

IDENTITY CRISIS WITHIN THE ROLE OF THE EMERGENCY  
NURSE PRACTITIONER?  
AN EXPLORATION OF AUTONOMY AND IDENTITY.

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## ABSTRACT

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**Introduction:** Whilst the Emergency Nurse Practitioner (ENP) role is now well established within urgent care settings in the UK, it has evolved in an *ad hoc* manner with a range of titles and scope of practice.

**Aims:** The aims of this study were to:

- Explore the concept of professional identity within the role of the ENP.
- Identify what factors contribute (positively or negatively) to a sense of professional identity.
- Consider the implications for managers, organisations and educationalists of changing identities within emerging roles in health care.

**Methods:** A qualitative approach was adopted to explore in depth attitudes and perceptions of professional identity amongst a group of ENPs from two different settings; a nurse-led unit and a multi professional Emergency Department. A case study methodology was chosen, and data was collected using focus groups (n= 13 band 7 ENPs) and two semi-structured interviews (n=2 Senior Managers). The data was analysed using thematic analysis.

**Findings:** The study identified several key factors that influenced the ENPs' sense of professional identity. These fit broadly into three categories: career structure; education; the role. Participants reported high levels of pride and self-confidence related to the delivery of high quality care and their clinical expertise, and gained job satisfaction from the autonomous nature of the role. Participants also reported feelings of uncertainty, and were less confident in other areas such as relationships with other nurses, the public perception of the role, education and career structure.

**Discussion:** Participants in this study described moving away from their traditional nursing practice and expressed that they felt different to other nurses, although they were clear that they were not a doctor substitute. This thesis applies the concept of the 'third space' to the findings of the study, and suggests that ENPs have adopted a hybrid role that is operating within a 'third (or hybrid) space', where new identity is formed.

**Conclusion:** ENPs have a central role within the urgent care setting, and professional identity is an important facet of the role as it relates to autonomy and job satisfaction. This in turn impacts on organisational loyalty and retention. The creation of a standardised national framework for the development of the ACP is welcome. However, this initiative will require support from educationalists, employers and commissioners to develop all four pillars of advanced practice, thereby ensuring that the success of the role is fully maximised for both practitioner and employer.

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## Definitions and abbreviations

A&E	Accident and Emergency.
AHP	Allied Health Professional.
ANP	Advanced Nurse Practitioner; generally accepted to be a nurse practitioner who has developed a broader scope of practice.
ACP	Advanced Clinical Practitioner; a practitioner educated to masters level who has a broad scope of practice.
CPD	Continuing Professional Development.
CoP	Community of Practice.
CCG	Clinical Commissioning Groups; these commission services in the NHS.
DH	Department of Health.
ECP	Emergency Care Practitioner; usually a paramedic working within the ED or MIU over and above their normal scope of practice.
ENP	Emergency Nurse Practitioner: a nurse working over and above their normal scope of practice.
ESP	Extended Scope Physiotherapist: a physiotherapist working over and above their normal scope of practice.
ED	Emergency Department.
HCA	Health Care Assistant; unqualified nurse.
HCP	Health Care Professional.
HEE	Health Education England.
IPE	Interprofessional Education.
Majors	“Major end” of the ED, where more seriously ill and complex cases are seen and treated.
Minors	“Minor end” of ED, where patients who are usually mobile and not seriously ill are seen and treated.

MIU	Minor injury unit.
NMC	Nursing and Midwifery Council.
NHS	National Health Service.
RCEM	Royal College of Emergency Medicine.
RCEMACP	Royal College of Emergency Medicine Advanced Clinical Practitioner.
RCN	Royal College of Nursing.
RCT	Randomised Controlled Trial.
SHO	Senior House Officer; a junior doctor.
TA	Thematic Analysis.
UCC	Urgent Care Centre.
UK	United Kingdom.
UKCC	United Kingdom Central Council.
USA	United States of America.

## 1. Introduction to the thesis

This research aims to explore concepts and perceptions around issues of identity and autonomy within the role of the Emergency Nurse Practitioner (ENP). The ever changing landscape of healthcare has had a significant impact on the development of nursing roles both within the UK and internationally (Kennedy *et al.* 2011; Lloyd –Rees 2016), and as a consequence has seen the growth and transformation of existing professions and the introduction of new roles in health care (McClellan *et al.* 2006; Hoskins 2011). Whilst the role of the ENP is now well established within urgent care settings it has tended to evolve in an *ad hoc* manner responding to service demand. This has resulted in a role that has a wide ranging scope of practice with varying levels of job satisfaction.

## 1.1 Rationale for my study

My interest in this area of study is derived from a background of working in both Emergency Care and Higher Education. My professional background is that of a nurse working in the Emergency Department (ED), and being one of the first ENPs to deliver the service in my hospital in the early 1990s. The training I received was brief and had no academic accreditation attached to it. At that time nurse education was just moving into Higher Education (HE), but there was little academic provision for those of us that had trained before the move into a University based programme. I certainly learnt 'on the job', guided heavily by my medical colleagues. My career progressed and I moved into Higher Education and quickly became interested in developing a more formal programme of study for ENPs which has since grown and developed over the years.

During this time there has been further expansion of roles across other disciplines for example the emergence of the extended scope physiotherapist and more recently the development of the Advanced Clinical Practitioner within emergency care with a clearly defined competency based curriculum and whilst educationalists have attempted to keep a pace with the evolving workforce by developing a range of programmes to support role development, the debate around what constitutes to be advanced practice continues and will be discussed later in this and following chapters.

Over the years my enthusiasm for the ENP role has remained, and it is with interest and sometimes frustration that I have witnessed the pace of its evolution to support clinical need whilst not always acknowledging the development needs of the emerging workforce. Indeed, I have listened to ENP students recount recurring tales of mixed levels of support, discrepancies in pay, titles and working conditions, with each practitioner demonstrating differing levels of confidence and scope in their practice.

This varying practice is well documented (Brook & Crouch 2004; Fotheringham 2011), with a clear acknowledgement of varying levels of scope of practice, lack of standardisation of education and a range of titles. However, the current body of research does not specifically address issues of professional identity relating to the role, and if these differences in pay, education, role clarity and title have an impact on a clinician's level of autonomy and perceived professional identity as an ENP. Whilst much of the research suggests a lack of identity for these practitioners, there is little

research that has addressed this from the emic perspective of the ENPs themselves, and I therefore wish to contribute to the professional development of the profession by building on the research in this field. Additionally, as an educationalist with a special interest in advanced practice curriculum development, I seek to contribute to the development of a curricula that will support the development of the ENP role.

The following section will briefly explore the difference between medical and nurse education, and the impact this has had on the evolution of professional identity for this workforce. However it is arguable that the differences in nurse and medical education may play a significant role in the 'mini-doctor/maxi-nurse' debate (Castledine 1995; Mathieson 1996). As noted below, the differences in ideology may influence the developing role of the ENP which comes from a nursing background and yet is moving into a medically based role. There is a plethora of literature trying to establish the meaning of 'advanced' nursing practice (Woods 1999; McGee and Castledine 2003; Thompson and Watson 2003; Bonsall and Cheater 2008; Callaghan 2007; Swan *et al.* 2013; Sujan *et al.* 2017). Brook and Crouch (2004) ask the question at what point does an expanded nurse become a doctor? And further what is the impact of this convergence, and can there ever be true autonomy for these practitioners?

This research will go some way to addressing the above question by gaining an understanding of professional identity within the role of the ENP, and will ultimately have an impact on educationalists who are developing curricula to support the role, policy makers and those involved in workforce development.

## 1.2 Background and policy context

Demand for NHS services continues to increase year on year. In 2013 there were over 21 million attendances to Emergency Departments (ED), Minor Injury Units (MIU) and Urgent Care Centres (UCC) (NHS England 2013). By 2016 this figure had increased to 23.57 million attendances with an increase of 5.2% from 2015 (NHS England 2017). Of these attendances, 65% attended major EDs with the remaining attending MIUs and UCCs. Demand on primary care services also continues to increase with 340 million General Practitioner (GP) consultations taking place every year. Many of these present with increasing complexity, as people live longer with more challenging long



term conditions than ever before. The Urgent Care Review (NHS England 2013) highlights this ever increasing demand, reporting a 12% annual increase in the number of attendances at Walk-In Centres (WIC) over the last decade and the number of calls received by the ambulance service over the last decade increasing from 4.9 million to over 9 million. This demand, coupled with rising expectations and technological advances, points to an unsustainable urgent care service whereby demand will outstrip supply (NHS England 2013). The review argues for a twofold restructure in provision whereby most patients can access services 'closer to home' with the introduction of two levels of hospital based Emergency Centres. Fundamental to the review is the notion that patients will be seen by the most appropriate practitioner and that roles will need to be flexible in order to meet this demand.

The ever changing landscape of healthcare has had a significant impact on the development of expanding nursing roles both within the UK and internationally, and has seen the growth and transformation of existing professions and the introduction of new roles in health care (Hoskins 2011). Of the 1.3 million staff employed within the NHS, only approximately 130,000 (10%) are doctors (Imison *et al.* 2016) suggesting that a range of non-medical practitioners are delivering different models of care to patients across the NHS. One of the key roles that has emerged from this change in healthcare landscape is that of the Emergency Nurse Practitioner (ENP), a concept that was first introduced in the 1960s due to a shortage of doctors in North America. By the late 1980s ENPs were becoming established within UK Emergency Departments in an attempt to reduce excessive waiting times for patients presenting with minor injuries (Marsden *et al.* 2003). The implementation of the European Working Time Directive (EEC 2000) reduced the hours of the working week for junior doctors, and the introduction of "Modernising Medical Careers" in 2004 (DH 2004a) began a major reform in post-graduate medical training that further facilitated the development of ENPs across the health care spectrum, with an emphasis in Emergency Departments due to a recognised shortage of doctors (Carter and Chochinov 2007; Imison and Bohmer 2013). A survey in 2006 (RCN 2006) established that ENPs were commonplace in a range of settings such as general practices, walk-in centres, minor injury units, medical assessment units and areas such as paediatrics and ophthalmology.

Over the last 25 years policy makers and eminent authors have attempted to define the ENP role. In 1992 The Royal College of Nursing (RCN 1992 p2) defined the Emergency Nurse Practitioner (ENP) as:

*‘an accident and emergency nurse who has a sound nursing practice base in all aspects of A&E nursing, with formal post basic education in holistic assessment, physical diagnosis, in prescription of treatment and in the promotion of health’* (RCN 1992, p2).

There is evidence that the scope of practice within these setting is vast, ranging from managing minor injuries and illnesses to those working in urgent care settings managing more complex acute and chronic cases (Grant *et al.* 2002; Rosen and Mountford, 2002). Interestingly, it is worth noting that the role description in 1992 focused heavily on managing illness and injury and promoting health and there was little or no mention of leadership both at a local level or nationally. More recently, however, the emergence of the Advanced Clinical Practitioner (ACP), whereby practitioners do not limit their practice to pre-defined protocols within the realm of minor injury and illness but manage acute and complex patients and have undergone a comprehensive programme endorsed by the Royal College of Emergency Medicine (RCEM) has led to a new definition of advanced practice:

*‘Advanced clinical practice is delivered by experienced registered healthcare practitioners. It is a level of practice characterised by a high level 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, management and leadership, education and research, with demonstration of core and specific clinical competence’* (Health Education England. Accessed on 08/04/17).

This recent development further questions where ENPs sit on the ‘advanced practice spectrum’ and this will be explored further in Chapter Two. Policy documents and initiatives from the government have consistently supported the concept that the boundaries between nursing and medicine need to be further broken down to meet the demands of a patient centred NHS (DH 1997, 1999, 2001, 2002, 2003, 2006, 2008, 2014, 2017). The Five Year Forward View (DH 2014; DH 2017) calls for delivery of

care to be '*the right care, the right time and the right place*' for patients. It outlines a review of both medical training (Shape of Training Review for the Medical Profession 2013) and nurse training (Shape of Care Review for the Nursing Profession 2015) to ensure a flexible workforce to deliver flexible models of care. In addition to this, it is well documented that recruitment of middle grade doctors is problematic, and that a more flexible approach to workforce development is needed in order maintain a sustainable workforce for the future.

Boundaries between doctor and nurse roles have been explored by Brook and Crouch (2004), and in their review of the literature they highlight that the significant range in educational preparedness within the UK, combined with a lack of regulation of the ENP role, has allowed the development of an *ad hoc* role that has many different titles with varying degrees of autonomy and practice. Other research supports this, for example Fotheringham *et al.* (2011) undertook a longitudinal study examining the evolving role of the Emergency Nurse Practitioner in Scotland. A key finding was the variation in titles across the 55 departments that participated accounting for 446 nurses. Differences in pay, education and practice were also observed across the departments. Although this research was confined to Scotland, its findings are likely to be representative of the wider United Kingdom (UK). However, despite a lack of standardisation in role definition and scope of practice the role of the ENP, as noted by Lloyd-Rees (2016), is a well-established role and one that continues to evolve within all urgent care settings both nationally and internationally.

### 1.3 Historical context

Nurse education has traditionally focused on a humanist approach to learning. Dewey (1915) first described the notion of nurse education as a process for facilitating individual development and as a problem-solving activity. Traditionally, nurse education was viewed as an apprenticeship, often undertaken in religious institutions such as convents by young women. After the Crimean War Florence Nightingale, widely identified as the founder of modern day nursing, set up the first training school in London at St Thomas' Hospital. Early curricula were based on practical learning in hospital ward settings and focused on clinical tasks, competence and hygiene. Nurses in this context were often viewed as handmaidens to doctors, who unlike modern day

nurses were not encouraged to question or take an active role in decision making by drawing on research or evidence (Allan and Jolley 1982).

Prior to nursing becoming a university based programme nurses were not encouraged to reflect or question practice. However after 1992, and with the introduction of 'project 2000' and a university based teaching model, nurse education has fully embraced this style of learning. Nursing theorists have tried to identify and capture the substantive (and professional) uniqueness of nursing. The Royal College of Nursing (2003) makes claims that nursing has a focus on health rather than disease, that the 'whole' person is their core concern and not just the pathology of illness, with an emphasis on a problem solving approach rather than a diagnostic focus.

Medical education, on the other hand, is based on the biomedical model of illness (Engel 1977). The literature surrounding this is unequivocal in that it assumes that disease can be accounted for by deviations from the norm of measurable biological (somatic) variables (Engel 1977). Medical education was devised by scientists for the study of disease, and has historically been the dominant model in medical education. Alongside this, medicine has adopted a master-apprentice style of education assuming that the 'experts' teach the novice in a transmission of knowledge acquisition (Lauvas and Handal 2001; Woolliscroft 2002). Modelling is central to this theory, with senior doctors and clinical teachers perceiving that they act as a role model to achieve knowledge transfer. Role modelling is also linked to professional identity (Finn *et al.* 2010), and role models have been shown to contribute powerfully to identity formation (Goldie *et al.* 2007). In recent years, however, the traditional medical model of education has moved toward a more problem based learning (PBL) approach, which was first introduced into medical education in the late 1960s (Finucane *et al.* 2009). Recent studies have shown that students demonstrate increased problem-solving skills, communication and critical thinking when adopting this approach (Gurpinar 2016), however the impact on developing professional identity is less clearly understood.

## 1.4 Professional identity

The term professional identity is not always clearly defined in the nursing literature. Johnson *et al.* (2012) in a review of the literature around professional identity in nursing found that professional identity is often intertwined with the theory of self-concept (Arthur and Randle 2007). Self-concept is defined as our personal understanding of our perceived attributes, and is about how we think and feel about ourselves (Marsh and Scalas 2010). However professional identity refers to a component of a person's overall identity and is augmented by their '*position in society*', '*interactions with others*' and their '*interpretations of experiences*' (Sutherland *et al.* 2010, p455).

### 1.4.1 Knowledge acquisition and identity

The acquisition of knowledge as a commodity has the connotation of material wealth (Sfard 1998). As noted above, knowledge is regarded as a highly prized possession and therefore can allow the possessor of that knowledge to become powerful and establish identity within a professional group. Studies suggest that medical students demonstrate a strong sense of shared identity which is often apparent even before they start their training (Ware 2008; Cruess *et al.* 2009). The reliance on evidence based practice within medicine is a good example of how medicine maintains a strong sense of professional inclusivity (Tajfel and Turner 1986; Hogg and Adams 1988 and Weaver *et al.* 2011), which arguably reinforces a sense of professional identity. Moreover, the dominance of the biomedical model of illness has ensured that the medical profession maintains its position of power within society. Foucault (1972-1979) in his observations of the 'medical gaze'; in which medicine dominates how we see illness and the widespread medicalisation of modern life, sits well with this analogy of medical education and the acquisition of knowledge and identity.

Nursing theorists have been writing and attempting to identify what the true essence of nursing is for many decades, as part of an endeavour to seek professional status. The move to university based education resulted in proponents of nursing attempting to further consolidate the robustness of their case for independence by developing a body of scientific and quasi-scientific knowledge (King 1981; RCN 2003). However, others have hinted that the endeavour may be fruitless, suggesting that nursing is

more like teaching than medicine, and that nursing is a shifting field of practice rather than a discipline in its own right (Jarvis 1995). Arguably this has an impact on professional identity, as we know that to possess knowledge which is linked to identity is a powerful commodity. Fawcett (2003, p229) argues that *'without the foundations provided by conceptual models of nursing we are nothing more or less than skilled trades people'*. As with medical students, nursing students enter nursing with pre-existing values and beliefs about what nursing is, and this has already shaped their professional identity (Bolan and Grainger 2009). Studies have shown that some students entering nursing believe that doctors will direct all care and that nursing is *'underpaid and strenuous'* and *'without a lot of prestige'* (Grainger and Bolan 2009, p 39). This misconception of nursing will undoubtedly have a long term impact on an individual's self-concept or feeling of worth, and therefore professional identity.

Advances in medical technology have led to nurses becoming more technically competent, which is seen as a key indicator of professional practice and identity. Undergraduate nurse education has moved to a more competency based curriculum, and most advanced practice courses within the UK focus on a medical model of delivery, emphasising the importance of physical examination, diagnostic reasoning and disease management. There is less emphasis on the more traditional skills of caring and the nurse-patient relationship. Leadership, teamwork and the impact of policy is also notably lacking in most programmes. There is no doubt that education plays a vital role in the development of professional identity, both in the clinical and academic setting, and it is arguable that educators are not doing enough to support both student nurses and experienced ENPs in formulating their professional identity. Educators themselves need to understand the drivers that develop a positive identity, and how these drivers can influence a sense of identity within a group.

#### 1.4.2 The role of the ENP and professional identity

A study by Williams and Sibbald (1999) examined the changing roles and identities of a group of practitioners in primary care settings. They concluded that one of the key factors contributing to uncertainty in the workplace was the perceived breakdown of professional identity and working within new roles. They found that working within new roles had led to tension between doctors and nurses, and also between nurses themselves as different 'specialist groups' developed. Tension within and between

professional groups have been common themes emerging from the literature in relation to ENPs (Thrasher and Purc-Stephenson 2007; Currie and Crouch 2008; Hoskins 2011). Shirikov and Vondracek (2011) suggest that professional identity is assembled (and disassembled) around the interpersonal relationships that are important, and professional identity is dependent on how much an individual invests in these relationships. A sense of belonging is also identified within the literature as an important component of forming professional identity, since without it individuals cannot participate in the relationships that shape their professional selves (Levett-Jones and Lathlean 2008). Lack of clarity of role and a fear of litigation are common themes within the literature in relation to ENPs, and these have been linked to a perceived lack of identity within the role. (Williams and Sibbald 1999). Hiscock and Pearson (1996) agree, suggesting that a lack of professional networking can lead to demarcation and a sense of diminished autonomy and identity. Arguably this notion of lack of identity and diminished autonomy will have a direct impact on clinical practice, service delivery and possibly patient safety as identity is linked to confidence and positive performance (Ohlen and Segesten 1998; Bjorkstrom *et al.* 2008). This will be discussed further in Chapter Two.

## 1.5 Summary of research design

This introductory chapter has outlined the rationale for the study, and has introduced the policy context and relevant supporting literature. A short summary of the research design is outlined below including the aims of the study, the methodological approach, the method of data collection employed and the method of data analysis used.

### 1.5.1 Aim of the study

The broad aims of this study were to:

- Explore the concept of professional identity within the role of the ENP.
- Identify what factors contribute (positively or negatively) to a sense of professional identity.
- Consider the implications for managers, organisations and educationalists of changing identities within emerging roles in healthcare.

In order to address these aims, the following question and sub-questions were devised:

What are the key factors that influence a sense of identity and autonomy for the Emergency Nurse Practitioner?

Sub-questions:

1. From which sources do ENPs draw their knowledge base, and why?
2. Does the title ENP or ANP give post holders a sense of identity, and if so why?
3. Is there a perceived link between professional autonomy and professional identity?
4. Do medical colleagues positively or negatively influence an ENPs perceived sense of autonomy and/or identity?
5. Does location or organisational structure have an influence on perceived autonomy and or identity?

#### 1.5.2 Research methodology

This research adopts a qualitative interpretive approach, since the main focus is to explore perceptions of professional identity and autonomy from the ENP perspective using a case study methodology. Qualitative research attempts to '*study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them.*' (Denzin and Lincoln 2011, p3). Nursing research that has focused on perceptions and attitudes has tended to adopt a qualitative methodology in order to interpret meaning within the participant's natural setting, therefore adopting a more interpretative approach.

#### 1.5.3 Data collection methods

Data was collected using focus groups as the primary method. Two organisations were selected to draw the focus groups from; one was from an Emergency Department (ED) within an inner city National Health Service (NHS) Foundation Trust and the other was a Minor Injury Unit (MIU) within an Urgent Care Centre. The ED was chosen due to the interdisciplinary nature of the department, whilst the MIU was chosen as it



operates as a nurse-led unit and I was interested in comparing the perceptions of the participants from different organizational contexts. Participants in the focus groups were all band 7 ENPs working within either of the identified units. Following the focus groups, further data was collected from senior managers from the respective organisations using semi-structured interviews.

#### 1.5.4 Data analysis

The chosen method of data analysis was thematic analysis (TA). TA is a method used for identifying, analysing and interpreting patterned meanings or themes in qualitative data (Braun and Clarke 2006, 2012, 2013), and is a widely accepted method of analysis (Howitt 2010; Howitt and Cramer 2008; Stainton Rogers 2011; Joffe 2012).

#### 1.5.5 Structure of the thesis

This doctoral thesis uses a case study approach to explore concepts of identity and autonomy within a community of ENPs, and was carried out within two urgent care settings as outlined above. Chapter One has outlined the rationale for the study and has introduced the policy context and literature surrounding the study. It has also outlined the research design of the study. The relevant literature surrounding the study is critically explored in Chapter Two and covers the following areas:

- Nurse practitioners: role development.
- Education.
- Professionalism and professions.
- Professional identity.
- Theoretical framework which underpins this study - communities of practice.
- Social theory which has informed my understanding of professional identity – Bourdieu.

Chapter Three explores the methodological approach taken and justifies this, examining the personal and philosophical assumptions that underpin this approach. It identifies why a case study approach was adopted, and explores the relevant literature around case study research. Chapter Four outlines the research methods used for the study including methods of data collection and analysis. Ethical considerations are

explored and the practical aspects of gaining ethics committee approval are reflected upon. My position as a researcher within this arena is also explored through reflexivity and reflection.

The results of the focus groups are presented in Chapter Five using Braun and Clarke's Thematic Analysis model. Themes and sub-themes are presented using photographs to illustrate the themes, with an overview of each theme being presented. Extracts from the data are used to demonstrate and underpin the themes presented.

Chapter Six discusses the implications of the findings and interrogates the themes utilising relevant current literature. The implications of the findings are discussed in relation to educationalists, policy development and workforce planning. The thesis concludes by exploring whether the research questions have been answered, and describing the areas of new knowledge that have been identified.

## 1.6 Summary

This chapter has introduced the literature surrounding the study, and the policy context within the domain of the role of ENP. The rationale for the study comes from a personal perspective of working within the field of Emergency Care and educational delivery of an ENP programme. The chapter has set out the framework and structure of the thesis, and outlined the chosen methodology and methods. The following chapter will examine the relevant literature.

## 2. Literature review

### 2.1 Introduction

The previous chapter introduced the study and outlined the policy context within which the ENP role exists. This chapter will review and analyse the literature in three parts. The first part will examine the literature relating to the evolution of the ENP role and advanced practice, the scope of practice within the role and the range in titles. It will also consider the education which underpins the role and how this has evolved. As this role is embedded internationally, research from both within the UK and internationally will be explored. In addition to this, policy documents that have informed the development of the role will be considered.

The second part of the review examines the concepts of professional identity and socialisation, and the relationship to the professionalization of nursing. This section also explores professional identity within advanced practice roles. The final section of the chapter will explore the theoretical framework of communities of practice (CoP) as a vehicle for developing identity within nursing and the ENP role. Bourdieu's theory of cultural capital and its link to professional identity within nursing and the ENP role will be examined.

### 2.2 The search strategy

The literature was accessed using several databases including: MEDLINE; British Nursing Index; CINAHL; and EMBASE. Key words, and Boolean operators such as 'AND', were used to combine keywords in order to narrow the search for example 'Emergency Nurse Practitioner' and 'title'. Additional Boolean words were also used such as 'Or' to further ensure the search was broad enough to capture terms which are often used interchangeably such as 'Emergency Nurse Practitioner' or 'Advanced Nurse Practitioner'. The results of the literature search are summarised in the table in Appendix One. Further to this, grey literature was reviewed using Google Scholar, Department of Health resources and policy documents, professional body publications and unpublished thesis. The review was conducted systematically using title and

abstracts to gain the initial relevant articles. From this, relevant full text articles were selected. Only studies published in English were selected and articles were drawn from both UK based studies and international studies. Snowballing was incorporated into the search strategy whereby references cited within articles were searched and where relevant included in the review. The initial search period was from 1980- 2016. Drawing on literature from 1980 ensured that all seminal work relating to the development of the role at that time would be included. A final search was conducted in early 2017 during the final write up of the thesis to ensure any new studies would be included. The appraisal of the literature focused on research studies, however, editorial and published opinion pieces were included when deemed relevant or when there was a paucity of primary studies. Government policy documents and professional body publications were also included where relevant to the discussion.

