a more patient-focused service. This adjustment in team skill mix introduced surgical practitioners, one of the new medical assistant professions (DH 2017). Elsewhere, Physicians Associates, also recognised as able to contribute to addressing medical shortages are being considered to add to the skill mix. Currently overseen by the Royal College of Physicians, they have potential to become a regulated body under the auspices of the General Medical Council (DHSC 2023). Prepared using the medical model, they are a new workforce not drawn from existing health professions, and are able to assess and manage patient care episodes under medical supervision. As an emerging response, their inclusion offers potential to release Advanced Nurse Practitioners to broaden their response to patient need and increase non-clinical pillar activity.

7.2.2 Concept 2: Advanced Nursing Practice

Table 23 reflects common and separate findings between Case Study 1 and 2, for Concept 2: Advanced Nursing:

Case Study 1: Acute Services Acute Medicine/Surgery	Case Study 2: Non-Acute Services
Common Findings	
• Identity as a nurse was important to all nurse participants, including consultant nurses. • Emphasis of participants lay in holistic response to patient need, though this was obstructed where the emphasis of role was on medical substitution. • Being a constant presence, a connector and link between colleagues was important. • Participants carried the respect of medical staff, especially consultant medical staff, for their experience, knowledge and communication skills and for their practical responses to complex problems. They were often regarded as 'go-to people'/'fixers'.	
Case Study 1: Acute Services Acute Medicine/Surgery	**Case Study 2: Non-Acute Services**
Separate Case findings	
• Disease-centric role required use of the medical model limiting delivery of patient-centred care. • A narrow response to patient-need by seeing only part of the picture • No emphasis on unmet need • Nursing autonomy limited • No role in leading nursing	• Seeing patients through a 'nursing lens' and by using a nursing model key to delivering patient-centred care • A comprehensive response to patient need by actively seeing the whole picture • Focused on unmet need • Autonomous role in leading nursing, including input from consultant nurses • Significant role in leading nursing practice and developing nurses

Table 23: Summary of the Comparison of Findings Between the Two Case Studies (Concept 2: Advanced Nursing)

7.2.2.1 Promoting Advanced Nursing (Reduced Super Category RSC2)

When patients encounter what they perceive as 'good' or effective nursing, it is delivered by a person who is compassionate and caring, but also knowledgeable and skilled in a wide variety of practical, helping, and therapeutic measures (Jackson et al 2021; Corbin 2008). Advanced Nursing therefore is in every way an expansion of 'ordinary' nursing, and participants were clear that nursing was of prime importance when it was developed to a level of practice, governing a bigger, wider grasp and understanding of patients and their problems, and their family circumstances and relationships. It incorporated an ability to 'see', which was all embracing, engaging with and including: the patient, the family, the professional team, the service and the individual's profession group (RCN 2018a; 2018b).

To provide a clearer understanding of the Advanced Nurse's orientation within their Advanced Nursing Practice role, the notion of a 'tool-box' was helpful, illustrating what the practitioner brought to patient encounters (Leary 2012). First, they brought themselves, their personal attributes, including ability to communicate and interact, which were therapeutic in their own right (RCN 2018a RCN 2015). However, practitioners also had a range of other resources to draw on, their advanced knowledge, abilities, clinical and other skills, and competencies. Collectively, these were likened to 'tools in their toolbox', underpinned by most crucial aspect of all, the level of critical thinking and decision making that the practitioner used to decide which 'tools' were needed, or not in a given situation. Alongside this they also had capacity to fulfil capabilities which supported their decision making (Gloster and Leigh 2022). Capabilities are not well understood, but in fact supersede competencies, which while useful and appropriate in stable situations, are not in complex situations (O'Connell, Gardner and Coyer 2014). Capabilities by contrast are better suited to unstable situations where using good judgement determines which choices are appropriate (HEE 2017). Advanced Nurses select the tools appropriate for the patient's need. Indeed, it may be medical, nursing or both, but the key determinant in choice is what does the patient need? Therefore, the patient remains central, not their disease or primary problem alone (Carryer and Adams 2021).

7.2.2.2 Creating Vision for the Advanced Nursing Journey (Final Category FC1)

One of the unique attributes of nursing revealed in the study is Advanced Nursing's ability to collaborate with colleagues, determining together who is best suited to respond to a patient's particular need and how it may best be managed. This particularly necessary in complex long-term conditions (DHSC 2019), where patients may receive suboptimal care and treatment if their whole situation is not considered.

7.2.3 Concept 3: Enablers of Advanced Nursing Practice

This table reflects common and separate findings between Case Study 1 and 2, for Concept 3: Enablers of Advanced Nursing Practice:

Case Study 1: Acute Services Acute Medicine/Surgery	**Case Study 2: Non-Acute Services**
Common Findings	
• The need to explain Advanced Nursing Practice was necessary, but was laborious to break through preconceived ideas • There was need for qualitative research and clear examples of Advanced Nursing Practice to demonstrate and reveal its potential • Advanced Nursing Practice was associated with being a 'constant' positive presence. This was important in enabling efficient service flow, through expert communication skills, support, education, challenge and promotion of innovation, all of which were characteristic of Advanced Nursing. • Why Advanced Nursing Practice Services were set up dictated its character • Where services were placed in their developmental journey was significant for the type of Advanced Nursing Practice that was demonstrated • Better workforce planning was needed to ensure effective Advanced Nursing Practice was found in service delivery.	
Separate Case Findings	
• Set up as medical replacement/ disease-centric services • Had a restricted vision for role, majoring on clinical pillar and gap filling. • This type of role (Type 1: Advanced Nursing Practice) supports existing culture rather than challenges it • Stories about the role emphasise disease-centric, not patient-centric practice • Participants proving effectiveness or 'worth' was important (Surgical Service) in gaining support for inclusion of Advanced Nursing.	• Typically set up as an Advanced Nursing service. • Broad vision for role, beyond just clinical pillar • This type of role (Type 2: Advanced Nursing Practice) challenges existing culture • Autonomy was associated with clear vision and proactive mindset • Stories about the role emphasise holistic benefits of Advanced Nursing • Consultant nurse leadership needed to establish service on right footing from outset • Medical consultant support significant

Table 25: Summary of the Comparison of Findings Between the Two Case Studies (Concept 3: Enablers of Advanced Nursing Practice)

7.2.3.1 Enabling Nursing to Advance (Reduced Super Category – RSC3)

The National Health Service culture of norms, values, traditions and hierarchy has been recognised as a powerful influence, always present, affecting all employees (Manley, Jackson and McKenzie 2019). Doctor's positions however within the hierarchical structure at the centre of that culture were unique, at the pinnacle of the health professions' structure. The professional socialisation of medicine, nursing and probably others served to reinforce and maintain their relative positions. Consequently, changing how medical staff perceived their nursing colleagues, their working relationships and 'the work' itself was challenging, especially during a time of substantial change and

transition in services. Type 1 Advanced Nursing Practice reflected maintenance of the status quo, with nurses subject to medical direction, sometimes subsumed into the medical workforce, however, Type 2 Advanced Nursing Practice was a different matter. As participants sought to develop Advanced Nursing to meet patients' diverse and complex needs, they noted that medical staff and managers initially found moving beyond the notion of medical substitution and medical direction difficult to grasp. The service development journey consequently was challenging for all, but over time trust and understanding grew and services became more patient-centric as Advanced Nurses demonstrated what they could do through patient-centric and collaborative practice (Hooks and Walker 2020), being a constant presence, and by using evidence to support and make visible their impact, their message did gain traction with medical colleagues (Hill 2017).

Participants frequently shared aspects of their journey through the medium of their story; what Advanced Nursing Practice meant to them, how they experienced it, their encounters with patients, colleagues, and snapshots of what they had achieved (Attenborough and Abbott 2020). These were powerful in illustrating the role and its impact and participants spoke of the value of sharing them, making it real for observers. There was considerable value in sharing stories as living illustrations, they had power to reveal and inspire in a way that sometimes research does not (Attenborough and Abbott 2020). This part of participant dialogue reminded me of Kucera, Higgins, and McMillan's (2010) research, reviewed during my contextual review in Chapter 2, which analysed practitioner stories revealing the varied but substantial impact that Advanced Nursing Practice had. This was reflected in Casey et al's (2017) systematic rapid review and narrative synthesis of the literature of outcomes and impact of advanced practice.

7.2.3.2 Developing an Advanced Nursing Evidence Base (Final Category FC3)

Participants recognised the value of and need for formal evidence to both support what they were doing, and highlighted this to support the case for Advanced Nursing Practice both within and outside the Trust (Anokye Badu 2023). Though concerned about the limited research effort, participants in both case study groups were equally clear that it was difficult for generating research to be a priority. Time to do this was restricted by the amount of clinical work that needed to be done, which took up the majority of their working time. The result of this was relatively little good quality research revealing the impact of Advanced Nursing in the United Kingdom was undertaken by clinicians (Hardy et al 2021).

Participants recognised that while their master's in Advanced Practice course had progressed their knowledge and understanding about the research process, more practical help was now needed to

make it happen. They were aware that their development of this part of their personal and professional development Journey was slow. The aim therefore was to improve research skills, progress research pillar activity and embed a research culture within Advanced Practice roles. Getting this subject high on the local Trust agenda was a key objective since this would place a requirement on service managers to support ongoing continuing professional development, especially focusing on non-clinical pillar activity. Central support from the trust and a realistic strategy, missing during the early part of the study, but emerging latterly, compliment the Chief Nurse's new research strategy (DHSC 2021), and the earlier work, Promoting Clinical Research Careers (HEE 2018).

It was heartening to read work by Evans et al (2020) designed to directly address this situation, by setting out a protocol for a scoping review to identify and provide detailed data on the existing body of research about Advanced Clinical Practice in the United Kingdom. The expectation was to set out the evidence of impact across a broad selection of areas and to identify things which helped and hindered the role. It also anticipated that organisational and workforce issues surrounding Advanced Clinical Practice would be identified and thus its findings would inform policy formation. While many will eagerly await its findings, one significant issue highlighted by this work, is that it is focused on generic Advanced Clinical Practice, not specifically Advanced Nursing. This focus is at least potentially a problem, since it will not help to reveal the specific nature and value of Advanced Nursing. Indeed, much current research being done in the field is focused on Advanced Clinical Practice (Anokye Badu 2023; Snaith et al 2023; Fielding et al 2022; Diamond-Fox and Stone 2021; Lawler et al 2021; Stewart-Lord et al 2020).

The findings of a slightly earlier paper, a report of a national debate which posed the question 'When does Advanced Clinical Practice stop being nursing?' (Nadaf 2018) echoed findings within this study including: calling for stories, narratives and case studies to be developed to make explicit what it is that Advanced Nurse Practitioners do (see Chapter 5, page 162); similarly, the calling for the title nurse to be retained (see Chapter 5, page 147) because 'patients know what nurses do'; finally, the need for radical change in workforce planning matched to demand certainly resonated with participants views.

7.2.4 Concept 4- Restrictors of Advanced Nursing Practice

This table reflects common and separate findings between Case Study 1 and 2, for Concept 4: Restrictors of Advanced Nursing Practice:

<table>
<tr><th colspan="2">Case Study 1: Acute Services
Acute Medicine/Surgery</th><th>Case Study 2: Non-Acute Services</th></tr>
<tr><td colspan="3">Common Findings</td></tr>
<tr><td colspan="3">• Two types of Advanced Nursing Practice were evident: Type 1: disease-centric, which dominated the clinical scene, and Type 2: patient-centric
• While four pillars of activity were associated with Advanced Nursing Practice, the clinical pillar was pre-eminent.
• Two versions of the clinical pillar existed: disease-centric, which tended to dominate, and patient centric.
• Clinical workload, particularly managing disease, restricted available time for patient-centred care and Advanced Nursing, and there was limited opportunity to develop non-clinical pillar activity
• The personal and professional development journey for participants often began with a lack of clarity about the scope of Advanced Nursing Practice. Most initially felt it was a medical substitution role
• The presence of a journey of development was evident for both participants, and their teams and services, however restricted learning /continuing professional development (CPD) was the norm
• There was limited vision / support for Consultant Nurses and lack of recognition of their role in supporting the development of Advanced Nursing with Advanced Nursing Practice
• Role /concept confusion was prevalent. It was suggested that this was because of: lack of definition; multiple different expressions of the role; the advent of the Advanced Clinical Practice title
• Risk was perceived to the promotion of patient-centred practice by removal of the ‘nurse’ descriptor from the Advanced Clinical Practice title. Similarly, risk perceived of over promotion of the clinical pillar by inclusion of the ‘clinical’ descriptor in the Advanced Practice title</td></tr>
<tr><td colspan="3">Separate Case findings</td></tr>
<tr><td colspan="2">• Set up as disease-centric role.
• Disease-centric priority forces substitution role.
• Clinical pillar dominates activity, limited scope for non-clinical pillar activity
• Role restrictions initially by need to prove clinical ability and worth.
• Turnover present, and frustration in role present because of restricted nursing input. One participant moved to a Case Study 2 Service.</td><td>• Set up as patient-centred role.
• Patient centred focus promotes Advanced Nursing role.
• Clinical pillar preeminent but scope for non-clinical pillar activity for those willing to prioritise it.
• Restrictions present but less about scope, more on issues of growth and development, team instability/ relative team immaturity.
• Turnover of team hindered cohesion.</td></tr>
</table>

Table 27 continued on page 238

• Restricted learning /continuing professional development (CPD). • Consultant Nurse leadership distracted with attention on service management. • Autonomy restricted in medical substitution role. Supervised by / accountable to senior doctors- professional challenge here. • Difficult to fulfil four pillars.	• Continuing professional development (CPD) supported to some degree, including non-clinical content. • Consultant Nurse leadership supportive, some distraction with service management and role limitations. • Autonomy variable but generally enhanced. Supervised by senior nurses for nursing functions, doctors for medical components. • Able to fulfil non-clinical pillars, though limited with research.

Table 27: Summary of the Comparison of Findings Between the Two Case Studies (Concept 4: Restrictors of Advanced Nursing Practice)

7.2.4.1 Removing Restrictions on Advanced Nursing (Reduced Super Category RSC4)

Existing culture was a critical aspect in hindering development of services at every level of the organisation (Manley, Jackson and McKenzie 2019). Culture in the organisation involved groups and their interactions, and shifting the status quo where medicine was typically dominant over nurses and others held potential for conflict. Participants certainly experienced doctors' beliefs that since they occupied the positions of clinical leader, so they should lead in all aspects of practice where the medical model and cure paradigm were pre-eminent. However, the relevance of the dominance of the medical model of care has increasingly been called into question (Maxwell and Radford 2021; Nadaf 2018), including the Department of Health and Social Care (DHSC 2019) who are clear that this must change. The reality of chronic disease is that patients need very different things than have been required previously (DHSC 2019; Ham, Charles and Wellings 2018). To recognise that nurses and nursing may have solutions to offer patients that medicine does not, was a key challenge to the status quo. Patient-centred holistic care was not just desirable but essential if self-management of disease was to become the norm. For medical staff to recognise that nurses were not simply there to fulfil medical gaps appeared to be a reality that was not widely recognised, nor indeed by many managers. Change then was difficult to achieve for a variety of reasons, including that there was a general acceptance of the status quo, even when it was widely complained about. Helping health professionals as well as patients to move thinking and behaviour to recognise 'new' needs, 'new' reality, new ways of delivering services was a critical challenge, requiring very skilled interventions. I was reminded of the size of the challenge when re-reading this famous quote by Niccolo Machiavelli, the master manager of public affairs,

> "It should be borne in mind that there is nothing more difficult to handle, more doubtful of success, and more dangerous to carry through than initiating changes in a state's constitution. The innovator makes enemies of all those who prospered under the old order, and only lukewarm support is forthcoming from those who would prosper under the new." (Machiavelli, the Prince, 1513)

The need in the midst of this was for leadership and vision, at every level and for this to be coherent and persuasive. The appointment of Consultant Nurses was raised as an excellent way of establishing experienced leadership, able to build teams and services with a focus of patient centred care (Taylor and Wiseman 2019).

As considered to some extent already, the advent of Advanced Clinical Practice (HEE 2017) expanded Advanced Practice beyond nurses to health professionals from a variety of backgrounds including pharmacy, paramedic science, occupational therapy, physiotherapy and midwifery. Although this achieved recognition of Advanced Practice as a level of practice with common main characteristics, it added to the complexity of practice (Leary and MacLaine 2019). Perhaps more importantly in the context of this study it coincidentally acted to obscure nursing. Some participants were specifically concerned about this, advocating instead for the title 'Advanced Practice - Nurse'. They recognised that the same approach could be taken for other professions too, for example, 'Advanced Practice - Physiotherapist', this appeared to be desired by other allied health professionals (APPN 2023).

7.2.4.2 Enabling a Learning Journey for All (Final Category FC4)

Since from at least the introduction of the NHS Plan (DH 2000) the importance of ongoing learning, even life-long learning has been a stated organisational objective. This was applicable for participants and their Personal and Professional Journey, but also to the aligned Team and Service Journeys. Learning was not just about acquiring knowledge, information or skills, but about transforming culture, and creating an enquiring, questioning environment. In such an environment growth happens, change occurs, services move forward, care improves (Newton et al 2014). Therefore, establishing the priority of learning at the heart of the organisation was a key objective in bringing about culture change. Moreover, this applied to the whole workforce, most of whom had been trained under a biomedical model of acute, single disease-based need, whereas the major need had shifted to older patients with multi-morbidities. This required a complete rethink about the knowledge and skills required to respond effectively (Pearce and Breen 2018).

Considering the university educators' role in shifting the culture, there was a wider but specific challenge in creating curricula at both pre-registration and post registration levels that achieved balance between cross disciplinary understanding and working, and gaining professional understanding and identity. Participants were clear that nursing had something unique to contribute, but if this was not taught from the earliest stages, students would not grow to a place where they could both challenge the status quo and contribute to the necessary changes needed in health care delivery (Morgan 2022; Coulter et al 2013). Turning to supporting Advanced Nurse

Practitioners' Personal and Professional Journeys, courses needed to both provoke critical thinking and an intention for autonomous practice, and facilitate further development of professional identity and purpose (Jackson et al 2021). The suggestion was that this would maximise the likelihood of the emergence of practitioners with confidence in their professional identity, and so challenge the status quo, promoting the primacy of patient-centric holistic care and management (Newton et al 2014). There was also a role for educators in influencing responses to the impacts of the Intersecting and Associate Journeys, this will be considered shortly.

A key part of learning was the sharing of stories as part of evidence exchange, challenging thinking and changing culture. Indeed, the importance of culture and its relevance and influence upon all aspects of the health service, the trust and the service, was evident throughout participant data. It was particularly significant in its influence on Advanced Nursing Practice, but often in negative contexts of restriction and hinderance. It was also very clear that there was an ongoing need to both challenge and change it (Ham, Charles and Wellings 2018; Manley, Sanders, Cardiff and Webster 2011).

7.2.5 The Core Concept - 'Advanced Nursing Practice is a Personal and Professional Journey not an End Point'.

As discussed in Chapter 6, (see page 214-215), the Core Concept is the precursor to the construction of the grounded theory. The two contributors to the participants' journey, Personal and Professional, were key to them becoming and being Advanced Nurse Practitioners. The 'Personal' focused on participants' personal growth and acquisition of personal attributes that enabled them to be successful. The 'Professional' focused on the development of professional identity and commitment to it, capability, skills set, experience; speciality understanding, sound problem solving with effective critical thinking and decision-making skills. The presence or absence of particular factors, represented in the findings were significant for participants in terms of success or not in expressing Advanced Nursing within Advanced Nursing Practice.

In addition to the Personal and Professional Journey taken by participants revealed in the Core Concept, the findings revealed several other Journeys running concurrently. They variously, informed, helped, or hindered the development of Advanced Nursing within Advanced Nursing Practice.

7.2.6 Intersecting Journeys

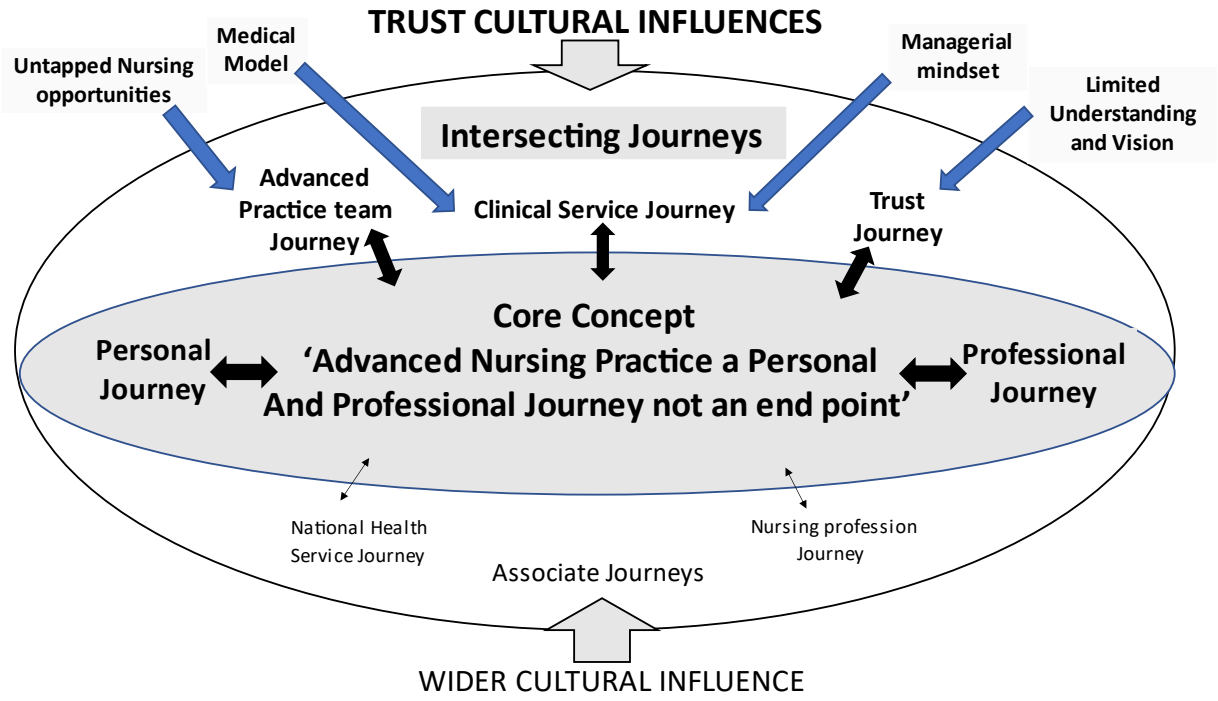


Figure 25: Relationships between the Core Concept – 'Advanced Nursing Practice is a Personal and Professional Journey not an End Point', Intersecting Journeys and Trust Cultural Influences -Untapped Opportunities, Medical Model, Managerial Mindset, Limited Understanding and Vision

Key influences on the Intersecting Journeys, as shown in Figure 25 will now be considered.