## 2.3 Part 1: Advanced practice

### 2.3.1 Evolution of the ENP role

The ENP role is now a well-established and highly valued role within the Emergency Department workforce. It is well evaluated, and provides safe and effective care whilst contributing to the national Department of Health (DH) target of managing the whole ED patient episode within 4 hours (DH 2001). Sakr *et al.* (2003) found in their seminal work that there were no significant differences between ENPs and junior doctors in the accuracy of examination, adequacy of treatment, planned follow-up, or requests for radiography. The accuracy of x-ray interpretation was also similar in both groups. Further, the study found that ENPs were more effective than junior doctors at recording medical history, and fewer patients seen by an ENP sought unplanned follow-up advice about their injury. A plethora of studies both within the UK (Bryne *et al.* 2000; Barr *et al.* 2000; Walsh, 2001; Bengner, 2002; Cooper *et al.* 2002) and outside of the UK (Clarke, 2000; Jennings *et al.* 2008; Steiner *et al.* 2009; Chattopadhyay *et al.* 2015) have since indicated the benefits of an ENP service within urgent care settings citing reduced patient waiting times, increased quality and cost effective care, reduced patient complaints and increased staff morale.

As noted in Chapter One, the emergence of the ENP role within the Emergency Department (ED) occurred in the late 1980s and 1990s, largely in response to an

increasing demand on the service and in an attempt to free up doctors to see patients with more complex conditions (Woolich 1992). The concept was initially developed in primary care in the early 1980s by Stilwell *et al.* (1987), however it soon spread into the ED. The ENP service expanded in an *ad hoc* and sporadic manner across most EDs throughout the 1990s, with some departments having a well-established ENP tier by the mid-1990s and others still trying to establish a service (Crinson 1995). At the same time a range of UK policy initiatives, such as the implementation of the European Working time Directive (EEC 2000) and the introduction of Modernising Medical Careers in 2004 (DH 2004a), further accelerated expansion of the role. The reform in post graduate medical (doctor) training had a direct impact on ED workforce supply as training requirements for experience in the ED as a junior doctor were removed from the national requirement for surgical trainees. This had the knock-on effect of fewer doctors applying for posts within EDs, leaving a gap in the workforce (Keltie *et al.* 1997). Meanwhile, implementation of the four hour emergency access target (DH 2001) placed even greater pressure on the ED to ensure that patients were seen, treated and discharged within four hours. This led to the burgeoning expansion of the ENP role throughout the UK, but without any formal standardisation of role development, title or educational preparation (Considine *et al.* 2006; Thrasher and Purcell 2008).

As previously outlined, policy documents have continued to encourage the notion that boundaries between nurses and doctors should become further broken down. The NHS Five Year Forward View (DH 2014) demands a workforce that works '*across organisation and sector boundaries*' promising education and training that '*equips the current workforce with the skills and flexibility to deliver new models of care*' (DH 2014, p30). Resulting from this constant drive towards a more flexible workforce with less defined boundaries is the continual role expansion of the ENP. A role that in the late twentieth century focused on managing minor injuries under defined protocols has now emerged in the early twenty first century as one that has developed to include the management and care of patients with increasingly complex, acute and chronic conditions (Grant *et al.* 2002; Rosen and Mountford 2002). Where once the role of the ENP within the UK was confined to the realms of the 'minor end' (the area of the ED in which patients with minor injuries or illnesses are traditionally seen), ENPs are now occupying space at the 'major end' (where patients with more complex health needs

are managed), seeing and treating more complex conditions such as hip fractures and chest pain (Martin 2002; Davies-Gray 2003). This recent evolution has reopened the debate around defining the role and what constitutes 'advanced practice'. A review of the literature on advanced practice will be presented later in this chapter.

### 2.3.2 ENP scope of practice

As noted above, the scope of practice within the ENP role is varied and has developed in an *ad hoc* manner over the last twenty years. The following section will provide an overview of the literature on the range and scope of practice within the ENP role. Hoskins (2011) highlighted that there is a paucity of literature pertaining to the scope of practice for ENPs, and this is still the case to date. In a literature review evaluating the role she found only two studies that specifically examined the scope of practice of the ENP (Cole and Ramirez, 2000; Considine *et al.* 2006), although a range of studies did mention scope of practice as part of a wider discussion. Hoskins (2011) also notes that these two studies are not UK based (one was Australian and the other from the USA), and identifies that most of the UK studies focus on patient satisfaction and evaluation.

Considine *et al.* (2006) examined the scope of practice of one ENP over an eight month period in an Australian ED. During that time 476 patients were seen with an average of six patients per shift. The most common presentations managed by the ENP were patients with lacerations/wounds and distal limb injuries. This finding is in line with other studies at the time that attempted to examine the scope of practice. Cooper *et al.* (2002) found that within the UK the most common presenting problems that were managed by the ENP were wounds (including burns and scalds), and ankle and foot injuries. Cole and Ramirez (2000) concur, finding that in their North American study 52% of patients seen by an ENP presented with an injury. Hoskins (2011) notes that the UK had the most limited range of practice, and in the review of the literature found that minor injuries and minor illness are the most common presentations treated by ENPs.

As highlighted above, previous studies have attempted to compare patient outcomes between ENPs and doctors. Considine *et al.* (2006) found that there was no significant difference in the X-ray requesting patterns of emergency physicians and ENPs. This

was in keeping with other studies (Cole and Ramirez 2000), suggesting that ENPs were working at a similar level to their medical colleagues and were safely and appropriately requesting x-rays for a comparable group of patients. Discharge rates between ENPs and doctors were also examined. Discharge rates for ENPs within the Considine study were 77.2%, whereas in the Cooper *et al.* (2002) and Cole and Ramirez (2000) studies discharge rates were higher at 94%. It is unclear from the literature why the discharge rates in the Considine study were lower than the other two studies, however the Considine study took place in Australia whereas the Cooper *et al.* (2000) and Cole and Ramirez (2000) studies took place in the UK and USA respectively. It is possible that the scope of practice for ENPs within the UK and USA is more comparable, which might account for the similar rates of discharge compared to those in Australia. It is also worth noting that the studies in question do not define what is meant by the term 'discharge'. This could also contribute to the discrepancy, as the most common discharge referral in all studies was to the patient's General Practitioner (GP). In all of the studies mentioned here approximately one third of the patients managed by ENPs required referral to out-patient or follow-up clinics, suggesting a consistency of referral methods.

Fotheringham *et al.* (2011) undertook a longitudinal study to examine how the role of the ENP has developed in Scotland. The study was first undertaken in 1998, but as the role and political landscape has shifted so rapidly the original study was replicated ten years later. Although the study did not specifically examine the full scope of practice for ENPs it identified a shift in trends around role expansion, titles and scope of practice. The study found an increase in the number of ENPs across Scotland from 306 in 1998 to 446 in 2009, which meant that ENPs were practising in 89% of EDs within Scotland by 2009. Of these, the majority (79%) managed patients where there was a protocol or guideline to work to, which fell into the minor illness or injury category. Interestingly, this was a clear reduction from the 1998 study which found that 91% of ENPs used formal protocols or guidelines. Similarly there was a significant shift in ENPs requesting and interpreting x-rays during this period. In 1998 less than half the departments with ENPs (47%) allowed their ENPs to request x-rays, with only 14% interpreting x-rays, whereas by 2009 the majority of ENPs were requesting X-rays (80%) and also interpreting them (73%). This study clearly demonstrated that roles had expanded as more ENPs were now requesting and interpreting x-rays. In

addition, the reduction in ENPs using protocols and guidelines suggested an increased degree of autonomy within the role.

An interesting element of the Considine *et al.* (2006) study is that it examined the percentage of time that the ENP spent on seeing patients (direct care) and the percentage of time spent on indirect care. In their study the majority of time (55%) was spent on direct patient care, with the rest spent on indirect activities (clinical practice guidelines and research development 24%, education (self and others) 17%, administration 2% and assisting in emergency cases 2%). This finding concurs with other studies (Knaus *et al.* 1997), although in a study investigating ENP and patient interactions in the USA Courtney and Rice (1997) found that ENPs spent 90% of their time providing direct patient care. These findings are worthy of noting here as the Health Education England (HEE) recommended definition of advanced practice (as described in Chapter One) requires the practitioner to demonstrate four pillars: clinical practice; management and leadership; education; research. The implications for this and the division of time spent on each pillar will be discussed later in this thesis.

### 2.3.3 Role title

The ENP title is protected within Canada and the USA, and is regulated by the regulatory bodies in those countries, whereas within the UK the role does not carry a protected title, and therefore the range of titles is varied. In addition to this, it is unclear how many ENPs are practising within the UK as a national register does not exist. This lack of regulation and standardisation is well documented as a frustration amongst ENPs, and a potential barrier to implementation of a successful ENP service (Currie and Crouch 2008; Keating *et al.* 2010; Lloyd-Rees 2016). In a study by Fotheringham *et al.* (2011) the titles used within fifty five departments within the UK ranged across: 'ENP', 'Minor Injury Nurse', 'Advanced Nurse Practitioner', 'Specialist Nurse' and 'Unscheduled Care Nurse Practitioner', to name only a few. This varied range of titles is indicative of the range of practice that exists within the role which, as Fotheringham *et al.* (2011) suggests, implies a group of practitioners who have different skills, different decision-making abilities and levels of autonomy, and who display different characteristics. Arguably, a diverse range of practitioners such as this does not describe a homogenous group with a shared sense of purpose and professional identity.



Occupational groups such as nurses, doctors or lawyers are uniquely identified by their name (Thupayagale and Dithole 2005). This name generally describes the nature of the work undertaken by that group, and generates perceptions of the characteristics of the profession. In healthcare, adjuncts to the word 'nurse' are often added to the title in order to inspire greater respect and understanding of the role (Cashin *et al.* 2007). As outlined above, for ENPs this has resulted in a proliferation of titles which all aim to define a similar role with the same objectives. In the early development of the role it was recognised that the range of titles was unhelpful in trying to gain recognition of an emerging workforce. Lorentzon and Hooker (1996) suggest that just as a name uniquely describes an individual it should also uniquely define a discrete group. Cashin *et al.* (2007) argue that this 'add on' development in titles has contributed to the lack of success within the role over time, and that in order to ensure acceptability and success in advanced practice roles a clear vision of the desired outcomes, with a widely recognised and consistently used title to delineate the role, is essential. MacDonald *et al.* (2006) go further and discuss the value of using one title (advanced practice nurse) to encompass all roles which share a 'sameness of character' in order to develop a common sense of identity. Identity here is defined as the '*sameness of essential or generic character in different instances*' (Merriam Webster Incorporated 2014, p575). MacDonald *et al.* (2006) argue that using one title which encapsulates many areas of 'sameness' will justify a common 'advanced nursing practice' identity.

#### 2.3.4 The evolution of advanced practice

It is evident from the literature that the ENP role is accepted in many settings, and commonplace within EDs both within the UK (Tye and Ross 2000; Fotheringham *et al.* 2011; Hoskins 2011 and Lloyd-Rees 2016) and internationally (Coopers and Lybrand 2011; Chattopadhyay *et al.* 2016). Despite differences in scope of practice and discrepancies in pay and titles, research studies within the UK consistently demonstrate no difference between ENPs and doctors in terms of clinical outcomes and patient satisfaction (Scum *et al.* 2000; Horrocks *et al.* 2002; Sakr *et al.* 2003). Laurent *et al.* (2004) undertook a systematic review of 24 UK and international studies and found higher overall scores of patient satisfaction with nurse led care and reduced risk of hospital admission with nurse led care. However the concept of 'advanced

practice' is one that remains uncertain, and has many connotations within both the literature and clinical practice. 'Advanced practice' is often used as an umbrella term that denotes the array of non-traditional nursing roles and practices that populate the clinical arena (DH 2010). As noted above, the abundance of titles associated with these roles has added to the complexity in defining what 'advanced practice' is, and confusion between 'specialist practice' and 'advanced practice' has persisted over the years.

Within this confusion is the concept of autonomy and what defines 'true autonomy' for a profession. Policy documents have advocated the blurring of roles, and consequently professional boundaries, with support for the development of roles that allow practitioners to take on tasks that were previously assigned to doctors. Responsibility and accountability within these roles are often confused with autonomy, and the terms may be used interchangeably. Changes within roles have occurred in many arenas across the health sector, for example, within mental health the development of multi-disciplinary and multi-agency teamwork within mental health provided an opportunity for the delivery of a flexible patient-centred service. However, this also brought about some confusion around roles and responsibilities for practitioners, medical consultants and employers. In response to this, the publication of the 'Responsibility and Accountability best practice guide-moving on from New Ways of Working to a creative, capable workforce' (DH 2010) sought to clarify issues of responsibility, accountability and delegation for staff and employers within mental health and the wider healthcare system. It drew on professional regulators from both nursing and medicine in relation to delegation:

*'Delegation involves asking a colleague to provide treatment or care on your behalf. Although you may not be accountable for the decisions and actions of those to whom you delegate, you will still be responsible for the overall management of the patient, and accountable for the decision to delegate'* (GMC, 2006).

Similarly the NMC states that:

*'Where a nurse or midwife has authority to delegate tasks to another, they will retain responsibility and accountability for that delegation... Where another,*

*such as an employer, has the responsibility to delegate an aspect of care, the employer becomes accountable for that delegation' (NMC 2001).*

However, the picture is further clouded by the distinction between delegation and assignment, whereby the practitioner may delegate work to a support worker (or to an ENP from a doctor) who is deemed competent to undertake the task such as a haematoma block. This worker then carries the responsibility for the task, however, the employer has the responsibility to ensure that the worker to whom the task has been delegated has the requisite training. Clearly the picture is complex, and whilst it is not the intention of this literature review to discuss in depth the intricacies of the law, it is worth noting that within the realm of advanced practice the legal responsibility for patient care always resides with the medical consultant as described by the British Medical Association's Consultant Handbook (2009):

*'Only a consultant or principal in general practice can accept ultimate medical responsibility in NHS units and the development of new working patterns and multi-disciplinary working should not alter this basic principle' (Consultant Handbook, 2005).*

Within the UK attempts to define advanced practice have only gone so far. In 1998 the United Kingdom Central Council (UKCC) introduced a 'higher level of practice' that attempted to give a framework to all roles and titles under this umbrella. It was based on competencies and defined standards, and was designed to be a generic framework that would allow practitioners to practice under this 'higher level of practice' (UKCC 1998). However, as the regulatory body changed and became the Nursing and Midwifery Council (NMC) this recognised title was incorporated and diluted into the new NMC register for nurses and midwives (NMC 2001). At the same time the majority of the Western world was struggling to develop a coherent approach to advanced practice, resulting in the International Council of Nurses (ICN) developing an internationally recognised definition:

*'A Nurse practitioner-advanced practice nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are*

*shaped by the context and/or country in which s/he is credentialed to practice. A Master's degree is recommended for entry level' (ICN 2001, p1).*

This definition prompted further development of the concept within the UK, with the NMC describing advanced practitioners as *'highly experienced and educated members of the team who can treat and discharge or refer to an appropriate specialist if needed'* (NMC 2005). The Skills for Health agency went further, describing advanced practitioners as *'highly experienced professionals with highly developed knowledge and skills, with the ability to make high level clinical decisions and have their own case load.'* (Skills for Health 2007). It appeared momentum was gathering around what advanced practitioners could do as government policy endorsed the definitions (DH 2004; DH 2010). In 2008 the Scottish Executive produced the 'Advanced Practice Toolkit', which was a competency based framework for practitioners to use and was close to becoming a framework for practitioners to practice within.

However, arguably the most definitive progress was made in 2015 with the publication of a competency based curriculum by the Royal College of Emergency Medicine (RCEM). Whilst developed as a competency based pathway for doctors, Health Education England in collaboration with the RCEM developed the Emergency Care Advanced Clinical Practice curriculum for ACPs working within urgent care settings. This curriculum has since been endorsed by the Royal College of Nursing (RCN) for all nurse practitioners across the health care arena. The RCN curriculum allows practitioners (through a process called credentialing) to demonstrate that they have achieved defined competencies, and this concept is being adopted by other health professionals such as physiotherapists and paramedics. Whilst still in the early stages of roll-out, this could be viewed as a breakthrough in defining advanced practice and national standardization, and has formed the basis for the RCN concept of credentialing advanced level practice for nurses and all other disciplines. Of particular importance is that it is firmly based at Master's level:

*'Advanced clinical practice is delivered by experienced registered healthcare practitioners. It is a level of practice characterised by a high level 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, management*

*and leadership, education and research, with demonstration of core and area specific competence'* (Health Education England. Accessed on 30/04/17).

In addition to establishing a more formal definition of advanced practice, there has also been a drive to define the difference between an advanced nurse practitioner and those working in extended roles. The abundance of titles noted above has allowed a vast range of ambiguous roles. The Nuffield Trust has recently attempted to define the difference between advanced roles and extended roles suggesting that:

*'Extended roles are roles where registered professional take on tasks not traditionally within their scope of practice but which do not require training to Master's degree level. Advanced roles meanwhile refer to those roles that require registered professional to undertake additional training at Master's level or above'* (Imison et al. 2016, p2).

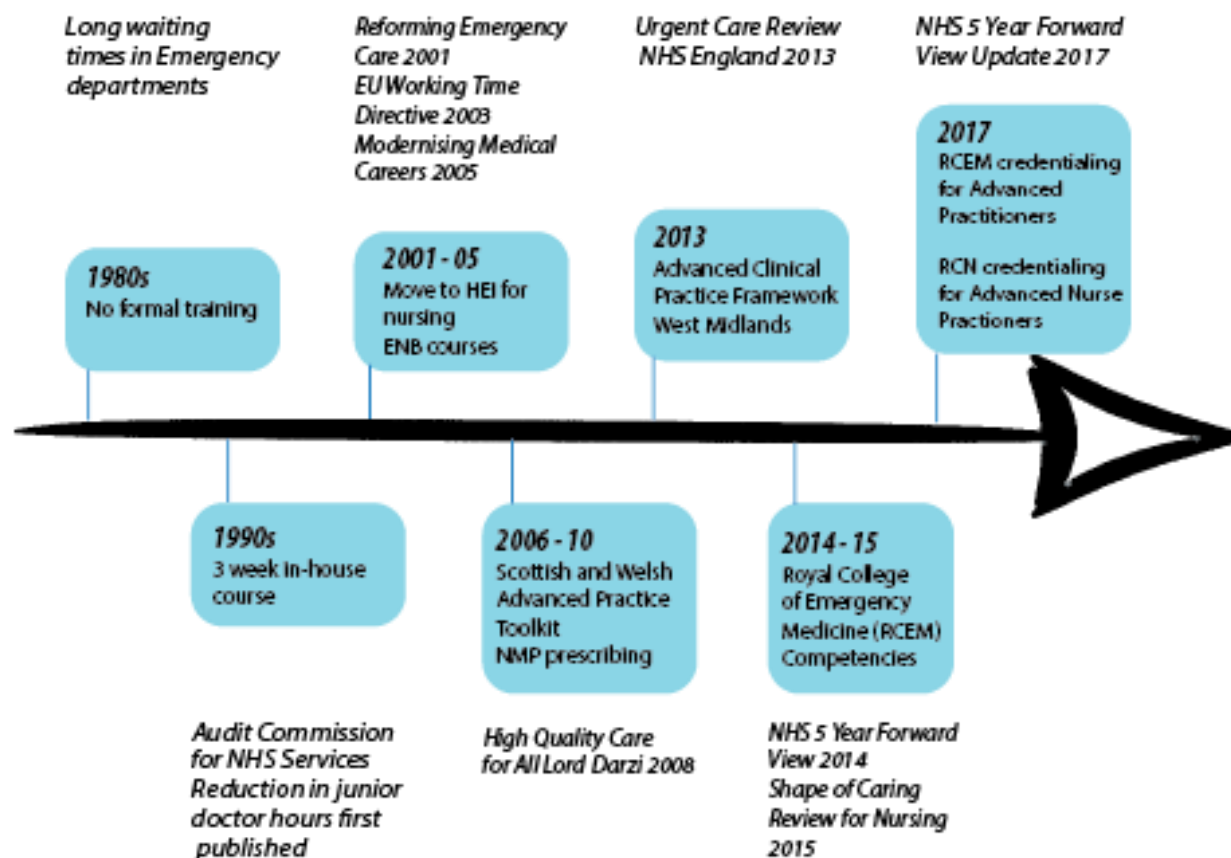
The RCN have further attempted to define roles within the emergency care arena with the development of an Emergency Nurse Development Pathway. The pathway identifies a clear definition between the role of the ENP and the ACP:

*'Emergency nurse practitioner (ENP): A registered nurse who has undertaken specific additional training in order to assess, diagnose and prescribe treatment for patients who present with minor injuries or illness. The role of emergency nurse practitioner is subject to local variation in education and practice provision, therefore this framework does not provide the competencies required for this role. Typically they would be band 6 or 7'* (RCN, 2017).

*'Advanced Clinical Practitioner (ACP): An emergency nurse or other registered allied health professional who has undergone masters level education in examination, diagnosis and treatment and can provide a clinical consultation for any patient presenting to emergency care. They should be working to the Royal College of Emergency Medicine/Health Education England emergency care ACP competency standards. Typically they would be Band 8a or 8b'* (RCN, 2017).

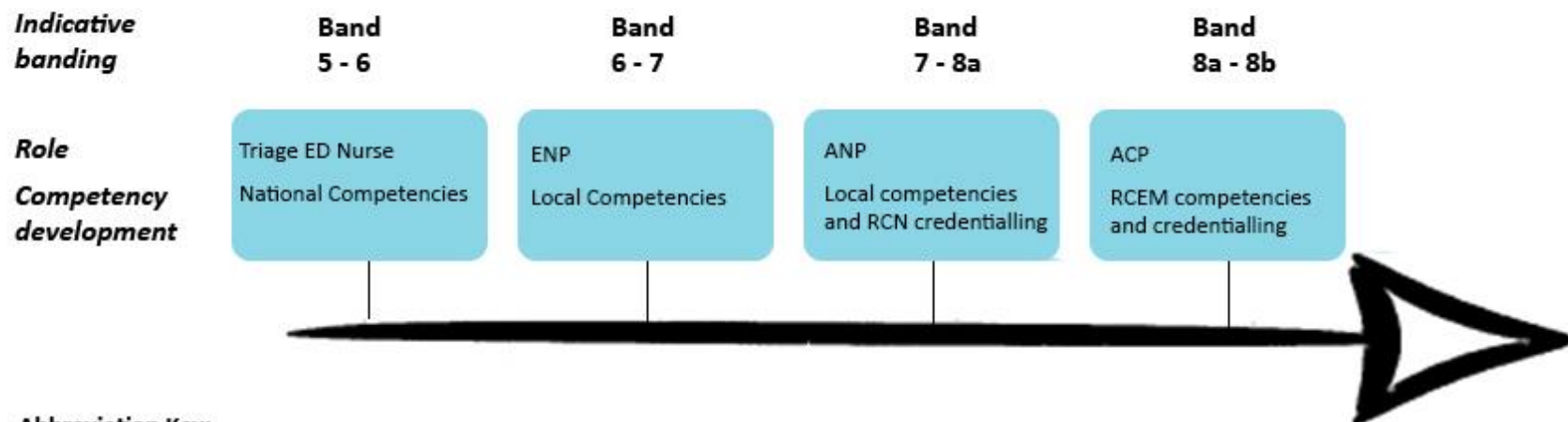
Whilst this is undoubtedly a positive move towards identifying which roles require a Master's level programme and which do not, there will inevitably be further discussion around a plethora of roles that do not neatly sit within one camp or the other, and how best to determine the education level that is required for each. Interestingly, the definition also highlights the lack of educational standardisation and local variations in practice within the ENP role and seems to firmly locate the role within the realm of managing minor injury and illness. The literature reviewed thus far has focused on advanced practice and the clinical aspects of the ENP role, including inconsistency in pay and titles. The following section draws further upon the educational provision of the role, while considering recent developments in the ACP curriculum. Figure 1A is a conceptual map that draws together the evolution of advanced practice against the backdrop of drivers for change incorporating the educational developments that have underpinned the evolution of the role to date. Figure 1B demonstrates where ENPs sit on the advanced practice continuum based on the literature and policy documents reviewed in this chapter.

Figure 1A. Timeline of the evolution of advanced practice: education (shown in blue boxes) and drivers for change



**Timeline of the evolution of advanced practice education and drivers for change**

Figure 1B. Advanced practice continuum in emergency care



**Abbreviation Key:**

*ED - Emergency Department*

*ENP - Emergency Nurse Practitioner*

*ANP - Advanced Nurse Practitioner*

*ACP - Advanced Clinical Practitioner*

*RCEM - Royal College Emergency Medicine*

*RCN - Royal College Nursing*



### 2.3.5 Advanced practice education

As noted above, several studies have attempted to define what advanced practice is. Most of these studies identify a varying range of educational preparation as a factor that has hindered the implementation of the role (Currie and Crouch 2008; Lloyd-Rees 2016). International studies also highlight the varying range of preparation as a barrier to successful implementation for example an Australian study by Keating *et al* (2010) revealed a myriad of barriers to role sustainability and progression, including funding for Masters programmes and legislative constraints. The evolution of the role progressed, but without any national benchmark qualification or accreditation system, and with an education model that allowed nurses to be 'topped up' with medical science (Brook and Crouch 2004). Other UK based studies note that participants also believe that the *ad hoc* nature of education has caused uncertainty and been a barrier to successful role implementation (Williams and Sibbald 1999). In addition to this, the multitude of titles previously described has further complicated the position as to what education requirements are needed for those working under the umbrella term of 'advanced practice', since each title may denote a slightly different role. However, the 'advanced practice framework' outlined by HEE (2015) has now attempted to define what is meant by an advanced practitioner and supports an educational framework to underpin the role. The HEE definition of advanced practice suggests that:

*'Advanced clinical practice embodies the ability to manage complex clinical care in partnership with patients/carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance patient experience and improve outcomes'* (Health Education England. Accessed on 10/05/17).

As outlined above, the debate around the appropriate level of education is not confined to the UK; whilst many agree that Master's level study is now appropriate for advanced practice roles, not all countries have reached this goal. Many countries are now offering Master's level study (United Kingdom, America, Australia and Canada), but these programmes are not compulsory, and there is no nationally accredited academic programme (Keogh *et al.* 2016). In the UK, programmes are often offered at both Master's and bachelor level, as many practitioners who trained before nursing became a graduate profession do not possess a first degree.