7.2.6.1 Advanced Nursing Practice Team Journey - Untapped Nursing Opportunities

As participants reported that the influence of the Advanced Nurse role itself was both underdeveloped and obstructed in a number of areas, they pointed to the influence of the associated Consultant Nurse role. One participant argued that the Consultant Nurse role was the pinnacle of Advanced Nursing Practice, and cogently argued for the appointment of Consultant Nurses to come first within each new service, since this would enable an Advanced Nurse Practitioner service to be most effectively established (HEE 2021) (see Chapter 5 page 170). It was also felt that this was needed to actively shape the service culture into which Advanced Nurse Practitioners could then be recruited (Taylor and Wiseman 2019; Manley, Sanders, Cardiff and Webster: 2011)

In one example (see Chapter 5 page 166), the presence of a Consultant Nurse who was also the service manager, further strengthened the case and embedded the role. This was an excellent

example of a structure and process that promoted a broad interpretation of the Advanced Nurse Practitioner role and was able to transform that idea into a living reality, a role that gained service support and made a significant impact expressing an integrated use of all four pillars of practice (Doody 2014). A change in culture had been achieved that understood the benefits and accepted the role into the existing structure, which prior to that had been variously resistant or ignorant of its benefits (Taylor and Wiseman 2019). Health Education England along with its work to develop Advanced Practice, formed a workstream to promote consultant level practice, establishing the multi-professional consultant-level practice capability and impact framework (HEE 2021). This is very significant and detailed work that gives shape and direction to work established first in the NHS Plan (DoH 2000), but which since its inception had a chequered history, lacking a uniform approach to support and make it happen. More recent work develops participants earlier thoughts providing case studies which promote the value of the role in whole systems change (Manley et al 2022).

7.2.6.2 Clinical Service Journey - Medical Model

The medical model dominated the clinical environment and made it challenging for participants to break through its restrictions on their practice. The medical team locally was keen to support Advanced Nurse Practitioners, reflecting the national view where several Medical Royal Colleges not only showed interest in the Multi-professional Framework (HEE 2017) but seized the opportunity to inform the workforce development agenda. Curricula and competency frameworks were produced to support 'non-medical staff' within their speciality at advanced level. The Royal College of Emergency Medicine (RCEM 2019) at the forefront of this work, recognised that Advanced Nurse Practitioners initially and more recently paramedics and others could really help workforce pressures in emergency medicine. While those roles undoubtedly supported specialist role activity, the focus was on disease-centric activity, and did not address concerns about their limited scope and minimal impact on total patient need. Nonetheless, those policies gained traction among trust services, since the presence of these frameworks do offer governance safeguards for Advanced Nurse Practitioners working in a medical replacement role (Hill and Mitchell 2021).

Traditionally medical mentorship has been the norm in Advanced Nurse Practitioner preparation, but it is increasingly clear that this falls short of the breadth of expertise that is needed to effectively support non-clinical pillar ability required by Advanced Practitioners,

> *'…who have **advanced level capabilities across the four pillars of clinical, leadership and management, education and research,** as set out in the Multi-professional Framework for Advanced Clinical Practice in England, (NHS, 2017). Development in advanced clinical practice usually combines practice-based (workplace) learning and training with academic learning at level 7, (masters), delivered in a traditional higher education institution (HEI) such as a university… **it cannot be assumed that existing uni-professional workplace supervision practices will map neatly to the learning needs of developing multi-professional advanced clinical practitioners/trainees**. Nor can it be assumed that uni-professional colleagues have shared understanding of the professional scope or typical clinical practice profile of developing advanced clinical practitioner/ trainees from different qualifying professions.'* **(HEE 2021: 2)**

While typically excellent in terms of medical clinical knowledge and skills, the medical model was limited in the broader sense of mentoring Advanced Nurse Practitioners to provide holistic care, the end point of the development journey for them (Krishnan 2018) fundamentally different from junior medical staff. The earlier conversation about medical versus nursing Lens reflects the difference in outlook and expectation that different health professionals take depending upon their professional group and their development Journey. This is where the importance and value of trust central direction for new roles becomes clear. The journey for Advanced Nurse Practitioners is broad not narrow, it is clinically focused but not just disease-centric, and the non-clinical pillars are integrated into their work. By contrast the journey for junior medical staff is furtherance of the medical clinical role and focus alone.

Many of the Royal Medical Colleges have been astute in continuing to exert medical influence over nursing, and now other professions (Lawler et al 2021), through curriculum and competency design that are largely written to support the medical perspective of patient management. Nurses and others have become drawn into that mentality valuing perceived status by association with medicine (Por 2008). It is perhaps not surprising that some nurses have taken on the biomedical model governing their practice.

7.2.6.3 Clinical Service Journey - Managerial Mindset

Participants spoke about issues that hindered or stopped them from practicing in a patient centric manner: restrictive culture and mindsets, wedded to old ways of doing things; structures that were rigid and inflexible; fragmentation and disconnection of people and services that inevitably failed patients. It was similarly evident that the power to enact change was restricted and lay in the hands of a management culture and medical oversight that effectively restricted and controlled rather than liberated and freed Advanced Nurse Practitioners to achieve their best work. It was suggested that to address what was experienced as a rigid and fixed managerial mindset, with a value only for

medical substitution roles, a campaign to explain what Advanced Nursing could contribute to new and emerging needs as well as existing needs was essential. It was perceived that this would help develop the service journey towards addressing the demands of complex care set out in the NHS Long Term Plan (DHSC 2019)

7.2.6.4 Trust Journey - Limited Understanding and Vision

Continuing the last point, clear vision was considered essential for success (Martin et al. 2014) yet participants from both case study groups were very clear that a lack of central trust vision has contributed to a very confused picture and a muddled journey for practitioners as they struggled to match what was taught in university, with their own emerging vision for the role, and what was required in their work setting and the expectations of medical mentors. A suggestion by one of the Consultant Nurse participants was interesting when she suggested that the Advanced Nurse Practitioner development journey should note that significant learning should come, 'from practice for practice'. In other words, by focusing on the patient and the patient journey, what knowledge and skills are needed to meet those needs, what opportunities are needed and who is best placed to mentor them would become clear. This was a radically different approach, celebrating a patient centric rather than a profession centric model (Maxwell and Radford 2021).

It was clear from the study findings that where there was an over emphasis on medical substitution this limited the impact of Advanced Nurse Practitioners working in Case Study 1: Acute Services settings. What tended to result was a reductionist approach to the patients' presenting problems, whereas in Case Study 2: Non-Acute Services, by contrast, Advanced Nurse practitioners tended to operate in a broader way, bringing Advanced Nursing skills and attributes to bear on complex chronic disease processes. Participants in both case studies noted that in their experience when Advanced Nursing Practice was in effect directed towards addressing medical gaps alone, it could not also address the breadth of patient problems that are undoubtedly also present. They may have had their 'medical' needs addressed, but their wider needs were often ignored, though they could easily have been addressed by a broader comprehensive response typical of Advanced Nursing.

However, despite the apparently negative picture, there was also evidence that the Trust was engaging in its own developmental journey in relation to formulating its plans and intentions for Advanced Nursing Practice. While they were undeveloped and lacked co-ordination, nonetheless it was encouraging that In Case Study 2: Non- Acute Services, there were examples of job descriptions that were fit for purpose and this reflected a journey nurturing Advanced Nursing within that service. The presence of a consultant nurse who understood and had a vision for Advanced Nursing

Practice and recognised the importance of Advanced Nursing in that service was critical in taking forward the infrastructure to support the participants there.

Creating a new vision for Advanced Nursing Practice in the Trust required senior leadership support and active support from the Trust Board. As referred to already, the health policy direction is towards an increase in holistic patient centre activity exemplified by the NHS Long Term Plan (DHSC 2019). Although it doesn't expressly speak about Advanced Practice, it is plain that new ways of working are essential, and the tone of those intervention needs to be patient-centric.

Participants reported that Trust Policy had in their estimate tended towards being 'pragmatic' in effect, simply using the available workforce, largely driven by the need to respond to continuing absence of medical staff within the Trust. Yet, it was clear that this was the product of poor understanding of the Advanced Nursing Practice role and its potential when fully carried out (Carryer and Adams 2021). The NHS Long Term Plan (DHSC 2019: 11) spoke to this topic directly in saying that if services were being designed 'from scratch' many things would be done quite differently.

This, and criticisms of an absence of clear workforce planning and service design were significant issues raised by participants about service and trust leadership. To counter this, careful construction of a workforce case by one of the participants, with evidence and thorough justification, did show signs of changing existing thoughts of managers. Consequently, an Advanced Nurse Practitioner was appointed because of that business case. It set out clearly the scope of the role integrating all four pillars (HEE 2017) and it was successfully implemented because it was well put together.

7.2.7 Associate Journeys

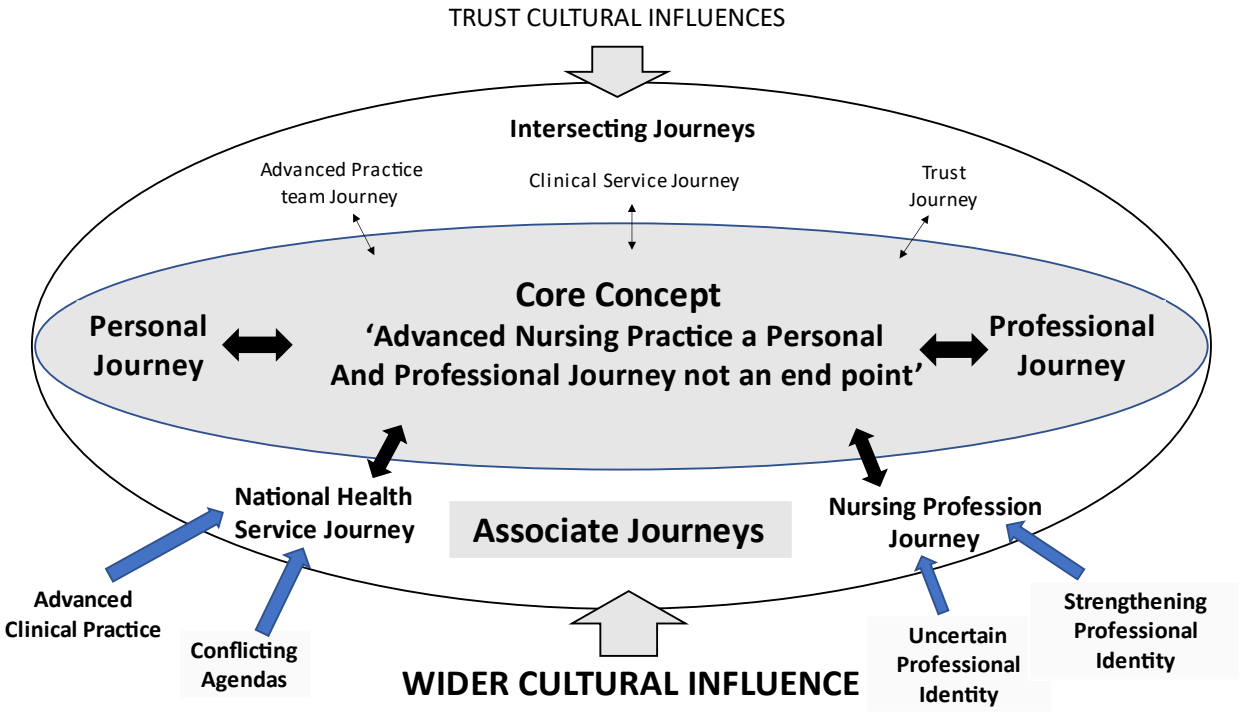


Figure 26: Relationships Between the Core Concept- Advanced Nursing Practice is a Personal and Professional Journey not an End Point, and Associate Journeys-NHS and Nursing

7.2.7.1 The National Health Service Journey - Advanced Clinical Practice

The contextual review in Chapter 2 revealed the limited clarity around the concept of Advanced Nursing Practice during the 1980s in Britain. The Health Department was slow to speak to the emerging Advanced Nursing Practice agenda, eventually withdrawing earlier central direction regarding extended nursing roles, supervised by doctors (DHSS 1977 and 1988), leaving it to trusts to manage their own arrangements. The nurse regulator meanwhile was active debating the issue and issued various papers including the Scope of Practice (UKCC 1992), more on this in the next section. Health policies developed to respond practically to this agenda are set out in Chapter 2 (see page 15) and broadly supported over time the development of medical substitution roles for nurses (DoH 2002b). A number of strategy documents were produced (DoH 2006; Scottish Government 2008; DoH 2010) and though generally constructed well, unfortunately they had limited impact. Latterly new momentum came when Health Education England initiated activity to establish a firm and current foundation for what Advanced Practice should look like (HEE 2017).

The effort invested this project has been substantial and continues to be so (HEE 2017c, 2020a, 2020b 2021). Many good things have emerged from this work, not least the framework (HEE 2017) including a definition making clear it is about a level of practice and not a role, that it not a medical substitution role, and that all the pillars are integral to the role. These are important principles, now clearly recorded:

> *'Advanced clinical practice is delivered by experienced, registered health and care practitioners.* ***It is a level of practice characterised by a high degree of autonomy and complex decision making****. This is underpinned by a master's level award or equivalent that* ***encompasses the four pillars of clinical practice, leadership and management, education and research****, with demonstration of core capabilities and area specific clinical competence. Advanced clinical practice embodies the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people's experience and improve outcomes.' (HEE 2017)*

The framework also signalled a move away from 'competencies' to 'capabilities' recognising and requiring a higher level of thinking and judgement making abilities (Krishnan 2018; O'Connell, Gardner & Coyer 2014). Other key aspects of work include: a momentum for supporting master's education programmes; mentorship standards in practice (HEE 2020b); accreditation of both courses and individuals; establishing a portfolio route for those who want to validate their experience; commissioning research (Evans et al 2020); establishing the Centre for Advancing Practice, the central body overseeing the development of Advanced Clinical Practice in England (HEE 2020a); establishing regional centres to work with stakeholders and interested parties locally to further the embedding of Advanced Practice within the Health Service in England; and establishing a framework for consultant level practice (HEE 2021).

The aim to permanently shift the culture of workforce relationships within the NHS by promoting Advanced Practice is welcome. It is encouraging that the ongoing discussions within the Advanced Practice world have reinforced certain assertions within the centre's work, that the purpose for this framework and activity is not to service medical replacement activity at the expense of patient centred and profession supported activity:

> *'Importantly, the advanced clinical practitioner is a registered professional meeting practice demands within the scope of their own professional registration and adding value to the clinical pathway; not as a substitute for another profession.'* **(HEE 2021: 9)**

While these are valid and important things emerging from work by the Centre for Advancing Practice, there is concern that the importance and uniqueness of nursing is challenged by the all-encompassing 'Advanced Clinical Practitioner' title. The advent of Advanced Clinical Practice (HEE 2017) has expanded Advanced Practice beyond nurses to health professionals from a variety of backgrounds including pharmacy, paramedic science, occupational therapy, physiotherapy and midwifery. Although this achieves recognition of Advanced Practice as a level of practice with common main characteristics, it does add to the complexity of practice (Leary and MacLaine 2019) raising questions about professional identity and how professional regulation can be achieved (Palmer, Julian and Vaughan 2023). It is however in the context of this study, that the obscuring of nursing is the main concern. Participants in the study recognised this, advocating for the title 'Advanced Practice - Nurse'. They recognised that the same approach could be used by other professions too, and interestingly this was not a concern only of nurses, but the Advanced Practice Physiotherapy Network (APPN) retains physiotherapists' identity supporting its members. Its home page clearly stating their purpose, "Connecting and supporting advanced practice physiotherapy across the UK, safely exploring emerging healthcare horizons and enhancing person-centred care through clinical excellence" (AAPN 2023).

A welcome development recently has been a small but increasing emphasis on use of 'Advanced Practice' rather than 'Advanced Clinical Practice', also the body charged with the responsibility for moving the Advanced Practice agenda forward is the 'Centre for Advancing Practice', rather than the 'Centre for Advancing Clinical Practice'.

7.2.7.2 National Health Service Journey - Conflicting Agendas

The last two decades have seen the emphasis in health policy shift from hospital to community-based care. Alongside this, traditional workforce structures, hierarchy and medical hegemony were challenged by calls for movement towards different models of care (Carryer and Adams 2021; Maxwell and Radford 2021; Nancarrow & Borthwick 2005). Increasing recognition that existing service delivery models could not adequately meet patients' needs (HEE, SFH and SFC 2017; HSJ 2010) were emphasised in the NHS Long Term Plan (DHSC 2019. New models and structures were required and Advanced Nursing within Advanced Nursing Practice, was recognised as an important element in addressing these policy imperatives (Poghosyan and Brooks-Carthon 2017).

There was also a focus on quality, striving for a more innovative, efficient and robust NHS, but also included efficiency and economic savings. This revealed tension between potential cost savings and the cost of meeting assessed patient need, particularly increasing numbers of those with complex

chronic disease. To get a sense of the size of the challenge, chronic disease required the largest proportion of the health budget, 70% of the health service budget as recently as 2017 (DoH 2017: 6). However, efficiency does not just mean cheaper services but how effective identified needs and outcomes of a patient responsive service are met. While the NHS Long Term Plan (DHSC 2019) celebrated progress since the Five Year Forward View (DoH 2014), declaring that funding had been secured and wide agreement had been achieved as to which way to go, its themes of ensuring 'joined up working' remains far from the case (Ham, Charles and Wellings 2018) despite the continuing policy objective of the creation of 'genuinely integrated teams of GPs, community health and social care staff' (DoH 2020: 6).

Participants reflected the conflicts, just highlighted, in their own services where there was continuing fragmentation and disconnection between and within services. Participants commented on the attitudes and beliefs, mainly in Case Study 1: Acute Services, of senior managerial, medical and nursing colleagues, who appeared content to embrace old models of delivery focused on disease-centric priorities. Hierarchical relationships and medical dominance remained that limited collaborative working or for the value of Advanced Nursing to be demonstrated. This was a huge issue for participants since not only was the emphasis on disease-centric clinical practice, but engagement with non-clinical pillar activity, where this was possible, was also disease-centric. So, for example, participants commented that teaching focused on clinical subjects that served the biomedical model often orientated towards junior medical staff, with little emphasis given to teach nurses about nursing topics. Moreover, opportunity to role model excellent nursing, so important for students (Baldwin et al 2017) and existing workforce was limited. The need to regularly assert the purpose, place and role of nursing was recognised as important in building confidence and assertiveness for themselves and their junior colleagues but it was and remained challenging to do this in all of the participants workplaces (Carryer and Adams 2021).

Once more the NHS Long Term Plan (DHSC 2019: 11-12) explicitly speaks of the urgent need for changes in service models and to workforce structures no longer fit for purpose. It speaks of the need for The National Health Service to be: 'more joined-up and coordinated in its care; more proactive in the services it provides; more differentiated in its support offer to individuals.' Indeed, the importance of 'what matters to someone' is not just 'what's the matter with someone' (DHSC 2019: 25). Sharing responsibility for health requires effective support for patients to make the necessary changes. The thrust of this discussion argues that where Advanced Nurse Practitioners are

free to practice the full range of their skills, they can make a considerable difference in bringing about the difference in service culture and practice that is required,

> *'Where once the primary purpose of the health care system was to provide episodic treatment for people with acute illnesses, it now needs to deliver joined-up support for older people and others living with long-term conditions. It must also provide ongoing care for the growing numbers of people who have survived cancers and other major causes of premature death as a result of medical advances. Prevention as well as treatment depends on people playing their part in making healthy choices, for example in relation to rising levels of overweight and obesity in the population and preventing or delaying the onset and progression of chronic diseases…'* (Ham, Charles and Wells 2018).

However, the translation of policy into reality remains part of an ongoing journey, by NHS England, trusts, and services to make this happen. Support for Advanced Nurse Practitioners fulfilling Advanced Nursing roles remains at a very early stage of development, particularly in Case Study 1: Acute Services setting, where the prevailing view was to stick with the tried and trusted though perhaps failing model.

7.2.7.3 The Nursing Profession Journey - Uncertain Professional Identity

Early responses by the nursing profession in the late 1980's and 1990's, were vigorously reflected in actions by the nursing regulator at the time (UKCC 1990, 1992, 1994, 1994b), supported by the Royal College of Nursing who had established a course of training in the early 1990's (RCN 2003). However, as the work of the regulator began to stall in light of notable divisions within the profession (Rolfe 2014a UKCC 1997). The divisions, referred to here as the 'great divide', centred on whether Advanced Nursing Practice should embrace medical substitution as its focus, or an enhanced patient-centric, holistic approach. No decisive conclusions were reached and the regulator was either unable, unwilling or were obstructed in drawing the interested parties to a consensus position.

The medical profession however, was keen to support nurses taking on enhanced substitution roles and the Health Department appears to have supported that emphasis (DoH 2002). The Royal College of Nursing effectively took over the leadership of this issue, speaking for nursing by developing role descriptors, competencies, and education standards for education providers (RCN 2003). It also made clear its beliefs as to where nurses were positioned in relation to 'the great divide':

> 'The RCN does not believe that the nurse practitioner is a doctor substitute, or a means of providing medical services at reduced cost. The nurse practitioner offers a complementary source of care to that offered by medical practitioners. Nurse practitioners augment the care doctors give, as well as acting as primary care providers in their own right.' (RCN 2003: 3)

As new roles developed however, many nurses did accept the path of medical substitution and embraced it as a means of career progression (Swann et al 2013). Alongside this, during the 2000s, nursing was faced with some really difficult challenges:

- First, to its integrity and standing. The Francis Enquiry, revealed poor standards of care and ineffective leadership within nursing (Francis 2013). Its recommendations for better leadership of nursing rather than management only partially addressed.
- Second, a climate of continuing nursing shortages, nurses leaving the profession, skill mix changes together with low pay and conditions, have together weakened morale (Morgan 2022);
- Third and perhaps most importantly, identity challenges around the nature of nursing itself (van der Cingel and Brouwer 2020; Shields and Watson 2007). The increased use of healthcare assistants taking on former 'nursing' actions (Jackson et al 2021) added to the effect of the previous issues, cumulatively altering how nurses worked, leading to greater task-centred rather than patient-centric activity, raising continuing concerns for the quality of patient care (Aiken et al 2016). This also weakened momentum for promotion of Advanced Nursing.
- Finally, more recently the advent of the title Advanced 'Clinical' Practice (HEE 2017) has replaced the title 'Nursing' in many places (Diamond-Fox and Stone 2021). It has acted to obscure what type of practitioner is treating the patient.

These factors, taken together, raised serious questions concerning the nature of nursing, what was it for, what is its future direction? As this applied to nursing generally, how much more relevant for 'Advanced Nursing' within Advanced Nursing/ Advanced Clinical Practice?

In light of the previous discussion, with which participants largely concurred, it is vital to see that the findings from this study demonstrated that while there was pressure for focus on medical substitution and disease-centric roles in the Trust, a series of exchanges from participants in Case 1:Acute Services) revealed that they did not take the pressure from senior staff to act as medical substitutes as the only factor in determining how they practiced. They recognised that the minimalization of the expression of patient-centric nursing expertise at the patient interface by Advanced Nurses was a significant loss to both patients, and nursing colleagues learning how to practice. The impact of Advanced Nursing in all its facets needed to be expressed (Poghosyan and Brooks-Carthon 2017). While fulfilling their required substitution roles, many adopted a persistent attitude of taking every opportunity to demonstrate the knowledge and skills of Advanced Nursing, in both their direct practice, but also through integrating four pillar activity into their work. The

distinction made here between 'nursing' and 'Advanced Nursing' is an important one, 'nursing' is identified as the composite knowledge, skills and attitudes to deliver effective, compassionate care to patients. Advanced Nursing however, is more than this, it is a level of practice, managing complexity, making decisions, acting as a broad source of expertise, providing leadership and being a collaborating constant presence (Maxwell and Radford 2021; HEE 2017). Moreover, it is 'the glue' that holds the service together (Hooks and Walker 2023; Williamson et al 2012). Indeed, the consultant surgeon participant, expressly indicated this had become true of his Advanced Nursing Practice colleagues over time. Importantly, this was not how the role started, or was envisaged for some participants, but as they proved their worth as Advanced Nurses, fulfilling the required substitution role, so their determination enabled their roles to expand leading to the demonstration of patient-centred care and four pillar activity. Their journey of personal and professional development was clearly evident and their level of autonomy grew.

While little research has been undertaken on autonomy and Advanced Nursing Practice (Lockwood et al 2022), it has been for some time an expected characteristic at this level of practice (HEE 2017). However, historically, as nursing began to embrace Advanced Nursing Practice it was apparent that not all nurses wanted autonomy (Chiarella 1998). Practitioners who became nurses during the late 1990s and early 2000's grew up during a time of increasing task focussed practice. The relatively short-lived period of patient-centric care and primary nursing fostered prior to that during the 1980's and 1990's had faded, never really becoming established (Rolfe 2014b). Consequently, it was not implausible that nurses socialised into 'task-focused' practice as the way nursing was increasingly carried out would have few problems embracing disease-centred Advanced Nursing Practice (van der Cingel and Brouwer 2020). Its focus often embracing medical skills guided by the biomedical model, the familiar hierarchical relationship with doctors was maintained, autonomy was limited and accountability for this substitutionary role would be to the senior doctor. This was a very much reduced level of autonomy than that envisaged by participants keen to maximise nursing impact.

In terms of the form of autonomy participants engaged with, two forms were identified, first 'structural autonomy' (see Glossary page xvii; Johns 1989). This was the level of autonomy permitted by the trust, generally overseen by senior doctors and managers, it was perceived by participants to restrict their Advanced Nursing activities, focusing them instead on medical skills and biomedical approaches. However, participants reported becoming skilled at 'workarounds' to achieve their objectives for their patients (see Chapter 4, Memo 3, page 90). This attitude reflects the second form, 'personal autonomy' (see Glossary, page xvii; Johns 1989) located within the individual practitioner. Where personal identity as an Advanced Nurse was strong, this was reflected in the

confidence to take risks and push the boundaries or extending nursing practice, not simply being restricted to medical practice.

7.2.7.4 The Nursing Profession Journey - Strengthening Professional Identity

Despite this apparent negative picture, several concurrent developments offered the potential for nursing to make progress in what was a challenging health care arena in the United Kingdom. First, the decision for nursing to become as a graduate profession from 2013, with potential for raising the standard of knowledge base that would underpin and influence quality practice; second, the introduction of nursing associates, who though not at the same level as registered nurses are academically prepared and regulated by the nursing regulatory body to provide skilled patient care (NMC 2018b); third, increase of contemporary nursing research including evidence, among other things, to support safe staffing levels (Saville et al 2019); fourth, the re-establishment of the reputation of nursing by the general public following the Covid Pandemic (Foster 2023).

Interestingly one of the effects of the Covid Pandemic was to raise the profile of Advanced Nurse Practitioners, whose contributions were widely admired by patients, and also by fellow health professionals, who witnessed the significant impact their range and depth of nursing skills had during that period (Maxwell and Radford 2021). The ongoing holistic needs of patients with Long Covid has further highlighted the need for the sorts of chronic disease management highlighted by the NHS Long Term Plan (DHSC 2019) for which patient-centric practice could make a real contribution (Maxwell and Radford 2021). A second, less heralded development has been in the quiet dropping in some instances of the 'clinical' term from Advanced Clinical Practice, restyling it as simply 'Advanced Practice'. This is entirely in keeping with the intentions of the multi-professional document (HEE 2017) which put emphasis on the value of individual professions. Participants were very keen to retain 'nursing' in their job titles, and it is interesting that other health professions are also keen to maintain their discreet professional identity, as exemplified by the Advanced Practice Physiotherapy Network (APPN 2023) Finally, the third development is the significant decision by the Nursing and Midwifery Council to engage with the notion of regulating Advanced Nursing Practice. It commissioned and has just received an independent report on its potential role in regulating Advanced Nursing Practice (Palmer, Julian and Vaughan 2023). There were mixed views about this among participants, some welcoming the identity distinction it would bring for profession specific Advanced Nursing (Hill and Mitchell 2021), while other sensing it would stifle the necessary varieties of Advanced Nursing tailored to patient need (Rolfe 2014b).

7.2.8 The Grounded Theory - Advancing Practice Momentum.

'The Advanced Nursing Practice Journey transitions from Advanced to Advancing Nursing Practice when enabled by an Advancing Practice Momentum'

7.2.8.1 Momentum

The experience of momentum observed within individual Advanced Nurse Practitioners was the critical agent of transformation, it was enabled by a range of internal factors (see Chapter 6 page 189). These included: their own developed personal characteristics that valued patient-centricity, such as empathy and compassion, or were problem focused such as determination, courage and resilience. A commitment to patient centric-care and Advanced Nursing was foundational, as was the capacity for risk taking and a strong desire to push services forward. Momentum was not achieved where there was absence of these factors or where they were underdeveloped.

Factors external to the individual Advanced Practitioner were also important and featured the presence of supportive leadership and appropriate mentorship. As discussed earlier, medical mentors were excellent for medical issues, but not necessarily for project management or nursing leadership. Participants experience of momentum in these areas was related to the presence of trust level support for Advanced Nursing from trust leadership and the release of structural autonomy, discussed earlier, to maximise their impact. Once again absence or presence of these factor impacted momentum and successful advancement of their role.

7.3 Evaluation of the merits of the study

This section includes evaluation of the merits of the study regarding its contribution to creating new knowledge and understanding about Advanced Nursing Practice. The benefit of using grounded theory was that it seeks to understand the world of the individual from their perspective (Birks and Mills 2015) and create theory grounded in data generated from the study of that world. Moreover, constructivist grounded theory enables the co-construction of that theory with participants such that the end result is not a direct reporting of participants reality, but an interpretation and 'rendering' of it (Charmaz 2014).

7.3.1 An Assessment of the Quality of the Research in this Study

Reflecting on and evaluating the rigour and quality of a grounded theory study was not an easy prospect for this constructivist researcher, since the end product, the grounded theory, makes sense because of immersion in the process (Charmaz 2014). It may make less immediate sense to the audience, so it was necessary to select criteria to help with an appraisal of the merits of the study. Several sets of criteria were considered for use in Chapter 4, see page 96, including: Glaser's (1978: 4-5) fit, work, relevance and modifiability, related to how the constructed theory renders study data; Guba and Lincoln's transferability, credibility, dependability and confirmability; Morse's (1997: 180) clarity, structure, coherence, scope, generalisability and pragmatic application, related to assessment of theory derived from qualitative studies; finally, Charmaz's (2014) four criteria, credibility, originality, resonance and usefulness.

Figure 27: Charmaz's (2014) Four Criteria

Charmaz's criteria was considered a suitable fit with the inclusion of 'transferability' and 'credibility' from Lincoln and Guba's (1985) Work.

1. **Credibility.** This was reflected in effective sampling, ensuring there was complete representation of participants views, thoughts and experiences reflecting achievement of data saturation. Data therefore was relevant, had substance, scope and depth. The study demonstrates familiarity with participants and their case study groups. Extensive use of examples of participant commentary across the two case study groups is presented throughout Chapter 5, with systematic comparison between them provided, see Chapter 5 pages 140, 157, 176, 197. Literature was used in triangulating participants assertions and behaviours with the emerging categories and concepts, (see Chapter 4, pages 108-111).

2. **Originality.** The analysis provides a new conceptual rendering of data with new insights, these are considered further in the claims for originality section, see page 268. 'Coherence' is evident, and ambiguities and paradoxes were accounted for and not ignored, linkages are explained, for example, why was Advanced Nursing evident in some Advanced Nursing Practice roles but not others?

3. **Resonance.** Categories represented the experiences of Advanced Nursing Practice as presented within the two case study groups in the study. The Core Concept and grounded theory constructed were recognised and acknowledged by a group of Advanced Nurse Practitioners, as 'making sense' (Charmaz 2014: 338) when presented to them in a key note presentation of the study at a regional Health Education England (HEE) Conference in 2023. Delegates shared similar Advanced Nurse Practitioner roles to participants in the study and 10 of those delegates sharing their 'recognition' were also former students on the MSc Advanced Practice Course referred to throughout the thesis for which I was their course director.

4. **Usefulness.** The study findings, in Chapter 5, provided numerous, varied and comprehensive examples of categories generated from participant data which addressed the study research questions concerning: features and scope of Advanced Nursing Practice; what Advanced Nursing was; and factors which enabled or restricted the expression of Advanced Nursing within Advanced Nursing Practice. There is justification for confidence that those findings, the Core Concept constructed from them, 'Advanced Nursing Practice is a Personal and Professional Journey not an End Point', and the enablers and restrictors of the personal and professional

journey, (see Chapter 6 page 216-217), will be recognised by readers familiar with these roles. Moreover, the Core Concept together with the grounded theory, 'The Advanced Nursing Practice Journey transitions from Advanced to Advancing Nursing Practice when enabled by an Advancing Practice Momentum' will significantly aid recognition and understanding of the specific factors that enabled or restricted the participant journey and their impact on momentum revealed at the core of this dynamic level of practice.

An important assessment of usefulness will come following the disseminating of findings, especially to participants and appraising their responses (Charmaz 2014), so this will form part of the recommendations made later in this chapter. Other recommendations will highlight how enablers can be promoted and restrictions can be addressed, so that Advanced Nursing can be fully employed within Advanced Nursing Practice as it transitions to Advancing Nursing Practice.

7.4 The implications and recommendations for policy and practice, education and research

Advanced Nursing Practice has much more to offer than simply filling other health professionals' gaps (Hooks and Walker 2020; Pearce and Breen 2018). Yet there is a need for Advanced Nurses to articulate, promote and explain what Advancing Nursing within Advanced Nursing Practice can do. As the findings in this study have demonstrated, Advanced Nursing fosters and develops excellent patient-centric care; it has the ability to lead and shape the culture of the care environment; to build collaborative teams that ensure a holistic comprehensive and un-fragmented care, that empowers and supports self-management where this is possible and timely care and management where it is not.

7.4.1 Implications - Policy and Senior leadership

7.4.1.1 Establish Trust Vision - Promoting Advanced Nursing

The term 'advanced' has been frequently used to refer to more skills and competencies but not to a new level of nursing practice. This study has identified significant opportunities for Advanced Nursing to make a considerable contribution to patient-centred care and the management of complex, chronic conditions and acute exacerbation of those conditions, when it practiced using a nursing lens (Nadaf 2018). This carries the ability to practice holistically, delivering seamless and compassionate care. In addition, it carries the ability to lead, and work collaboratively, continually developing and improving services, making a substantial contribution to team leadership, building and developing those teams (Maxwell and Radford 2021). However, vision must be created and a strategy be put into effect if its potential is to be realised.

7.4.1.2 Appointment of Trust Lead for Advanced Nursing Practice

Patients need more than a fragmented and reductionist approach to their health problems (DHSC 2019) and this requires an urgent review of human resources since the shortage of medical practitioners is not the only significant issue (Morgan 2022). Nursing is also in the midst of a recruitment and staffing crisis. Enabling a realistic career structure that fosters clinical nursing, provides opportunities to develop Advanced Nursing roles and not just substitution roles that fill medical gaps, is an urgent priority and one achieved elsewhere (Hooks and Walker 2020). This requires a greater emphasis on clinical leadership, rather than management, to inspire, role model, motivate and develop real solutions for real problems.

Reform of workforce planning is needed, including a skill mix review (Saville et al 2019). Revised approaches would be well advised to consider as a maxim, not so much of what the service needs, but what do patients need? These implications are challenging and the need for a trust Advanced Practice lead, to drive these changes is highly advisable (Poole and Goodhew 2017).

7.4.1.3 Consultant Nurses - Strategic Role

Consultant Nurses have a strategic role (Manley et al 2022; HEE 2021) and therefore should not simply be placed within clinical services without playing a wider strategic role at trust board level, working with the Trust Lead to promote patient centred services throughout the organisation.

7.4.2 Implications for Practice - Clinical Services

7.4.2.1 Consultant Nurse Appointment

As considered in the last section, the type of leadership required is significant. Participants reported that services were largely managed not led, which did not create the necessary momentum to consistently move services forward (Hill and Mitchell 2021). This revealed a space in the team and opportunity for the appointment of a Consultant Nurse, typically a leader not a manager to lead services and offer opportunity to redress imbalance and build Advanced Nursing within Advanced Nursing Practice services (Manley et al 2022; HEE 2020).

7.4.2.2 New Service Design- Building Effective Teams

The implications for services relate to the purpose for each service and therefore how best to meet patients' needs. A key finding presented in Chapter 5 (see page 173) was a novel service design model suggested by one Consultant Nurse participant. This advocated taking a in depth look at what patients using that service needed, asking questions, and then identifying the skills, type of staff and service delivery model required, that would meet that need. New service models are needed and a re-appraisal of which staff groups are needed to achieve this. Effective leadership with team building skills was an essential ingredient in creating healthy teams (Torrens et al 2020). Participants pointed to examples in their experience where this was and was not present.

Consideration should also be given to the wider skill mix and inclusion of new roles including Medical Assistant Practitioner/ Physician Associates roles (HEE 2017b). They offer support for medical shortages and would also serve to enable space for Advanced Nurse Practitioners to fulfil the full scope of their role. This should not rule out Advanced Nurse Practitioners delivering elements of disease-centric practice, but does mean not at the expense of, or instead of Advanced Nursing elements of the role and full expression of four-pillar activity (HEE 2017).

7.4.2.3 Establishing a Learning Culture

Most participants had not experienced the presence of a consistent learning culture in their services, but all recognised the need for (Karas et al 2020; Sholl et al 2019), and benefits of, both direct and indirect learning in supporting their ongoing personal and professional development (Newton et al 2015). Its presence has been associated with improved motivation and care standards (van der Cingel and Brouwer 2020; Karas et al 2020).

7.4.3 Implications for Education

The study has revealed implication for education based upon needs at different stages of the journey to become and be an Advanced Nurse Practitioner.

7.4.3.1 Pre-registration Nursing Courses

This may appear a strange place to start, but it became clear from participants comments that the nursing foundations laid for them in their pre-registration courses had not always been sufficient to provide a strong basis to promote the full scope of nursing practice to competing voices and agendas. Those voices tended to support an entrenched culture that maintained the dominance of the biomedical model and positivist perspectives on health and research evidence production (Krishnan 2018). The strength of participants own values and beliefs were crucial in their ability to assert, develop and maintain a strong Advanced Nursing dimension within their roles. Though this was challenged particularly in practice settings where both medical staff desiring that nurses simply helped them fulfil disease-centric objectives, and also by a large number of nurses who wished them to acquiesce to the status quo.

This situation has implications for: the Nursing Midwifery Council (NMC) as nurse regulator; nurse educators in curriculum design and delivery; nurses in practice, including Advanced Nurse Practitioners, mentoring students; and, nurse managers managing the practice environment. The implications are to collectively support, reiterate and enable nursing identity founded on a sound philosophical and theoretical base. Introducing intuitive concepts sufficiently early have the benefit of preparing students to reflect and think critically in a way compatible with a nursing and not just a biomedical model (Maxwell and Radford 2021). Re-emphasising nursing models and perspectives, taught well, increase potential for them to support and enable nursing not merely biomedical practice. Concerns have been raised recently about the lack of general impact that ‘graduate’ preparation of nurses is having on practice since its introduction (Maxwell and Radford 2021), however, since fifty percent of student nurse preparation is in clinical practice it can only help if

Advanced Nurse Practitioners are actively engaged in student mentorship as role models, facilitators and teachers demonstrating what it means to be a nurse. However, this remains contingent on them being released to do this (Hill and Mitchell 2021), which as demonstrated earlier has been a problem for participants in Case Study 1: Acute Care settings.

Henderson, the famous American nurse theorist, in her writing emphasised a necessary shift in thinking, for nurses to see themselves not as doctors' assistants, but as patients' assistants (Hunt and Wainwright 1993: 13). This was not just semantics but a completely different way of thinking and behaving, necessary to empower patient-centric rather than disease-centric practice becoming the norm. Thus, nurses in accepting personal accountability for their decision making, actions and their consequences truly reflect professional practice (NMC 2018). Nothing less is sufficient a basis for Advanced Nursing within Advanced Nursing Practice.

7.4.3.2 Advanced Practice Courses

Increasingly, courses preparing practitioners to become Advanced Practitioners have become multi-professional, attracting not just nurses but a wide range of allied health professionals. This presents three challenges: first, that educators have a crucial role in course design so that they are truly fit for purpose and encompass teaching and learning that embrace all elements of the four pillars (HEE 2017); second, to ensure that in celebrating and enabling multi-professional learning and working to develop, that professional identities are not weakened, but fostered, developed and celebrated so that professional identity remains valued and intact (HEE 2017); third, to ensure mentorship is sufficient to fully support student development across the four pillars and support advancement of nursing practice (HEE 2020b).

7.4.3.3 Continuing Professional Development (CPD)

The need for to support ongoing development was observed to be an important issue for participants. This was generally either absent, or restricted to clinical topics. Participants identified role broadening issues as important, including project management and research project support, but this was lacking. Moreover, there was a prevailing sense of resistance shown by managers, showing limited understanding of participant need for addition education to compliment and extend the achievement of their 'qualifying' Master's course. It appeared that limited resources caused managers to perceive participants had, 'had their share' and 'now it was someone else's turn'.

7.4.4 Implications for Research

This study reveals several issues for research, including appraisal of the grounded theory presented in this study. However, the primary issue in developing research is learning how to embed this activity within Advanced Nurse Practitioner roles, and how to ensure a wide range of research is commissioned, so that answering a wider range of patient-focused questions becomes the norm (Smyth et al 2022; Fielding et al 2022). The impact of Advanced Nursing Practice is a major need especially the way in which patient-centric needs are achieved.