As noted previously, ENPs have been demonstrated to be as clinically effective as junior doctors (Sakr *et al.* 1999; Barr *et al.* 2000; Jennings *et al.* 2008; Steiner *et al.* 2009), however interestingly there is a paucity of literature evaluating the effect that the level of study has on other aspects of the advanced practice role such as research, leadership or education. Gerrish *et al.* (2011) undertook a UK study identifying the factors that influence advanced practice nurses' contribution to promoting evidence based practice. In this study, less than one third of ENPs had a Master's qualification. Those participants who did possess a Master's qualification were more confident in their ability to support evidence based practice and were more likely to consider themselves to be competent or expert in this field. Additionally, Profetto-McGrath *et al.* (2007) found in their Canadian based study that the use of evidence based practice was influenced by the practitioner's education level.

In the Gerrish *et al.* (2011) study it was interesting to note that 41% of ENPs did not possess a bachelor's degree or higher degree, therefore as Profetto-McGrath (2005) suggests, this lack of opportunity to develop critical thinking and appraisal skills seems to have a negative impact on the ability to promote and develop evidence based practice. It is worth noting, however, that as all nurses are now educated to degree level these findings would probably be different if the study were to be repeated today, as 'newer' nurses take up roles within advanced practice. The study also found that there was a heavy reliance on policies and guidelines, and only half of the advanced practitioners felt competent or confident in evaluating research. It concluded that there was heavy reliance on research that had already been processed and disseminated, either through a programme of study or a policy or guideline (Gerrish *et al.* 2011).

These findings are important in debates around education, as a lack of confidence suggests that this could also impact on leadership qualities and the ability to transform and deliver change within clinical practice. UK and international studies examining the use of research by frontline nurses have found that they are heavily influenced by 'opinion leaders'. ENPs, it is suggested, are identified as opinion leaders and have a significant positive role to play in developing others (Fitzgerald *et al.* 2003; Hogan and Logan 2004). Confidence is also linked to developing a professional identity within a role (Pill *et al.* 2012), which will be explored in more detail in the following sections.

## 2.4 Part 2: Professional identity and professionalization of nursing

### 2.4.1 Professional identity in nursing

Nurses' concepts of their professional roles have continued to evolve over time, from doctors' assistants in the mid-20<sup>th</sup> century to now portraying themselves as more active in patient care, and autonomous in their role (Johnson *et al.* 2012). Modern global healthcare demands that nurses demonstrate the skills of effective decision making and emotional intelligence while delivering safe, compassionate and patient-centred care (DH 2012a; DH 2012b; Cummings 2012; Mazhindu *et al.* 2016). Nurses (and teachers) are cited as being the 'most trusted professions' (Saad 2008), and yet both professions still struggle to obtain legitimate professional status (Adams 2010). The ongoing debate around professionalization and the evolution of nursing identity is multifaceted and complex. Andrew (2012) proposes that nursing sits in the grey margins between vocational and professional status, suggesting that polarised opinions within the profession, media stereotyping and political vote-catching have all contributed to a confused picture of professional identity (Andrew *et al.* 2009). The following sections will explore the concepts associated with professional identity and summarise the evolution of professionalism within nursing, while exploring the impact of public perception. The literature relating to the impact of advanced practice and extended roles on professional identity will also be explored within this section.

### 2.4.2 Self-concept, socialisation and professional identity

It appears from the literature that professional identity is inextricably linked to the construct of self-concept (Arthur and Randle 2007; Johnson *et al.* 2010 and Kroger and Marcia 2011). Self-concept is defined in the literature as '*our personal understanding of our perceived attributes (as a social, physical and cognitive person)*' (Marsh and Scalas 2010 p 660). In other words, self-concept describes how an individual thinks and feels about themselves including self-awareness and self-esteem, confidence and self-worth. Studies exploring the impact of role change and professional identity have found that self-image and self-esteem are core to an individual's professional identity (Ohlen and Segesten 1998; Pill *et al.* 2012). Pill *et al.* (2012) found that nurses in expanded roles experienced greater self-esteem and confidence which led to changes in their perceived sense of professional identity. In

relation to nursing, Takase *et al.* (2002) suggest that nurses' self-concept (or professional self) can be defined '*as information and beliefs that nurses have about their roles, values and behaviours*' (Takase *et al.* 2002, p197). The Social Identity Theory as proposed by Tajifel and Turner (1986) argues that self-concept of an individual or group (for example nurses) is derived from the perceived image of the group by society. It focuses on the premise that if society thinks well of the group this enhances its self-concept. Alternatively, if society thinks less well of the group it will have the opposite effect. Tajifel and Turner (1986) suggests that group members will attempt to enhance their own self-image by portraying negative images of other groups. Hoeve *et al.* (2013) found in their review of the literature on self-concept and professional identity that professional identity can be reflected in the nurse's professional self-concept which is also based on the general public opinion of nurses. The notion of public image and the impact on professional identity will be discussed later in this chapter. Others suggest that how nurses think and feel about themselves supports patient care within a positive environment, and associate factors such as career choice, job satisfaction and positive nursing image with retention rates (Cowan and Hengstberger-Sims 2006; O'Brien *et al.* 2008; Cho *et al.* 2010; Horton *et al.* 2010). Bjorkstrom *et al.* (2008) suggest that nurses' judgements of their own competencies and professional selves are crucial to their achievement of positive performance standards.

Professional identity is often referred to as a career, occupational or vocational identity (Holland *et al.* 1993; Skorikov and Vondracek 2011). Professional identity develops through a process of socialization. Professional socialization is the process whereby individuals acquire and integrate into their lives the expected knowledge, behaviours, skills and attitudes, values, roles and norms deemed appropriate and acceptable to their chosen profession (Pilhammar-Andersson 1999). Socialisation of an individual into a profession has been recognised within healthcare since the 1950s (Becker and Geer 1958; Williams and Williams 1959). Goldenberg and Iwasiw (1993) define socialisation as:

*'A complex interactive process by which the content of the professional role (skills, knowledge, behaviour) is learned, and the values, attitudes and goals integral to the profession and sense of occupational identity which are*

*characteristic of a member of that profession are internalised'* (Goldenberg and Iwasiw 1993, p4).

As noted in Chapter One, the process of socialisation begins before the individual enters their chosen profession (Shuval and Adler 1980; Nicholson 1984; Du Troit 1995; Ware 2008), arising from pre-existing values and beliefs. Historically, new nursing students were acculturated to become obedient and have '*respect for authority and loyalty to the team*' (Levett-Jones and Lathlean 2009, p343). Early studies on the socialization of pre-registration nurses describe a one-way process of socialisation, whereby student nurses have to fit into the system or comply with it in order to gain acceptance (Wyatt 1978; Melia 1983; Manninen 1998). Socialization takes place during the student nurses' educational programme, which in these early studies was largely based in the practice domain. The education establishment has been identified as a critical component of the socialisation process (Wilson and Startup 1991), and is therefore a key factor in determining nurses' professional identity. It is arguable that since the move into higher education (HE) there has been a change in the socialisation of nurses to become more independent, questioning and autonomous learners than those described above.

Values and beliefs are not the only factors to influence self-concept; the formation of identity is influenced by the relationship of the individual with their immediate professional community (Lave and Wegner 1991). The concept of communities of practice as a framework for developing professional identity, as described by Lave and Wegner, is discussed later in this chapter (see Section 2.5). Work environment and work culture (Mills and Blaesing 2000; Ewens 2003; Allen 2004) are also known to influence professional identity, and are therefore explored as well.

A person's professional identity is a component of their overall identity, and is often attributed to their 'position within society', 'interactions with others' (nurses, patients and other health professionals) or their 'interpretations of experiences' (Sutherland *et al.* 2010). In other words the 'sense of self' is derived from the perceived role that an individual takes within the work community. Evetts (1998, p61) describes professional identity as:

*'Professional identity is assumed to be associated with a sense of shared experiences, understandings and expertise, common ways of perceiving*

*problems and their possible solutions. This is ideally produced and reproduced through a shared and common educational background and professional training, by similarities in work practices and procedures, by shared ways of perceiving and interacting with customers and clients and by memberships in professional associations and societies where practitioners develop and maintain a shared work culture'* (Evetts 1999, p14).

Fagermoen (1997) defines nursing professional identity as:

*'The values and beliefs held by nurses that guide his/her thinking, actions and interactions with the patients'* (Fagermoen 1997, p431).

There is a considerable literature describing nursing as a profession, and how it is perceived by both the public and other professions. As noted above, this has an impact on self-concept and as a consequence professional identity. Therefore, the following section will summarise the professionalization and public image of nursing, in order to explore professional identity within advanced practice roles.

#### 2.4.3 The professionalization of nursing

The professionalization of nursing has been an ongoing discussion for many decades. Originally seen as harlots, charlatans and drunkards with no place in society, it was not until social reform and the first school of nursing was established by Florence Nightingale in 1855 that nursing began to establish formal training and 'rules' of practice (Hood and Leddy 2006). Florence Nightingale saw nursing as an independent profession that was equal to the medical profession (Nightingale 1969), however for many years nursing was viewed as inseparable to medicine, and medical (and male) dominance strongly influenced public image and the development of nursing throughout the 20<sup>th</sup> century (Hallam 2000; Gordon 2005; Fletcher 2006).

Nurses (and others) have sought to be recognised as a profession on the basis of an ever-increasing body of knowledge. Whilst this debate continues, and will not be fully resolved here, it is worth exploring briefly the concept of professionalism to gain an 'accepted' understanding of the general characteristics. A profession can be defined as *'a vocation with a body of knowledge and skills (expertise) put into service for the*

*good of others; welfare or society*' (Van Mook *et al.* (2009, p81). Historically, Millerson (1964) theorised that a profession has certain characteristics that set it apart from other roles. Such attributes include: a skill based on theoretical knowledge, one that requires training and education, a test of competence, a code of practice, organization and a service to the public (Millerson 1964). Other related and accepted characteristics of a profession include autonomy of practice, an exclusive knowledge base, occupational control of rewards and a noble work ethic (Popkewitz 1994). If these characteristics of a 'profession' are accepted as correct, nursing could be viewed as fulfilling them since nursing practice is tested and regulated, and is derived from a body of knowledge that is evidence based. The practice of nursing is set within a 'code of practice' which serves the public.

Within the healthcare arena medicine has been the dominating profession since the early 1900s when medicine became a powerful force, and the care of the sick became institutionalised (Twaddle and Hassler 1987). Over time other health care roles have attempted to establish themselves as a profession within their own right. For example, professional status for physiotherapists was sought over many years, but it was not until the late 1970s that autonomy of patient care by physiotherapists was endorsed (DH 1977). In today's healthcare systems, there appears to be a shift in the balance of power between professions, some suggesting that patients themselves have disrupted the dominance that medicine has enjoyed (Barr 1998). Others go further by suggesting that in the context of a competitive and client-focused health care service that is based on accountability and collaboration with others, the dominance of a medical model of practice in a hierarchical consultant-led health care system may be outdated, offering the possibility of a new model of professionalism (Richardson 1999; Sullivan 2000; Van Mook *et al.* 2008; Evans 2008 and Chulach and Gagnon 2015).

The issue of autonomy appears in the literature as a key characteristic of professionalism. Over time, nursing has attempted to describe itself as an autonomous body, and has developed roles that fit within this concept. As highlighted previously, the role of the ENP is often defined as 'autonomous'. Friedson (2001) suggests that autonomy implies self-governance, and identifies this as one of the key professional attributes (Friedson 2001). Piil (2012) found in her study of expanded practice that participants identified autonomy as an important factor that impacted on their perceived professional identity. However, participants also noted that there were

several areas of restriction that arose from decisions made by physicians and healthcare managers. Adams (2010) argues that nurses are not truly autonomous as practice is directed by external sources and influenced by government. That aside, many nurses value their qualifications, extended roles and levels of internal autonomy, and see this as an integral part of their professional status (Laperriere 2008; Murray *et al.* 2010). As a result, when this is not achieved it has been a notable source of frustration and conflict (Lamarche and Tullai-McGuinness 2009).

Whilst nursing may no longer be seen as an altruistic vocation for some, many nurses choose to remain at a level close to delivering patient care, and do not advance further up the career ladder. Some argue, however, that the increasing popularity of specialization, with a growing number of extended roles and advanced practitioners, has resulted in nurses becoming removed from the public, and distanced their role from society so that nurses are now more academic and less accessible (Carr and Harnett 1996).

Whilst nurses see themselves as well trained professionals, the public still see nursing as a low-status profession that is subordinate to doctors, and lacking in professional autonomy (ten Hoeve *et al.* 2013). Bridges (1990) identified 34 different stereotypes of nurses, most of which were negative. The media often portrays nurses working at the patient's bedside and performing routine repetitive tasks. Studies have shown that the public image of nurses does not always match their professional image, insofar as nurses are not always portrayed as autonomous professionals (Gordan 2005). The public are not necessarily aware that nursing is now a theory based and scholarly profession (Dominiak 2004). This is compounded by the media headlines of 'too posh to wash', and recent government leaders questioning the value of a degree-based nursing qualification (Santry 2010). The introduction of degree apprenticeships, which some would see as a move away from an academic discipline, risks introducing a dichotomy in the perception of what nurses do within their own profession and externally to the public. Some would argue that this inability to show a united front has prevented nursing from fully meeting the needs of the public, and gaining professional status (Stummer 2001).

#### 2.4.4 Professional identity within advanced practice roles



The literature is unequivocal that there has been a change in nursing practice over the last twenty or thirty years in relation to role expansion. It is unclear whether this has had a direct impact on nurses' perception of professional identity, though studies have attempted to explore this concept. It appears from the literature that underpinning this notion is the issue of the values that support nursing practice, and there is a dichotomy of views. Some authors suggest that expanded roles run the risk of nurses losing their focus on compassion and caring (Roberts 2000; Callaghan 2007; Burman *et al.* 2008), and that education will shift from the traditional humanistic model to a more medical approach that focuses on the biomedical concept of illness. Authors within this camp argue that it is increasingly difficult to differentiate the nurses' expanded role from other biomedical, cure orientated identities (Dowlings 1997; Scott 1999; Nielson 1999; McClellan *et al.* 2014).

As described previously, medicine has been integral to the development of the current advanced practice competency framework that has been adopted by emergency nursing. This appears to be a key point within the discussion on identity, with some nursing theorists arguing that the core values that underpin changes to nursing practice should be based on nursing values rather than those of medicine in order to assure nursing's professional autonomy (Brush and Capezuti 1997; Scott 1999; Nielson 1999). Piil (2012) explored these issues with advanced practitioners, and found that although the participants felt that changes to their practice influenced their sense of identity, they did not believe this would result in a change in their underlying values. Participants in this study indicated that their expanded practice had not changed their view on the professional field in which their practice was grounded in (Piil 2012). In this study three themes emerged as the key influencers on professional identity: autonomy; change of boundaries; self-esteem and confidence. It is important to note that this was a small study (n= 5), although the issues support findings from previous work.

Role boundary changes were also highlighted as a factor affecting identity in a study by Williams and Sibbald (1999), who explored issues of professional identity with a group of practitioners (n=15) in extended roles within primary care. They found that the shift in roles between GPs and nurses had created tensions not only between the two professional groups but also within different groups of community nurses. Issues of resentment were identified between groups of nurses due to changes in the 'internal

market'. It was suggested that changes in hierarchy and a lack of professional networking had impacted negatively on identity and autonomy, creating a sense of uncertainty and isolation. Respondents indicated that they had conflicting allegiances to their profession and their place of work as roles changed. The second finding from this research related to the notion of 'patient surveillance', as participants expressed uncertainty around how patients perceive them and issues of legal accountability. Education was found to be an important factor in influencing this and, as discussed previously, participants felt frustrated by inconsistencies in the level of education required for the role. Finally, the issue of uncertainty around titles and role definition, linked to perceived professional identity, was highlighted, and is congruent with other studies discussed previously.

#### 2.4.5 'Hybridity', 'third space' and professional identity

The notion of a 'third space' or an 'in between space' was first introduced by Bhabha (1994) to describe the phenomena that takes place when different cultural systems come into contact (Chulach and Gagnon 2015). In this 'space' identities are reconstructed, existing cultural relations are transformed and new boundaries are created (English 2005). Jacobs and Brandt (2012) assert that those situated in this in-between or 'third' space often combine aspects of both cultures to create something unique (Jacobs and Brandt 2012). Verbaan and Cox (2014) suggest that when operating within the 'third space' traditional views and established ways of working come under scrutiny, which can result in both cultural clashes and opportunities for transformation. The concept has been widely discussed within disciplines such as education and social work practice, however it has also been discussed within the nursing arena in an attempt to offer insight into identity and implementation of the ENP role (Rashotte and Jensen 2010).

Chulach and Gagnon (2015) go further, using this concept as a model to explore the notion of hybridity within the ENP role. Bhabha (1994) uses the term 'cultural hybridity' to describe situations in which elements of different cultural systems come together to form something new, for example medicine and nursing. Tye and Ross (2000) in their seminal work on ENP practice identified the notion of hybridity, suggesting that viewing the ENP as a replacement for doctors was problematic. They proposed a move away from the artificial distinction between curing and caring, focussing on the needs of the

patient instead (Tye and Ross 2000). As noted previously, government policy consistently encourages 'blurring of boundaries' (DH 2014), and literature (Murray *et al.* 2010) recognises the hybrid role of the ENP as one that crosses traditional boundaries between medicine and nursing. However, with hybridity comes disruption, as described by Bhabha in 2000:

*'Hybridization is not some happy, consensual mix of diverse cultures: it is the strategic translational transfer of tone, value, signification and position - a transfer of power - from an authoritative system of cultural hegemony to an emergent process of cultural relocation and reiteration'* (Bhabha 2000, p370).

This suggests that what emerges from this hybridity is a change in the way healthcare is organised and delivered that can lead to changes within hierarchies between nurses and doctors, and within nursing itself. This can give rise to resistance from elements of the healthcare system such as medical and/or nursing colleagues, or others such as patients and managers. Uncertainties within relationships and breakdown of professional boundaries have been identified previously as barriers to successful implementation (Williams and Sibbald 1999 and Piil 2012). Chulach and Gagnon (2015) note that whilst these changes in relationships should be expected, the problem arises because they are often not planned for or addressed since ENPs are still perceived as a 'special model' within nursing or a 'replacement' for doctors, rather than a hybrid practitioner in their own right. Rashotte and Jenson (2010) suggest that this results in "essentializing" practices, whereby either all nurses and ENPs are viewed as being the same, or all ENPs and doctors are viewed as being the same, which further diminishes the identity of the ENP.

The lack of 'belonging' to a group (nursing or medicine), according to Chulach and Gagnon (2015) and based on Bhabha's (1994) work, further impacts on the professional identity of the practitioner, with ENPs reporting a sense of 'isolation' or 'marginalisation'. Rashotte (2010) noted that hybrid practitioners may also have difficulty in making explicit their experiential, clinical and decision making capabilities, further emphasising their lack of professional identity.

Churlach and Gagnon (2015) draw on the concept of 'otherness', as defined by Bhabha (1994) as it relates to the formation of the identity of a professional group (in

this instance ENPs). According to Bhabha being identified as 'other' implies a degree of 'truth' which informs the way in which we see ourselves and how we understand the world we live in, and this further extends to who holds the knowledge, expertise and status (or dominance). The holder of the 'truth' is recognised as the 'colonizer' and the 'other' is seen as the colonized. Within this concept the colonizer (in this case the biomedical model) exerts dominance and influence over the colonized or 'other' (the ENP and their identity), rather than recognising their knowledge and autonomous practice (Bailey et al. 2006). Those that are different (for example ENPs) occupy a visible 'otherness' as their point of identity (Chulach and Gagnon 2015). The colonizer maintains their natural position of dominance through a system of surveillance during which knowledge is categorised and the colonizer 'marks' or directs the colonized. Over time this hierarchy becomes 'normal' for both the colonizer and the colonized, and a status quo exists. An example of this occurs when nurse practitioners undertake non-medical prescribing training, which requires supervision by a doctor (colonizer). Over time the colonizer may relinquish aspects of the knowledge to the other, for example the doctor may relinquish the requirement to supervise the nurse prescriber, but this only happens when the colonizer decides it is acceptable, therefore maintaining the dominance.

Arguably this notion of 'otherness' can also be seen within nursing itself, as tasks that were once the remit of qualified nurses are transferred to non-qualified staff, and within other professions such as teaching as responsibility that was once 'owned' by the teacher becomes the domain of the 'higher level teaching assistant' (Boville 2017).

## 2.5 Part 3: Theoretical framework and social theory

When reviewing the literature, it is apparent that education (or learning) appears to underpin many of the aspects that support a positive professional identity. Key themes or words that have emerged from the literature include concepts such as: self-esteem; confidence; sense of belonging; learning; autonomy; role clarity; professional boundaries. Communities of practice have been identified as a framework that supports the development of a professional identity within a professional group (Wenger 1998; McArthur-Rouse 2008; Andrew et al. 2009) and has been used within

nurse education in recent years. The following section will review the literature on communities of practice as a theoretical framework.

### 2.5.1 The social context of learning

In the late 1980s and 90s a growing body of educational research stimulated a reappraisal of the meaning of learning and understanding by suggesting that learning is a process that takes place within a framework of social participation, rather than within the individual mind (Spouse 1998b). Prior to this, it had been assumed that learning is something that individuals do and that learning has '*a beginning and an end; that it is best separated from the rest of our activities and that it is as a result of teaching*' (Wegner 1998, p3). Participation is regarded as central to the learning as learning is not an individual task, but something that is produced and reproduced in the social relations of individuals when they participate in society (Gherradi 1999). Key authors in the rethinking of learning were Jean Lave and Etienne Wegner who developed three concepts that support the social participation framework: communities of practice; situated learning; legitimate peripheral participation.

### 2.5.2 Communities of practice

One of the key frameworks written extensively about within the participation paradigm is that of the community of practice (CoP). A community of practice is described by Wenger (1998) as a model of situational learning based on collaboration among peers, where individuals work to a common purpose defined by knowledge rather than task. Lave and Wengner (1991) argue that learning is integrated with practice, and through engagement with a community of practitioner's students, or newcomers, become increasingly competent in their identity as practitioners. The learning (or knowledge) here is almost seen as an incidental by-product of the social interactions and collaborations (Andrew and Wilkie 2007). This is in stark contrast to the common belief in education that knowledge is a formal commodity that can easily be transferred to practice (White 2010).

Lave and Wegner identify three components that are required for a CoP to exist:

1. The domain - the CoP has a shared domain of interest with membership implying a shared competence and commitment to that domain.

2. The community - members interact and engage in shared activities, build relationships that enable them to learn from, and share information with, each other.
3. The practice - members of the CoP are practitioners who develop a shared repertoire of resources, tools or experiences that are developed over time.

It could be argued that the characteristics identified here would be suited to a community of ENPs, and would support the development of professional identity. However, the interprofessional nature of working in the healthcare arena, and the tensions both between professions and within professions as already described, suggest that the development of a CoP may not be straightforward. The following sections will examine the literature further, and explore relevance to the ENP role and professional identity.

### 2.5.3 Situated learning

Key to Lave and Wenger's theory is that learning is central to forming individual identity. Learning is seen as social participation, whereby the individual is an active participant in the practices of the community (Wenger 1998). This idea goes further than simply 'learning by doing' or experiential learning, as people continuously create their shared identity through engaging in, and contributing to, the practices of their communities. It is suggested that students will be more motivated to participate and develop skills if those they look up to also participate and have the same skills. The motivation to become a more central participant in the community provides a powerful incentive to learn (White 2010). Elcock *et al.* (2007) suggest that student nurses will have a desire to develop skills if the people they admire have the same skills, and they will work towards becoming a member. Wegner *et al.* (2002) promote CoPs as a gateway to informal professional learning, suggesting that when students are embedded in the workplace they can create identity and give meaning to professional practice.

### 2.5.4 Legitimate peripheral participation

A critical part of the socialization into practice is the opportunity to make an authentic contribution to the communal enterprise (Cope *et al.* 2000). For learning to make

sense to students it must be situated in real life contexts where they are allowed to participate legitimately as learners in order to interpret situations and deal with them (White 2010). A novice student is not sufficiently skilled to play a central role; therefore they are given responsibilities and tasks that are peripheral but authentic to the activity. This is what Lave and Wenger (1991) describe as 'legitimate peripheral participation'.

According to Lave and Wenger it would be normal for a student just starting their clinical placement to feel less embedded and participate less than a student at the end of the placement or nearing qualification. Fundamental to the success of increased participation is the role of the supervisor or mentor, and a planned increase in participation by the student. Ideally the amount and nature of participation should be planned according to a student's readiness and ability to learn, and should not cease as soon as the learner becomes competent in one aspect. As the student gains competence they become more involved, and move from legitimate peripheral participation to full participation. This model can be identified within nursing as 'preceptorship', which allows a newly qualified nurse to have support/mentorship in their first year post-qualification. As the year progresses the support is slowly withdrawn and the nurse integrates fully into the ward environment.

Likewise, the ENP also moves through phases of participation. A novice ENP should start the programme with full support from clinical practice. This is to ensure that each student has the opportunity to practice and develop new skills and apply new knowledge in a supportive environment under close supervision. As confidence develops the practitioner starts to practice more independently until fully autonomous. MacLellan and Higgins (2015) examined how ENPs transition into their role, and concluded that the transition is complex with success dependent on the individual and the health care team around them. Change and adaptation are required by both the ENP and the team, and failure in this resulted in feelings of low self-esteem and confidence within the role. This is interesting to note here as the literature discussed previously links low self-esteem and confidence to a dismantled professional identity.

For a CoP to be successful and continue there needs to be a sense of belonging, participation and collaboration. Wenger *et al.* (2002) propose that the desire to learn and belong arises from an individual's motivation and desire to fit in with peers. This could certainly be the case for students and newly qualified nurses, however

sustaining this within those practitioners who have been qualified for several years is likely to be more complex and challenging. Kupferberg (1999) agrees, suggesting that motivation depends on extrinsic as well as intrinsic factors. He describes newly qualified nurses emerging into a profession that exhibits a 'cultural lag', whereby expectations do not match reality. Consequently they do not move forward or participate in workplace developments. It could be argued that this is commonplace within nursing, and indeed across most professions within the healthcare spectrum. Compounded by a climate of resource limitation such extrinsic factors are likely to impact on the practitioner's desire to actively participate in the CoP. It would be unrealistic, however, to assume that a CoP has participants that are operating in full participation at all times. Wenger *et al.* (2002) describe this process as fluid, in which members become active or passive participants depending on their personal circumstance.

The literature suggests that a CoP may be ideally placed for groups of experienced practitioners to challenge and change outdated care practices. Young and Mitchell (2003) promote the notion that CoPs can act as a tool for the transfer of knowledge and the development of new skills. They further suggest that CoPs have the potential to be a powerful, dynamic and versatile tool that can bring about change and act as an effective knowledge resource. Wenger (1998) argues that workplace CoPs evolve anywhere that individuals are drawn together. He firmly believes that the desire to learn and belong arises from individual motivation, and continues to develop as the result of ongoing work centered engagement and collaboration.