The Chief Nursing Officer's for England's recent strategy has an important part to play in supporting the release of Advanced Nurse Practitioners to undertake meaningful research. They will need to be bold to pursue this and ensure the focus is right (NHSE and I 2021)

7.4.5 Implications for the Nursing Profession Journey

Much has been made of the leadership role of Advanced Nursing Practice (Hill and Mitchell 2021), and which participants demonstrated in different ways both at local and strategic levels. Engagement with the nursing regulatory body has long been associated with Advanced Nursing Practice (Rolfe 2014a) and arising from participants' comments there appeared to be three significant issues that nursing and the Nursing and Midwifery Council in particular need to address: to strengthen the professional identity of nursing; to regulate Advanced Nursing Practice; and to improve cross professional body communication and connections.

First, questions are raised about the professions' confidence in itself and the value of nursing. Since the 'golden days' of innovations in nursing professionalisation during the 1980s and 1990s, the general nursing scene has become much more challenging, even hostile with some very negative press about nursing and nurses in recent years (Francis 2013). In the light of that nursing appears to have retreated and lost confidence. Nursing shortages have led to the reintroduction of task allocation, with patient centred care reduced as a consequence (Maxwell and Radford 2021).

Concerns were raised about whether nurse education programmes were doing enough to prepare students to become nurses and whether that identity was firmly enough shaped and formed. Maxwell and Radford (2021) and earlier McCrae (2012) expresses concerns about an over emphasis on clinical skills, rather than addressing deeper knowledge and searching questions. In pre-registration education, teaching of nursing theory has been disregarded as no longer relevant yet the question remains what models are being used to shape assessment and decision making? The evidence is, electronic pre-prepared examples, not patient centric, but based upon a 'standard

patient', the antithesis of holistic practice. Moreover, task focused thinking and practice is happening more and more commonly, yet this combination does not work well for the development of autonomous thinking and decision making associated with professional practice (Maxwell and Radford 2021; McCrae 2012). The ability of any profession to establish its own theory base and to refine and develop it is well known, yet it appears that nurses have become content to ignore this in favour of being led and directed by others. Bureaucratic management structures and medical hegemony have retained dominance and effectively restrict and curtail professional practice. It is no wonder that nursing continues to have difficulty in asserting itself as a profession. There is urgent need for a shift, Maxwell and Radford (2021) enter this conversation boldly asking the same questions.

7.4.6 Recommendations

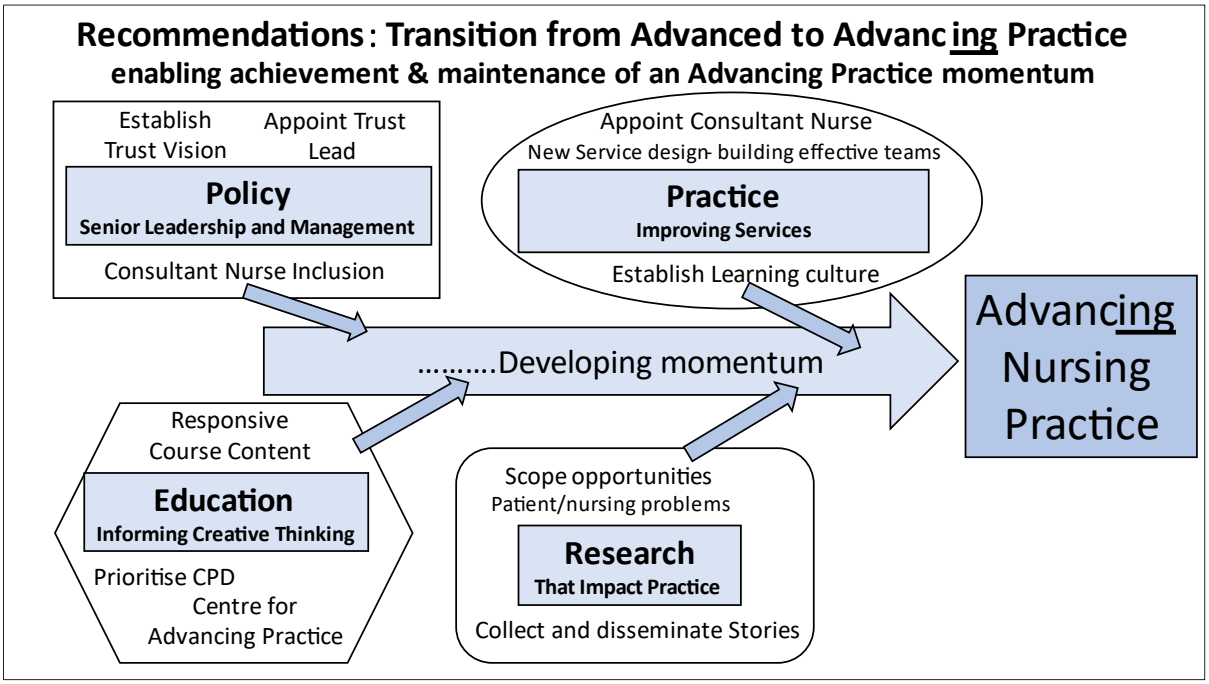


Figure 28: Recommendations: Transition from Advanced to Advancing Practice-Enabling Achievement and Maintenance of an Advancing Practice Momentum

7.4.6.1 Policy: Senior Leadership and Management

The limited understanding of the breadth of scope of Advanced Nursing Practice by senior leaders including managers and clinical directors can be effectively addressed by the following:

- Establish a unified and clear trust vision for Advanced Practice which respects each profession's unique contribution;
- Appointment of a strategic lead for Advanced Nursing Practice. Key elements that such a post holder would need to identify and introduce include:
    - A workforce planning tool to help managers assess whether or not there was a need for Advanced Nurse Practitioner posts in their services, preventing roles simply evolving rather being established and included in a work plan.
    - A model/ framework for writing effective business cases for such roles (Pearce and Breen 2018);
    - Aligned, appropriate and meaningful job descriptions and job summaries;
    - Effective recruitment strategies that enable recruitment of the right calibre of people, with an appropriate level of critical thinking and decision-making ability, experience, and confidence based on good judgement (Pearce and Breen 2018);

    - Establishing a database of who is functioning as Advanced Nurse Practitioners, and who simply carries a title not reflecting the ethos of the role (Leary et al 2017);
    - A review of governance arrangements, (HEE 2022b; Poole and Goodhew 2017) to ensure patient safety, support mechanisms, and clear accountability pathways are in place;
    - Build a research, evidence base and case study/story base to explain and reveal the benefits of Advanced Nurse Practitioner roles;
    - Establish a functioning Advanced Nursing Practice group, to foster support for members, and with the ability to plan and carry out actions to drive the role forward.
- Establish a clear place for Consultant Nurses within the trust nursing management/leadership structure to promote the role in leadership of nursing and Advanced Nursing Practice

7.4.6.2 Practice: Improving Services - Clinical Level Practice

- Existing service
    - Recruit and appoint a Consultant Nurse if not present already.
    - Review service, re-establish vision, identify priorities and opportunities and plan for expansion of Advanced Nurse Practitioner role to address missing elements.
    - Review existing team, re-envision and enable to match vision expectations.
- New service
    - Recruit and appoint a Consultant Nurse to design, envision, establish and lead an Advanced Nursing Practice Service and work with the service manager and others to establish a skill mix fit for patients using the service.
    - Establish a clear place for Advanced Nursing Practice within the clinical service structure.
    - Recruit, establish and build a functioning team (Torrens et al 2019)

- All services
    - Build vision, clarify and explain Advanced Nurse Practice purpose and contribution to the service and how this will positively impact the service and the wider team (Hill and Mitchell 2021).
    - Take steps to establish a learning culture (van der Cingel and Brouwer 2020; Sholl et al 2019).
    - Prioritise continuing professional development, with broad based knowledge and skills, not just medical clinical subjects. Including non-clinical pillar subjects, advanced communication, advocacy, coaching, consultancy, project planning and research to enable role fulfilment.

- To enable and strengthen patient-centric care, support access for the patient voice at all level of service

7.4.6.3 Education: Informing Creative Thinking

- Engage with and support pre-registration education course content.
  - Support emphasis on the purpose and role of nursing, promote identity and socialisation into its unique character and purpose (van der Cingel and Brouwer 2020).
  - Contextualise for students the philosophical and theoretical base for nursing (Krishnan 2018)
  - Further develop leadership skill and potential both taught and applied (HEE 2018a)
  - Explain Advanced Nursing in context of nursing career structure, emphasising need for experience building the foundation for Advanced Nursing Practice and Consultant Nurse roles.
- Advanced Practice Course Content.
  - Support and engage with comprehensive four pillar content, practice and assessment.
  - Use of interactive and problem-based learning
- Support mentorship, varied and broad to develop breadth of ability (HEE 2020b).
- Engage with and support input from Centre for Advancing Practice (HEE 2020a).

7.4.6.4 Research

- Develop/establish service links with trust/university research teams and Practice/Academic Centres (NHSE and I 2021).
- Scope useful opportunities for research relevant to the service priorities that are patient-centric (Kilpatrick et al 2023)
- Scope useful opportunities for research focused on nursing and nursing problems that contribute to greater understanding of and respect for the value of nursing (Cowley et al 2016). The Chief Nurse's research strategy, 'Making Research Matter- Chief Nursing Officer for England's strategic plan for research' is a welcome help (NHSE and I 2021) speaking as it does to and for nursing.
- Collect Advanced Nursing Practice 'stories', recognising storytelling reveals the nature of Advanced Nursing Practice, its potential and impact in an engaging and accessible way (Attenborough and Abbott 2020). This could easily develop into a central repository of stories for wider dissemination.

- Recognising that the considerable focussed demand of research for some Advanced Nurses will lead to them developing a dedicated clinical academic career and will play a significant part in moving the research agenda forward (HEE 2018).

7.5 The Unique Contribution and Claim for Originality

7.5.1 The Uniqueness of this Study

The study:

1. Is an in-depth current study examining contrasting cases, two groups of Advanced Nurse Practitioners, in an acute hospital setting.

2. Uses a study design that has an explanatory methodology, constructivist grounded theory, in order to explain rather than simply describe Advanced Nursing Practice (Charmaz 2014).

3. Uses appropriate methods to collect, generate and analyse data: constant comparative analysis of data was employed from the outset of its gathering; continually asking questions of the data using literature to support the analytical effort; ongoing reflexivity and memoing to remain close to the data and aid the production of understandings, theorising with increasing levels of abstraction.

4. Co-constructs new perspectives about Advanced Nursing Practice, not a direct reporting of participants reality, but my interpretation and 'rendering' of it (Charmaz 2014).

5. Identifies and explains similarities and differences in the experiences of Advanced Nursing Practice between two case studies which represent contrasting services in one National Health Service regional hospital.

6. Provides a novel counter-cultural perspective, emphasising the value and importance of nursing, in a culture which is placing a high value on multi-professional practice.

7. Identifies and reveals the characteristics of Advanced Nursing, explaining why it is essential for achieving patient-centred care. The characteristics of Advanced Nursing, generated from the data, are:

    - A value for the uniqueness of nursing in its focus on the primacy of patient need, as the key motivator for designing actions necessary for achieving patient-centric holistic care.

- A central value for the clinical pillar, but because its approach is patient-centric while it normally will include disease-centric activity, it is not limited to it. It is broader in scope, responding to the totality of patient need.

- A unique approach to how 'need' is identified and recognised, through the use of the 'nursing lens'*, which makes sense of where the 'needs' are and how best to respond to them. It works collaboratively with patients, carers, colleagues, the Advanced Nursing Practice team, the service, the trust and wider partners.

- Being thoughtful, reflective, dynamic, adaptable & flexible, supported by having problem solving abilities which are innovative and creative.

- Being a constant and consistent presence in the clinical setting that enables continuity, stability and inclusive working.

7.5.2 Originality Claims of this Study

The study makes five claims of originality:

1. It's features and design, as referred to in the Uniqueness of this Study section (see page 268)

2. The presentation of Advanced Nursing Practice, not as was initially proposed, where individual Advanced Nurse Practitioners were regarded as positioned as one or other of two Types of Advanced Nursing Practice at polar extremes to each other, but rather where individual Advanced Nurse Practitioners have potential to move along a dynamic continuum that actually exists between the two polar extreme Types. The potential for movement is activated or not in response to 'factors' internal and external to the Advanced Nurse Practitioners (see Chapter 6 page 195).

3. The construction of the Core Concept, **'**Advanced Nursing Practice is a Personal and Professional Journey not an End Point'. This reveals and explains the potential open-ended nature of development for Advanced Nurses. That it isn't a static phenomenon achieved at the point of qualification or appointment to an Advanced Nurse Practice role, but carries a continuing potential for dynamic development (see Chapter 6 page 204).

4. The construction of the grounded theory, 'The Advanced Nursing Practice Journey transitions from Advanced to Advancing Nursing Practice when enabled by an Advancing Practice Momentum'. This reveals and explains that when this 'Advancing Practice Momentum' is present and is supported, the impact of Advanced Nursing Practice as a level of practice, is transformed to a dynamic process of growth, progress and development for the individual Advanced Nurse Practitioner. This powerfully impacts their patients, carers, teams and colleagues, their service, organisation and wider partners. Because Advanced Nursing is fundamentally patient-centred, patients are the first to benefit from the effects of this momentum.

5. The potential within the grounded theory is such that even where the Personal and Professional Journey of the individual Advanced Nurse Practitioner is restricted by elements affecting them from Intersecting and Associate Journeys, those restricting effects can be reduced and even negated by the impact of an 'Advancing Practice Momentum'. It is essential therefore that in a climate and culture that is difficult to change everything possible is done to promote

7.6 Chapter Summary

This chapter has drawn the thesis to a close, it has critically discussed the findings of the study and explained the relevance of those findings for the promotion and advancement of nursing within Advanced Nursing Practice, as found within one National Health Service Hospital Trust in England. It has critically discussed how the findings of this study align with, and relate to, what is currently known about Advanced Nursing Practice as revealed in the literature, research and policy evidence base. It has contextualised the key findings and discussed the implications of those findings, the Core Concept and the grounded theory, for policy and practice, education and research, and made recommendations for each of these areas**.** It has also explained the unique contribution of this study to the science base of Advanced Practice.

7.6.1 The Position of Advanced Nursing Practice Revealed in this Study

While it has been largely recognised that since its inception, Advanced Nursing Practice in the United Kingdom has been a widely misunderstood concept, nurse participants in this study did not tend to reflect that view, but reported a clearer understanding of what Advanced Nursing Practice was or certainly could be. They repeatedly referenced two distinguishing elements revealed in the literature over the preceding ten to fifteen years, reported in the contextualising review in Chapter 2. These two elements were: first, that Advanced Practice is a 'level' of practice, rather than a role; and second, that four dimensions, or pillars, of activity are central to its effective function and purpose. This has been articulated most recently in the Multi-professional Framework (HEE 2017). Participants also recognised the two types of Advanced Nursing Practice proposed in this study in Chapter 2 (see page 37). Type 1 was significant in impact, but limited in scope; Type 2 was similarly significant, but broad in scope and holistic in nature. Though these types were originally understood as at polar extremes to each other, in fact they were more accurately revealed in the data and findings, as identifiable points on a continuum. The reality of participants experience was that they were located at different points along that continuum. Where participants were located on the continuum depended on: their value for nursing; their own personal beliefs about the purpose and place of Advanced Nursing within Advanced Nursing Practice; the focus of the service they worked in; and the expectations of and levels of support from their managers and clinical leads.

However, it was clear that positions and roles developed and changed over time. Where there was a strong commitment to nursing and as individuals and team matured, significant movement was

towards being less disease-centric focused and more patient-centric, innovating and addressing broader patient needs (Hooks and Walker 2020; Pottle 2018).

7.6.2 Advanced or Advancing Nursing Practice: The Future Direction for Nursing?

As the study progressed what became increasingly evident was the bewildering speed of activity and complexity that was the constant within the clinical environment, very little was static. This applied to individual participants experience, revealing that they were each on a dynamic personal and professional journey of development and growth reflected in the Core Concept:

'Advanced Nursing Practice is a Personal and Professional Journey not an End Point'

It was apparent that around this principal journey there were also a series of interacting journeys that were taking place. Those journeys impacted the individual journeys of the Advanced Nurse Practitioners, variously facilitating or restricting their activity. They included: Intersecting Journeys of Team, Service, Trust; and Associate Journeys of National Health Service and Nursing Profession. Each of these journeys was complex, often messy and challenging. When the elements of these journey came together with minimal friction and conflict, patients benefitted, but conversely where there was friction and conflict between them, then hinderance and restriction was the result. Advanced Nursing Practice at its best intervened consistently to maximise helping and minimise restrictions, unfortunately not infrequently it was restricted in its endeavour by the impact of other journeys and was not always successful in mitigating them.

In Chapter 2 (see page 37) two distinct Types of Advanced Nursing Practice were proposed, followed by a proposed definition of Advancing Nursing Practice (see page 38). Advancing Nursing Practice was referred to there as 'an aspirational fulfilment of nursing potential' (see page 37). However, in the light of the findings concerning experiences of a number of participants in this study, Advancing is more than an aspiration but is displayed as a reality. That original proposed definition for Advancing Nursing Practice has been superseded by the findings which suggest a revised definition is appropriate, (see Box 14, page 272).

Advancing Nursing Practice…

> *'…consistently demonstrates momentum within a continually evolving level and scope of autonomous comprehensive patient-centred nursing practice. It is delivered by experienced, expert, registered nurses who have achieved at least an appropriate master of science degree, at the outset of achieving the status of Advanced Nurse Practitioner. It is enabled by expert knowledge base, complex decision-making skills and practice capabilities. It deliberately and consistently utilises learning from practice and decision-making involving patients and their families, and from colleagues in the clinical environment, to initiate dynamic and innovative responses which continually improve practice. It is actively engaged with research that informs practice and with policy formation that shapes and keeps practice current and effective. It has a central role in leading professional nursing practice and fosters an active learning culture, including colleagues and patients. Specific features are shaped by the context of engagement but demonstrate effective collaborative working with colleagues and teams.' (Gray 2023)*

Box 14: Revised Description Advancing Nursing Practice

The momentum referred to in Box 14 is critical in understanding how the Core Concept enabled the construction of the grounded theory, because it explained that the continuing journey of Advanced Nursing Practice has momentum inherent within it. It has its genesis in the ethos and values of nursing, it is patient-centric, and when fostered and matured internally, and enabled and supported externally, it enables the transition from Advanced Nursing within Advanced Nursing Practice, to become Advancing Nursing Practice:

'The Advanced Nursing Practice Journey transitions from Advanced to Advancing Nursing Practice when enabled by an Advancing Practice Momentum'

7.7 Conclusion

The study has identified significant opportunities for Advanced Nursing Practice to make a considerable contribution to patient-centred care and management of complex, chronic conditions and acute exacerbation of those conditions, when practiced with a nursing lens.

While it would be untrue to suggest that Advanced Nursing within Advanced Nursing Practice will solve all the problems of the National Health Service (NHS) there is every reason to suggest it will continue to make a real difference where it flourishes. The reason for this is because of the orientation and way that Advanced Nurses work. They begin their interaction with patients by seeing them first as people, not diseases or objects. They practice Advanced Nursing assessment, seeking to first assess and understand the problem or typically problems, comprehensively. They then plan a complete response, collaboratively with the patient, and include fellow health professionals with contributions to make in a timely way. However, Advanced Nursing within Advanced Nursing Practice is not just a clinical response, it also learns from each patient encounter, what needs to change/ be developed/ be improved? It then plans collaboratively with the wider team how to bring about innovation. It involves the team, examines the research base, develops a project, enacts, and introduces the change, evaluates it, embeds it. Meanwhile, it continues to challenge existing norms where they are unhelpful in serving patients, and created a new culture. Alongside this there is teaching and learning, mentoring and coaching, and more team interaction. Undertaking research and contributing to the evidence base is also important. All this activity starts with an Advanced Nurse Practitioner assessing a patient, holistically….and then a service evolves! May the dynamic of that momentum flourish unabated.

The Study:

Advanced or Advancing Nursing Practice: The Future Direction for Nursing?

⬇

The Core Concept:

'Advanced Nursing Practice is a Personal and Professional Journey not an End Point.

⬇

The Grounded Theory:

'The Advanced Nursing Practice Journey transitions from Advanced to Advancing Nursing Practice when enabled by an Advancing Practice Momentum'

⬇

The Conclusion:

Advancing Nursing Practice is the Future Direction for Nursing!