It would be natural to assume that a CoP would exist that brings together both advanced practitioners and doctors, since their roles are blurred and both are working to achieve the same goal. However, the notion of ENPs developing CoPs with their medical counterparts is not straightforward. As highlighted previously, the inconsistency in advanced nursing practice coupled with differing educational programmes and a lack of recognition from professional bodies has tended to result in ENPs lacking their own identity. At the same time, they are trying to develop themselves as a true profession, with a body of discreet, specialist and unique knowledge as they move into roles that are outside their traditional sphere of practice and associated with the medical domain. In contrast, doctors have a clear identity that is harnessed right from the start (if not before) their medical training. Many of Lave



and Wenger's arguments are built on the notion that a CoP evolves as a result of the participants' motivation to develop a sense of identity and belonging. In this sense Wenger believes that shared identity is created through engaging in, and contributing to, the practices of their community. (Wenger 1988). However it could be suggested that Wenger is naive in this assertion, and underestimates the power of professional identity.

As noted previously, discussion around professionalism and identity is not new, but is linked inextricably to interprofessional learning and key to the potential success of a CoP involving two or more professions. Communities of practice work on the premise that participants will work effectively together as they all have the same goal and shared vision. This suggests that interprofessional working (and learning) is effective. Salhani and Couter (2009) indicate that the idea of interprofessional collaboration means that professional boundaries are flexible. This implies that traditional characteristics such as identity, jurisdiction, self-regulation and professional territorialism (Axelsson and Axelsson 2009) are challenged by an interprofessional approach.

Lewey (2010) suggests that interprofessional learning provides an environment in which structured opportunities are put in place to facilitate the transfer of professional knowledge, and where team processes and working are developed in a structured and formal way. However, Hoskins (2011) proposes that interprofessional learning takes place in a more controlled environment such as the classroom, rather than the clinical area. This is contradictory to the ethos of CoP within the workplace, although it could be seen as a more realistic viewpoint when taking account of the barriers to interprofessional working that are identified in the literature. McPherson *et al.* (2001) support this view, suggesting that barriers include a lack of knowledge of the capabilities of other professions, rivalries and resentment amongst professions, and concern that the blurring of boundaries and identity are a threat to professional status. Abbott and Meerabeau (1998) adds that all professions are striving for jurisdiction over their field of work, and that the medical profession ensures that doctors maintain the central role within health care (Yong 2006). However, Carrier and Kendall (1995, p18) offer a different viewpoint, which is more in keeping with a participatory model of collaboration:

*'Interprofessional working implies the sharing of knowledge; respect for the individual autonomy of different professional groups; the surrender of professional territory where necessary and a shared set of values'* (Carrier and Kendall 1995, p18).

Barriers around professional identity and disciplines owning their own body of knowledge may be a significant obstacle within the CoP paradigm.

Supporters of the participatory paradigm would argue that the transfer of knowledge does not fit into the conceptual framework of participation, as this would mean transferring knowledge across contextual boundaries (for example medical knowledge into a nursing role). In the truest form of the participation framework there is no knowledge or definite boundary to cross (Sfrad 1998). Yakhelf (2010) suggests that knowledge transfer takes place among individuals who are embedded in certain relations with others. He proposes that knowledge is accepted and stabilized when it is deemed epistemologically successful. For example, a change in treatment option only occurs when the body of evidence has reached a large enough audience. The quality of individual research/evidence may not always be as robust as it should be, but the combined effect generates the acceptance of a change in practice (Yakhelf 2010). Collins (1985) and Longino (2002) go further, suggesting that certain knowledge can be accepted without participation on the basis of trust, and that practitioners are embedded within a supporting matrix of trust.

Yakhelf (2010) explores another concept within the participation paradigm, which is the notion that practitioners may belong to more than one community of practice. Membership, he suggests, can be of multiple communities and therefore a source of learning as individuals can benchmark the standards of different communities and evaluate the process of producing knowledge within them. Innovations and ideas can then be transferred from one community to another. This idea certainly aligns well with the difficulties that can occur between professional groups in clinical practice, and almost accepts and welcomes the diversity different groups bring to learning when not constrained by the notion of sharing the same values, beliefs or identities. This is summed up by Yakhelf (2010) who asserts that:

*'Practitioners may entertain different personal beliefs and views that draw on their particular habitus but share a basic set of standards of justification with each of the communities in which they happen to participate and to which they belong'* (Yakhelf 2010, p45).

## 2.6 Social theory

The previous sections have examined the literature relating to the development of the ENP role, and the development of professional identity within this group of practitioners. They have explored the notion of professionalism within nursing, and the impact this has on professional identity. CoP have been critiqued as a concept for supporting the development of professional identity both within nursing and the ENP role. However, whilst the previous sections have explored the perceived dominance of medicine in relation to the professionalization of nursing it is useful to consider sociological theories that take into account the social context within which individuals live and operate, and how these may effect the development of identity within a professional group or individually. Bourdieu's (1973) notion of habitus attempts to theorise how the social context within which people live impacts on identity formation and the capacity to change their identity over time. This is an interesting concept worthy of exploration as it potentially encounters the work of Bhaba, described previously, who suggests that new identity is formed when different cultural systems come into contact to form something new (or hybrid) (Bhaba 1994). Bourdieu argues that the social world is divided into 'fields' within which professions occupy dominant positions (education, law or medicine, for example) and whereby deep rooted beliefs and identity are formed and held, implying that moving between fields (or identities) is difficult. The following section draws further on the work of Pierre Bourdieu and the concepts of cultural capital, habitus and fields in relation to professional identity formation.

### 2.6.1 Cultural capital

Bourdieu's (1973) concept of cultural capital refers to the collection of symbolic elements such as skills, tastes, posture, clothing, material belongings or credentials that are acquired through belonging to a particular social class. According to Bourdieu,

sharing similar forms of cultural capital with others, for example the same taste in music, belonging to a club or studying for a particular degree within a group, creates a sense of collective identity and group position, or as Bourdieu puts it 'people like us' (Bourdieu 1999).

This link to collective identity is interesting, in that it can be translated to professional identity within the nursing and other health care professions, and is linked to habitus as described below. Sfard (1998) suggested that the possession of knowledge has the connotation of material wealth, and is regarded as a highly prized commodity that can allow the possessor of the knowledge to become powerful and establish a strong sense of identity within a professional group. Moreover, the concept of knowledge as a commodity or possession fits well within the Bourdieu idea of cultural capital. It could be argued that the medical profession has acquired this commodity and established a powerful hold on it. Therefore, medical students have a strong sense of 'people like us', which strengthens and builds their sense of professional identity.

As noted previously, studies suggest that medical students demonstrate a strong sense of shared identity and professional inclusivity (Tajfel and Turner 1986, Hogg and Adams 1988 and Weaver *et al.* 2011). Since moving to degree-based education, nursing has been attempting to define a 'new' professional identity, and as described by Lave and Wenger (2002) student nurses encounter tensions when the desire to be accepted by qualified staff in placement competes with the desire to question outdated practices (Bathmaker and Avis 2005). Students may also experience conflict between the values of nursing such as care, holism and empathy, and an emphasis on targets, adherence to care pathways and protocols that stifle autonomous client-centred approaches to care (Abbott and Meerabeau 2003). Furthermore, some studies suggest that hostility, resentment, prejudice and suspicion towards nurse colleagues is not uncommon (Castledine 2005; Winkelmann-Gleed and Steely 2005). It is therefore possible that the sense of 'professional inclusivity' or 'people like us' experienced by medical students is less apparent within nursing.

Studies examining identity within the ENP role suggest that role boundary changes are a factor affecting professional identity (Williams and Sibbald 1999, Pill 2012), and a source of tension within the group and between professions. Relating this to the work of Bourdieu and the notion of 'belonging to a club' with a shared or collective identity

further highlights the potential difficulty in developing a professional identity within this professional group, and having a sense of belonging. As Chulach and Gagnon (2015) note, ENPs are often viewed as either a 'special model' within nursing or as a 'replacement' for doctors rather than a hybrid practitioner within their own right. This results in what Rashotte and Jenson (2010) describe as "essentializing practices", whereby either all nurses are viewed as being the same or all ENPs and doctors are viewed as being the same. The effect of this is that ENPs are unable to develop their 'own club' to belong to. Bourdieu goes further, suggesting that within the social context in which the 'club' operates are fields that are dominated by certain occupations, each with their own defining (and fixed) characteristics and practices, and that this further hinders the formation of new identity. This is explored further later in this chapter.

### 2.6.2 Habitus

The notion of habitus is intricately linked with the social structures within which we exist. Bourdieu defines this as '*a structuring structure, which organises practices and the perceptions of practices* (Bourdieu 1984, p170). According to Bourdieu, habitus refers to the physical embodiment of cultural capital. In other words, the social context of people's lives becomes 'internalised', and this impacts on their identity formation and capacity to change. Habitus consists of our thoughts, tastes, beliefs, interests and our understanding of the world around us, often referred to by Bourdieu as 'the feel for the game' (Bourdieu 1973). The 'game' in this metaphor refers to the social context within which we live (our cultural capital) and our habitus allows us to successfully navigate social environments. Habitus, according to Bourdieu, is neither a result of free will nor determined by structures; rather it is created by an interplay over time. It is quite enduring and transferable from one context to another. Although Bourdieu acknowledges that habitus is not fixed or permanent, it is difficult to change except in circumstances of prolonged historical change or under unexpected situations. It is arguable that the notion of habitus is inextricably linked to hierarchy and carries distinct lines of class, race, gender and sexuality. Indeed, Lawler (2014) suggests that not all habituses have equal worth. According to Bourdieu it is through these habituses that power is constantly re-legitimised, as habitus or 'social norms' guide behaviour and thinking.

Within the professional context it could be suggested that habitus is linked to professional status (and therefore identity). In western culture three professions have historically been recognised in common law. These evolved from societal concerns and have largely remained the most powerful in society; clergy, doctors and lawyers have all traditionally been regarded as high status. Despite a decline in traditional religion and some change in social order over the last century, doctors have become one of the most powerful, most respected and well-paid professional groups in the western world (Clarke 2013). They have also been the most resistant to reform (Dale and Salsbury 1999) and have been criticised for putting professional unity and status before the interests of the public and patients (Stacey 1992). Doctors have historically come from a habitus that is largely male, white and middle class (Cockerham 2016), and as noted above medical students demonstrate a strong sense of shared identity and professional inclusivity which comes from a habitus (and a feel for the game) that develops before they start their training and continues throughout it.

Nursing, on the other hand, has struggled to adopt and maintain the status of a profession, and is often referred to as a semi-profession which is unable to lay claim to a discrete body of knowledge (Salvage 1985), because it continues to view the development of practice through the lens of others, principally medicine (Tolsen *et al.* 2005). In addition, nursing has been more open to change and has historically not focused on defending its title, role or place in the social hierarchy (McKendry *et al.* 2011). Central to the nursing ethos is the patient, and nursing has traditionally responded positively to change when the patient is at the heart of that change. Santry (2010) goes further, suggesting that nursing is viewed through an emotional lens that focuses on the subjective rather than objective. Tolsen *et al.* (2005) argue that if nursing continues to use medicine as a benchmark for its achievement it will not flourish as a profession within its own right, and therefore not establish its own identity. This 'borrowing' of knowledge, and reliance on medicine, ensures that nursing remains within a 'nursing habitus' with lower social status and a less well-defined identity.

Conversely, however, Beck and Young (2005, p188) offer a different view and support the notion of a '*professional habitus*' in which a common moral and ethical code, a sense of purpose and the development of a strong professional identity are determined by socialisation into one's subject loyalty (Bernstein 2000). Like the notion of a CoP, a professional habitus is developed through the '*basic building blocks of a social*

*learning system, in which members are bound together by their collectively developed understanding of what their community is about* (Wenger 2000, p229). The professional habitus concept goes further than developing an underpinning curriculum which equips practitioners with the knowledge base required to practice. Bernstein argues that alongside this, practitioners develop a moral code that determines why practitioners engage in certain activities. In other words, there are two elements to professional habitus; the attainment of knowledge and the personal and moral growth that Bernstein terms the 'inner dedication' (Bernstein 2000, p 54). Taylor and Care (1999, p35) describe this within nursing as *'the covert decision making processes, values and cultures that guide the selection and implementation of these behaviours'*. As discussed previously within this chapter, the process of socialisation begins before the individual enters their chosen profession and continues throughout their programme of study. As a result, the notion of professional habitus is inextricably linked to this process and is key to the formation of professional identity for nurses and ENPs.

### 2.6.3 Fields

Bourdieu describes a 'field' as being *'various social and institutional arenas in which people express and reproduce their dispositions, and where they compete for distribution of different kinds of capital'* (Gaventa 2003, p6). A field is described as *'a network, structure or set of relationships which may be intellectual, religious, educational and cultural'* (Navarro 2006, p18). In other words, the field could be described as the 'game' in which people exist. Bourdieu sees each field as being fairly autonomous, in that each field has its own set of positions or practices or 'social fields'. During each field members may struggle for position and to stake a claim within that field. Fields are inextricably linked to habitus, in that habitus refers to the internalisation of behaviours and beliefs that are determined over time and which are associated with hierarchy and behaviour. According to Bourdieu, habitus allows people to navigate social environments (or the 'game'). In other words, the field is the 'game' in which people exist, however how they act within the field (or game) is determined by their habitus which is developed over time and is associated with capital in that people act a certain way when they belong to a club or have a collective identity within a group.

Medicine and nursing, it could be argued, are 'fields' within which there are different practices and claims and power struggles. Whilst there may be some overlap between fields, Bourdieu suggests that, on the whole, each field exists autonomously, though people experience power differently depending on which field they are in at a given moment (Gaventa 2003). Revisiting the concept of 'otherness' as described by Bhaba, and relating this to ENPs, it appears that those who adopt the status of the 'other' (ENP) will remain within the same 'field', as the colonizer (medicine) adopts the position of power and influence over the 'other' (or colonized), ensuring that movement between the domains (or fields) does not occur. Although the colonizer may relinquish aspects of knowledge and responsibility, this only happens when the colonizer decides it is acceptable, thereby ensuring that the 'other' (ENP) remains within the same field and the status quo continues.

Conversely, however, when relating back to the work of Bhabha (1994) and the notion of the cultural hybridity that results from the merging of two different cultural systems, it could also be argued that fields are more fluid than Bourdieu suggests. Tye and Ross (2000) explored the notion of hybridity within the role of the ENP, suggesting that to view the role as either a replacement doctor or an extended nurse was unhelpful. Studies have consistently found that ENPs suggest a sense of conflict and uncertainty in relation to other professional groups (Willimas and Sibbald 1999; Lloyd- Rees 2016). This resonates with the concept of hybridity in that hybridity is associated with uncertainty and conflict during its formation, however the result is the emergence of a change in the way people think, act or believe, and this in turn leads to a change in hierarchy and culture. In this instance it could be suggested that ENPs are moving into, and operating within, a different field from their original nursing field, and this will in time develop its own set of 'social fields' with a unique sense of belonging and identity (and 'people like us').

## 2.7 Chapter summary

In this chapter, relevant literature relating to the development of the ENP role within urgent care, and more specifically the development of the 'advanced practitioner', has been reviewed. It is clear from the literature that issues around titles, autonomy and scope of practice remain a challenge for those within advanced practice roles with



studies suggesting that these issues contribute to uncertainty in the workplace. However, there is less evidence looking at whether these issues impact on a sense of identity and autonomy for ENPs, and whether these factors contribute positively or negatively to their sense of professional identity. This has helped to frame the overarching research question for this study. Literature relating to the professionalization of nursing and the concept of professional identity has also been explored within this chapter. It is evident that identity is in part formed through a process of socialisation, whereby a group creates a professional identity by developing a set of behaviours, knowledge formation, values and attitudes. This section highlighted how professions such as nurses and doctors start to develop their sense of identity before joining the profession, and that the perceptions of others (both in society and within the workplace) is an important factor in developing their identity. This has facilitated the development of the sub questions for this study, specifically around an exploration of the influence of others in developing professional identity.

The community of practice framework has been considered as a model of situated learning that can act as a tool for the transfer of knowledge and the development of professional identity. This was a useful consideration as the owner of knowledge and the transfer of knowledge have been identified previously as contributing to the development of professional identity. Further, exploring the CoP framework supported the conceptualisation of the research design, in that case study research is often used to explore multifaceted and complex issues. The work of Lave and Wenger identify three components that are required for a COP to exist: the domain (shared interest); community (shared activities) and practice (shared experiences). This description resonates well with a community of ENPs, and therefore supported the choice of case study and focus groups to explore perceptions.

Bourdieu's concept of cultural capital, habitus and fields has also been explored in relation to the position of nursing and the ENP's professional role and identity. Bourdieu explores the notion that belonging to a club or studying together develops a sense of 'people like us', and therefore a strong sense of identity. Habitus refers to an understanding of the world around us or 'feel for the game' and Bourdieu asserts that this is associated with social hierarchy and status and is difficult to change. Literature explored within this chapter identified that medicine has a strong habitus and has historically put professional status before public interest. As Sfard (1998) recognises,

this is associated with the possession of knowledge and power. Nursing, however, is less resistant to change and arguably occupies a less defined habitus with lower social status. Further, it is assumed in the literature that lower status impacts directly on professional identity, resulting in a less defined professional identity. How this translates to the professional identity of ENPs, who are operating within a nursing domain but with distinctive influences from a medical model of practice, is an important and unanswered question. This highlights the need to explore whether ENPs have a shared sense of 'people like us' (or professional identity), and whether or not this is influenced by medical colleagues, organisational structures or social hierarchy.

### 3. Research methodology

#### 3.1 Introduction

Previous chapters have described the context in which the role of the ENP has evolved, and the challenges that the NHS faces in relation to an ever-increasing demand on resource that necessitates a flexible workforce for the future. (DH 1997, 1999, 2001, 2002, 2003, 2006, 2008, NHS England 2013). Whilst the ENP role itself is now well established (Hoskins 2011), it is still a relatively new role that is constantly evolving and developing as healthcare demands change at pace. The literature identified that the role has developed in an *ad hoc* way, with varying educational programmes encompassing elements of both medicine and nursing leading to the creation of a 'hybrid' that may lack professional identity. In addition, one of the key factors contributing to uncertainty in the workplace is the breakdown of professional identity and working within new roles (Williams and Sibbald 1999). Other key themes emerging from the literature suggest tension within and between professional groups, whereas interpersonal relationships and a sense of belonging are all important components of forming a professional identity. Anecdotal evidence suggests that retention in some posts is difficult, with ENPs leaving for less demanding jobs.

The key aim of this study was to explore what factors influence ENPs' perceptions of professional identity, in order to gain some understanding of how both educationalists and NHS organisations can support the role and maximize its potential for the future. The purpose of this chapter is to outline the methodological approach chosen, and provide a rationale for this. In order to do this the dominant paradigms within health and social science research will be explored, and the paradigm within which this research sits will be described. A brief discussion around the ontological and epistemological assumptions that underpin the research will be included, and the chapter will conclude with a review of the literature on case study research as the chosen methodological approach.

## 3.2 Research paradigm

In order to determine the methodology and methods for the research it is important to understand the philosophical paradigm that underpins the research (and researcher). Guba and Lincoln (1994) point out the importance of identifying the paradigm within which the research is conceived and carried out, and suggest that *'a paradigm may be viewed as a set of basic beliefs (or assumptions) that deals with ultimate or first principles'* (Guba and Lincoln 1994, p107).

Historically, the two most prominent research paradigms have been the scientific (positivist) and the interpretive (post-positivist) approaches. In health care research the scientific approach has arguably been the most influential and seen as the 'gold standard' for over 400 years (Knipschild 1993; Black 1996; May 1997). One of the central tenets of the positivist paradigms is that logic of the experiment is the only acceptable logic for scientific research, and that only knowledge acquired in this way is scientific research (Guba and Lincoln 1994). Within the positivist paradigm knowledge (and truth) is discovered through systematic testing of hypotheses, allowing people (or professions or policy makers) to explain, predict or control events which in turn guides professional practice and decision making (Grant and Giddings 2002). This paradigm has historically dominated medical research, often adopting the assumed gold standard of randomised controlled trials (RCTs) to replicate and verify evidence-based practice. As described in Chapter Two, medical education was devised by scientists for the study of disease (Engel 1977), whereby it is assumed that disease can be accounted for by deviations from the norm of measurable biological variables, therefore placing medical education firmly within the positivist paradigm. It is not surprising, therefore, that the positivist paradigm is dominant within medical research, as it supports the underpinning model of education.

Whilst nursing research has historically adopted a more interpretative (or qualitative) approach (Lawler 1998) there have, since the second half of the twentieth century, been moves to define unique bodies of knowledge that 'belong' to nursing in an attempt to claim its status as a profession in its own right (Grant and Giddings 2002). Here, evidence often takes the form of systematic reviews to highlight 'best practice', which then becomes a 'gold standard'. The assumption is that this will in turn result in

excellent care. (Grant and Giddings 2002). That said, the majority of nursing research does utilise an interpretative approach, offering rich insights into the experiences and perspectives of patients. Like medicine, this mirrors the educational approach taken which is based on a humanistic model with a focus on health rather than disease, and a concern for the 'whole' person not just the illness (RCN 2003).

Interpretivism has gained popularity since the mid-20<sup>th</sup> century, when social scientists contested the positivist deterministic and reductionist approach. Rather than seeking the 'truth' of the experience, they sought to understand what it is to be human and the meaning that people attach to experiences (Grant and Giddings 2002). Critics of the positivist paradigm suggest that positivist methodology neglects the influence of human behaviour (Guba and Lincoln 1994), and relies too heavily on the etic (outsider) view that may have little in common with the emic (insider) view of the study group (Glaser and Strauss, 1967; Strauss and Corbin 1997). Within the interpretivist paradigm the researcher relates and interacts with the participants in order to understand their experiences, and to gain meaning. Whereas within the positive paradigm the researcher is viewed as the 'expert' and maintains an objective position, within the interpretivist paradigm the researcher must explain their position in relation to the phenomena, and will interpret the data given to him/her by the participant.

This study sits within the interpretivist paradigm as it is concerned with exploring participants' perceptions, feelings and their understanding of a professional group within which their role sits. As the researcher (and also a former ENP) my intention was to interact with the participants (through focus groups) and use the 'insider' knowledge to help clarify and gain understanding to ensure I was able to interpret the data accurately. Whilst being an 'insider' within this paradigm is viewed positively, it is worth noting that there can be disadvantages and concerns regarding the 'insider researcher'. This will be explored in more detail in Chapter Four. The purpose of the chosen methodology (case study) was to gain an understanding of the situation from an emic perspective, which sits well within the interpretative paradigm as outlined above. Case study as a methodology will be discussed later in this chapter.

The research framework adopted also relies on ontology and epistemology (Ramazanoglu and Holland 2002), as this demarcates what can and cannot count as meaningful knowledge and further informs the methodology (Braun and Clarke 2013).

### 3.3 Ontological assumptions

According to the literature (Neuman 2011) ontological assumptions specify the relationship between the world and our human interpretations and practices. They determine whether we think reality exists entirely separate from human practices and understandings (including the research we undertake to find out about human practices and understandings), or whether we think it cannot be separated and therefore knowledge will always reflect one perspective (Braun and Clarke 2013). It is important to acknowledge that as a researcher my own 'view of the world' and interpretation of human interactions within it are important factors when planning a research project of this type. Relativism (at one end of the continuum) assumes reality is entirely dependent on human interpretation and knowledge, and this will differ across time and context (Braun and Clarke 2013). Relativism often underpins qualitative research in that qualitative research is primarily used to study things in their natural setting, attempting to make sense of, or interpret, phenomena in terms of the meaning people bring to them (Denzin and Lincoln 2000). At the opposite end of the continuum sits realism which assumes that there is only one truth that can be accessed by the appropriate (usually quantitative) research methods (Braun and Clarke 2013). However, not all research (or viewpoints) can be packaged into the neat boxes described above. There is, according to the literature, a point in-between these two poles called critical realism (Madill *et al.* 2000). According to Madill *et al.* (2000) there is a real and knowledgeable world that sits behind the subjective and socially-located knowledge that the researcher can access. In other words, the way reality is experienced and interpreted is influenced by culture, language and experience. Stainton-Rogers and Stainton-Rogers (1997) claim that some 'authentic' reality exists to produce knowledge that *might* make a difference to our understanding (or knowledge). To make sense of this further it is useful to compare this assumption to potential findings in this research. The findings in this study would need to be able to claim (for example) that the lack of career structure that some ENPs feel is real in order to produce 'knowledge' that might result in organisations developing a more coherent career structure for staff. The external reality in this instance would be the ENP's feeling of frustration or apathy and would (according to Braun and Clarke 2013) provide a foundation for knowledge.

### 3.4 Epistemological assumptions

Although ontology and epistemology are inextricably linked, epistemology is generally concerned with what is the nature of knowledge or what is counted as trustworthy or true knowledge (Neuman 2011). There are three dominant epistemological positions that individuals may align to: positivism, constructionism and contextualism. I will briefly outline these within the context of this research.

Positivism relates to objectivity and uses traditional scientific methods to support research findings with the aim of finding valid (objective) knowledge in order to discover the truth (Cocks 2000). This position sits within the positivist paradigm as discussed previously, and is often associated with medical research that uses traditional methods such as RCTs or surveys to obtain data. This research study was developed to understand participants' perspectives of professional identity while exploring issues that may have an effect on their perceptions of identity. Whilst certain positivist methods could extrapolate some of this information (such as questionnaires) it was important to understand the meaning behind the voices and therefore a more interpretative approach was needed. As a nurse and social scientist, positivism has significant drawbacks because it doesn't allow for meaning or an understanding of an experience; it would merely report the experience. It is worth noting here that since the 1960s positivism has been challenged (Kuhn 1970; Popper 1992) with the emergence of the notion that there are multiple and competing views of science and multiple truths (post-positivism) (Guba and Lincoln 1994). Social and cultural contexts began to emerge as worthy of recognition, and this results in a more mixed method approach to scientific research. Although this has now become a recognised approach within scientific research, some argue (Grant and Giddings 2002) that the post-positivism belief still sits firmly within the positivist camp, and this methodology and ideology continues to dominate health and scientific research.

The second position described in the literature is constructionism. Constructionism supports the notion that what we know of the world is constructed by various discourses and meaning that may change at different times (Berger and Luckman 1967; Burr 2003; Gergan 1999). In other words, knowledge changes as ideologies change, as meaning and discoveries change. Burr (2003) suggests that knowledge is

a product of how we understand things, and that there are multiple knowledges and no single truth. This position aligns more to the type of research conducted here, as it assumes that the world that we understand (and therefore knowledge) is related to social and cultural contexts. Certainly when exploring perceptions it would be irresponsible not to set context, culture and ideologies within the research. However, as a researcher within health it is difficult to concur with the notion that there is no truth.

The third position is that of contextualism. As with critical realism, this sits between the two poles of positivism and constructionism (Henwood and Pigeon 1994). Here knowledge is seen as emerging from contexts, reflecting the researcher's position so that it is local, situated and always provisional (Madill *et al.* 2000; Tebes 2005). Contextualism does not reject that truth exists (unlike constructionism), but asserts that truth will come from different methods (Tebes 2005). Again this position aligns with this research, in that the researcher is situated within the research and the knowledge (results or truth) will emerge from the context of the research undertaken. It is important to note, however, that research does not need to 'sit' in one camp or another and neither is it right or wrong. However what is important is to understand how a researcher's position will and should determine the type of research undertaken, and will inform the chosen framework.



### 3.5 Qualitative research

Qualitative research has a long and complex history dating back to North America in the 20<sup>th</sup> century. It has evolved over time, being influenced by changing political ideologies. The key difference between qualitative research and quantitative research is that qualitative researchers seek to clarify how social experiences are created and given meaning, whereas quantitative research emphasise the measurement and analysis of causal relationships between variables (Denzin and Lincoln 2011).

Denzin and Lincoln (2011) offer the following definition of qualitative research:

*'Qualitative research is a situated activity that locates the observer in the world... it consists of a set of interpretive, material practices that make the world visible. These practices transform the world... Qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them'* (Denzin and Lincoln, p3).

They go on to outline that:

*'Qualitative research involves the studied use and collection of a variety of empirical materials- case study, personal experience, life story, introspection, interviews, artefacts...visual texts.. that describe routine and problematic moments and meanings in individuals' lives'* (Denzin and Lincoln, p4).

Traditionally, health related research has been based on a quantitative approach, with the main purpose being to prove a hypothesis or to answer specific questions. However, in recent years there is a growing momentum around the need to demonstrate the impact of research findings on practice (Song *et al.* 2010), with researchers opting for a mixed methods approach. For example, Chang *et al.* (1999) opted for a mixed methods approach when evaluating the ENP role in a rural emergency department. Fulop *et al.* (2001) concur, suggesting a growing need to understand the impact of the delivery, with a focus on process as well as outcomes. Research that has focused on the perceptions and attitudes of ENPs, such as Tye and Ross (2000); Fisher (2006); Weiland *et al.* (2010), has tended to adopt a purely

qualitative approach in order to interpret meaning within the ENP's natural setting, therefore taking a more interpretative approach.

This research adopted a qualitative approach because its main focus was to explore attitudes and perceptions of professional identity in the participants. The next section will consider alternative approaches and discuss the use of case study as a methodological approach

### 3.5.1 Evaluation of qualitative approaches

As noted previously, qualitative research approaches focus on the emic perspective of the individual and are concerned with understanding life from the perspective of the participants in an uncontrolled natural setting (Morse and Field 1996). The previous section highlights how the researcher's epistemological orientation often influences the type of approach taken, and it is important to consider different approaches as part of the research design process. Ethnography as an approach was considered within this study as it is a means of gaining access to health beliefs and practices of culture, and allows the researcher to view phenomena in context (Morse and Field 1996).

Ethnographic approaches as described by Atkinson *et al.* (2001) are grounded in a commitment to the first-hand experience and exploration of a particular social or cultural setting on the basis of participant observation. Ethnographers are deeply concerned with immersing themselves within the natural or cultural setting, and suggest that the most effective way of collecting data and generating knowledge is for the researcher to get right inside the participant setting, often (although not exclusively) through participant observation and developing a relationship whereby it is difficult to distinguish between the researcher and the participant. This immersion of the researcher stems from their epistemological viewpoint that culture can be known from cultural and social settings, and these settings are the key source of data collection (Mason 2007).

As the focus of this research was to understand the perceptions of the participants relating to their role and their identity, ethnography was considered as an approach because it would allow deep immersion in the culture of the ENP and elicit 'how they see the world' in relation to their professional identity. However, due to the immersive nature of ethnography it is important to consider any power relationships between

participant and researcher as researchers can become so embedded that they almost become one of the participants, or participants become a co-researcher with interviews and conversations becoming indistinguishable from each other (Mason 2007). As many of the participants in this study had been students of the researcher, with the potential for a power imbalance, ethnography was discounted as the research approach.

On the other hand, interpretivism is largely concerned with exploring perceptions, meanings and understandings. Interpretivism does not rely on 'total immersion' as it aims to explore individual or collective meaning (Mason 2007). Blaikie (2000) goes further by suggesting that an interpretive approach not only sees people as source of primary data, but seeks their perceptions or their 'insider' view rather than imposing an 'outsider view'. Data collection methods within this approach often include interviews and focus groups because they allow the researcher to gain a deep understanding of the participants' perceptions and interpretations of the situation without becoming too immersed in the environment within which they operate. This maintains a more neutral relationship and power balance. Data collection methods used in this study will be discussed in Chapter Four.

### 3.6 Case study – review of the literature and justification

A case study is a research approach that is used to generate an in-depth, multi-faceted understanding of a complex issue in its real life context (Crowe *et al.* 2011). It can be defined in a variety of ways; however, the central tenet is the need to explore a phenomenon in depth and in its natural context. Case study research seeks to explore and find out what is going on, rather than to analyse or account for it. It seeks to understand the 'how', 'what' and 'why' of a particular phenomenon or issue, rather than test a hypothesis or an intervention. Partlett and Hamilton (1974) suggest that it seeks to 'illuminate the readers' understanding of an issue. In this sense case study research sits firmly in the interpretative paradigm, adopting a contextualism epistemological approach.

Keen and Packwood (1995) suggest that case study research is useful in health care settings when used to ask participants about their experiences of work practices and

the impact of change or organisational processes. For example, Lo (2004) undertook a longitudinal study of perceived level of stress, coping and self-esteem of undergraduate nursing students using a case study approach. Sharp (1998) advocates the value of case study in nursing research, suggesting that the activity of nursing is centred around 'cases', both in the conventional sense of using patients as cases but also in the broader professional context whereby nursing is situated in particular organizational and social contexts that can be said to constitute 'cases'. For example, a study by Roberston *et al.* (2010) used a case study approach to evaluate the introduction of electronic health records in English hospitals. In their study the primary focus of the research was to investigate how the technology was being implemented; therefore, the 'cases' in this instance were the NHS Trusts and not the individual. However, it could be suggested that if the research had focused on how the implementation had impacted on the doctors or nurses using the records, the cases would have been groups of doctors and nurses and not the Trusts. Different authors have different views on how the case study approach should be considered within qualitative research. There are numerous texts on the case study approach, however two key authors for consideration are Robert Yin and Robert Stake. The following section will examine both authors' critique of the case study approach, and will seek to identify and explain the preferred approach for this study.

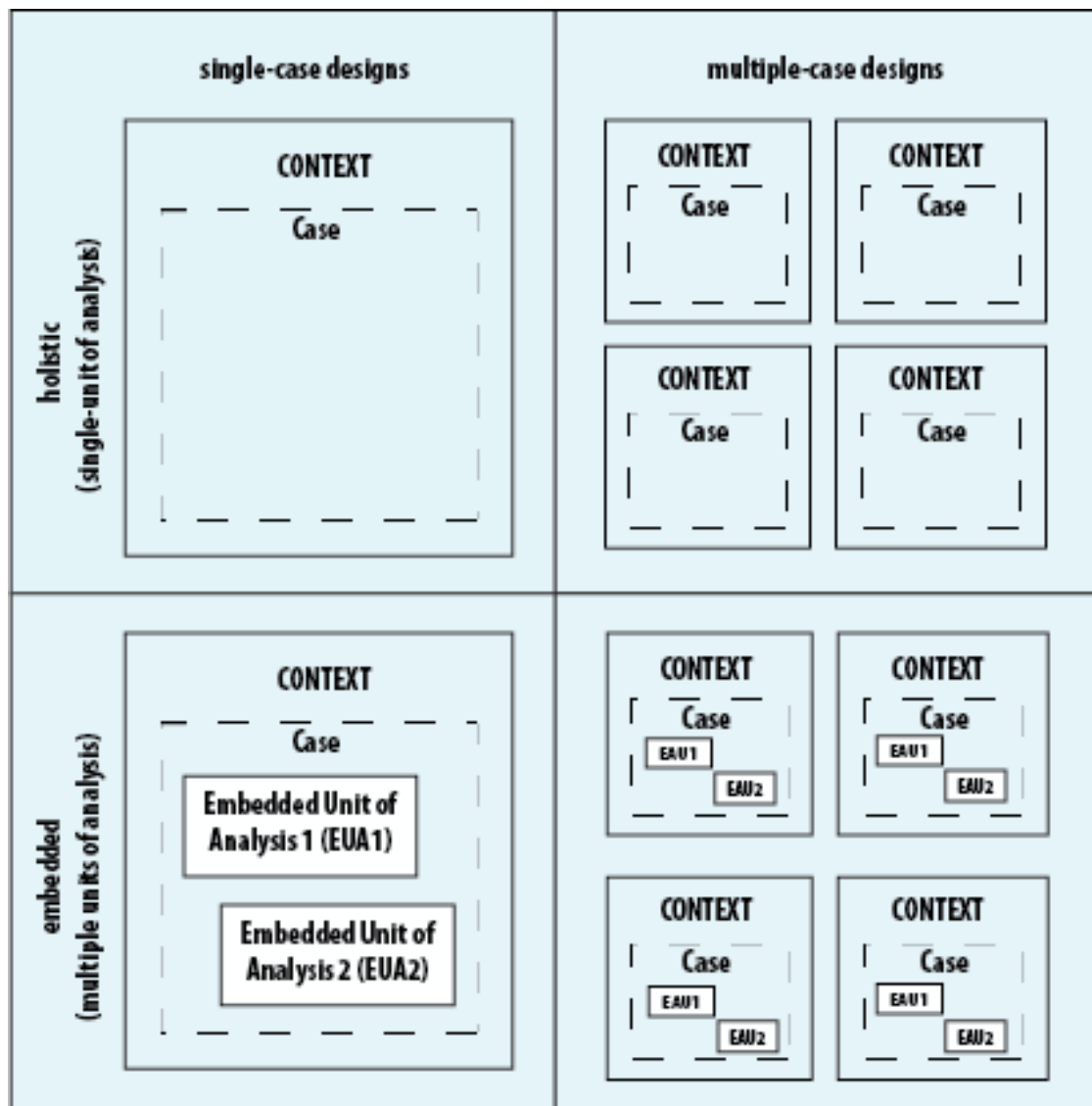
### 3.6.1 Defining the case

Different authors define the case in different ways; however, all agree that defining the case is the first step in this type of research methodology. According to Yin (2009), case studies can be used to 'explain, describe or explore events of phenomena in the everyday contexts, especially when the boundaries between phenomenon and context are not clearly evident' (Yin 2009, p18). Yin suggests that a case is a '*bounded entity (person, organization, behavioural condition, event or other social phenomena*' (Yin 2012, p8). He goes on to state that the boundary between the case and the context surrounding it can be blurred. The case itself serves as the unit of analysis; however, there can also be 'embedded' units within the main unit. For example, within this study the case could be defined as a group of ENPs that work in a single Trust or organisation, or the case could be defined by their pay grade rather than their place of work. In either case, the phenomena that will be explored relate to their perception of

professional identity as a group of practitioners, and the boundary between this and their place of work; pay grade may be inextricably linked.

Yin suggests that there are four types of case study designs (see Figure Two). From this diagram, it can be seen that a case study can be single or multiple, and can be either holistic (for example using one NHS Trust) or embedded (more than one NHS Trust for analysis). The diagram demonstrates that a combination of these variables is possible. In this study the case is the group of ENPs being researched, and the units of analysis are the two different places of work in which the ENPs are employed.

Figure 2. Basic types of designs for case studies (Yin 2012).



(Used with permission of the author)

On the other hand, Stake (1995) suggests that ‘a case study is both the process of learning about the case and the product of our learning.’ He goes further by suggesting that there are three types of case study: intrinsic (usually undertaken to understand a unique phenomenon); instrumental (which uses a case to gain a better understanding or appreciation of an issue or phenomena); collective (which involves studying multiple cases simultaneously or sequentially in order to gain an even broader understanding of the issue). With an intrinsic case study the case in question is often ‘given’ to the researcher. In other words, the researcher wants to learn about the particular case or phenomena because there is an intrinsic interest in the case. In this instance the researcher is not trying to gain an understanding of a different case or using the case

to understand a problem (Stake 1995). The case is selected not because it is representative of other cases but due to the genuine interest of the researcher. An intrinsic case study represents a study that aims to focus enquiry towards the context and interpretations of the case itself (Stake 1995). An instrumental case study, on the other hand, is useful when the researcher is trying to understand a particular problem, or the effects of an intervention, rather than gain understanding of the case itself (Stake 1995). The case selected may be a 'typical' case, since the case itself is of less importance. Similarly, it may be valuable to use several cases to gain this understanding, and Stake describes this as a collective case study. A collective case study offers the researcher the opportunity to generate theory by comparing several cases, or to replicate the findings in a second or third case (Stake 1995).

However, none of these types of cases are exclusive, and it is arguable that within my study there is potentially an element of two of the types described by Stake. The focus of this research is to explore in depth a particular professional group (ENPs) which is intrinsic and is of genuine interest to the researcher. However, other variables such as whether organisational structures and location influence perceived autonomy and identity need to be explored, and to do this ENPs working in two different contexts are researched. Stake would describe this as an instrumental case study, although he supports the notion that researchers often cannot decide which type of case study they are using, and it is possible to use more than one approach. However, Stake does advocate that it is useful to understand which type of interest (intrinsic or instrumental) a researcher has, as this will affect the type of methods used for collecting data.

### 3.6.2 Selecting the case

The purpose of case study research is to achieve the greatest amount of information on a given problem or phenomena (Flyvbjerg 2006). Stake (1995) concurs, suggesting that case study research is not sampling research. The main concern is to understand the case, whether that is the intrinsic case that has been given to the researcher, or for an instrumental case this might be a 'typical' case or an unusual one that will provide rich data about the phenomena. In either type of case study, Stake argues that the key element in selecting the case is to maximise what can be learnt from the case rather than the typicality of it.

In a similar way to selecting the methodological approach to the research, when selecting the case it is important to consider one's own epistemological standpoint as this will guide the type of case study approach and case selected (Crowe *et al.* 2011). A critical approach to case study involves questioning one's own and others assumptions, taking into account the wider political and social environment. It interprets the power relationships that may influence behaviour. Key authors within this paradigm include Howcroft and Trauth (2005) and Doolin (1998). Critics of this approach suggest that it can give the researcher a position that is too privileged, and they may focus too heavily on the power relationship and miss other contributing factors. As discussed previously, an interpretative approach focuses on understanding individual and shared social meanings in order to generate theory. Stake (1995) is one of the key authors of this approach, however others argue that it can be difficult to explain unintended consequences and historical contexts may be forgotten. The third approach, as noted by Yin (2009) is the positivist approach, which involves establishing variables in advance and testing the findings against these variables. The focus is on testing and refining theory on the basis of the findings. The key criticism here is that it may not take into account the role of researcher in influencing findings. It is worth noting that each perspective does not necessarily act in isolation, and a combination of approaches to selecting the type of case study can be used. In this study my epistemological standpoint may be from an interpretative approach, however I would want to draw on a critical perspective in order to understand the wider political and social context within which the ENPs and NHS organisations are situated.

### 3.6.3 Issues of generalizability

One of the main criticisms of case study research is that it is not possible to generalise from one or a small number of cases to the whole population under study. However, Stake (2005) argues that the reader will recognise aspects of their own experiences from the case, and generalises to their own situation rather than the sample being statistically representative of the whole population. He goes further, suggesting that in most case studies modified generalization takes place whereby an entirely new understanding may not be reached, but refinement of understanding is. Stake (2005) also claims that this is common in most forms of research, and that '*the real business of case study is particularization not generalization*' (Stake 1995, p8). He suggests



that understanding the case and understanding its uniqueness is the important aspect, and this implies knowledge of others (cases).

However, Yin (2012) claims that generalization can and does take place within case study research. He suggests that there are two types of generalization; statistical (based on a determined sample point) and analytical, which uses '*a theoretical framework to establish a logic that might be applicable to other situations*' (Yin 2012, p18). Analytical generalization, Yin suggests, is most applicable to case study research. Sharpe (1998) suggests that theoretical explanations entail a process of generalisation, but in case study research generalizations are made on the basis of having identified a general principle concerning the phenomenon in question, rather than being based on the typicality of the sample. In other words, case studies are a means whereby theoretical explanations of phenomenon can be generated.

Flyvbjerg (2006) is a prominent author in discussing the misunderstandings of case study, and he asserts that the strategic choice of the case may greatly add to the generalizability of the case study. He notes that regarding the relationship between case study, large samples and discoveries W.I.B Beveridge (as quoted in Kuper and Kuper 1985) observed immediately prior to the breakthrough of the quantitative revolution of the social sciences '*more discoveries have arisen from intense observation than from statistics applied to a large group*' (p95, cited in Flyberg p236). He goes further, suggesting that formal generalization (large samples or single case study) is overrated as the main source of scientific progress, and that generalization is only one way by which knowledge can be accumulated and gained. A key aspect to consider when discussing generalisability is the type of data collection method employed, and even more importantly the method of data analysis used. Some (Johnson 1997; Schofield 1993) argue that generalisability is not a meaningful goal in qualitative research, while others point out that results are generalizable, but not in the same way as quantitative results (Sandelowski 2004). The method of data analysis used within this study is thematic analysis based on the Braun and Clarke (2013) method. Issues of generalisability and transferability will be discussed further in Chapter Four.

### 3.7 Summary of chapter

This chapter has explored the different paradigms and strategies that underpin research. An overview of the two dominant paradigms explored how understanding the ontological and epistemological position of the researcher (and their professional background) influences and may inform the type of research undertaken. The chapter argues that qualitative research has an important and valuable place in research methodology, because it interprets phenomena in the natural setting. Case study as a methodology was used for this research, and this chapter sought to justify this choice in that the central tenant of case study research is the need to explore a phenomenon in depth and in its natural context. Case study research seeks to explore and find out what is going on, rather than to analyse or account for it. It seeks to understand the 'how', 'what' and 'why' of a particular phenomenon or issue, rather than test a hypothesis or an intervention. Whilst some critics suggest case study is primarily a research method, this chapter argues that case study is a methodology in its own right because it is an umbrella approach that allows the use of different methods of data collection to support the 'case'.

## 4 Research methods

### 4.1 Introduction

The previous chapter illustrated the methodological approach used in this study. This chapter will build on this, by outlining the methods used for data collection and describing how the data was analysed using the Braun and Clarke (2013) Thematic Analysis Model. The primary method of data collection was through focus groups, however this chapter will also explore how the use of photographs within the focus group proved to be a powerful tool in exploring issues of identity. The concept of photography as a research tool will be explored. From the focus groups, it emerged that semi-structured interviews would be useful with senior managers and therefore two semi-structured interviews also took place. Table Three on page 99 outlines the full range of research methods utilised. The use of semi-structured interviews as a data collection tool is discussed along with issues of data triangulation. The chapter will conclude with an overview of the ethical issues associated with this research, and reflections of the data collection process.

### 4.2 Focus groups

Focus groups have become a popular form of data collection within nursing research in recent years. Kruegar (1994, p10-11) defines focus groups as:

*'The focus group interview... taps into human tendencies. Attitudes and perceptions relating to concepts, products, services or programmes are developed in part by interactions with other people. We are a product of our environment and are influenced by people around it'* Kruegar (1994, p10-11).

Krueger further suggests there are six characteristics of a focus group:

1. People.
2. A series of groups.
3. The groups possess certain characteristics.
4. Provide data.
5. Qualitative in nature.
6. Focused discussion.

Kitzinger (1995, p299) highlights the emphasis on the interaction in the focus group suggesting that:

*'The idea behind the focus group method is that group processes can help people explore and clarify their views in ways that would be less easily accessible in a one to one interview...When group dynamics work well the participants work alongside the researcher, taking the research in new and often unexpected directions'* Kitzinger (1995, p299).

Focus groups were selected for data collection because the main purpose of focus groups is to draw upon respondents' beliefs, attitudes and feelings by exploiting group processes (Freeman 2006). Kitzinger (1995) explains that group processes can help people explore and clarify their views and attitudes efficiently, and encourages participation from those who feel they have little to say. As described previously the aim of the research was to explore concepts of identity and factors that may influence a sense of identity and the research question posed allowed participants to explore their feelings relating to knowledge, identity, autonomy and organisational loyalty. Focus groups therefore allowed the group to explore this within the safety of the group and as the participants all knew each other they were able to express themselves freely. As noted above group processes are a key factor in the success of a focus group to ensure that those individuals who may feel they have less to contribute to have a say. To help break down this potential barrier, and to give the participants a prompt for discussion, visual aids (photographs) were used to help encourage the participants to discuss issues around identity. Photographs as a research tool are discussed in more detail later.

Freeman (2006) compares the two eminent authors in focus group research, and highlights that their different views on 'best practice' when conducting a focus group may relate to the researcher's epistemological viewpoint. As discussed in the previous

chapter, those in the positivist/realism camp seek to represent reality (Hammersley 1992, Mays and Pope 2000). They strive for consistency, validity and reliability in their sampling and data analysis, and suggest that findings may be considered 'true' (represent reality) if they reflect events (Hammersley 1992). It is suggested that Kruegar (1994) draws his methodology from a realism perspective in his arguments around focus group sampling, interaction and generalisability of results. In contrast, those who are guided by a constructionist epistemology reject objectivity and reliability in favour of the use of multiple methods of data collection for richness rather than consensus (Fielding and Fielding 1986). Kitzinger (1995), in her arguments around focus group sampling and homogeneity, suggest she is grounded in a contextual/constructionist viewpoint. Kitzinger emphasises the situated nature of human interactions, recognising the naturally occurring data that becomes available for analysis (Kitzinger 1994). In other words, the data developed is a response to specific situations (or prompts within the focus group), and the subjective nature of the data is accepted as part of the knowledge construction. In contrast, Krueger (1994) rejects subjectivity, suggesting this supports bias within the data and should be managed.

#### 4.2.1 Selection of participants

Focus groups generally employ convenience or purposive sampling. Purposive sampling is a type of non-probability sampling in which participants are selected by the researcher based upon a variety of criteria such as specialist knowledge or willingness to participate. The principle of purposive sampling is the researcher's judgement of typicality or interest (Robson 2002). This type of sampling is criticised for its lack of external validity (Kruegar 1994; Barbour 2011). Kruegar goes further, suggesting that using groups that already know each other poses problems for analysis since current relationships and the effect of formal and informal hierarchies may influence contributions. In contrast, Kitzinger (2005) defends the use of a convenience sample; she emphasizes the situated nature of human interaction, valuing the fragments of naturally occurring data that becomes available for analysis.

The discussion around external validity extends further within the two camps. Kruegar states that when the purpose of the focus group is to compare opinions of specific sub-groups within a study population then segmentation within homogenous sub-groups

is advised. He suggests that failure to segment groups may result in important information not being exposed, especially when there are status differences between the groups. Although Kitzinger agrees that homogeneity may be helpful when participants have marked status differences, she adds that homogenous groups may also lead to conformity and inhibit discussion. She argues that whilst status differences between participants may inhibit participation, it does not mean that people's 'real' thoughts may not emerge; rather that the situation will influence the discussion. The following section will outline how the focus groups in this study were constructed.

As reflected in the literature in previous chapters, there are many different types of ENPs with different qualifications and levels of autonomy. It is therefore impractical (and unrealistic) to recruit a truly homogenous group who have all had the same level of training and practice at the same level. In addition to this, one of the variables I explored was the perceived effect of organisation/location. Therefore, a sample (or sub-group) was drawn from the Emergency Department of an acute NHS Trust that has medical colleagues (and others) working alongside the ENP tier, and a second sub-group was selected from a Minor Injury Unit in a community setting that has no medical input and is nurse-led. Table Three on page 99 outlines how many participants took part in each focus group and which location they were drawn from. The two groups were compared to explore perceptions of identity in relation to autonomy, knowledge and role expansion. In addition to this, the aim was also to explore whether the perceived influence of organisational structure and medical support influenced their perception of identity.

The participants chosen for each focus group knew each other, and were selected due to their place of work, rather than by random selection. This may reaffirm Krueger's observations about the potential limitations of purposive and convenience sampling. However, both Krueger and Kitzinger agree that the interaction is the most important factor when determining the focus group, and arguably a focus group that has participants who are used to working together and already have a relationship in which they feel comfortable would be advantageous. The discussion goes further, however, as Krueger asserts that a focus group represents a device to encourage discussion on a given topic (and pays less attention to the interaction of the group), whereas for Kitzinger the interaction is the central analytical resource inasmuch as it is the defining

feature of the technique. Both of these features are important elements of the focus group, and are unlikely to act in isolation of each other. In this study, the focus group not only allowed the participants an opportunity to discuss a chosen topic; the interaction within the group was essential. Each participant shared their sense of identity through a photograph that enhanced the interaction between them. This became very powerful in the analysis of the data.

As previously noted, photographs were used as a prompt to draw the participants into a discussion around their identity. Studying a group of practitioners who already knew each other was advantageous, in that they felt more comfortable 'exposing' their photographs. Participants had already formed relationships within the group, and had established a level of trust with each other. This had the advantage that the participants did not need time to get to know each other and form a relationship that would allow open and honest conversations.

In the pilot study, focus group participants highlighted that a 'mixed' group (from two different sites) would enable a rich discussion about their different roles, and suggested that they would like to hear about the difference in roles from those who worked in a community setting. However, in this case there would be a risk of practitioners becoming fixed in their discussions, with a focus on how roles differ between the two groups, rather than issues relating to their identity and the influence of the organisation and other colleagues. In addition to this, there are the practical aspects of getting mixed groups of practitioners together, and the time required to ensure that they would feel open and comfortable sharing their experiences. Kruegar (1994) does acknowledge that tensions exist around homogeneity, and concedes that organisational contexts and practical concerns can influence how the researcher brings together the focus group. Based on this, the focus groups within this study were drawn from participants within each organisation separately, rather than developing a mixed group. From an organisational perspective, it was helpful having the participants selected in this way as they were able to arrange shifts in order to attend the focus group and shared lifts to the location. The following section offers an analysis of the advantages and limitations of using focus groups as a data collection method, with a summary in Table One.