Figure 29: Key Statements from the Study Including its Conclusion

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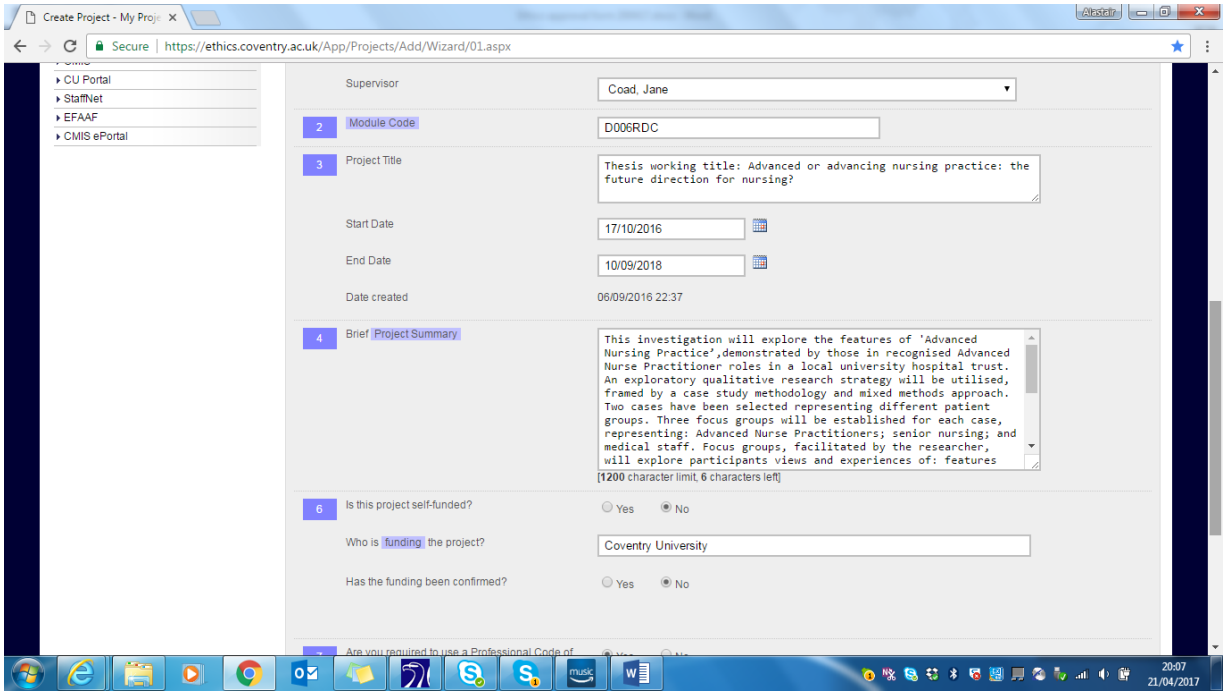
Appendices

Appendix 1: Ethical approval form, Coventry University Ethics Committee



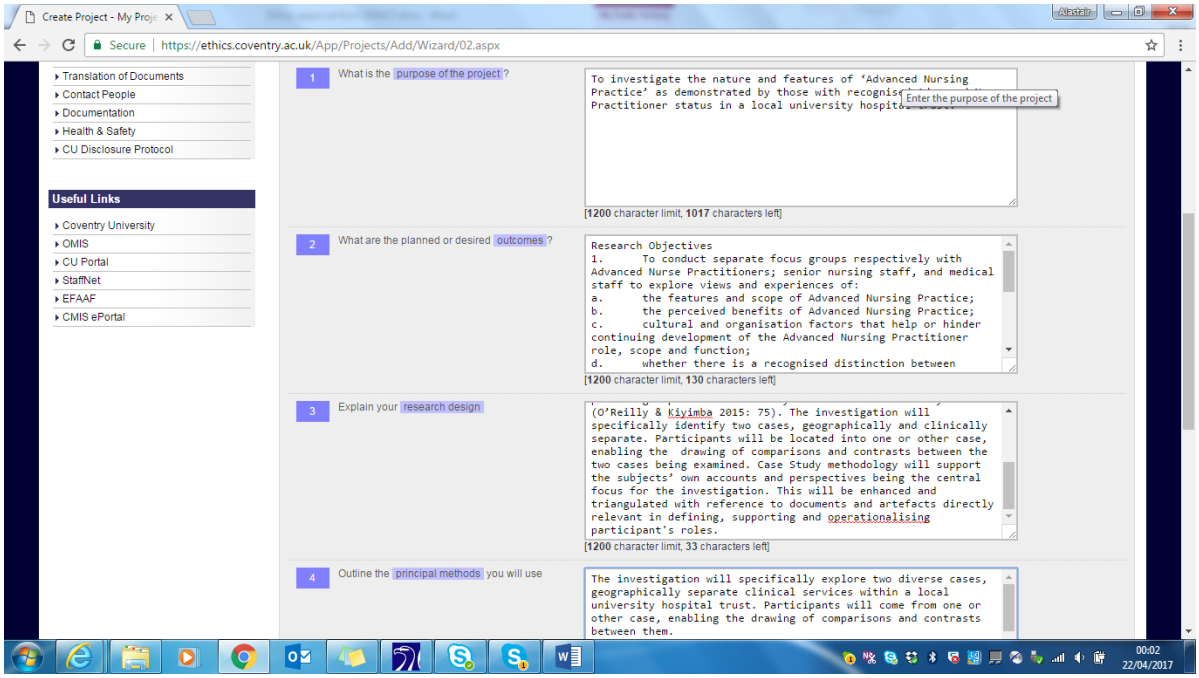
Brief Project Summary

This study will explore, features, significance and impact of 'Advanced Nursing', demonstrated by nurses in recognised Advanced Practitioner posts in a local university hospital trust. An exploratory qualitative strategy will be utilised, framed by case study methodology and mixed methods approach. Two 'cases' are identified representing particular patient groups. Three focus groups will be established for each case, including: Advanced Practitioners (Nurses); senior nurses; and medical staff. The researcher will facilitate the groups which will explore participants' views and experiences of: features, significance and impact of Advanced Practice n undertaken by nurses; cultural and organisation factors enabling or hindering Advanced Nursing Practice; participants perceptions of distinctions between 'Advanced' and 'Advancing' Practice.

Individual interviews will subsequently be conducted with participants, wishing to comment further.

Relevant trust documents impacting the Advanced Practitioner role will be sought from participants, these will be subjected to discourse analysis.

All data collected will be subject to Thematic analysis, with findings presented and conclusions drawn.



Purpose of the project

The purpose of this study is to reveal the features, significance and impact of 'Advanced Nursing', demonstrated by nurses in recognised Advanced Practitioner posts in a local university hospital. Two very different clinical services have been selected to reveal if there is:

- A commonality in the features, significance and impact demonstrated within and between these clinical services, and;
- If and where there are significant differences, the extent to which this is influenced by the focus of the clinical service and the specific requirements of the role practiced in that clinical service.

It is hoped that the findings will encourage a fresh awareness of, and confidence in the significance and impact of 'Advanced Nursing' on direct patient care; on the culture and practice of nursing more generally; and on the wider quality of clinical services within the National Health Service.

Research Objectives

1. To conduct separate focus group and individual interviews with health professionals who have experience working with nurses in advanced practitioner roles, including: nurses who are Advanced Practitioners; senior nurses, and; senior doctors.
2. To invite focus group and individual participants to share their thoughts, observations and experiences of Advanced Practice, as undertaken by nurses, in relation to:
    - it's features and scope;
    - it's significance and relevance to clinical services;
    - it's impact and perceived benefits;
    - the organisation and structural factors that help or hinder expression of its features, significance and impact;
    - whether there is a recognition and common understanding of a distinction between Advanced and Advancing Practice

3. To carry out thematic analysis of data collected from focus group and individual participant transcripts.
4. To critically appraise documents and artefacts identified by participants in group and individual interviews and determine the extent to which these help or hinder continuing development of the features, significance and impact of Advanced Practice by nurses.
5. To identify areas for future research to further understand the features, significance and impact of Advanced Practice by nurses.

Research Design

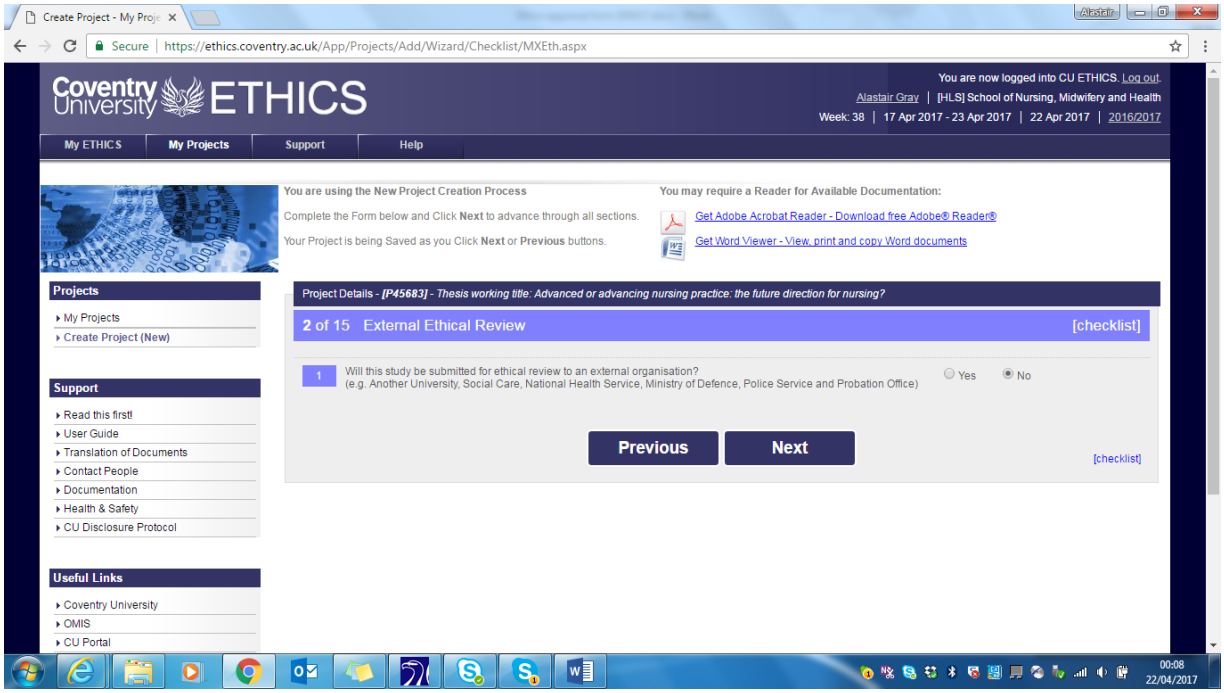
The aim of the study is exploratory in nature, seeking participants' views and experience of Advanced Practice roles, when conducted by nurses. A broad, descriptive qualitative methodology was deemed most appropriate (Polit and Beck 2010: 273; Denzil & Lincoln 1998: 389). The study will use a Case Study methodology to shape it, so judged as an appropriate way of effectively obtaining the views of a variety of participants, with varying perspectives, thus providing ample data for rich thematic analysis (O'Reilly & Kiyimba 2015: 75). The study will specifically identify two cases, geographically and clinically separate. Participants will be located into one or other case, enabling the drawing of comparisons and contrasts between them. Case Study methodology will support the participants' own accounts and perspectives being the central focus for the study. This will be enhanced and triangulated with reference to documents and artefacts directly relevant in defining, supporting and operationalising participants' roles.

Principal methods

The study will specifically explore two diverse cases, geographically separate clinical services within a local university hospital trust. Participants will come from one or other case, enabling the drawing of comparisons and contrasts between them.

A focus group method has been selected to gather data from three distinct groups within each case; nurses who are Advanced Practitioners, senior nurses, and senior doctors. This method has the potential to capture additional insights based upon different professional perspectives and cultural impact on shaping practice roles (Thomas 2016: 191). Since it is not entirely clear what will be learnt from the study, a further collection of data will come from individual interviews, with participants who volunteer to give additional commentary. All interviews will be facilitated by the primary researcher, well known to the Advanced Practitioners and who carries credibility with them. Finally, documents that shape, direct and influence participants in the expression of their roles (Gomm 2004:267) will be examined by the researcher using discourse analysis (McDonald 2008: 287).

External ethical review



I have said no to this because UHCW R&D ethics (Sonia Kandola) has told me no NHS REC needed. I do have to complete a form for letter of access to the trust

Data collection: Conflict of interest

Most participants will be or will have been students on the MSc Advancing practice or Advancing Clinical Practice Courses for which I am course director.

All invited participants will be free not to take part if they feel a conflict of interest exists, which would render them uncomfortable / intimidated by their involvement and /or my facilitation of the data collection sessions.

Data Management

Locked drawer in office to which only named persons have access.

Data collection off site (Local NHS Hospital Trust)

Interviews will be conducted in the local university hospital trust seminar rooms, a secure room accessible by trust staff swipe card. a senior trust colleague will facilitate use of this room and will be aware of arrival departure timings. The researcher has a mobile phone available should it be needed to summon help. Colleagues in the University will also be aware of my activities.

Appendix 2: Research Passport, permission to conduct research, University Hospital Coventry and Warwickshire

R&D
Research & Development

NHS
University Hospitals Coventry and Warwickshire
NHS Trust

Research & Development Department
University Hospitals Coventry & Warwickshire NHS Trust
4th Floor Rotunda, ADA40014
University Hospital
Clifford Bridge Road
Coventry
CV2 2DX

Commercial enquiries: 02476 964995
Governance/Non-commercial enquiries: 02476 966195
Research Funding & Grant enquires: 02476 964958
Email: R&D@uhcw.nhs.uk

08 April 2019

Alastair Gray
School of Nursing Midwifery and Health
Richard Crossman Building
Coventry University
Priory Street
Coventry
CV1 5FB

Dear Alastair,

Study Title: Advanced or Advancing Practice the future direction for nursing?

Study Ref: GF0268

Thank you for sending in the required documents and completing the GafREC form for the above study. Having reviewed the details of your proposed project, studies where staff are being approached due to the nature of their role, NHS Research Ethics Committee (REC) approval is not required, therefore, I can confirm that we are happy for you to carry out this project within UHCW NHS Trust.

Please be aware that should you wish to change the project in anyway, you must notify our office using the above reference.

I have logged your study on behalf of the Trust, which means you can proceed. I wish you every success with your project.

Yours Sincerely,

This item has been removed due to 3rd Party Copyright.

Jasmeet Bhambra
Research Administration Specialist

We **Care.** We **Achieve.** We **Innovate.**

University Hospitals
Coventry and Warwickshire
NHS Trust

Research & Development Department
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Commercial enquiries: 02476 964995
Governance/Non-commercial enquiries: 02476 966195
Research Funding & Grant enquires: 02476 964958
Email: R&D@uhcw.nhs.uk

Re-issued on 11 March 2021 due to error on the end date
12 April 2019

Alastair Gray
School of Nursing, Midwifery and Health
Richard Crossman Building
Coventry University
Priory Street
Coventry
CV1 5FB

Dear Alastair,

Letter of access for research:
Study Title: Advanced or Advancing Practice the future direction for nursing?
R&D Reference: GF0268

This letter confirms your right of access to conduct research through University Hospitals Coventry and Warwickshire NHS Trust for the purpose and on the terms and conditions set out below. This right of access commences on **12 April 2019** and ends on **20 February 2022** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research at University Hospitals Coventry and Warwickshire NHS Trust has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out. To enable you to engage in research studies at UHCW NHS Trust and in line with the New Data Protection Legislation, you are advised that personal information provided to us by you will be held securely in the Investigators Site file. This file will have restricted access and be held for the duration of the clinical trial and subsequent archiving period, after which time it will be destroyed

You are considered to be a legal visitor to University Hospitals Coventry and Warwickshire NHS Trust premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

Appendix 3: Appraisal of Chapter 2 literature

Author, Year, Title & Country of publication	Aims	Design & methods	Findings/outcomes	Comments
Ball, J. et al. (2013) Care left undone during nursing shifts: associations with workload and perceived quality of care United Kingdom	To examine the nature and amount of missed care episodes by nurses in English National Health Service hospitals, also, to consider if this is connected with nurse staffing levels and their assessment of the quality of nursing and patient safety.	A cross-sectional survey of registered nurses (2917) employed in 401 general medical/ surgical wards in 46 general acute English National Health Service hospitals	Nurses working in English hospitals report that there are frequent episodes of missed care. Care not being undertaken may be the result of low nurse staffing levels which then adversely affects quality and safety. Hospital trusts could use nurse-rated scales to report 'missed care' as an early warning indicator identifying wards with insufficient nurses.	Significant that that the care activity nurses reported were not completed included: talking with and comforting, educating, and, developing/ updating care plans (47%). The ratio of patients to registered nurses was particularly associated with 'missed care' events.
Barton, D. & Mashlan, W. (2011) An advanced nurse practitioner - led service – consequences of service redesign for managers and organizational infrastructure United Kingdom	Service review of advanced nurse practitioner-led service in secondary care.	Opinion data collected from 38 professionals and non-professionals within the rehabilitation service.	Organizational infrastructure and traditions had impact on advanced nurse practitioner service delivery. Need for action on developmental constraints by senior management.	A positive model of collaborative service negatively impacted by service and cultural restrictions.
Barton, T.D. Bevan, L. and Mooney, G. (2012a) The development of advanced nursing roles United Kingdom	First of three-part series on advanced nursing practice, examines its historical evolution.	Discussion paper, written by experienced and knowledgeable advanced nursing academics.	Articles challenges the idea that there is a single formula that will address and explain advanced nursing.	Useful historical perspective provided. Explains the diversity of expression of advanced nursing.
Barton, T.D. Bevan, L. and Mooney, G. (2012b) A governance framework for advanced nursing United Kingdom	Second in a three-part series outlines the introduction of a governance framework for advanced nursing practice.	Discussion paper, written by experienced and knowledgeable advanced nursing academics.	Asserted generally no desire or perceived need for regulation of advanced nursing practice, but that the code of professional conduct was insufficient to guarantee public protection. So, employer-led governance was seen as necessary.	Useful exploration of importance of local governance of Advanced Nursing Practice asserted.

Author, Year, Title & Country of publication	Aims	Design & methods	Findings/outcomes	Comments
Barton, T.D. Bevan, L. and Mooney, G. (2012c) What does the future hold for advanced nursing? United Kingdom	Third in three-part series on advanced nursing explores future demand for flexible but regulated career framework.	Discussion paper, written by experienced and knowledgeable advanced nursing academics.	The concept and evidence base for advanced nursing is receiving wider acknowledgement as it develops.	Exploration of difficulty in setting up governance arrangements but also why these are necessary.
Benner, P. (2000) From Novice to Expert: Excellence and Power in Clinical Nursing Practice. United States of America	To report the first of three major studies investigating skill acquisition and articulation of knowledge embedded in expert practice in nursing	21 paired interviews with newly graduated nurses and their preceptors. Interviews and/or participant observations were conducted with 51 additional experienced nurse clinicians, 11 newly graduated nurses, and 5 senior nursing students to further delineate and describe characteristics of nurse performance at different levels of education and experience.	This study, known as the "From Novice to Expert" study, was conducted from 1978 to 1981 drawing on and adding to the Dreyfus model which considered experiential learning in a complex field over time. It contrasted with linear models of formal expertise emphasizing understanding of the situation and relevance over time.	Seminal and influential work Indicating that the sciences of medicine and nursing are broad drawing on multiple disciplines. Utilizing knowledge and skill for nursing demands interpretation and intelligent application with each practice event.
Benner, P. (2000) From Novice to Expert: Excellence and Power in Clinical Nursing Practice USA	To present the first of three studies examining skill acquisition, revealing a stance on how nurses learn and progress from being inexperienced to expert practitioners	Seminal research through interview and observation of nurses. A model of skill acquisition by Dreyfus and Dreyfus is applied to the work of those nurses. It provides a vivid description of what expertise in nursing looks like	The book reports dialogue with nurses revealing five levels of clinical competency. Examples from real experience come from where nurses have learned from encounters or where they have made significant contributions to patient wellbeing. The book challenges nursing orthodoxy in a number of ways. It asserts that perceptual awareness if critical to effective judgement and that this may come first from 'hunches' that may bypass critical analysis and scientific rationale initially, though will be confirmed later	A radical approach to decision making in practice based upon the development of experience, not merely on rules which are often limited and inflexible. Also speaks of the realities of doctor -nurse relationships which are complex. Reveals that nurses commonly fill gaps for doctors in crises.

Author, Year, & Country of publication	Aims	Design & methods	Findings/outcomes	Comments
Benner, P. Tanner, C. and Chesla, C. (2009) Expertise in Nursing Practice: Clinical Judgement and Ethics. United States of America	To report the second of three major studies investigating skill acquisition and articulation of knowledge embedded in expert practice in nursing	This was an interpretive phenomenological study of 130 nurses in 8 critical care units. Conducted between 1988 and 1994 it accessed the everyday practice and skill to explain particular and distinct patterns of meaning and action in the practice of nurses studied, noting the context in which they worked, their history, and particular concerns.	This second study has articulated what nurses know about their practice and the importance and knowledge inherent in the caring, understanding, impactful work they undertake. An aspiration of the work is that in collaboration with multiple other agencies there can be better design of institutions of caring.	Important ideas speaking to the real world of practice that provide a useful theoretical basis for action.
Beresford, M. (2010) 'Medical Reductionism: Lessons from the Great Philosophers' United Kingdom	To debate advantages and disadvantages of reductionism in relation to medicine.	Discussion paper, written by experienced and knowledgeable doctor comparing and contrasting reductionism and holism.	While naive to dismiss benefits of reductionist approach in the study of the disease, something is lost in the translation from theory to the clinic. Holism should not be dismissed.	Effective comparison of benefits and drawbacks of reductionism with holism
Brown, S. (1998) A Framework for Advanced Practice Nursing United States of America	To propose a framework that synthesizes previous work on models of advanced practice	The framework proposed in this article represents an integrative synthesis of previous work on advanced nursing practice.	The range of advanced nursing practice literature lacked a comprehensive conceptual framework to organize and guide substantive work. A framework is needed for health care policy, educational curricula, role descriptions, and research. The proposed framework represents integrative synthesis of previous work	The proposed framework is based on a definition of advanced practice nursing on activities that (1) focus on clinical services provided at the nurse-patient interface, (2) use a nursing orientation, (3) have a defined but dynamic and evolving scope, and (4) are competency based acquired through Masters level preparation.