#### 4.2.2 Advantages of using focus groups

One of the key advantages of using focus groups is that they produce qualitative data that provides insights into the attitudes, perception and opinions of participants (Freeman 2006). They offer a natural environment that allows the participants to explore ideas and clarify their views and understanding of a given topic. Morgan (1997) goes further, arguing that focus groups are not a substitute for other forms of data collection; rather they allow researchers to understand not only what participants think but also why they think in that way. This was particularly useful in this study as both the researcher and participants were from a similar professional background which allowed the researcher to ask for clarification on certain issues without having to interrupt the flow of conversation. In health related research focus groups have been used to test hypotheses during the preliminary stages of a research project. More recently, however, and with an increasing need to incorporate the patient voice within health research, focus groups have given rise to an approach that allows researchers to work in partnership with patients (Cawston and Barbour 2003). In a similar vein, the student voice is now a familiar component of any educational research, and focus groups lend themselves to this type of research since they pay particular attention to the perceptions of the users and consumers of solutions, products and services (Kruegar 1994). For students, talking amongst peers can shift any power imbalance they may feel between themselves and the researcher (Barbour 2005).

Focus groups are also useful when trying to access hard to reach groups within health research, because they offer a relatively safe environment in which to share experiences (Kitzinger and Barbour 1999). In addition, participants can use vocabulary that is important to them. This allows the conversation to travel in a direction set by the participants, rather than the researcher, which has the positive effect of diluting the power imbalance between researcher and the researched (Madriz 2000; Barbour 2005). It encourages participation from those who may feel they have little to say, and allows a level of interpersonal communication that helps clarify the similarities and differences expressed between group members and from the researcher (Freeman 2006). As noted previously this was key advantage of using focus groups for this study as the participants were all ENPs the language they used was familiar to all and therefore allowed the conversation to flow naturally and in a direction that was meaningful for the participants.



#### 4.2.3 Limitations of using Focus groups

One of the key criticisms of using focus groups has been around the validity of the data collected. Nicolsen and Anderson (2003) are critical of studies that use focus groups, whereby findings are narrowed down to become valid, reliable and measurable factors or dimensions. Others have expressed concerns around their use in ascertaining the views of the lay public to inform healthcare, and have questioned the validity of findings from such studies (Patton 1990). One of the key challenges attributed to the argument of validity is that focus groups may not be sufficiently in-depth to allow the researcher to gain a real understanding of the participants' views and experiences. There are many reasons why this may be the case, and most of these focus on the dynamic of the group. For example, some participants may not contribute as fully as others, and the dominant characters views may prevail in the group discussion with other members conforming to these ideas (Hollander 2004; Krueger and Casey 2008). For some, the influence of their workplace or talking in front of colleagues can also have a negative impact on the dynamic of the group, as can the influence of the researcher and the relationship the researcher has with the participants. The topic under discussion may also be a barrier to the effective engagement of participants.

Table One. Advantages and disadvantages of focus groups (based on Braun and Clarke, 2013).

<b>Advantages</b>	<b>Disadvantages</b>
Flexibility in exploring unanticipated issues	Do not allow for in-depth follow-up of an individual's views or experiences
Good for gathering new knowledge about issues where little is already known	Can be difficult to manage
Access to everyday ways of talking about topics	Can easily get 'off topic', and be hard to bring back on topic.
Access to meaning-making processes	Logistically difficult to recruit to and organise
Can facilitate disclosure (including potentially sensitive topics)	Not a good method to use with busy people
Can lead to some level of empowerment of participants, or social change	Not good for people who are geographically dispersed
Reduces the power and control of the researcher; the data is potentially less influenced by the moderator	More inconvenient for participants if they have to travel to the researcher at a particular time
Good for groups where research participation might be daunting	Focus groups are generally longer than interviews, and so are more time consuming for participants
	May need an assistant to manage practical matters
	Transcription of focus group data is very time-consuming

#### 4.2.4 Size, location and running of the focus groups

There are differing views on what the optimum number of participants is within a focus group. Some suggest between 4 and 12 (Bender and Ewbank 1994), whilst others suggest that the number of participants depends on the topic (Krueger and Casey 2008). For example, if the topic under discussion is sensitive it may be more helpful to have smaller numbers to allow the group to develop trust and cohesion. A large group can be difficult to manage, and as noted above strong personalities may dominate the discussion and influence the conversation excessively. Krueger and Casey (2008) suggest that the questioning route and the participants' characteristics are also important factors to consider. For example, if the purpose of the questioning is to understand peoples' experience a smaller group is preferable. In addition, if the group has a lot to share about a topic, or are particularly knowledgeable, a smaller group is advantageous. The focus groups in this study were small (three and four per group).

In part this was due to the pragmatic considerations of releasing staff from clinical shifts, however when considering the topic, the experience of the participants and the potentially intimate nature of sharing their photographs, a smaller focus group was considered appropriate. The size of the focus was tested during the pilot study (n=4) during which participants had the opportunity to express their views freely and felt that the size of group afforded an intimate and safe discussion with all participants having an opportunity to 'have their say'. Participants expressed that they felt more comfortable in a smaller group and were able to share their photos and experiences which produced a rich data set for analysis.

In all, four focus groups took place with a total of thirteen participants. Due to the nature of the organisation from which the participants were recruited, staffing levels in the ED were higher and therefore it was easier to recruit more participants (n=5). In the MIU staffing levels were slightly lower which was reflected in the number of participants (n=4). The pilot study (n=4) brought the total participant number to thirteen. Recruitment stopped at thirteen for several reasons. Firstly, from a pragmatic perspective working with healthcare professionals is challenging in that being released from clinical practice is difficult, and at the time of the study staffing in both sites was sub-optimal. Secondly, the focus groups had reached saturation with no new themes being generated, and the range of perspectives which were emerging from the groups had very similar characteristics (Morgan, 1997). Finally, no other ENPs opted to take part at that time. I considered whether adding a further site would be feasible, however as this would delay the study and saturation had been reached it was decided to stop at thirteen participants.

Location of the focus group is also an important consideration. Kitzinger and Barbour (1999) suggest that there is no such thing as a neutral or ideal location. Barbour (2005) asserts that location influences the discussion, and this should be acknowledged within the analysis. In this study the location of the focus groups was chosen by the participants during the recruitment phase. For some of the participants the preferred option was to hold the focus group away from their place of work, and therefore a location at the University was selected. For one group the preferred location was the place of work, since the focus group was planned to take place after a pre-scheduled meeting that most of the participants were attending. Krueger and Casey (2008) term

this 'piggyback focus groups', and suggest that this can be a useful way of capturing key individuals.

The literature suggests that a pilot study is an important part of developing good practice for running a focus group (Barbour 2005). A pilot study allows the researcher to test their topic guide or prompt sheet and can check practical issues such as videoing the focus group. Barbour stresses that using stimulus material (such as photographs) can be a valuable addition to the focus group, but advises caution as this added dimension needs careful management and further promotes the need for a pilot study. This study utilised a pilot study, and the lessons learnt from this are explored later in this chapter.

The moderator of the focus group is described as one of the factors that is most influential on the quality of focus group results (Krueger and Casey 2008). Some of the key characteristics of a successful moderator include: active listening skills; empathy and positive regard for participants; background knowledge of the subject; communication skills (written and verbal); self-discipline to control personal views; friendly demeanour with a sense of humour. For a novice researcher this list can seem quite daunting, but taking time to think about questioning, posture and the relationship between the moderator (researcher) and the participants was a useful exercise for me within this study. To help develop my skills further I kept a diary of each focus group and (interview). The purpose of the diary was to note the challenges that I encountered during the focus group and then consider how I could overcome these during the next group. For example, in the first focus group each participant talked through their photograph in turn and whilst this ensured each person got an opportunity to discuss their photographs, the conversation at times became stilted. In the diary (see Appendix Eleven) I note this observation and during the following focus group the group are encouraged to bring their photographs into the discussion in a more informal manner and comment on each other's. This allowed a more relaxed flow to the discussion whilst still capturing the essence of what their photographs represented. My experience as an educator and a facilitator within the university helped me gain cohesion within the group. As a practitioner I had a good understanding of the subject matter, and I had either taught or worked with all of the participants previously. This familiarity made it easier for the participants to be open and honest, and I was able to understand the jargon. However, I was aware that my role as a researcher had the

potential to influence the discussion; for example, the participants may have perceived my role as one of power, and this may have inhibited their responses or caused them to answer in ways that they thought I wanted, therefore leading to bias. Costly *et al.* (2010) describe this as 'insider research', whereby the researcher undertakes research within their own professional setting. Insider research can result in potential bias as the researcher may have a vested interest or a lack of impartiality. This is reflected on in more detail later in the chapter.

### 4.3 Photography as a research tool

Photography as a research tool falls into the broad category of visual research, and has for many years been used by anthropologists for documentary purposes or as a tool to aid the research process (Collier and Collier 1986). Visual aids have increased in their use within social science research (Collier and Collier 1986), with most being used as an illustration of the text rather than analysis of the photograph itself (Banks 2010). Photographs are also commonly used to elicit information from participants in interviews, and are taken either by the researcher for the participant to comment on or by the participants themselves (Heisley and Levy 1991). Photographs taken by the participants are considered '*to reflect the participants' views and open a world that the researcher might not otherwise have access to or consider important*' (Warren and Karner 2005, p171). Critics argue that there can often be a strong element of bias within this type of data collection, because participants may take photographs knowing how they will be represented, however this could be viewed as no different to a participant answering a question in the way they think the researcher wants them to. A third method of using photographs is to use pre-existing photographs. These are most commonly used to reconstruct events, relationships and rituals. Participants might also use pre-existing photographs from the past as a contrast to their current situation, or to indicate a change in their lives (Banks 2000).

Photographs as a research tool have traditionally been viewed as documenting reality and the 'truth' (Bogdan and Biklen 2003), however, more recently others suggest that photographs can destabilise the notion of 'truth', and that reality is a '*negotiated version of reality*' (Pink 2005, p20), where the researcher and participant bring their experiences together to form the negotiated reality (Pink 2005). In other words, the

photographs represent the experience of the participants as they see it at that time, which might be different from how someone else views it at another time. Emmison and Smith (2000) suggest that visual data should be thought of not in terms of what the camera can record but of '*what the eye can see*' (p4). They argue that photographs are a means of preserving, storing or representing information, rather than a source of data collection.

Visual images can be analysed by several methods, for example content analysis or discourse analysis, both of which attempt to translate the visual into verbal text. Pink (2005) is critical of the prescriptive nature of data collection and analysis, however Emmison and Smith (2000) argue that without any general theoretical agreement about how to approach the analysis, and alongside concerns about surveillance of the vulnerable or misunderstandings of representation as a result of increasing cultural diversity, the use of visual research is marginalised.

Photographs were used in this study as a prompt for further discussion within the focus groups. One of the key areas for exploration was around the participants' perceptions of professional identity. This is an area that cannot necessarily be articulated easily, and therefore using photographs allowed a 'starting point' for the participants, and encouraged others to draw out further areas of discussion. During the initial information meeting that was held for each focus group (during which consent was obtained), participants were asked to bring three or four photographs to the focus group that represented professional identity from a personal perspective. Most of the participants did not express any concern over this, but the briefing meeting allowed me to answer any concerns or questions for example:

- Do you want personal or professional photos?
- Can they be abstract or do they have to be objects?
- Do I need to be in them?

Participants were reassured that there were no 'rules'. Rather they were just asked to bring any photograph that they felt represented their professional identity. The aim was to create a different dynamic within the conversation, whilst adding a layering effect as participants drew on their own photographs and had the opportunity to discuss each other's. During the analysis of the focus groups the photographs were

used to illustrate the themes that were identified, and additional photographs were used to highlight individual perceptions when it was felt they were a useful adjunct to the text. In this sense the photographs were as Banks (2000) described; an illustration of the text.

#### 4.4 Interviews

The original intention of the study was to use focus groups to identify perceptions of professional identity amongst ENPs, however during the focus groups it became apparent that participants had a perception of senior managers' views relating to their role as an ENP. Therefore I decided that interviewing two senior managers (one from each institution) would enable me to triangulate the data and would add a further dimension to the data. Semi-structured interviews were chosen as they provide deeper insights than other more structured forms of data collection such as questionnaires or surveys. Interviews are a common method of data collection in qualitative research since they explore an individual's own perceptions, interpretations, experiences and practices (Silverman 2008). The framework that was adopted was similar to the prompts used in the focus groups (see Appendix Two), although some open ended questions relating to role were also asked.

Active interviewing is a form of interpretative practice involving respondent and interviewer (Holstein and Gubrium 1995). Open ended interviews have the advantage that they have no prior list or pre-set questions, and are grounded in the views of the respondent in order to adopt strategies appropriate to the specific nature of social contexts and processes (Schostak 2002). They build conversationally, mapping the themes as they unfold (Schostak 2010). However, as the purpose of these interviews was to specifically triangulate the data from the focus groups, I decided that semi-structured interviews would be more appropriate as they would give some structure to the areas for discussion. In addition to this, open ended interviews tend to take longer and the senior managers were under time constraints due to the nature of their roles. Similar to focus groups, it is important for the researcher to recognise both the benefits and the limitations and potential risks associated with interviewing. The following section will briefly outline the advantages and limitations of using interviews as a

method of data collection. Table Two provides an overview of the strengths and limitations of using interviews as a method of data collection. Further considerations such as power relationships between interviewer and interviewee and personal disclosure will also be explored.

#### 4.4.1 Advantages of interviews

One of the main advantages of conducting interviews is their flexible nature (Rubin and Rubin 1995). Questions can be probed and added to the schedule, and allow the participant to determine the direction. Interviews are also ideal when discussing sensitive issues, and can garner rich and detailed descriptions. They are also deemed to be accessible for hard to reach groups such as children, and have the benefit of only needing small numbers to generate a large data set (Braun and Clarke 2013). The interviews in this study generated a large data set because each interview took up to an hour-and-a-half to complete. Using a prompt sheet as a focus for the questioning the participant was able to explore their feelings with rich descriptions of perceptions and experiences. The location of the interview is an important factor to consider. Ideally a room that is quiet, without distractions and away from the place of work, is considered optimal and this gives a sense of anonymity for the participant. However, this is negotiable and for pragmatic reasons the participants in this study chose to have their interview conducted at their place of work as they felt this was the most convenient option. The whole interview was recorded verbatim and subsequently transcribed and analysed using thematic analysis which is discussed later in this chapter.

#### 4.4.2 Limitations of interviews

There are several limitations that need to be considered when deciding whether to use interviews as a method of data collection. Due to the small sample ( $n=2$ ) there can be a lack of breadth to the data collected. In addition, it is more difficult to ensure anonymity for the low number of participants, and it is important that this is explained clearly prior to the interview. As discussed above, providing a location away from the usual place of work can help to enhance comfort and anonymity, for example, using a room at the University. However, issues such as access, locating the room and the sterile nature of a classroom can equally be off-putting for participants. Further,



interviews can be both time consuming to conduct and also to transcribe due to the large volume of data collected.

Table Two: Strengths and limitations of interviews (based on Braun and Clarke, 2013)

Strengths	Limitations
Rich and detailed data about individual experiences and perspectives	Time consuming for researcher to organise, conduct and transcribe
Flexible-ability to probe and ask unplanned questions	Lack of breadth due to smaller sample size
Smaller samples: Only a small sample required to generate adequate data.	Not necessarily ideal for sensitive issues- some people may prefer to discuss sensitive issues in a group or anonymously through a survey.
Accessible: Able to collect data from vulnerable groups.	Time consuming for participants
Ideal for sensitive issues.	Lack of anonymity may be off putting for participants.
Researcher control over data produced increases the likelihood of generating useful data.	Not necessarily 'empowering' for participants due to less control of data produced.

#### 4.4.3 Other issues to consider when using interviews

One of the key concepts outlined in the literature is around power structures and social position. This is heavily linked to trust, as both interviewer and interviewee may have feelings of suspicion. For example, the interviewee may be wondering what the interviewer really wants to know and may adapt their answer to this. Equally, the interviewer may be wondering why are they holding back or what are they hiding? Bordieu (1993) argues that there is a symbolic violence here in the presumed power, social status and knowledge of the researcher that may be used to manipulate the interview. In addition, the interviewer may impose his/her agenda, which may hinder the expression of the interviewee's real views and feelings. He offers a solution to this by suggesting that adopting a pose, language and manner similar to the interviewee may allow the views of the interviewee to emerge naturally. Further, it is important to consider professional hierarchy when designing the interview. The relationship between interviewer and interviewee is usually perceived as a hierarchical one (Braun and Clarke 2013). Even when interviewing someone of a similar social or professional background the interviewee may perceive the interviewer as the 'expert', and having the status as a 'researcher' may often override other aspects of the relationship. In the two interviews conducted within this study the interviewees were both senior

managers and hold a significant level of responsibility. However, one of the participants was undertaking a Master's degree and was interested in discussing this at the beginning of the interview. This commonality in terms of shared student status allowed the interview to develop into a more equal relationship rather than a 'researcher' and 'participant' relationship. This is often referred to as 'interviewing across the difference' (Braun and Clarke 2013), whereby participants feel more comfortable disclosing information to someone who is socially or professionally similar to them (Sawyer *et al.* 1995). That said, it is important to remember that even when the interviewer and interviewee are speaking the same language, differences in connotations and meaning can still be present (Rubin and Rubin 1995).

Personal disclosure is also important to consider before undertaking the interview. Personal disclosure can either involve the interviewer disclosing themselves in relation to the professional group to which they belong (and therefore disclosing their status) or by giving an opinion during the interview itself (Braun and Clarke 2013). There are, of course, advantages to personal disclosure; for example, it may enhance the rapport between the researcher and participant and therefore challenges the hierarchy that may exist (Oakley 1981). However, excessive disclosure can result in a false sense of intimacy and encourage the participant to do likewise (Finch 1984). During the two interviews I disclosed my background and purpose for undertaking the research, which in itself was a form of disclosure. However, this enabled the participants to feel reassured about my motivations to do the research and enabled a conversation to flow that used language that was common to both researcher and participant. However, I was mindful not to commit my opinions relating to the questions and prompts during the interview, and was able to keep disclosure in check. Cotterill (1992) asserts that the interview is not a place to make new friends or to talk about oneself. The interview should be conducted within a professional framework, and this was achieved.

Table Three: Outline of research methods used.

Method of data collection	Number of participants	Role of participant	Where participant drawn from	Place of intervention	Length of intervention	Method of collection
Focus group (pilot study)	4	Band 7 ENP	ED Acute Trust and UWE staff	UWE	2.5 hours	Video
Focus group	3	Band 7 ENP	Emergency Department (ED) in Acute Trust	UWE	2.5 hours	Video
Focus group	4	Band 7 ENP	Minor Injury Unit (MIU) in Community Trust	Place of work	2.5 hours	Video
Focus group	2	Band 7 ENP	ED	UWE	2.5 hours	Video
Interview	1	Senior Manager	Community Trust	Place of work	1.5 hours	Audio recorder
Interview	1	Senior manager	Acute Trust	Place of work	1.5 hours	Audio recorder

#### 4.5 Ethical Considerations

All research should be of the highest ethical standard. Undertaking research within healthcare is particularly challenging, however the Department of Health (DH) provides robust guidelines on how to ensure that research protocols are developed to protect both staff and patients (DH 2011). Ethics committee approval for the study was sought from the University of the West of England (see Appendix Three) and University Hospitals Bristol NHS Foundation Trust Research and Development Department (see Appendix Four). At the time of the application the process involved completing an in-depth form on the computerised Integrated Research Application System (IRAS), which determined whether or not the research would require full NHS ethics committee approval. Although NHS ethics committee approval was not required, the form was then submitted to the NHS Trust Research and Development

Department for approval. The process of approval was rigorous and time consuming, but ensured that the research protocol was robust and ethically sound. The key ethical areas that needed addressing for this study included consent, confidentiality and anonymity. These are addressed within the Ethical Guidelines for Educational Research (BERA 2011), which outline the ethical considerations for all educational research. The BERA association considers that all educational research should be considered within an ethic of respect for:

- The person.
- Knowledge.
- Democratic values.
- The quality of educational research.
- Academic freedom.

#### 4.5.1 Consent

Informed consent within qualitative research can be complex (Weatherall et al. 2002). This is primarily because of the iterative nature of qualitative data, which makes it difficult to predict the exact nature of the data analysis or how the data will be presented. In this study consent occurred in two parts. Firstly the participants for the focus groups were given a presentation and overview of the research proposal and invited to ask questions and discuss the project during a staff meeting which took place at both sites. Participant information leaflets (see Appendix Five) were left for the focus group participants to read, and consent forms (see Appendix Six) were left for them to fill in at a later date, which reduced any pressure to agree to take part in the study. The information leaflets explained to the potential focus participants the purpose of the study, why they had been invited to take part and what would happen to the data. As the focus groups were being video recorded, the information leaflet also contained details of where the data would be stored and how it would be destroyed after the study in accordance with the Data Protection Act (1998). The second part of the consent process involved me collecting the consent forms from the sites a week later, and making contact with those participants who had agreed to take part. Participants were reassured verbally and in writing that they could withdraw at any time, however the anonymised data would still be used for the study as it is recognised that in focus groups it is almost impossible to remove data from the discussion without losing the

whole group (Braun and Clarke 2013). The process of consent for the semi-structured interviews involved sending a letter outlining their involvement and information about the study to the potential participants asking them to consider taking part (see Appendix Seven). Formal consent was completed at the start of the interview with participants signing the consent form. The interviews were audio recorded and this was explained at the beginning of the interview. The principles of data protection remained.

#### 4.5.2 Confidentiality

Confidentiality is an inherent risk within focus groups, as participants in the group may break it (Liamputtong 2011). At the start of each focus group ground rules were established which all group members agreed to. One of the rules included confidentiality, both immediately after the focus group (as they left the building) and for the foreseeable future. It must be recognised, however, that this would be very difficult to police as there would be no way of knowing if the participants discussed the contents of the focus groups with peers or family members. However, it was important to recognise that participants would want to talk to colleagues and therefore time was spent clarifying what could be discussed about the group so participants felt they could talk in general terms about the experience.

To help participants understand the meaning of confidentiality within the focus group, and the parameters of this, the NMC Code of Conduct (2001), which is the overarching guide to practice for all nurses and midwives, was used as a central focus. There are clear guidelines within the code relating to confidentiality, and it was agreed at the beginning of the focus group that these principles would apply. Further to this, however, it was equally important that participants understood responsibilities relating to issues of disclosure; for example if a participant disclosed examples of bullying or safeguarding issues relating to their workplace. The NMC Code of Conduct has clear guidelines on how this should be handled within the practice setting, and again this was related to the focus group. As a researcher and a nurse my own practice is also bound by these principles, and it was important that this was made clear to the participants at the start of the focus groups. In addition, participants were reminded of strategies that are in place to support them in the workplace such as reporting to senior

managers, human resources and occupational health referrals should they feel the need for additional support.

Within the interviews the participants were not in a group setting, and it was important for me to consider their needs slightly differently before and during the interview. For example, an interview does not have the benefits of peer support during discussion, and it is appropriate to consider support for the interviewee should they disclose something sensitive or something that would require further action. As both interviewees were health care professionals and bound by their own Codes of Practice it was important to refer to these at the start of the interview. As with the focus groups, I ensured that each interviewee had access to support within their workplace, should they require it after the interview.

#### 4.5.3 Anonymity

Participants in both the focus groups and interviews were anonymised during transcription and allocated a numerical code. It is well recognised that anonymising participants is more difficult in qualitative research than in quantitative research (Silverman 2008), as usually the method of data collection involves small numbers. Both the focus groups and semi-structured interviews involved small numbers who potentially all knew each other and belonged to a small professional community so maintaining anonymity was challenging. Gavey and Braun (1997) and Williams and Robson (2004) agree, noting that when participants are part of a small community issues of anonymity require extra attention. In an attempt to further ensure anonymity, the demographics of the participants were not included in the study as this had the potential to 'expose' participants due to the small numbers. Similarly, the sites at which the participants worked were not identified by the numerical number assigned. However, it is important to recognise that in a research such as this study complete anonymity is difficult to completely guarantee.

## 4.6 The Pilot Study

In order to test the focus group questions and the use of photographs as prompts for discussion I undertook a pilot study focus group. Pilot studies are an important element when undertaking research as they offer advanced warning of potential errors in the research protocol, allow the testing of protocols and tools and offer researchers an opportunity to practice the skills required to undertake the study (van Teijlingen and Hundley 2002). Four colleagues from the department of Nursing & Midwifery were asked to take part in the pilot study. All four worked within a clinical setting as an Emergency Nurse Practitioner as well as working at UWE as a senior lecturer. The participants were asked to bring along photographs that represented their idea of their professional identity, and all were advised that the focus group would be video recorded. The focus group schedule was used to steer the focus group discussion (see Appendix Two).

### 4.6.1 Lessons learnt from the pilot study

From a practical position, undertaking the pilot study enabled me to refine some of the process issues involved in running a focus group using photographs. In addition to this, as a novice researcher it gave me an invaluable insight into some of the difficulties I would potentially encounter for example:

- Positioning of the camera in order to see each participant's photograph.
- Timing to ensure each participant gets the opportunity to share their photograph.
- Facilitating the discussion to ensure participants do not all speak at once.
- Guiding the discussion, and developing prompts when the discussion gets 'stuck'.
- The size of the group. Participants agreed that having a small group was beneficial as it allowed a more in-depth discussion.

The prompts used in the pilot study worked effectively, and didn't need to be changed for the focus groups. Therefore, the data from the pilot study was analysed in the same way as the focus groups and was used as 'real data' for this study.

## 4.7 Data Analysis

The method of data analysis used in this study was thematic analysis (TA). TA is a method for identifying, analysing and interpreting patterned meanings or themes in qualitative data (Braun and Clarke 2006, 2012, 2013). 'Thematic coding' is common across many forms of qualitative methods: grounded theory, pattern-based discourse analysis and phenomenological discourse analysis to name a few. However, TA has only become recognised as a distinctive method with a clearly outlined set of procedures since 2006 (Braun and Clarke 2006). Key advantages of using this approach are its unique flexibility and the fact that it is relatively easy to use for the novice researcher. In addition to this, the results from TA are described as generally accessible to the public, and can usefully summarise key features of a large body of data such as focus group data (Braun and Clarke 2006).

Braun and Clarke are clear in their definition that TA is purely a method for analysis centred on code development and theming. This means that it can be used to answer most qualitative research questions across a range of methodologies analysing most types of qualitative data. TA is now a widely accepted method of analysis (Howitt 2010; Howitt and Cramer 2008; Joffe 2012; Stainton- Rogers 2011), however critics argue that TA is 'unsophisticated' and simply describes or summarises patterns (Antaki *et al.* 2002). Braun and Clarke assert that this is not the case, but stress that the researcher needs to play an active role in the method, and have a clear understanding of how he/she wishes to use the method. The Braun and Clarke fifteen point checklist (see Appendix Eight) ensures the development of good thematic analysis for the novice researcher, and was used in this study.

### 4.7.1 Generating themes and sub-themes.

The Braun and Clarke six phases of thematic analysis (see Table Four) was followed in order to code the data, develop themes, sub-themes and allowed me to revisit the data to define and name the themes.



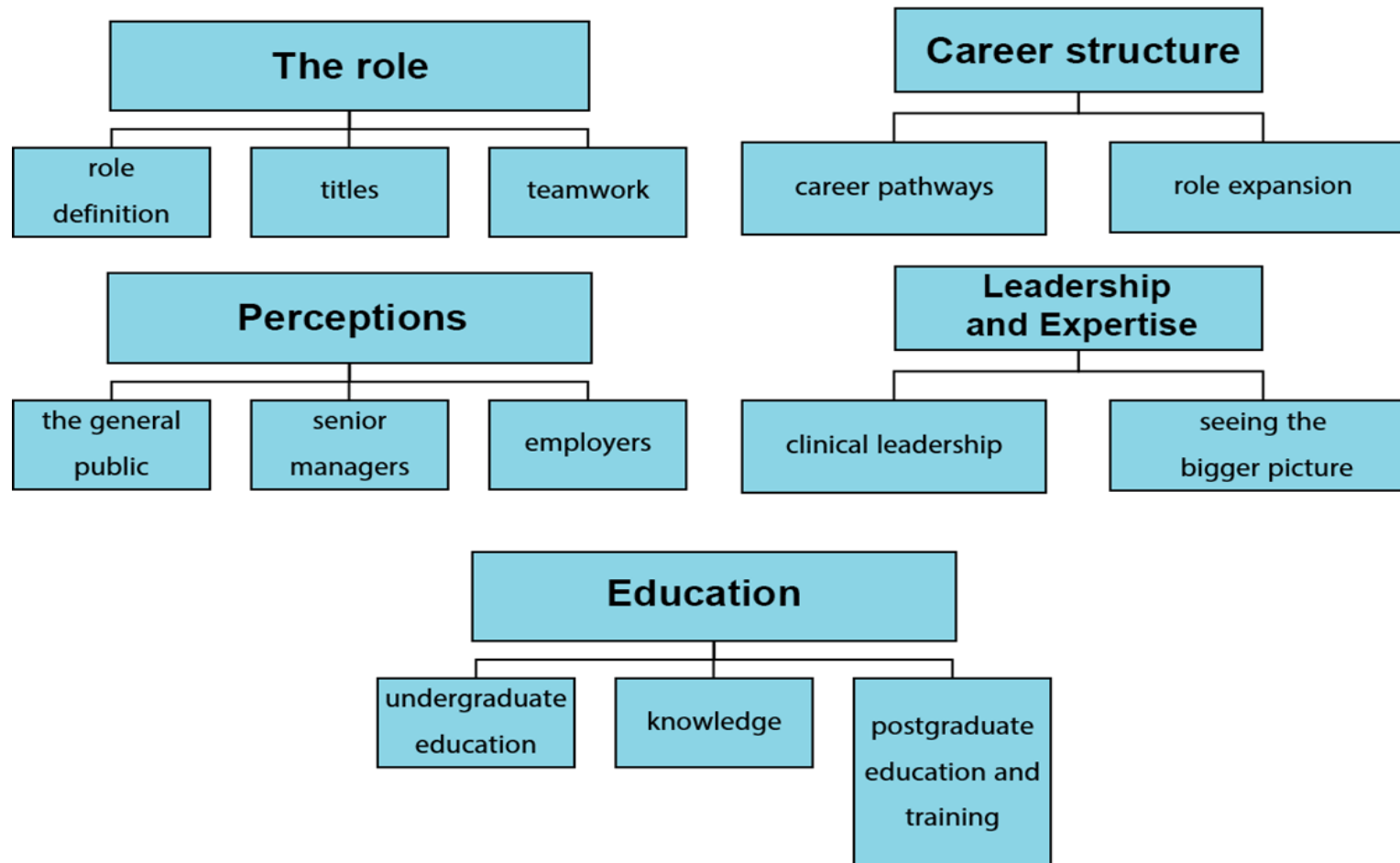
Table Four. Phases of thematic analysis (Braun and Clarke, 2013).

Phase	Description of Process
1. Familiarise yourself with the data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells: generating clear definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back the analysis to the research question and literature, producing a scholarly report of the analysis.

(Used with permission of the author)

Initially, I familiarised myself with the whole data set by reading through the transcripts and noting ideas. Following this, the transcripts were read line by line and interesting words or phrases relevant to the research questions were coded. This occurred across the whole data set and where similarities occurred, or there was frequency of phrases, the codes were then collated into potential themes. This process involved continual re-coding and reviewing of the codes and potential themes. Bryman (2012) supports this constant checking, suggesting that this type of analysis is an iterative process, but warns researchers to ensure that the final coded data and subsequent themes relate to the research questions and literature. Examples of this process can be seen in Appendix Nine. Checking the themes in relation to the coded extracts across the whole data set and developing a thematic map, allowed me to construct a thematic map of the themes and sub-themes which is reproduced in Figure 3A.

Figure 3A: Thematic map of themes and sub-themes.



Five themes: the role; perceptions; education; career structure; leadership and expertise, each with two or three sub-themes, emerged at this stage of the analysis and extract examples were identified to support the description of the themes. Braun and Clarke (2006) assert that it is important to clearly define themes and writing a theme definition at this stage helps ensure that the theme describes what is unique and specific about it. In addition, the descriptions provide a coherent picture of the dominant patterns from the coding and allows the reader to identify how the sub-themes are inter-related Table Five describes the five themes identified.

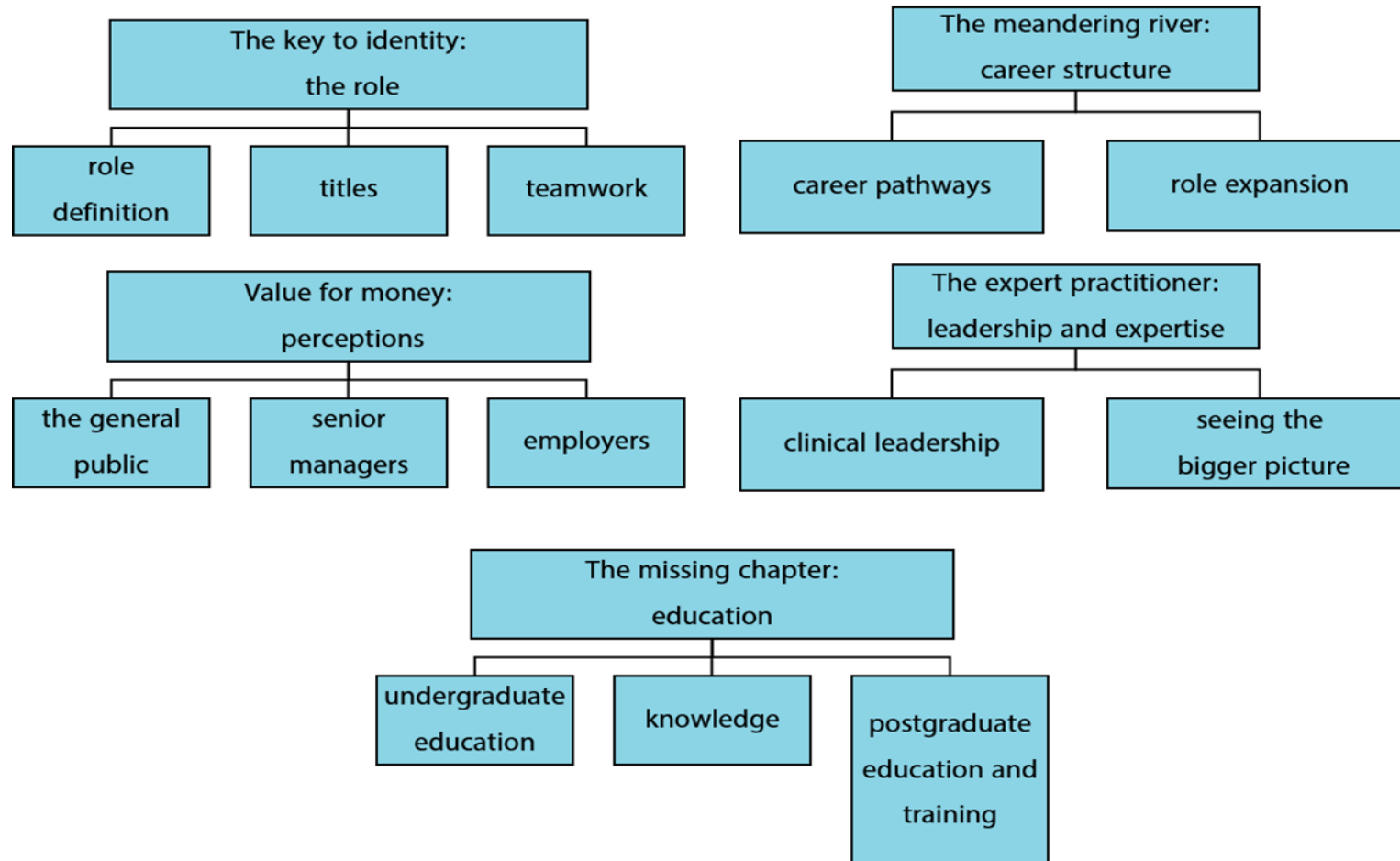
Table Five. Description of themes.

Theme	Description
The role	This theme captures many aspects of the role such as pride in the job, fear of litigation, job satisfaction and conflicting ideas the participants expressed around issues such as role title and role definition. It also illustrates the essence of the ENP's perceived sense of professional identity as participants explore what professional identity means to them individually, and as a group of practitioners. Through exploring identity and role the theme questions who 'the team' are, and who their perceived peers are within the workplace. The theme has been split into 3 sub-themes: role definition; titles; teamwork.
Perceptions	This theme relates to perceptions of the role by different groups which were identified by the participants. Within this theme participants explored concepts around stereotyping, professional status including pay and recognition and conflict. An overarching theme was the perception that some health professionals, managers and the general public do not understand the ENP role. Therefore, this theme has been split into three sub-themes: public perceptions; other health care professionals' perceptions; senior managers/commissioner's perceptions of the role.
Education	This theme considers gaps in knowledge and training relating to the ENP role and how this impacts on perceived identity. This theme relates to the participants' undergraduate degree training and their post-graduate education, in-house and 'on the job' training. Participants described the sense that they 'missed out' on some key areas during their initial training. Managers equally supported the need for more preparation of the role within the undergraduate curriculum. Participants expressed that their knowledge base was both medical and nursing and 'growing' in a different way. Support for training and education to develop the role both locally and nationally were highlighted within this theme. The theme is split into three sub-themes which are: undergraduate nurse education; knowledge; post qualifying education and training.
Career structure	This theme relates to career structure for ENPs, and role expansion into advanced practice. Participants explored how difficult it was to develop the role into the Advanced Clinical Practitioner role and how the role had evolved and expanded over the years. Other key concepts within this theme include education pathways linked to career structure which linked to job satisfaction and barriers to advancing career pathways. The theme has been split into two sub-themes: career pathways; role expansion.
Leadership and expertise	This theme includes several elements of leadership. Some participants viewed their role as involving leadership, whereas others felt that this was not part of their role, and viewed themselves as 'clinical experts'. Leadership for some was something that 'others' did. Also included within this theme is leadership from a broader context, in terms of outward facing leadership and developing the profession. Managers also explored how leadership should be embedded within the role and how this could be developed further in the current healthcare climate. This theme has two sub themes: clinical leadership; 'the bigger picture'.

Within qualitative research, extracts of the data can be used in two ways to support the themes presented. Firstly, they can be used as an illustration of the theme whereby the extracts are used to provide a rich description of the theme. Braun and Clarke describe this as *descriptive* or *essentialist* form of data analysis which aims to loosely tell the '*story of the data*' (Braun and Clarke 2006, p 252). The second approach is described as *conceptual* or *interpretative* form of analysis which provides a detailed analysis of the extract itself. This research adopted the former approach whereby extracts were used to illustrate the theme generated from the coding as the extracts provide detailed descriptions of the analysis and interpretation of the theme and sub-theme.

To further enhance the concept of descriptive illustration through extracts and data, photographs from the focus group participants were used as a visual representation of the theme and to give the theme names which further 'told the story' of the theme. This is represented in the final thematic map in Figure 3B. The photographs are also presented within the findings attached to each theme in Chapter Five.

Figure 3B. Final thematic map of themes and sub-themes with theme names.



#### 4.7.2 Reliability

Yardley (2008) refers to reliability as the possibility of generating the same results when the same measure is administered by different researchers to a different participant group. In quantitative research this is an important part of the process as the aim is to minimise the influence of the researcher, and therefore minimise bias. Qualitative research, however, acknowledges the influence of the researcher and qualitative researchers seek to 'maximise the benefits of engaging actively with the participants in the study' (Yardley 2008, p237). Braun and Clarke (2013) agree, suggesting that things that are said within the focus group will depend on the presence of the researcher, whilst the themes or categories generated in the analysis will be influenced by the position of the researcher. In addition, context is viewed as an important part of the data generated, and not something that should be removed (Yardley 2008). In this study the context of the participants was an important aspect of the focus groups; this was evidenced by the inclusion of the photographs, which gave a layer of context around the discussions.

As discussed in Chapter Three, qualitative approaches acknowledge multiple realities whereas quantitative research is '*rooted in a realist view of a single external reality knowledgeable through language*' (Seale 1999, p41). Braun and Clarke (2013) therefore argue that reliability is not an appropriate criterion for judging qualitative research, and reliability should be thought about more broadly in terms of the 'trustworthiness' or 'dependability' of the data collection and analysis (McLeod 2001). To enhance the dependability of the data collection all the focus groups were video recorded and transcribed verbatim. This ensured that the transcripts could be cross checked with the video recording, and allowed me to add visual context from the focus groups to the analysis.

#### 4.7.3 Generalisability and transferability

As noted previously, generalisability refers to whether or not the results generated in one study can be applied to wider or different populations (Braun and Clarke 2013). Some researchers (Schofield 1993; Johnson 1997) suggest that generalisability is not meaningful within qualitative research as the context surrounding the research is a key element, and may therefore be different in different populations. Others, however

(Sandelowski 2004), suggest that results are generalizable but in a different way. Sandelowski (2004) offers an alternative version of generalisability called analytic or idiographic generalisability. Here, deep and interpretative analysis of the data contributes to wider knowledge. Yin (2009) supports this notion, suggesting that analytical generalisation is applicable when the case study methodology involves observations that can be applied to a broader theory rather than a different population. This study is arguably within this category as it contributes to current understanding of the developing ENP role, and supports a growing body of knowledge relevant to new and emerging roles within healthcare. However, it would be wrong to assume that if this case study was replicated by a different researcher with different participants the results would be the same.

A more common term within qualitative research is that of transferability. Transferability refers to the extent to which aspects of the results can be 'transferred' to other groups of people and contexts (Lincoln and Guba 1985). Key to successful transferability is the description of the specific contexts, participants and setting involved in the study, allowing the reader to determine whether the results are transferable to other contexts. Skate (1995) adds that the emphasis is on the reader of the study determining the degree of transferability. Within this study context was sought through identifying current literature around the subject, and identifying certain characteristics of the sample (such as places of work, grade in practice, type of role) without identifying individuals. Rich descriptions from the data add further context, and allow the reader to decide whether the results presented within this study relate to their (or a similar) context elsewhere.

#### 4.8 Reflexivity

Throughout this research I was aware of my position within the study. As noted previously, my background both professionally as an ENP and an academic teaching ENPs had advantages and disadvantages. My professional background allowed me to gain access to a group of ENPs at two organisations. Participants were keen to be involved in the study as most of them had either worked with me or had been taught by me. I was aware that this involvement could have an impact on the research process in terms of subjectivity and bias, and that respondents may feel 'pressurised'



into consenting to the study due to a power imbalance between me as the educator and the participants as past students (Seidman 2002). Finlay (2002) suggests that the researcher has a responsibility to be aware of such bias, and take steps to minimise this. Costley *et al.* (2010) also note that 'insider researchers' must take steps to minimise bias during data collection and analysis. In order to address this, I visited the participants in their place of work to brief them on the study and left information leaflets for them. Consent was then gained at a later stage, allowing the participants to think about their involvement in the study. Social desirability is also a potential problem noted within qualitative research and is something that needs careful attention when designing and study. Social desirability occurs when participants answer question in a way that they think will make them liked or more accepted (Krumpal 2011). I was aware of this possibility and although traditional characteristics of ED nurses counters such desirability bias, as ED nurses are known to be open and extrovert (Kennedy *et al.* 2014), I attempted to ensure that all participants felt comfortable in voicing their opinions by encouraging each participant to have equal 'air time' and by agreeing during the ground rules that everyone would be able to voice their opinion in a safe and comfortable way. This is evidenced in the results in Chapter Five where different opinions are seen; for example, the following quotes demonstrate how during one of the focus groups participants were unable to agree on what a shared vision might look like:

- *A shared vision on getting through the day (laughs). ENP 2*
- *Or a shared vision of becoming Advanced Nurse Practitioners at the other end (major end). ENP 3*
- *I don't think we have a shared vision as such, we all have our own visions of where we see ourselves. We all want different things. ENP 1*

Reflexivity is also highlighted within the literature as being an essential component of good qualitative research (Braun and Clarke 2013). Reflexivity allows the researcher to critically reflect on the knowledge produced from the research and the researcher's involvement in that process (Braun and Clarke 2012) which helps to ensure that confirmation bias is not prevalent within the research. Keeping a journal is highlighted as good practice as it allows the researcher to record their thoughts and feelings on the process. Whilst I did not keep a formal log or journal I did make notes after each focus group recording both process issues and group dynamic issues when they

occurred. This was useful in that it allowed me to reflect on my own involvement and the group dynamic. An extract of this is shown in Appendix Eleven.

However, as noted above the position of being an 'insider' within qualitative research can also be beneficial, and actively contribute to the data collection and the subsequent analysis. The participants expressed 'enjoyment' and feeling 'invigorated' at being able to discuss the issues, and for some they described it as 'cathartic' My insider knowledge and enthusiasm for the development of the ENP role over many years empowered the participants to feel they could express themselves freely. It is, however, important to acknowledge that my professional background has undoubtedly influenced how I have interpreted the data, and this will be explored further here.

It is well recognised within the qualitative research methodology literature that the researcher will tell a different story from that told by the participants (Braun and Clarke 2013). Analysis of data involves interpretation, which is informed by the subjective opinions of the participants and the product of analysis is often different from the raw data. For some (Miles and Huberman 1994; Price 1996), this is disconcerting, and leads to the suggestion of a participatory approach whereby participants are active collaborators in the research process. However, Braun and Clarke (2013) assert that *'the story is our story about the data, not the participants' story, and our story may differ from theirs'* (p64). They go on to suggest that it is important to decide whether the analysis will be 'data driven' (the themes will depend on the data), or whether it will be 'theory driven' (the data is approached with specific questions, and is coded around these). In this study I decided that the data will be analysed using the data driven approach. In other words, the emerging themes came from the data. This is demonstrated by examples of data coding shown in Appendix Nine. It is important to note, however, that when using this method of data analysis not all the research questions in the study may be answered as the themes emerge from the data and not necessarily from the research questions. This will be further reflected upon later in the study.

There are other advantages to researching an area with which you are familiar. For example, during the focus groups my knowledge of the subject matter enabled the discussion to flow easily as I was able to interpret colloquial language and acronyms without having to pause for clarification. The following quote highlights the advantage

of having 'insider' knowledge of the subject matter, as I understood the language used and did not need to ask for clarification which may have interrupted the flow of the conversation:

- *'When I am in navy I still use my ENP skills, I will request X-rays and do bloods to speed things up, I am part of the nursing team. When I am in black I am part of the ENP team which is a separate entity'.*

Corbin and Strauss (2008) agree with this view, suggesting that the 'insider' researcher can synthesise concepts more quickly. I was also able to 'push' the discussion on further at times through an ability to interpret the ENPs' understanding of the questions or prompts. Dwyer and Buckle (2009) recognise that using your own insight and experience can have a positive effect on the group dynamic, and can provide further insight into the participants' responses.

#### 4.9 Summary of chapter

This chapter has outlined the methods used for data collection, and the subsequent method of analysis. It has described the benefits of using focus groups as the main source of data collection, whilst acknowledging the limitations of this approach. Thematic analysis was the chosen method of data analysis, and this chapter outlined the justification for this approach. Ethical considerations were explored, and some reflexivity offered on the methods used.



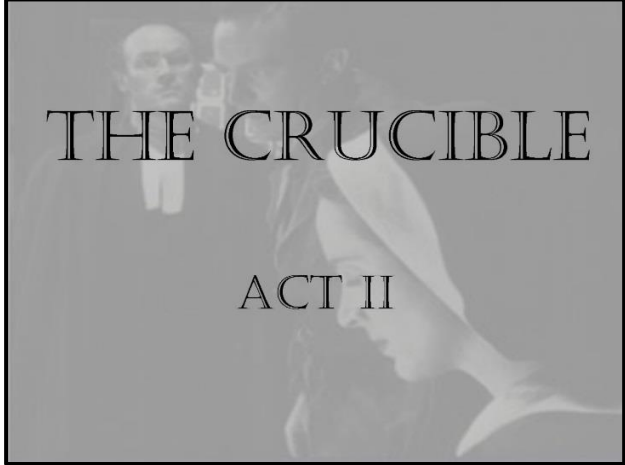
## 5. Case Findings

### 5.1 Introduction

This chapter aims to present the themes that emerged from the data analysis described in Chapter Four, using the Braun and Clarke (2013) method of thematic analysis (TA). The data was coded using the framework as set out in Appendix Eight, and each theme will be presented here.

Five overarching themes were identified using this method: The key to identity (the role); value for money (perceptions); the meandering river (education); the meandering river career structure; the expert practitioner (leadership). Table Six outlines the five themes, and the sub-themes within each theme. A brief summary of each theme will be presented, followed by an in-depth account using direct quotes from the focus groups with the ENPs and the interviews with the senior managers to provide a rich description of that theme. Photographs from the focus groups will also be used as a symbolic representation of the themes. A discussion of the analysis and the implications of the results will be presented in Chapter Six.

Table Six. Summary of named themes and sub-themes.

Theme	Sub-theme
<p>The key to identity: the role</p> 	<p><b>Role definition</b> Key words: job satisfaction; scope of practice; risk; different; conflict; holistic; guilt.</p> <p><b>Titles</b> Key words: pride; frustration; conflicting; varied.</p> <p><b>Team work</b> Key words: support; collegiality; peers; uncertainty; shared responsibility.</p>
<p>Value for money: perceptions</p> 	<p><b>The general public</b> Key words: misperceptions; influencing; frustration; media; stereotype.</p> <p><b>Senior Managers and employers</b> Key words: professional status; pay; misperceptions; targets; lack of understanding; gap.</p> <p><b>Other healthcare professionals</b> Key words: lack of understanding; conflict; guilt; tension.</p>
<p>The missing chapter: education</p> 	<p><b>Undergraduate education</b> Key words: gaps; missing out; catching up; preparation.</p> <p><b>Knowledge</b> Key words: nursing; medical model; growing; boundaries.</p> <p><b>Post graduate education and training</b> Key words: degree; frustration; uncertainty; leadership; support; training.</p>

The meandering river: career structure



Career pathways

Key words: structure; pathway; frustration; disempowered; advanced clinical practitioners.

Role expansion

Key words: 'major end'; advanced practice; expansion; growing; evolving; job satisfaction; confidence.

The expert practitioner: leadership and expertise



Clinical leadership

Key words: experts; clinical leader; skills; dual roles; confident.

Seeing the bigger picture

Key words: 'others'; time; barriers; clinicians; policy.

## 5.2 Theme 1: The key to identity: the role

Figure 4. Photograph presented by ENP 3: *'Keeping your registration or professional identity closely guarded'*.



This photograph is a visual representation of the overarching theme produced by one of the participants in the focus group discussion as he/she describes how professional identity and the role need to be kept 'safe'. This theme captures the essence of the ENP's perceived sense of professional identity. It covers aspects of the role such as pride in the job, fear of litigation and conflicting perceptions of title and role definition. It also questions who 'the team' are, and who their perceived peers are within the workplace. The theme has been split into 3 sub-themes: role definition; titles; teamwork.