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Bryant-Lukosius, D. et al (2004), Advanced Nursing Practice Roles Canada	The aim of this paper is to discuss six issues influencing the introduction of advanced practice nursing (APN) roles.	Discussion paper, written by experienced and knowledgeable advanced nursing academics	Differences in types of advanced practice roles presented. Guidance for introduction of Advanced Nursing Practice roles is provided in this paper. It includes the need for evidence to support-making the case, emphasizing a full nursing focus with all domains included, attention paid to a supportive environment and ongoing evaluation.	A thorough approach emphasizing the importance of nursing and all its facets, but also the key need for evidence and evaluation to prove its worth
Castledine, G. (1995) Will the Nurse Practitioner be a Mini Doctor or a Maxi Nurse?' United Kingdom	To assess the implications of nurse practitioner roles for nurses and nursing	Editorial article assessing implications of nurse practitioner roles for nurses and patients	Considers the effect of nurse practitioner roles on nursing and the nursing profession's aims. Concern that it will prove that nurses can work with a medical model but at the potential expense of the nursing one.	Raises the risk of the medical model dominating advanced nursing practice if nurses don't resist this.
Castledine, G. (1998) The role and criteria of an advanced nurse practitioner United Kingdom	To set out criteria, roles and function of advanced nurse practitioners in seven categories.	Discussion paper, written by an experienced and knowledgeable advanced nursing academic and member of then Nursing Regulatory Body (UKCC)	Advanced clinical nursing practice and expanded role function should be guided by a nursing model or emphasis. It should not be directed or dictated by physicians or a medical model.	Clear, justified approach that emphasizes advanced nursing practice must be a nursing role.
Castledine, G. (2003) New Nursing Roles must Maintain Nursing's principles United Kingdom	To provide perspective on a national conference to develop advanced nursing practice.	Discussion paper, written by an experienced and knowledgeable advanced nursing academic and member of then Nursing Regulatory Body (UKCC)	Nursing is present when patients are present. Patients interest should come first when developing new roles. There is political pressure for nurses to take on substitution roles Nurse must determine their own boundaries.	A challenging commentary promoting the uniqueness of nursing and the need to maintain this in new role
Christensen, M. (2011) Advancing nursing practice: redefining the theoretical and practical integration of knowledge United Kingdom	To offers an alternative framework of nursing knowledge, to that currently guiding advanced practice previously.	Discussion paper, presenting thematic analysis of the current discourse, by an experienced and knowledgeable advanced nursing academic	A dichotomy exists between different kinds of knowledge and skills for advanced practice. A revised approach to this is advocated, highlighting pattern recognition as the basis for knowledge that informs advanced nursing practice	Interesting and useful basis for developing advanced nursing knowledge that informs advanced nursing practice.

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Cope, L. Abuzour, A. and Tully, M. (2016) Nonmedical prescribing: where are we now? United Kingdom	To present a brief look back at the history of nonmedical prescribing, comparing with international practice.	Discussion paper, written by experienced and knowledgeable independent prescribing academics.	Presents a brief look back at the history of nonmedical prescribing, comparing with the international context. It describes how to qualify as a Non-Medical Prescriber in Britain, potential influences on nonmedical prescribing and its impact on patient opinions and outcomes and the opinions of doctors and other healthcare professionals.	Informative account reported its role in supporting medical staff and in disease management.
Corner, J. et al (2003) Exploring nursing outcomes for patients with advanced cancer following intervention by Macmillan specialist palliative care nurses. United Kingdom	To explore nursing outcomes for patients with advanced cancer that may be identified as resulting from the care of a Macmillan specialist palliative care nurse	A 28 day longitudinal study of 76 patients referred to 12 Macmillan specialist palliative care nursing services in the United Kingdom. Following referral to a Macmillan team, patients were interviewed three times, using a recognized outcomes scale. A nominated carer was interviewed at baseline and 28 days. Notes recorded were analysed.	A method to evaluate nursing care outcomes in complex situations including patients terminal care was developed. Majority of care provided by Macmillan specialist palliative care nurses was rated positive, though this was not the case for few patients	Study made clear and visible why Advanced Nursing was both important and worth investing in. Also highlighted a lack of focus on nursing issues found in undergraduate research which instead often focused on medical issues.
Corbin, J. (2008) Is Caring a Lost Art in Nursing? United Kingdom	To explore 'what is caring? What are the behaviors on the part of nurses that make persons feel ''cared about'' as well as ''cared for'' '	Journal editorial paper, based on a paper presented at The Royal College of Nursing International Nursing Research Conference, Dundee, Scotland, 4th May 2007. Supported by literature on Caring	Re-appraisal of the importance of caring in nursing. Dialogue needs to go beyond defining caring, to determine what the heart of nursing is, and where it should be in the future. Recognition that non nurses dictate what nursing can and cannot do based on financial limits must end. Declares it is time for nurses to voice their concerns and take back their practice crucially determining what practice should consist of and whether caring should be a part of it.	A challenging argument calling for a reappraisal of nursing by nursing, and for nursing to re-stablishing its place in determining its future and the role of caring in that future

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Coulter, A. Collins, A. (2011) Making Shared Decision-making a Reality. United Kingdom	To clarify what shared decision-making is and why it is not yet widely practiced. To suggest what needs to be done to make the aspiration a reality.	A report written by recognized experts in the field and prepared for a wide readership of policymakers, leaders in health care, patients and user groups. All of whom have a significant role in supporting the implementation of shared decision making. Also aimed at clinicians, as commissioners and providers of services.	Why shared decision-making is important. What shared decision-making involves. What are the implications of doing or not doing this for patients, clinicians and the NHS.	A detailed analysis with highly relevant findings and recommendations about this key area of patient centric care.
Coulter, A. Roberts, S. Dixon, A. (2013) Delivering better services for people with long-term conditions Building the house of care. United Kingdom	To describe a co-ordinated service model, the 'house of care', that reflects management of care for people with long-term conditions, which is proactive, holistic, preventive and patient-centred.	A report written by recognized experts in the field, includes learning from several locations in England working to achieve these aims of the project.	The house of care metaphor illustrates a whole-system approach, including the interdependence of each part and components needed to hold it together. Each part represents critical factors required to make it work.	An imaginative and detailed approach to support delivery of co-ordinated collaborative services for people wit long term complex conditions.
Dalton, M. A. (2013) Perceptions of the Advanced Nurse Practitioners Role in a Hospital Setting. United Kingdom	To identify barriers to advanced practice by ascertaining the perceptions of junior doctors, nurses and ANPs in relation to the role of the ANP during the day compared to the role of the ANP within the hospital at night	A small-scale qualitative cross-sectional design was used. A non-probability sample of six junior doctors, six ward nurses and six ANPs took part in focus groups and individual semi-structured interviews.	• Diverse definitions of the ANP role • Role vagueness and ambiguity • Communication and educational needs • Constraints and barriers Contrast between night and day teams of staff. Night team had clarity about the ANP role and utilized it well. Limited understanding of ANP role and purpose by day team.	Role complexity, variance of expression, and definition were considered. Role focus was on supporting medical rather than nursing aspects of practice. Collaboration did support service efficiency and effectiveness. Inefficient systems were an obstacle. Junior doctors had concerns that ANPs had the potential to restrict opportunities for training.

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Donald, F. et al (2013) A Systematic Review of the Effectiveness of Advanced Practice Nurses in Long Term Care United States of America	To evaluate quality of care provided by Advanced Practice Nurses in older person care and determine gaps in existing knowledge to inform future research.	First quantitative systematic review (Cochrane Collaboration systematic review) of Advanced Practice Nurses in older age care facilities. Four prospective studies conducted in the USA reported in 15 papers.	Findings demonstrated quality, and cost effectiveness of care where Advanced Nurse Practitioners were involved. Improvement or reduced decline in health status indicators, including depression, incontinence, pressure sores, aggressive behaviour, but also in the achievement of personal goals.	The achievement of patient centred care is significant in light of UK government policy on Long Term Conditions promoting this (DoH 2014). Limited similar research highlighted
Doody, O. (2014) The role and development of consultancy in nursing practice United Kingdom	To describe consultancy in nursing; including its development, approaches, application and future potential.	Discussion paper, written by experienced and knowledgeable advanced practice academic.	Consultancy is: a 'helping' role, a two-way process of seeking, giving and receiving help; and is needed to-advance nursing; ensure high standards of care for patients and families; impact positively upon nursing practice, practitioners and receivers of care.	Interesting paper examines a variety of dimensions of consultancy in advanced practice and its potential impact.
Dowling, M., Beauchesne, M., Farrelly, F., Murphy, K. (2013) Advanced Practice Nursing: A Concept Analysis Ireland	To clarify what is meant by advanced practice nursing internationally, what attributes what are its antecedents, consequences, references and related terms.	Concept analysis using Rodgers's evolutionary method, based on the assumption that concept development is a fluid ongoing process, subject to change within contextual and temporal aspects.	Numerous articulations of the advanced practice nursing role found in the literature. This hinders developments. Consensus on advanced practice nursing definitions, terminology, educational requirements and regulatory approaches is central to the implementation of the advanced practice nursing role internationally	Useful emphasis on attributes of APN including autonomy. Differentiates between role expansion and extension. The latter appearing to represent substitution roles.
Duffield, C. Gardner, G. Chang, A. Catling-Paull, C. (2009) Advanced nursing practice: A global perspective. Australia	To review the titles, roles and scope of practice of Advanced Practice Nurses internationally.	Systematised review of a wide range of sources undertaken.	Advanced Practice Nurses are essential for current and future services. It is cost-effective in care provision and valued by patients. They will provide a constant and permanent feature of health care. Clarification of their characteristics and regulation is needed in UK and other countries.	Advanced Nursing Practice is essential to meet forthcoming need. Its autonomous potential however will only be met by role expansion, not role extension, in substitution roles

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Duke, N. (2012) Exploring advanced nursing practice: past, present and future. United Kingdom	To examine the nature of advanced nursing practice.	Literature review and case study.	Reveals the existence of confusion around different forms of advanced practice. It considers what advanced practice is and how it has evolved, from a haphazard start to an organized approach. Considers current issues and discusses the experience of the author as an ANP in the primary care context.	Useful personal reflection on the experience of being ana advanced nurse practitioner
East L., Knowles K., Pettman, M. & Fisher, L. (2015) Advanced level nursing in England: organisational challenges and opportunities. United Kingdom	To explore background, activities and future development needs of advanced practice nurses within a large NHS Trust in England, including a wider review of the UK situation.	An electronic survey was sent to all nurses identified as practising at an advanced level within one Trust. 136 responses were received. Conducted by experienced advanced nursing practice academics	Reveals notable variation in titles, preparation and activities, even by similar roles. The need for more support for continuing professional development was identified by some. Findings reflect the picture across the UK, and support calls for active work to develop strategies for governance, education, and future planning.	Important to see support for establishing effective local governance that both governs practice but also supports its development including importance of continuing professional development.
Finlay, T. (2000) The Scope of Professional Practice: A literature review to determine the document's impact on nurses' role. United Kingdom	To investigate the impact of The Scope of Professional Practice (UKCC 1992)	Commissioned Literature review for the then Nursing regulator (UKCC)	Part of this study included a review of literature relating to Scope and its application. British and American literature was included because of the association of expanded practice roles using Scope, and because of the influence from America on the United Kingdom arena. Confusion over advanced practice is indicated with a call for further research	A thorough and detailed assessment of the impact of an important document influencing expanded and Advanced practice. Highlight two fundamentally different approaches to advanced practice.

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Furlong, E. & Smith, R. (2005) Advanced Nursing Practice: Policy, Education and Role Development Ireland	To explore the critical elements of advanced nursing practice in relation to policy, education and role development, to highlight an optimal structure for practice	Detailed literature review undertaken by experience advanced nurse practitioner academics	The paper emphasizes the importance of policy to guide the development of advanced nursing practice services. Education courses need to be ambitious but flexible to adequately prepare advanced nurse practitioner students for practice. Core concepts are identified and to achieve these students must develop advanced theoretical and clinical skills to meet patient, family and community need. There is still work to be done to ensure roles are legitimized and embedded through uniform criteria, educational standards and regulation	Reference to the four pillars of practice is clear. Autonomy in practice, clinical leadership, pioneering practice and undertaking research are promoted.
Gardner, G., Chang, A., Duffield, C. & Doubrovsky, A. (2013) Delineating the Practice Profile of Advanced Practice Nursing: A Cross-sectional Survey using the Modified Strong Model of Advanced Practice Australia	To test a model that delineates advanced practice nursing from the practice profile of other nursing roles and titles	A random sample of registered nurses/ midwives from government facilities in Queensland, Australia were surveyed, using the modified Strong Model of Advanced Practice Role Delineation tool. Analysis of variance compared total and subscale scores across groups according to grade. Linear, stepwise multiple regression analysis examined factors influencing advanced practice nursing activities across all domains	This study distinguished nursing work according to grade and level of practice, validating the Modified Strong model for the Queensland context, providing operational information for assigning innovative nursing services. There were important differences found according to grade. Nurses in advanced practice roles performed more activities across most advanced practice domains especially where they had higher levels of education. Most effective use of advanced nurse practitioners requires clarity in role definition and scope of practice.	Useful work highlighting the importance of education for advanced practice, but also the importance of organizational readiness and support for these innovative roles.

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Graham, I. (2007) Consultant nurse–consultant physician: a new partnership for patient-centred care? United Kingdom	To describe the process of role transition to, and explain the 'gestalt' of, being a consultant nurse in cardiovascular care	In depth interview method of free-association narrative, tape-recorded, with analysis including of field notes.	Analysis of the narrative reveals an emerging 'gestalt' for being a consultant nurse. A variety of concepts and attributes of the role are revealed. The gestalt explains the journey through 'apprenticeship' to role achievement with a new awareness of the professional self is realized.	Speaks of the transition journey and the change that occurred for this individual. Proposes things that will help the journey of similar colleagues in achieving recognition and acceptance.
Grant, M. J. & Booth, A. (2009) A Typology of Reviews: An Analysis of 14 Review Types and Associated Methodologies United Kingdom	To provide descriptive insight into the most common types of reviews, with illustrative examples from health and health information domains.	Scoping searches were undertaken with examination of vocabulary used in review and synthesis literature. The Search, AppraisaL, Synthesis and Analysis (SALSA) framework was used to examine main types of review.	Analysis of fourteen review types with associated methodologies was completed. A description of the key characteristics is provided, with identified strengths and limitations. Few review types were currently utilized within the health domain. Few possess specific and explicit methodologies. Many are not mutually exclusive. However, the typology provides a valuable reference for those requiring and undertaking the review process within the health care sector.	A very informative and detailed guide to the selection and undertaking of appropriate reviews to ensure and effective foundation for research.
Gray, A. (2016) Advanced or Advancing Nursing Practice: What is the Future Direction for Nursing? United Kingdom	To explore the future direction of Nursing in the United Kingdom.	A discursive paper undertaken by an experienced advanced practice academic.	Advanced nursing practice has not developed the potential of nursing practice to any significant degree. However, advance nursing practice retains the potential to maximise the impact of nursing. The clinical leadership dimension of advanced nursing practice is essential for encouraging effective nursing practice. Focusing on 'advancing' not 'advanced' is the necessary approach to ensure advanced nursing practice achieves its potential.	A paper challenging the apparent status quo, urging advanced nurse practitioners to seize the opportunity and show Nursing's worth.

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Ham, C., Charles, A. and Wellings, D. (2018) Shared Responsibility for Health: The Cultural Change We Need. United Kingdom	To outline what needs to be done to bridge the relationship gap between patients and staff and the NHS and the public, to enable personalised care.	Detailed evidence-based report by experienced recognised health policy experts, examining a wide range of literature which is used to craft proposals for specific responses to the problems it outlines.	The relationship between public and NHS, and between patients and staff, has for too long been neglected. The Wanless report (2002) advocated full engagement and this has not been achieved. There is real distance between the rhetoric of personalized-care and the experience of users, and people being supported to make healthy choices has not been fulfilled. Concerns are rising about consequences for population health. The paper sets out what needs to be done to bridge the gap proposing a move away from innovative projects to transformation system-wide, building on previous work by The King's Fund on shared decision-making.	Detailed evidence-based report emphasizing the absolute urgency in responding to the changing disease burden in western societies. Major reductions in premature deaths from heart disease, stroke and cancers have been achieved. However, increasing numbers of people are living with at least one long-term condition and requires a different response from health services.
Hamric, A., Hanson, C., Tracy, M. & O'Grady, E. (eds). (2014) Advanced Nursing Practice: An Integrative Approach United States of America	To address major advanced nursing practice themes providing an authoritative and comprehensive resource.	An edited text book prepared by senior advanced nursing practice academics	This book addresses major advanced nursing practice competencies, roles, and issues. It provides a clear, comprehensive, and current introduction to advanced nursing practice. It applies core competencies to advanced practice roles, and provides comprehensive coverage of current issues, including the value of integrated four pillar activity, consistent with advanced nursing practice literature in both UK and North America. Providing leadership to an integrated clinical team was a significant part of the non-clinical role.	An authoritative reference source for advanced nurse practitioners across the globe, emphasizing Advanced Nursing within Advanced Nurse practitioner roles.

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Higgins, A., et al (2014) Factors Influencing Advanced Practitioners' Ability to Enact Leadership: A Case Study within Irish Healthcare Ireland.	To report factors influencing clinical specialists' and advanced nurse practitioners' ability to enact their clinical and professional leadership roles, including findings from the SCAPE study	Data were collected using interview, observation and documentary analysis within a case study design. Participants were 23 clinical specialist/ advanced practitioners and multidisciplinary team members working with them, in services in Ireland.	Specialist/advanced practitioner's ability to perform leadership roles are influenced by four factors: 1) presence of a framework for the professional role development; 2) opportunity to act as leaders; 3) support for sustaining leadership; and 4) practitioners' personal attributes. Nursing/midwifery leaders and managers at all levels throughout organisations have a key role in supporting and encouraging leadership potential.	A highly relevant study emphasising the importance of leadership but that this must be both supported and encouraged
Johns, C. (1994) A Philosophical Basis for Nursing Practice. In The Burford NDU Model Caring in Practice. United Kingdom	To describe how the Burford Nursing Development Unit model was developed from the hospital's philosophy for practice.	Edited book with expert contributions from senior nurses in the filed	This is a philosophical, grounded and practical account of an inspirational patient centered model of nursing practice. Divided into two part theoretical and practical it is an effective guide for action, theory into practice.	Provides a philosophical and practical account of a seminal example of patient centered practice.
Kucera, K. et al (2010) Advanced Nursing Practice: A Futures Model Derived from Narrative Analysis of Nurses' Stories. Australia	To uncover meanings and experiences within personal stories provided by nurses. To develop a model of advanced nursing practice.	Narrative analysis of 59 nurse stories (Selected from 142, reduced to 91 and to final 59). Narrative analysis examines the story and analyses how it is put together, including the linguistic and cultural resources it draws on. The focus is not on the content but asks why the story was told that way?	It highlights what is described as the invisible but central place of the nurse in patient care. Insight into existing activities of participants is identified, with six themes emerging and a further three seen as particularly relevant to Advanced Practice. Distinction is made between ordinary Nursing and Advanced Nursing.	While this paper is not focused on the British context, findings are relevant in revealing the nature and quality of effective Advanced Nursing Practice. It emphasizes the importance of Advanced Nursing being visible role modelled so it can be adopted and so demonstrate the assertive, autonomous, accountable practice that the UKCC desired to promote in 1992.

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Jokiniemi, K et al (2012) Advanced Nursing Roles: A Systematic Review. Finland	To analyze and synthesize literature on one advanced nursing practice role in three countries. To describe and compare roles, and assess if international consensus was possible concerning advanced nursing practice definition.	A comprehensive systematic literature review of advanced nursing practice, results were analyzed and combined using qualitative content analysis method.	The research process led to a synthesized representation of one specialized advanced nursing practice role. It was clear the further work was required to define further the concept of advanced nursing practice, as well as its implementation among other cultures beyond the review. It appears that an international consensus regarding the definition of advanced nursing practice is possible.	Interesting outcomes demonstrated of positive impacts for patients, colleagues, clinical practice, and the organization. Similarly improved quality in care and health services, raising the profile of advanced nursing practice.
Leary, A. (2012) Advanced Nurse Practice is much more than simply Role Substitution United Kingdom	To refute the premise of a prior article celebrating doctor substitution roles for nurses.	Opinion article written by a national nursing figure in advanced practice refuting the argument for doctor substitution roles	Advanced nursing practice has the potential for providing much more than role substitution for doctors. Its virtues go beyond economic value in terms of reducing labour costs and being able to undertake technical skills. Their experience, range of skills and clinical understanding, separates them from junior doctors at many levels	Emphasises the attribute of clinical judgement used in the selection of 'tools' from a notional 'toolbag'- clinical and other skills- used to benefit patients' holistic, not just disease-centric needs
Lintern, S. (2012) Exclusive: 'disaster' warning follows 12% drop in nurse training places Nursing Times United Kingdom	To present evidence of a notable fall in nurse training places and its significance for future nursing shortages.	Nursing journal news report presented by experience health journalist.	Considerable reduction of commissioned nurse training places will have considerable impact on number of nurses working, ten years hence.	The report appears to have accurately predicted the outcome of reduced training numbers on the numbers of nurses working in the NHS.

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Mantzoukas & Watkinson (2006) Review of advanced nursing practice: the international literature and developing the generic features United Kingdom	To review advanced nursing practice literature and provide clarifications of the concept of advanced nurse practitioner and its generic features.	An informative and narrative systematic literature review was undertaken. The mass of retrieved material was carefully screened and methods of data saturation were used. Material was thoroughly read and indexed. Seven thematic units that formed the generic features of the ANP were formed.	Seven generic features emerged from the review: 1) use of knowledge applied to practice; 2) analytical and critical thinking skills; 3) clinical judgement and decision-making abilities; 4) professional leadership and clinical inquiry, 5) coaching and mentoring skills; 6) research skills, and 7) innovation and changing practice.	A very practical set of outcomes from this review, indicating the importance of the attainment of practice and professional autonomy for Advanced Nurse Practitioners roles to enable provision of improved practice.
McCrae (2012) Whither Nursing Models? The value of nursing theory in the context of evidence-based practice and multidisciplinary health care. United Kingdom	To discuss the role of nursing models and theory in current clinical practice	Literature on nursing models and theory since the 1950s, examined from health and social care databases to inform discussion of relevance of theory for practice.	Arguments against nursing theory are challenged. In the context of multidisciplinary, and the dominance of evidence-based practice, the implications for the art and science of nursing as a unique theoretical position is highly relevant. It should reflect the varied, practical practice of nursing. Educators and practitioners should embrace theory-based as well as evidence-based practice.	A challenging paper raises the importance of theoretical basis for nursing practice
Melling, S. Hewitt-Taylor, J. (2003) New flexible healthcare roles and the purpose of nursing.	To present the risks to the uniqueness of nursing as holistic practice, posed by policy emphasis on multi-professional working and blurring of professional boundaries	Discussion paper written by experience advanced nursing practice academics	Health policy is geared to health professionals working across professional boundaries there are significant risks as well as benefits to doing this. The main risk for nursing is that its unique contribution towards holistic care may be lost. Nurses themselves need to be clearer about their role, scope and professional priorities and speak up for what are sometimes unquantifiable humanistic dimensions of care.	Raises serious concerns about the risk to holistic practice if nurses too readily embrace blurring of boundaries and fail to stand up for nursing.

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Manley, K. (1997) A Conceptual Framework for Advanced Practice: An Action Research Project Operationalizing an Advanced Practitioner/ Consultant Nurse Role United Kingdom	To present an initial conceptual framework for an advanced practice/consultant nurse role which links the role to its context and outcomes.	3-year action research study involving the operationalization of an advanced practice/ consultant nurse role in a Nursing Development Unit A conceptual framework was developed from the process of data analysis.	Attributes of the advanced practitioner/ consultant nurse are revealed as having a consultancy knowledge and skills base. This is supported by an established nursing foundation, together with strong leadership, educator and researcher activities functions. Alongside this, the ability to facilitate a transformational culture was seen as key to activities and skills used in the role. Consideration was given to preparation and accreditation of the advanced practitioner/ consultant nurse.	A significant piece of work drawing out not just attributes, but also a substantial theoretical context for this role. The relevance of the context of the study is also noted as a Nursing Development Unit along with it values and aims of patient centered care.
Manley, K. et al (2008) Leadership role of Consultant Nurses working with Older People: a co-operative inquiry United Kingdom	To explore how the leadership component of the Consultant Nurse for Older People role was reflected in day-to-day working.	A 6-month co-operative inquiry approach was used. A type of Action Research, participants are co-subjects and co-researchers enabling insights to be gained into the leadership strategies of Consultant Nurses working in Older People nursing	The outcome of the study is a framework that describes the triggers and enabling factors that precede the use of leadership strategies at the clinical and organizational level and associated outcomes. In defining how leadership is reflected by Consultant Nurses for Older People, a complex picture emerges that is multifaceted and multidimensional. It is an under-researched area. However, they are central to ensuring the quality agenda within their organizations and are well positioned to provide leadership at both strategic and clinical levels and providing influence on operational development. Support is needed to make visible the valuable contribution Consultant Nurses make to enabling healthcare teams, organizations and work places.	A valuable study highlighting the potential and actual significance of consultant nurses in providing clinical leadership to nurses and the wider services they sit in. More research is needed to uncover the specifics of their potential.

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Mitchell, T. et al (2010) The consultant nurse — expert practitioner and much more. United Kingdom	To reveal the complexity and diversity of consultant nurse roles found in an NHS trust. To describe dimensions of practice which is extraordinary. To identify perceived differences between consultant nurse and other advanced practice roles	Accounts were written by six consultant nurses and these were then submitted for concept mapping to enable identification of extraordinary practice.	Concept mapping revealed four themes: entrepreneurial activity and innovation; clinical autonomy and role dynamism; influential national and international research conduct; consultancy and education across discipline boundaries. Comparisons with other advanced practice roles are drawn from the literature and data collected in this study. Underpinning these were descriptions of higher-level skills not normally found even in 'expert' or 'advanced' practice. Because of the uniqueness of the role, there are implications for sustainability.	Useful insights provided into the span of activity of consultant nurses and their potential and actual impact.
Nancarrow, S. and Borthwick, A. (2005) Dynamic Professional Boundaries in the Healthcare workforce United Kingdom	To describe four directions in which the existing workforce can change in response to multiple changes in the health sector and considers the implications of these changes for the workforce	Analytical discussion paper written by healthcare sociology academics	Healthcare provision has been defined by changing societal expectations and beliefs, new ways of perceiving health and illness, the introduction of technology, and recognition of healthcare providers through their education and regulation. The paper provides analysis of the evolution of the health care workforce as a whole rather than individual professions. It describes four ways that existing workforce can develop: diversification; specialisation and vertical and horizontal substitution, and discusses the implications of these changes.	Useful sociological observations of professions' reactions to each other amidst new pressures, challenging workforce boundaries, including unmet demand for some healthcare services. Useful perspectives on influence of neo-liberal management perspectives and increase of consumer preferences.

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Newhouse, R. et al (2011) Advanced Practice Nurse Outcomes 1900-2008: A Systematic Review. Unites States of America	To determine, when compared to other providers, including physicians or teams without advanced nurse practitioners, are advanced nurse practitioner patient outcomes of care similar?	Systematic review of published literature between 1990 and 2008 assessing all types of American advanced nurse practitioners, using intentionally broad outcomes, patient populations, and settings.	The review on care provided by American advanced nurse practitioners indicates patient outcomes of care, in collaboration with physicians, are similar to and in some ways better than care provided by physicians alone for the populations and settings chosen. In acute care settings length of stay and cost of care for hospitalized patients can be reduced. These findings develop what is known about outcomes from previous studies indicate advanced nurse practitioners provide high-quality effective care, and have a significant role in improving quality of patient care in the United States, and could help to support reform efforts aimed at expanding access to care.	While not a UK study these findings support the notion that advanced nurse practitioners bring something significant to the patient experience when working collaboratively with medical staff.
Payne, R. Steakley, B. (2015) Establishing a primary nursing model of care. United States of America	To report on work in one clinical centre to assess models of nursing being used to then recommend a consistent model of care to be utilized in all areas	Report of critical work undertaken by senior clinical and academic staff and its findings including illustrative case studies	Primary nursing was identified as the recommended evidence-based practice model. Its two main features were relationship building and rapport. Successful relationship building required repetitive positive interaction between the nurse and patient. This dynamic relationship led to establishing rapport. This was hindered by the actions of nurse managers, who though seeking to provide an appropriate environment for patients, often for operational reasons made decisions that effectively undermined these two principles. Nonetheless there's an opportunity for nurse managers to embrace primary nursing to support effective patient-centered philosophies and practice.	An effective paper that highlights the relevance of primary nursing and also reveals the same issues facing nurse managers and how their decision often hinder nurses in delivering patient centered care in the United Kingdom

Author, Year, Title & Country of publication	Aims	Design & methods	Findings/outcomes	Comments
Por, J. (2008) A Critical Engagement with the Concept of Advancing Nursing Practice United Kingdom.	To reveal the concept of advancing nursing practice through critical engagement with policy development in in the UK and with continuing debates found in international literature	Critically evaluative analysis of published papers and policy documents referring to the advancing nursing practice concept.	Understanding at the point of publishing this work revealed a lack of clarity about the role of advanced nurse practitioner and the nature of advanced practice. However, defining the activities practitioners engaged in, the skills and competencies involved and the qualities and attributes required helped reduce role ambiguities. Measuring the impact and outcome of what were complex advanced practice nursing roles was difficult.	An informative paper raises a variety of theoretical and philosophical issues pertinent to the development of advanced practice. Also, the notion of not just advanced but also advancing practice which was of particular interest in this study.
Roberts-Davis, M. et al (1998) Realizing specialist and advanced nursing practice: a typology of innovative nursing roles. United Kingdom.	To outline the findings of the first phase of a Department of Health funded project: 'Realizing Specialist and Advanced Nursing Practice establishing the parameters of and identifying competencies for 'Nurse Practitioner' roles and evaluating programmes of preparation.	An extensive literature review and interviews with 49 key informants was used to revise a typology of Domains of Innovative Nursing Roles which the authors, experienced academics in the field, had constructed.	A large number of participants believed the role of the nurse practitioner to be an amalgam of specialist and advanced practice. Although current preparation for 'specialist' roles would meet a number of the outcomes recognised as necessary to prepare individuals, more was required for nurse practitioners. The typology proposed was seen as helpful in identifying the major emphasis of nurse practitioner roles.	An informative early research paper uncovering the perceptions about new roles and where advanced practice was position in relation to other clinical roles.
Rolfe, G. (2014a) Understanding Advanced Nursing Practice United Kingdom	To trace the history of advanced nursing practice and present two distinct models and how they came about	Part 1 of an analytical discussion paper by an experienced advanced nursing practice academic and theorist.	While other papers present advanced practice as an extension into medical practice in response to healthcare resource pressures, this paper presents the historical evidence and theoretical justification for an alternative model	A very informative alternative analysis of advanced nursing practice development that prioritizes patients and patient centric care

Author, Year, Title & Country of publication	Aims	Design & methods	Findings/outcomes	Comments
Rolfe, G. (2014b) A New Vision for Advanced Nursing Practice United Kingdom	To propose an alternative advanced nursing practice model from one based on a role to one of a team of like-minded professional individuals working collaboratively in patient focused practice innovation units.	Part 2 of an analytical discussion paper by an experienced advanced nursing practice academic and theorist.	A thorough review of contrasting models of advanced practice, contrasted as 'authorized' and generally accepted, and 'alternative', the proposed new model focusing on the process of nursing rather than roles of nurses. It proposes the working on the development of teams of similarly minded professionals delivering patient-centered care. A key focus is on the development of the person of the nurse not the development of skills primarily to enable therapeutic relationships.	An innovative approach to advanced nursing practice is explained in some detail and contrasted with what may be regarded as the mainstream view, medical substitution and skills focused roles
Silver H, Ford L, and Stearly, S. (1967) A program to increase health care for children: the pediatric nurse practitioner programme USA	To describe an education and training programme for senior nurses (pediatric nurse practitioner programme) to prepare them to take on an expanded role in providing health care for children in areas with limited facilities.	An academic paper written by senior medical and nursing staff involved in the preparation and delivery of an academic programme for potential nurse practitioners.	This paper describes an innovative educational and training programme in children's care, preparing senior nurses for expanded roles in child healthcare in communities with limited health care. The rise in population in the United States has increased faster than introduction of medical and nursing staff ready to provide services at an appropriate level. This particularly affects lower socioeconomic groups in both rural and urban communities.	An informative paper composing seminal work in the development of nurse practitioner roles in the United States of America
Stillwell, B., et al (1987) A Nurse Practitioner in General Practice: Working Style and Pattern of Consultations United Kingdom	To present the findings of a six-month project reporting outcomes of the work of a specially prepared nurse practitioner in inner city general practitioner service.	Project report prepared by University Medical Academics /General Practitioners	Patients had open access to the nurse practitioner, with up to 20 minutes long appointment slots. 858 patients of all ages and ethnic origins were seen. Morbidity from every diagnostic group was presented but most problems were in preventive medicine; health education; social and family problems; administrative procedures. More than one-third of all consultations were managed without further referral for investigation, prescription or other medical advice. It was concluded that nurses have potential for a much larger autonomous role in GP services.	Seminal study indicating potential for increased autonomous role for nurses in general practice setting with additional education and training.

Author, Year, Title & Country of publication	Aims	Design & methods	Findings/outcomes	Comments
Sutton, F. & Smith, C. (1995) Advanced Nursing Practice: New Ideas and New Perspectives Australia	To assert the position that advanced nursing practice differs substantially from other forms of nursing practice, and to begin theorization about the different ways in which advanced nurse practitioners think, see and experience nursing practice.	Analytical discussion paper written by two experience advanced practice academics	Presentation of differences between advanced and other nursing roles plus the assertion that differences lay in the way that advanced nurse practitioners think about, see and experience clinical practice. The influence of North American nurses has not been entirely helpful leading to over emphasis on the nature, role and function of specialist and expert nursing practice to the detriment of developing understanding about the nature of advanced nursing practice in Australian nursing. Tentative theorizations about how advanced nurse practitioners think, see and experience nursing practice are presented.	A detailed explanation of the central value of nursing for patients. Useful critique of Benner's work included
Swann, G. et al. (2013) An autonomous role in emergency departments. United Kingdom	To provide an overview of the development and benefits of the Advanced Clinical Practitioner role, outlining the phases of a programme leading to achievement of senior clinician status in the Emergency Department.	An innovation report written by the senior medical and nursing clinical team responsible for its design and implementation	Referencing national health policy, this paper presents work undertaken in the emergency departments in a major named trust to create an advanced clinical practitioner role. The purpose was to enable patients to be seen in a timely manner in the context of rising demand for emergency services. A clear description of advanced clinical practitioners as non-medical clinicians is provided. Their training programme aimed for them ultimately to work autonomously at the medical middle-grade level managing patients with all types of clinical presentations in the emergency department (ED)	An example of an innovative role that makes a useful contribution to increasing workload in one center, reportedly generating wide ranging interest from similar services.

Author, Year, Title & Country of publication	Aims	Design & methods	Findings/outcomes	Comments
Wainwright, P. (1994) Professionalism and the Concept of Role Extension'. in Expanding the Role of the Nurse: The Scope of Professional Practice United Kingdom	To consider aspects of the development of nursing as a profession claiming independence, including discussion of role extension, expansion and scope.	Chapter focusing on critical discussion and appraisal of professionalism and role extension.	Historical perspectives of the origins of nursing and its subservient relationship with medicine, and its internal relationship with itself, give way to a discussion of new perspectives that seek to challenge: dependence on medicine, hierarchical structures, central decision making, functional approaches to care delivery and denial of nurse-patient relationships.	Excellent critique of historical development of nursing practice and movement from dependent to independent professional practice. Urgent questions regarding autonomy and authority are ably tackled.
Walsh, M. & Crumbie, A. (2003) Nurse Practitioner Education: What Level? United Kingdom	To present arguments for degree level preparation for nurse practitioner roles but masters' degree level for advanced practice roles.	Discussion paper by experienced advanced practice academics.	The authors argue that when the definitions of nursing bodies concerned with advanced practice roles in the United Kingdom the United States of America are compared with the UK Quality Assurance Agency Standards for Higher Education, then honours degree level courses are sufficient for initial role preparation for the role in the United Kingdom. Master's level courses are beyond what is required with the risk of excluding suitable nurses from these roles. However, where advanced roles include research, leadership and the management of clinically complex patients, a master's level qualification is appropriate. Moreover, educational standards need to be set on a country-by-country basis to comply with the desired clinical outcomes for roles there.	A cogently argued paper justifying its position for the time in which it was written. Their justification for why masters' level course remains relevant and appropriate at this time.

Author, Year, Title & Country of publication	Aims	Design & methods	Findings/outcomes	Comments
Williamson, Twelvetree, Thompson & Beaver (2012) United Kingdom	To examine the role of ward-based Advanced Nurse Practitioners and their impact on patient care and nursing practice.	An ethnographic approach using participant observation and interviews of five ward-based Advanced Nurse Practitioners working in a large teaching hospital in the North-West of England.	The main concept revealed by analysis was that the Advanced Nurse Practitioners were pivotal, using extensive expertise, connections and personal knowledge to enable patient care/journeys, facilitating both nursing and medical practice. They were excellent communicators and role models, pioneering the ANP role.	A small-scale study, but revealed a key collaborative role, working between Nursing and Medicine, enabling and facilitating the team and strongly impacting the patient experience
Wilson and Bunnell (2007) A review of the merits of the nurse practitioner role United Kingdom	To examine key issues concerning the emergence of advanced nurse practitioner roles and their impact on the nursing and medical professions	A literature review and discussion paper written by a nursing student supervised a nurse academic	This paper presents evidence both supporting and opposing advanced nursing practice and reveals many different manifestations of a role applied differently according to local circumstances. The advent of independent prescribing for nurses was a particular focus as was identifying perceived threats to the medical profession from the role. More research is called for to provide definitive evidence for the merits or otherwise of this role.	Draws useful attention to the wide variety of advanced practice manifestations and how this makes regulation more difficult to achieve. Points to the limitations of the evidence base for advanced nursing practice in the United Kingdom and calls for more.
Wong & Cummings (2007) The Relationship between Nursing Leadership and Patient Outcomes: A Systematic Review	To describe the findings of a systematic review of studies examining the relationship between patient outcomes and nursing leadership.	Systematic review of published English-only research articles examining patient outcomes and nursing leadership appropriately selected. Data extraction and methodological quality assessment were completed for seven final quantitative research articles.	Results revealed significant relationships between positive leadership practices and styles, and improved patient satisfaction along with reduced adverse events. The findings suggest an emphasis on using transformational nursing leadership is an important organizational strategy to improve patient outcomes.	Reveals the importance of effective leadership on the quality of patient experience. Promotes Transformational leadership style as a useful and appropriate c.

Appendix 4: Consent form Individual Interviews

Participant Consent form: Individual Interview

Study title: Advanced or advancing practice: the future direction for nursing?

7. I confirm that I have understood the above study (as explained by the researcher and the written information provided) and have had the opportunity to ask questions. ☐

8. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason. ☐

9. I agree to take part in the above study. ☐

10. I agree to my individual contributions being audio recorded. ☐

11. I agree to the use of anonymised quotes in publications. ☐

12. I agree to maintain confidentiality regarding the names of participants in this research and details of conversations that I participate in during my involvement in this research ☐

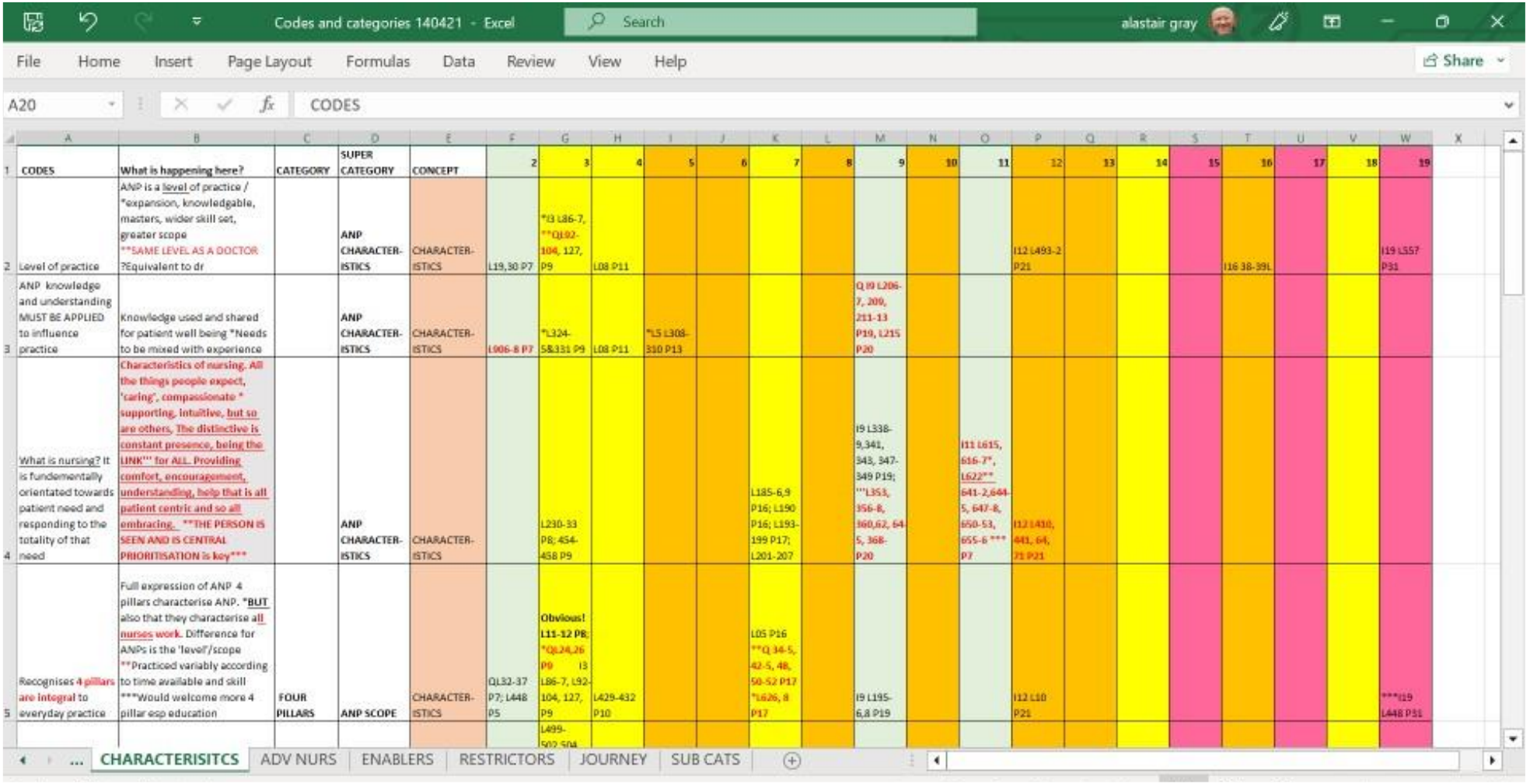
Name of Participant	Date	Signature
Alastair Gray Researcher	Date	Signature

Participant Number…….. (to be added by researcher as per Focus Group participant number)

Alastair Gray
Research Student No. 6075073
PhD Nursing and Health Studies (HLSR009)
graya14@uni.coventry.ac.uk 07773027950

Appendix 5: Spreadsheet extracts illustrating various stages of reducing data collected for Concepts 1-4

Appendix 5a Concept 1- Advanced Nursing

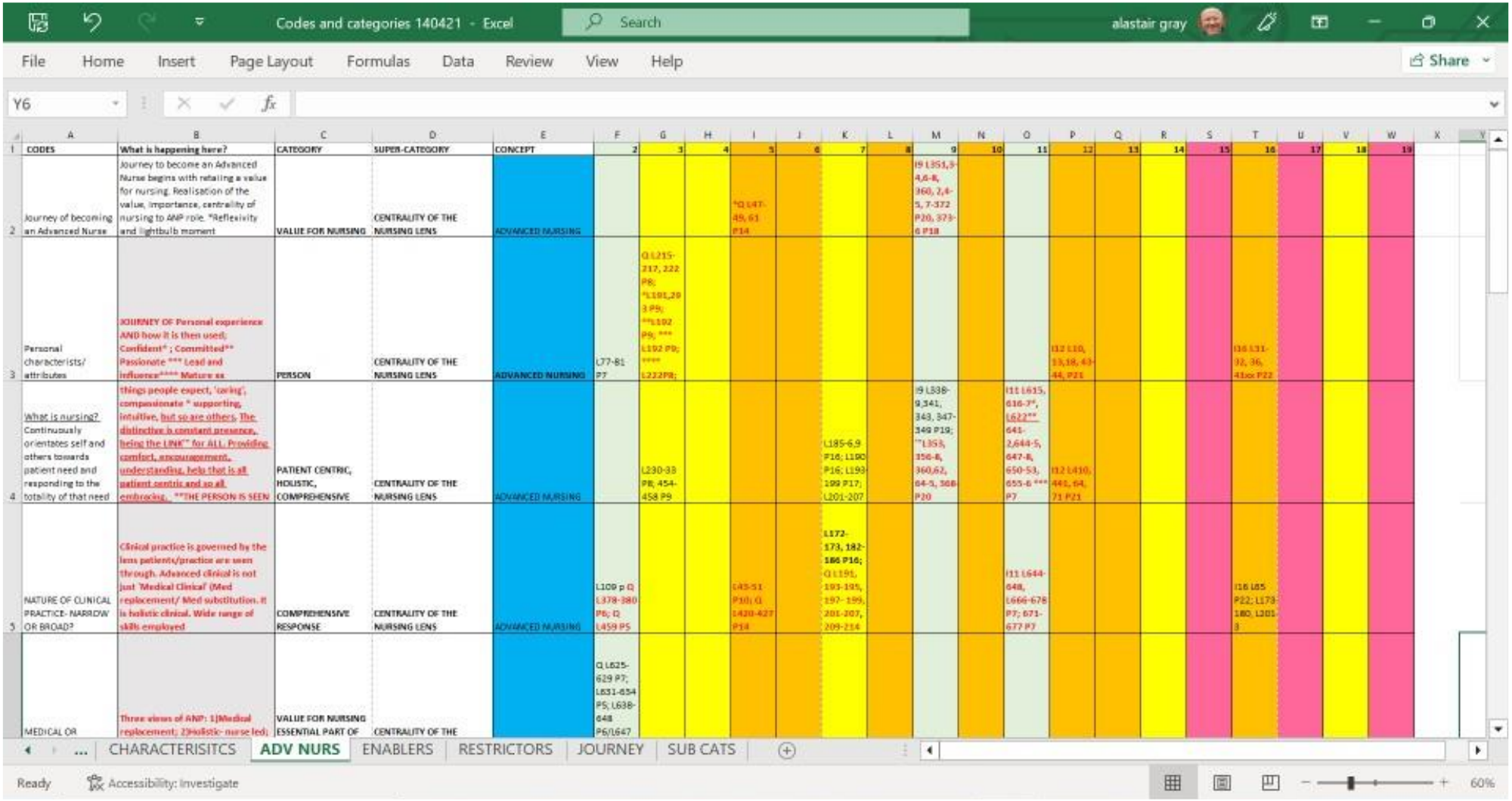


Codes and categories 140421 - Excel

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X
1	CODES	What is happening here?	CATEGORY	SUPER CATEGORY	CONCEPT	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	
2	Level of practice	ANP is a level of practice / *expansion, knowledgable, masters, wider skill set, greater scope **SAME LEVEL AS A DOCTOR ?Equivalent to dr		ANP CHARACTER-ISTICS	CHARACTER-ISTICS	L19,30 P7	*I3 L86-7, **QL92-104, 127, P9	L08 P11								I12 L493-2 P21				I16 38-39L			I19 L557 P31	
3	ANP knowledge and understanding MUST BE APPLIED to influence practice	Knowledge used and shared for patient well being *Needs to be mixed with experience		ANP CHARACTER-ISTICS	CHARACTER-ISTICS	L906-8 P7	*L324-5&331 P9	L08 P11	*L5 L308-310 P13				Q I9 L206-7, 209, 211-13 P19, L215 P20											
4	What is nursing? It is fundementally orientated towards patient need and responding to the totality of that need	Characteristics of nursing. All the things people expect, 'caring', compassionate * supporting, intuitive, but so are others. The distinctive is constant presence, being the LINK''' for ALL. Providing comfort, encouragement, understanding, help that is all patient centric and so all embracing. **THE PERSON IS SEEN AND IS CENTRAL PRIORITISATION is key***		ANP CHARACTER-ISTICS	CHARACTER-ISTICS		L230-33 P8; 454-458 P9				L185-6,9 P16; L190 P16; L193-199 P17; L201-207		I9 L338-9,341, 343, 347-349 P19; '''L353, 356-8, 360,62, 64-5, 368- P20		I11 L615, 616-7*, L622** 641-2,644-5, 647-8, 650-53, 655-6 *** P7		I12 L410, 441, 64, 71 P21							
5	Recognises 4 pillars are integral to everyday practice	Full expression of ANP 4 pillars characterise ANP. *BUT also that they characterise all nurses work. Difference for ANPs is the 'level'/scope **Practiced variably according to time available and skill ***Would welcome more 4 pillar esp education	FOUR PILLARS	ANP SCOPE	CHARACTER-ISTICS	QL32-37 P7; L448 P5	Obvious! L11-12 P8; *QL24,26 P9 I3 L86-7, L92-104, 127, P9 L499-502 S04	L429-432 P10			L05 P16 **Q 34-5, 42-5, 48, 50-52 P17 *L626, 8 P17		I9 L195-6,8 P19			I12 L10 P21						***I19 L448 P31	

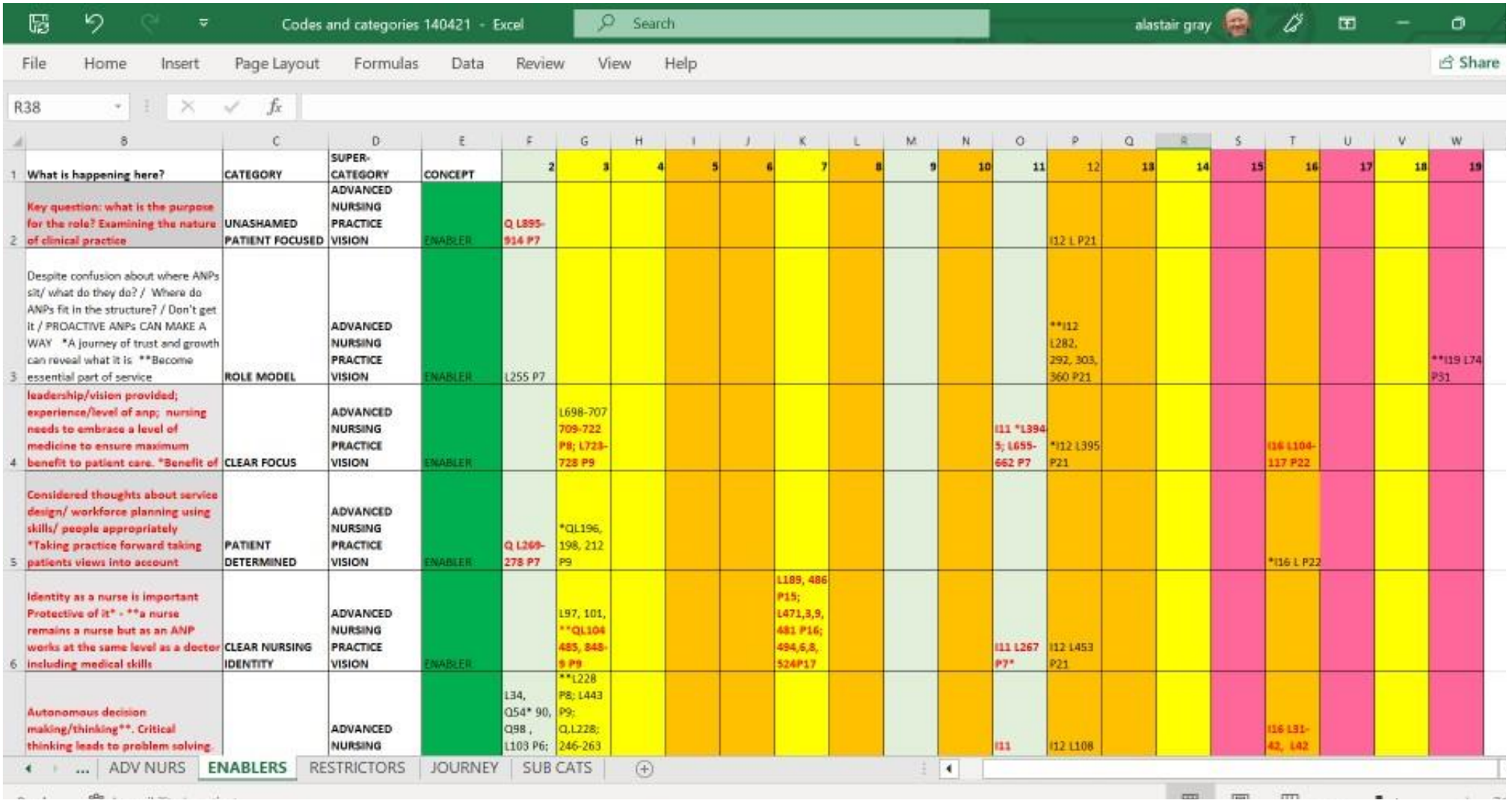
CHARACTERISITCS | ADV NURS | ENABLERS | RESTRICTORS | JOURNEY | SUB CATS

Appendix 5b Concept 2- Advanced Nursing



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y
1	CODES	What is happening here?	CATEGORY	SUPER-CATEGORY	CONCEPT	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19		
2	Journey of becoming an Advanced Nurse	Journey to become an Advanced Nurse begins with retaling a value for nursing. Realisation of the value, importance, centrality of nursing to ANP role. *Reflexivity and lightbulb moment	VALUE FOR NURSING	CENTRALITY OF THE NURSING LENS	ADVANCED NURSING				I5 L47-49, 61 P14				I9 L351,3-4,6-8, 360, 2,4-5, 7-372 P20, 373-6 P18												
3	Personal characterists/ attributes	JOURNEY OF Personal experience AND how it is then used; Confident* ; Committed** Passionate *** Lead and influence**** Mature as	PERSON	CENTRALITY OF THE NURSING LENS	ADVANCED NURSING	L77-81 P7	Q L215-217, 222 P8; *L191,203 P9; **L192 P9; *** L192 P9; **** L222P8;									I12 L10, 13,18, 43-44, P21				I16 L31-32, 36, 41ox P22					
4	What is nursing? Continuously orientates self and others towards patient need and responding to the totality of that need	things people expect, 'caring', compassionate * supporting, intuitive, but so are others, The distinctive is constant presence, being the LINK** for ALL. Providing comfort, encouragement, understanding, help that is all patient centric and so all embracing. **THE PERSON IS SEEN	PATIENT CENTRIC, HOLISTIC, COMPREHENSIVE	CENTRALITY OF THE NURSING LENS	ADVANCED NURSING		L230-38 P8; 454-458 P9				L185-6,9 P16; L190 P16; L193-199 P17; L201-207			I9 L338-9,341, 343, 347-349 P19; **L353, 356-8, 360,62, 64-5, 368 P20		I11 L615, 616-7*, L622** 641-2,644-5, 647-8, 650-53, 655-6 *** P7	I12 L410, 441, 64, 71 P21								
5	NATURE OF CLINICAL PRACTICE- NARROW OR BROAD?	Clinical practice is governed by the lens patients/practice are seen through. Advanced clinical is not just 'Medical Clinical' (Med replacement/ Med substitution. It is holistic clinical. Wide range of skills employed	COMPREHENSIVE RESPONSE	CENTRALITY OF THE NURSING LENS	ADVANCED NURSING	L109 p Q L378-380 P6; Q L459 P5			I45-51 P10; Q L420-427 P14		L172-173, 182-186 P16; Q L191, 193-195, 197-199, 201-207, 209-214				I11 L644-648, L666-678 P7; 671-677 P7					I16 L85 P22; L173-180, L201-3				
	MEDICAL OR	Three views of ANP: 1)Medical replacement; 2)Holistic- nurse led;	VALUE FOR NURSING ESSENTIAL PART OF	CENTRALITY OF THE		Q L625-629 P7; L631-654 P5; L638-648 P6/L647																			

Appendix 5c Concept 3- Enablers

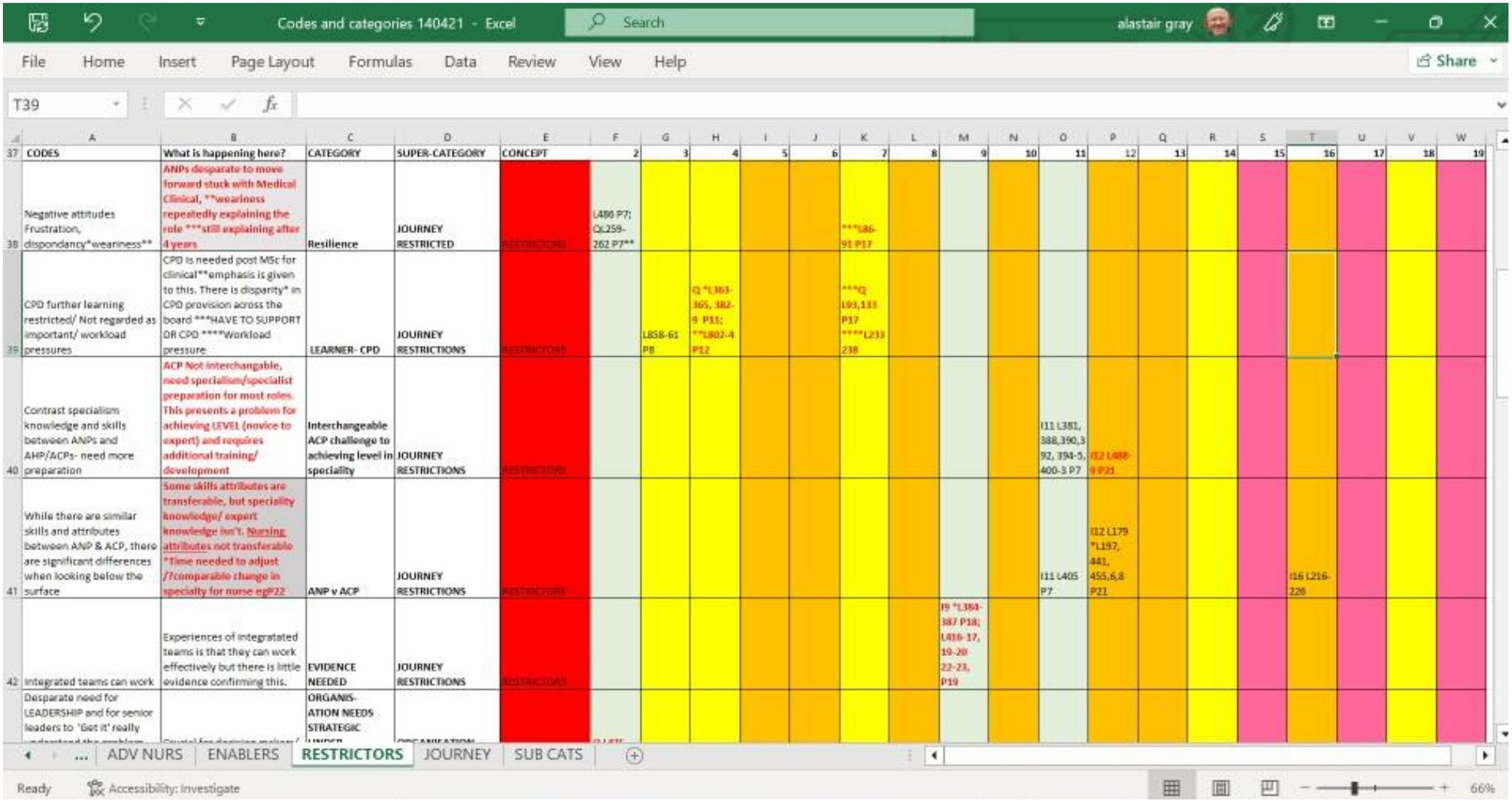


Codes and categories 140421 - Excel

	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
1	What is happening here?	CATEGORY	SUPER-CATEGORY	CONCEPT	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
2	Key question: what is the purpose for the role? Examining the nature of clinical practice	UNASHAMED PATIENT FOCUSED	ADVANCED NURSING PRACTICE VISION	ENABLER	Q L895-914 P7										I12 L P21							
3	Despite confusion about where ANPs sit/ what do they do? / Where do ANPs fit in the structure? / Don't get it / PROACTIVE ANPs CAN MAKE A WAY *A journey of trust and growth can reveal what it is **Become essential part of service	ROLE MODEL	ADVANCED NURSING PRACTICE VISION	ENABLER	L255 P7										**I12 L282, 292, 303, 360 P21							**I19 L74 P31
4	leadership/vision provided; experience/level of anp; nursing needs to embrace a level of medicine to ensure maximum benefit to patient care. *Benefit of	CLEAR FOCUS	ADVANCED NURSING PRACTICE VISION	ENABLER		L698-707 709-722 P8; L723-728 P9								I11 *L394-5; L655-662 P7	*I12 L395 P21				I16 L104-117 P22			
5	Considered thoughts about service design/ workforce planning using skills/ people appropriately *Taking practice forward taking patients views into account	PATIENT DETERMINED	ADVANCED NURSING PRACTICE VISION	ENABLER	Q L269-278 P7	*QL196, 198, 212 P9													*I16 L P22			
6	Identity as a nurse is important Protective of it* - **a nurse remains a nurse but as an ANP works at the same level as a doctor including medical skills	CLEAR NURSING IDENTITY	ADVANCED NURSING PRACTICE VISION	ENABLER		L97, 101, **QL104 485, 848-9 P9				L189, 486 P15; L471,3,9, 481 P16; 494,6,8, 524P17				I11 L267 P7*	I12 L453 P21							
	Autonomous decision making/thinking**. Critical thinking leads to problem solving.		ADVANCED NURSING		L34, Q54* 90, Q98 , L103 P6;	**L228 P8; L443 P9; Q.L228; 246-263								I11	I12 L108				I16 L31-42, L42			

ADV NURS | ENABLERS | RESTRICTORS | JOURNEY | SUB CATS

Appendix 5d Concept 4- Restrictors



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W
37	CODES	What is happening here?	CATEGORY	SUPER-CATEGORY	CONCEPT	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
38	Negative attitudes Frustration, dispondancy*weariness**	ANPs desparate to move forward stuck with Medical Clinical, **weariness repeatedly explaining the role ***still explaining after 4 years	Resilience	JOURNEY RESTRICTED	RESTRICTORS	L486 P7; QL259-262 P7**					***L86-91 P17												
39	CPD further learning restricted/ Not regarded as important/ workload pressures	CPD is needed post MSc for clinical**emphasis is given to this. There is disparity* in CPD provision across the board ***HAVE TO SUPPORT DR CPD ****Workload pressure	LEARNER- CPD	JOURNEY RESTRICTIONS	RESTRICTORS		LBS8-61 P8	Q *L363-365, 382-9 P11; **L802-4 P12			***Q L93,133 P17 ****L233 238												
40	Contrast specialism knowledge and skills between ANPs and AHP/ACPs- need more preparation	ACP Not interchangable, need specialism/specialist preparation for most roles. This presents a problem for achieving LEVEL (novice to expert) and requires additional training/ development	Interchangeable ACP challenge to achieving level in speciality	JOURNEY RESTRICTIONS	RESTRICTORS										I11 L381, 388,390,392, 394-5, 400-3 P7	I12 L488-9 P21								
41	While there are similar skills and attributes between ANP & ACP, there are significant differences when looking below the surface	Some skills attributes are transferable, but speciality knowledge/ expert knowledge isn't. Nursing attributes not transferable *Time needed to adjust /?comparable change in specialty for nurse egP22	ANP v ACP	JOURNEY RESTRICTIONS	RESTRICTORS										I11 L405 P7	I12 L179 *L197, 441, 455,6,8 P21				I16 L216-226			
42	Integrated teams can work	Experiences of integrated teams is that they can work effectively but there is little evidence confirming this.	EVIDENCE NEEDED	JOURNEY RESTRICTIONS	RESTRICTORS								I9 *L384-387 P18; L416-17, 19-20 22-23, P19										
	Desparate need for LEADERSHIP and for senior leaders to 'Get it' really		ORGANIS-ATION NEEDS STRATEGIC																				