### 5.2.1 Sub-theme 1: role definition

Within this sub-theme participants explored aspects of the role which encompassed the privilege they felt in undertaking the role, worry around the associated responsibility and moving between different roles. However, it was very clear from the case that the participants were proud of the role, and experienced an enormous amount of 'job satisfaction'. The participants described this using words such as 'privileged', 'unique' and 'precious', The following quotes are examples of how proud the participants felt about the ENP role:

- *To be able to say to someone 'you have come in with this but we have found out that it is this and I can sort this for you' is fantastic, the job satisfaction from that is amazing. I am proud of that and to be able to deliver that type of holistic care is something not only unique but actually quite precious. ENP 8*
- *I am so proud to be able to prescribe medicine as part of my role (and scared). ENP1*

Linked to pride was 'trust', as participants felt the huge sense of trust that was put in them. This was important and helped define them in terms of their identity, as this participant describes:

- *The reason I get out of bed in the morning is that I feel important about the job I do and that I feel privileged and trusted to prescribe. It makes my professional identity feel important. ENP 3*
- *I think the role of practitioner is something I am quite proud of and I think it's quite a thing. ENP 7*

In a later conversation this same practitioner goes back to the issue of pride in relation to 'earning the status' of being an ENP:

- *It is something you have earned, we are not just nurses, and not everyone can do it, it is something to be proud of. ENP 7*

Hand-in-hand with a sense of pride and privilege it seemed the participants had a sense of ownership or responsibility, in that they felt the role needed 'nurturing' and 'looking after' and 'not taken for granted'. This sense of nurturing was linked to their sense of professional identity as this participant describes:

- *My professional identity as an ENP is something that's not static, it has grown over the years and it's got more growing to do (shows a picture of a plant). You have to nurture it and keep it fed (with knowledge) and then you might choose*



*to grow in a different direction, off another branch. If you nurture it along the way you will gain confidence and see the fruits of your labours. ENP 3*

Conversely, one participant had a less positive view of role development, and described the growth of the role as surviving without water, where 'water' represented education and training:

- *As an ENP you come with deep roots (shows a picture of tree roots), which is your knowledge and experience, you need this because you have to advance yourself quite a lot without input. Without the deep roots and a little water you would die. ENP 5*

As noted in one of the extracts above, where one participant (ENP1) described being 'scared' of prescribing, participants shared a sense of risk associated with the role. Participants talked about the 'scope of practice', which is the guiding principle that all nurses work within as set out in the NMC Code of Conduct (2001). This was an important factor, and related not only to their responsibility within the role but also to their identity as a practitioner:

- *You have to keep your registration or professional identity closely guarded, secure and that's the scary bit, it's everything in life really (shows a picture of a lock and mortice). You have to keep your professional identity under lock and key, work within your competence, otherwise you will lose it. I think about that all the time, it scares me a bit. ENP 3*

The notion of risk also related to litigation, and was clearly something very important for this participant as they returned to this with a photograph:

- *If you make an error or one of your decisions are not sound (that is the risky bit) you know the sharks are underneath you (shows a cartoon picture of a tightrope with sharks circulating underneath). ENP 3*

When probed for clarity on who the sharks were the participant responded:

- *Litigation, like an adverse event that I am responsible for, so that's the risk I live with every day. ENP 3*

Others agreed:

- *It's not just about litigation, it's how you live with yourself if you make a mistake, that's what keeps me awake at night. It's also about your professional identity*

*and responsibility to other colleagues, I wouldn't want to let them down, multiple things worry me. ENP 1*

However, other practitioners felt that managing risk was a normal part of the role, and this was what defined them as 'different':

- *There is something about ENPs being comfortable with risk and being willing to say 'I think this is what's wrong with you and this is my plan'. ENP 6*
- *Having the actual responsibility of discharging the patients is different to the perceived responsibility of discharging. ENP 4*

For some of the participants the issue of managing risk led to a discussion on conflict between ENPs and doctors, as there was a perception that despite doing a very similar role ENPs were treated differently to doctors in relation to risk:

- *It's frustrating, we have to jump through so many more hoops. If we make a mistake it's the end of the world, if an SHO misses a fracture they are 'just learning'. Mistakes happen, there is a certain pattern to it and I don't think it always necessarily relates to what profession they are, they are the same mistakes. ENP 4*

The conversation about risk and responsibility developed into a discussion around defining what the role is, and the difference between them as ENPs, 'shop floor nurses' or 'front line nurses' and doctors:

- *The biggest thing in nursing is to take that step from being a nurse who does what the doctor says to becoming the nurse that does what the doctor does. I have never thought of myself as a doctor and when patients mistakenly call me a doctor I say 'please don't insult me'. I tell them I am a nurse and my name is xx. ENP 7*

For many the difference between being an ENP and a doctor was the sense that they carried out more than just diagnosing and prescribing. There was a sense that they used their nursing skills alongside their 'new' medical skills. Words such as 'holistic' and 'whole package' were used, as this participant describes:

- *For example last week a patient came in and needed a stethoscope and the whole medical thing but he was homeless and needed his feet scrubbed. I got down and stuck his feet in a bowl of hot water and scrubbed them, which maybe our medical colleagues wouldn't do, but that's because I am a nurse and I can do extra things, but I am still a nurse. Our medical colleagues would come out of the cubicle and say 'oh by the way they need a fresh pair of socks and their*

*feet scrubbed'. We wouldn't expect one of the nurses to do that for us, we would provide the whole package. ENP 1*

For some, the distinction between relating to a front line nurse or doctor and being an ENP was difficult as on some shifts they would work as an ENP, whilst on other shifts they would be the 'nurse in charge of the department'. These participants tried to explain this:

- *I think I am separate to both, somewhere in between, so I have a different head to certain nurses and we have very different opinions to them. I can usually give a good rationale to the nurses on the shop floor why I want to do something, because of the ENP stuff, so I don't necessarily relate to nurses and I do a bit less nursing (I think) but I am not a doctor, don't want to be one and I don't relate to them either. I think we have our own identity, as an ENP rather than a nurse or doctor, it's a completely separate identity. ENP 4*
- *It's a hard one isn't it? I feel part of both teams. I identify myself as an ENP but you do have to switch off from that when you are in charge of a shift. ENP 5*

For one participant the 'conflict' goes further, as they described guilt associated with the role:

- *Sometimes I feel guilty that I don't feel so much like a nurse anymore, even though that is where you were brought up. That grounding will never leave but I feel like I am almost living beyond that in terms of my role and how I see myself. ENP 2*

As noted above, some of the participants hold dual roles in that on some days they work within the ED as an ENP (and wear a black uniform) and on other days they work as a shift co-ordinator for the whole department and wear a navy-blue uniform. For one participant, this distinction between being an ENP and a 'front line nurse' was defined by the uniform, which identified her/him in the role on that particular day and related to their professional identity:

- *One day a week I wear black and have a stethoscope round my neck and I am an ENP and the other day of the week I wear navy and I am a nurse and although I might use some of my ENP skills predominantly I am a nurse on that day and carry out a nursing role. I feel different depending on which uniform I wear; it says who I am and what I do. ENP 1*

### 5.2.2 Sub-theme 2: titles

As noted in the literature described in Chapter Two, the issue of titles is one that is widely talked about when discussing role definition and identity. These participant ENPs were no different, in that the issue of titles was important and an influencing factor in their perceived identity and role definition. Some were proud of having the word nurse in their title, and felt that this was part of their identity as these extracts demonstrate:

- *I am really proud to have the word nurse in my title; it's who I am what I do. ENP 13*
- *I always say Nurse practitioner, if someone calls me a doctor I correct them. ENP 6*
- *I have never thought of myself as a doctor, if someone says it mistakenly I say my name is xx I am a Nurse Practitioner please don't insult me! (Laughs). ENP 7*

In all of the focus groups the discussion around titles continued for some time, and there were differing views on what the title should be:

- *I never say to people that I am a nurse, I always say I am a nurse practitioner and they always say what is that? ENP 3*
- *The role itself is miles apart, when you think about the role of the ENP and the role of the nurse they are miles apart. I find it quite frustrating, I think we are quite protective about how we are seen and our title is all about that. It's even worse now that we have band 4 health care assistants (HCA) calling themselves Assistant Practitioners when actually they are not. ENP 1*
- *I feel like I am an advanced practitioner, it's all about rubbishy titles. It bothers me that sometimes I am dismissed as a minor illness/injury nurse when I am not, I am an Advanced Nurse Practitioner. ENP 2.*

The frustration and confusion about varying titles was also felt by one of the managers, who conceded that he/she wasn't sure what titles they were using as there are so many:

- *We call them Emergency Care Practitioners or is it Emergency Nurse Practitioners - sorry I get confused with all the titles. SM 1*

As the discussion around titles and roles unfolded it seemed that the participants experienced conflict within themselves. They expressed pride in the role and being a

nurse, however it emerged that having the word nurse in the title was also problematic and conflicting for some:

- *It's because we have the word nurse associated with it (the role). The title 'nurse' we don't want to lose it but if we got rid of nurse more doors would open up for us. ENP 5*
- *It's funny, I don't know why because I am very proud of being a nurse and very proud of my training but I personally remove it without even knowing it. I do say Emergency Nurse Practitioner but it's the bit in the middle that makes me stutter and I don't know why but I would rather it was left out. ENP 3*
- *If I am talking to a colleague in the profession I tell them I am a practitioner as they understand what that means, if I am talking to a patient I am always a nurse. ENP 7*

### 5.2.3 Sub-theme 3: teamwork

One of the strongest areas that emerged from the case was the importance of teamwork, although being part of a team had different connotations for different groups of practitioners. Those in a nurse-led unit talked about other ENPs as their team, whereas those within a large ED talked about a wider team:

- *This picture (shows a picture of doctors and nurses and ENPs) represents from an identity point of view teamwork. Our little team within the bigger ED team is so important to me... I see our team as being the ENP team but with the extension of our medical colleagues. ENP 1*
- *My team are my ENP colleagues and the nurses who we work with. ENP 7*
- *We are all part of an ED team with different roles. ENP 11*

One participant shared a photo of a forest with a large tree in the foreground with a lone swing hanging from it. He/she used this to describe how they felt about teamwork:

- *Sometimes you have to swing on your own as your colleagues are busy, you have to make a decision and I am comfortable with that. I am happy on my own but I know that I have a big team, a group of people who help me, and that's the forest. ENP 6*

Support for each other came across as important for all participants, and for those working in the nurse-led unit there was sense of a 'shared ownership' and a strong sense of collegiality:

- *There are not a lot of egos involved in this, we know the group decisions are strong decisions and if you're not quite sure what to do with a patient you will*

*ask. There is never a thought of 'I don't want to show myself up or show my lack of knowledge or confidence'. I think this is tremendous. ENP 8*

- *The more input you have the more likely the decisions you make will be good ones, its intrinsic in the way we work here, we don't have medics so we support each other, its more collegiate than other environments. ENP 7*

As described previously, those who had a 'dual role' within the ED found it more difficult to identify their 'team'; they identified two or more teams that they felt a part of:

- *It's a hard one to answer, I feel part of two teams, when I am in charge of the shift I have to switch off (from the ENP role) and be part of the wider team supporting the juniors. I don't ever feel part of the doctor team as such. ENP4*
- *One day a week I am an ENP and I am part of the ENP team, on the other day I am a nurse and am part of the nursing team. ENP 1*

The participants were prompted on who they saw as their peers in relation to 'the team'. For some this was difficult, as although they had described the team clearly as the ENP team some observed that medics and others were their peers:

- *I feel medics are my peers... if you were going to be reviewed by your peers then I would have thought it needs to be someone who works at a similar level to you. ENP 2*
- *I still see the ENP team and the doctors as my peers. ENP 1*
- *It depends on what your definition of peer is? I would say peers are SHO (senior House Officer) level and clinical Nurse Specialists as we are nurse specialists within emergency medicine. ENP 3*

The notion of the team working together and supporting each other prompted a discussion on the potential for a shared vision, however participants in this focus group were unable to agree on what a shared vision might look like as these extracts demonstrate:

- *A shared vision on getting through the day (laughs). ENP 2*
- *Or a shared vision of becoming Advanced Nurse Practitioners at the other end (major end). ENP 3*
- *I don't think we have a shared vision as such, we all have our own visions of where we see ourselves. We all want different things. ENP 1*

This was consistent across all the focus groups, as none of the participants in the case were able to articulate a shared vision. However, the participants from the nurse-led unit expressed a shared sense of responsibility:

- *As a collective group of band 7s ENPs there is strong sense of collective responsibility. We are responsible for targets, closing the unit on time, all the junior staff and their development. We work together on achieving things. ENP 6*
- *Absolutely we are always checking up on each other, we keep a close eye on everyone. ENP 7*

### 5.3 Theme 2: Value for money: perceptions.

Figure 5. Photograph presented by ENP 2: *'We are a bargain, an absolute bargain'.*



This photograph is a visual representation of the overarching theme and was produced by one of the participants as he/she describes the role of ENP being value for money. This theme relates to perceptions of the role by different groups identified by the case. Therefore, this theme has been split into three sub-themes: public perceptions; other health care professionals' perceptions; senior managers/commissioner's perceptions of the role.

### 5.3.1 Sub-theme 1: the general public

As alluded to in theme one, the title of the role was discussed at length and whilst it was evident that the participants are very proud of being a nurse, some perceived that having nurse in their title was at times problematic for the general public as they (the public) didn't understand the extent of their role. As these participants explain:

- *When I introduce myself to the patient I don't think they fully understand what I am going to do for them, that I am an autonomous practitioner.... Sometimes I wish my title didn't have the word nurse in it as I think the public don't understand that I can do the whole thing...they (the public) think they have been short changed because they were expecting to see a doctor. ENP 3*
- *I was questioned a lot (about my role) in general practice, it was like a jaw drop to some who were not used to seeing ENPs in general practice. ENP 2*
- *I think public perception is still out there, they wouldn't understand that going to a nurse led autonomous unit they would actually get the care they needed for their situation. ENP 3*

It was clear from the case that the participants felt that the general public had misperceptions about their role, however as these participants explain they also felt that it was part of their job to educate the public on the emerging ENP role:

- *I feel it is part of my role to educate them and say 'this is a new type of nurse, we are doing things differently and have a different role' I feel quite passionate about that. ENP 6*
- *I always identify myself as a Nurse Practitioner to patients and I think that's important as then they can see what we do. ENP 5*
- *Patients will often say 'I've come to see a doctor' and I am constantly explaining that we are not doctors. It is important we don't give the impression or allow people to believe that is what we are. ENP 7*
- *There has only ever been one patient who said they wouldn't see me and then when you explained what you did and what the role was about they were quite happy to be seen and very impressed. A lot of it is about influencing people, that's why I always identify myself and a Nurse Practitioner, so they spread the word and there will be less resistance to be seen by an ENP. ENP 4*

It was evident that for some this was a source of frustration. One participant used a photograph to demonstrate this:

- *This is a photo of someone screaming; it represents that we still have to keep screaming about what we do and the role we have. ENP 10*



In contrast, however, this participant felt that public no longer seemed to mind who they saw as long as they were treated:

- *When the role first came out nobody knew who it was, we didn't really know at the time and as time has gone on it's completely accepted. I haven't had anyone for years say 'I'd rather see a doctor'. ENP 1*

The following quote from one participant explains how things are changing, as services are being reconfigured due to a shortage of GPs and how the role of ENP will be perceived:

- *It is more about what our service can do, GPs are drowning so we need to redefine what we do. Things are constantly evolving, roles change and the public expectations will change. If we meet their expectations that is great but if we don't and they are struggling to see their GP that is when the problems arise. ENP 7*

The public perception theme took on a further dimension in one focus group in which the part that the media plays in the portrayal of nurses and nurse practitioners was discussed. It was felt that the media continues to portray nurses in a stereotypical fashion. The following extracts are examples from the focus groups that support this view:

- *They (the public) have no idea; their picture of nursing is someone who mops your brow, gives you a commode and wipes your bum. Unless you know a nurse you are stuck with a stereotype of what a nurse does. A lot of people have said to me that they watched 24 Hours in A&E and I can't believe what you do. But they still have no idea until they have seen it. Casualty is not so helpful. ENP 5*
- *When you see people being interviewed on TV about emergency care stuff it is always the doctors. They never ask a nurse. ENP 4*
- *Even if a nurse was interviewed people wouldn't switch that to 'oh a nurse', they would still think a nurse is going to do a bedpan or they would assume it was a nurse manager I am sure. ENP 5*

### 5.3.2 Sub-theme 2: senior managers and employers

The consideration of public perceptions developed into a discussion around pay and remuneration for the role. For some the lack of recognition (both from employers and the public) was in part a result of the perceived low salary, which was directly linked to professional status.

- *We are like gold dust, I think we are a bargain for what we are doing and actually providing for them (the Trust). ENP 3*
- *BOGOF (buy one get one free) ENP 1*

The group laughed as they understood the concept that ENP1 was referring to (value for money):

- *Private companies are emerging and they are recognising through wages the level that we work at. The NHS has taken a very long time to recognise the value of what we do. Remuneration is a big issue for me. ENP 2*
- *I could earn more doing one agency shift as an ENP what I can earn in a week at the xx. The private sector is realising how valuable we are. ENP 1*
- *Money equals the respect that we'd be getting, not just taking on more jobs and more jobs, having the respect that these jobs are harder, making harder decisions, therefore it should come along automatically with money. The money shows value in our society as well. ENP 5*

There was a general feeling amongst the case that senior managers within the Trust did not understand the role, and this was identified as something that was a frustration and disappointment to the participants:

- *I don't think they (management) understand we do more or less the same the exact same job as our medical colleagues. They don't understand the scope of what we do, but I do think they understand the impact and know a good thing when they see it. ENP 3*

One participant used two photographs to describe the feeling that the Trust did not understand the role:

- *My photos are a contrast in what I see we are and can do (shows a picture of a fully leafed green tree) and what I think the Trust see (shows a picture of a bare tree). The Trust do not get how much we do. ENP 10*

However, when the senior managers were asked to define the role of the ENP both were able to articulate clearly what the role entailed:

- *They are nurses who deliver clinical decision making at an advanced level, they are autonomous within their practice which is underpinned by a set of competencies to demonstrate they are at that level. They are also independent prescribers. SM 1*

In addition to this, both senior managers recognised that ENPs play an important role in service delivery as this quote suggests:

- *They are an important part of the workforce, we do realise that they play an important role. SM 2*

Some of the participants raised the issue of targets, and there was a concern that the number of patients they see is more important to the Hospital Trust than what type of patient they see:

- *I think the management do understand a lot of how crucial we are, when you consider how target driven everything is, they can see how much impact the ENP service has had on targets. ENP 3*
- *If they came and shadowed an ENP for a shift, they'd have a much better idea of what we do and I'm not interested in numbers but I think they are just interested in the number (of patients) we see. ENP 4*
- *They talk about targets, numbers, finance and we talk about patient care. ENP 11*

Interestingly, the participants who work at a nurse-led minor injury unit focused on how commissioners perceive them rather than Trust managers. However, for some there was still a sense of a lack of understanding of the role:

- *I don't think they understand the role. They are all GPs and I don't think they have a great deal of priority for us, there is no element of pride of this service that we provide for them. ENP 8*

The discussion continued, highlighting a perceived gap in understanding of the role:

- *There is a massive gap between the commissioning services and us. They (the Trust) talk about the commissioners as though they are sat behind a wall with no faces. ENP 8*
- *There is no back up from them. ENP 7*

This perception was confirmed by the manager, who also felt that health professionals (GPs) outside of the unit had mixed perceptions of the role:

- *GPs are telling us that some of the work they do can be done by ENPs. I think their perception of what that is and the nurses' perception will vary and that will depend on trust and the clinical credibility of the ENP. SM 1*

One participant felt that although they might not understand the role, the commissioners did appreciate the service:

- *I suppose they see us happily tick away, I don't think they understand us but appreciate we do a good job. I don't think they understand the level of stress and urgent and complex patients we see, even though we give them all the figures. We haven't had huge disasters here and huge incidents and until that happens they don't understand the level of risk we deal with every day. ENP 6*

Conversely, one of the participants was more sympathetic to the gap that had been described, suggesting that this perceived 'gap' was not necessarily problematic, and perhaps unavoidable:

- *If they are not a clinician then you are always going to have to work harder to get your point across. Every now and then there are crunch points and you have to be steadfast in your opinion. It is always going to be a difficult interface. Visibility helps, when they come down and say hello and listen to staff concerns it really helps. ENP 9*

Within this theme loyalty to the department and organisational identity was discussed. For many of the participants, their loyalty was to their colleagues followed by the department they worked in. This appeared to be the same for those who worked in the nurse-led unit and those who worked in the ED, as evidenced by these extracts:

- *My loyalty lies within the department. I don't see the Trust managers down here saying thank you or well done or sticking up for us so I am sorry I don't have that loyalty. ENP 4*
- *The department is hell at the moment and I don't see us getting any support from the top. ENP 5*

Loyalty for the wider organisation was much less evident, as this participant describes:

- *We work well within this unit, we are proud to be here but as for the organisation I have no idea about that really. ENP 7*

However, there was recognition from some of the ENPs that the organisation had supported them through their education, as this participant explains:

- *I feel quite valued and I have achieved more than I hoped in nearly 6 years now in terms of education so I can't fault them (the organisation) on that. ENP3*
- *We have had a lot of Trust support in terms of education and doing the ENP course. ENP 11*

Interestingly, one of the senior managers articulated a view that ENPs do not have a sense of organisational loyalty or identity:

- *I think they have a strong identity with the ED but I am not sure they have a strong identity elsewhere. I don't think the ward nurses understand what they do but equally I am not convinced that the ENPs have any insight into the issues outside of the ED. SM 2*

One of the participants also recognised that there was 'barrier' between the ED and the rest of the hospital:

- *We work in a bubble here, there is a barrier between the ED and the rest of the hospital. ENP 12*

### 5.3.3 Sub-theme 3: other health care professionals

Some of the participants made reference to the experience of working with other health care professionals, and their perceptions of the role. This was especially apparent for those who worked in the ED, and who came into contact with a wide range of nurses, doctors and other health care professionals:

- *Our medical colleagues within the ED get it (the role) but Directors of Nursing, other nurses and AHPs (Allied Health Professionals) don't get it. ENP 10*

There was a feeling that junior nurses aspire to become ENPs, even though they may not really understand the role. As these two participants explained:

- *I think they (junior nurses) aspire to be ENPs, they see how varied the role is although I think they feel it is a bit odd being asked to do things. There was a bit of a ground swell when the junior staff said 'no we are not going to do that for ENPs they should do it themselves' I think we are over that now. ENP 3*
- *I don't think I truly understood the role until I started doing it so why would they understand. It's like when you were studying to be a nurse you thought you knew what you were going into and then when you qualify it's like 'oh my god!' ENP 4*

Although there was a sense that on the whole the role is respected by many nursing colleagues on a day-to-day basis, some felt that advancing roles within nursing *per se* can be seen negatively, and not valued very highly:

- *I think as nurses we are an oppressed group and we don't like it when someone sticks their head above the parapet (shows a picture of a field of poppies with one poppy sticking out above the rest). It's quite hard to be advancing yourself when you're doing things that perhaps others deem to be beyond and outside the scope of our practice. ENP 9*

- *If you don't give them the answers they want they (junior nurses) will go and ask a doctor, they go up the hierarchy. They put them in a higher esteem. I think they might understand the role but the role is not valued as highly as it should be. ENP 4*

When the participants discussed perceptions of other nurses (mainly ED nurses) they shared almost a sense of guilt, and the conversation became uncomfortable for some as they considered where their role and that of the 'cubicles nurse' (a nurse working in the "minor end" who carries out treatments for patients) overlaps. The following extract of the conversation demonstrates this:

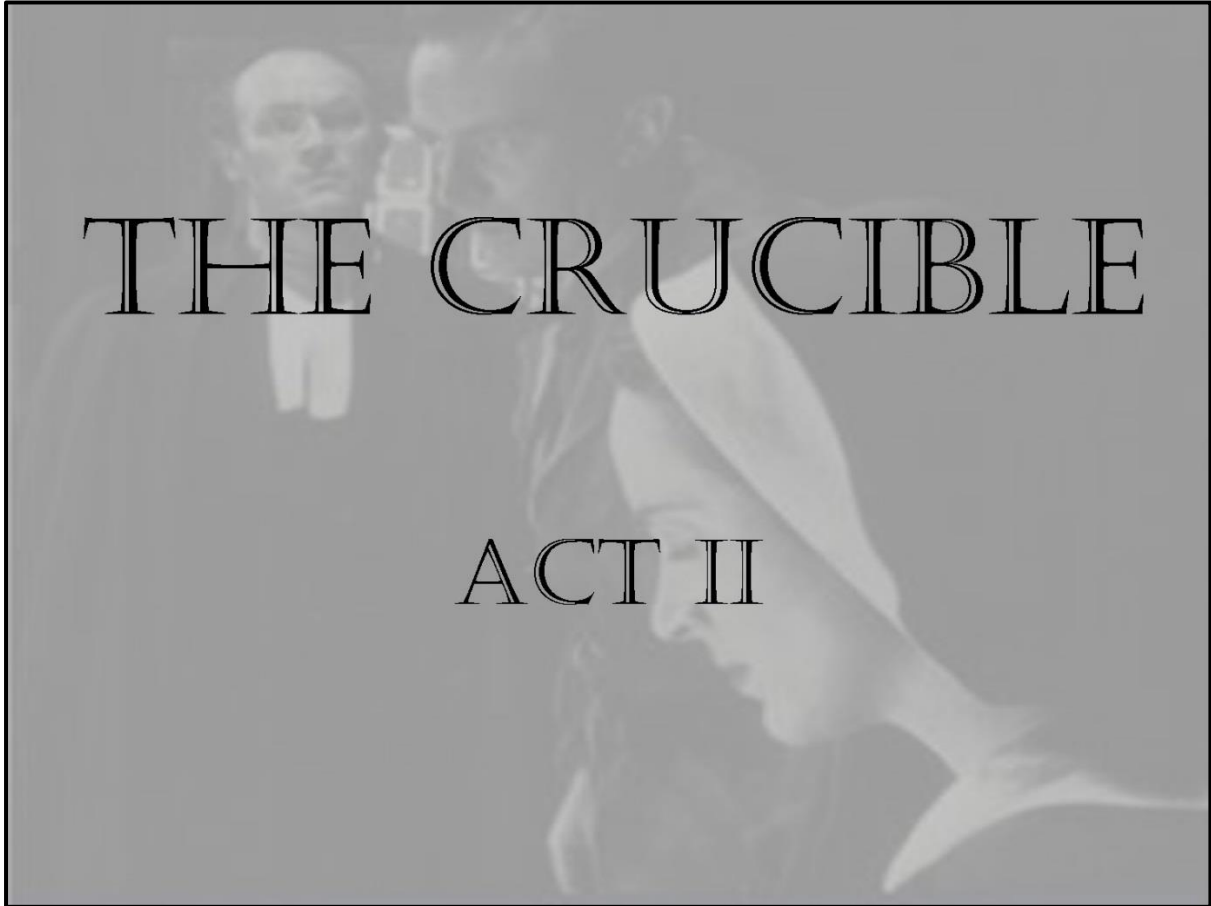
- *Do you ever think it's right to pass the care onto a cubicle nurse? ENP 2*
- *No I wouldn't unless it was ridiculously busy, for me it's all about providing the whole holistic provision of care. ENP 1*
- *Is that always feasible though? We are here to do a job and keep the queue down. Can't we pass on the treatments without feeling the guilt? ENP 2*
- *I wouldn't be able to ask unless they saw me doing it myself. I would only ask if I literally had no time and then I feel bad. ENP 3*

Some of the participants expressed a tension between the different nursing roles:

- *You don't get treated in the same way as they (the shop floor/cubicle nurses) treat the doctors, which irritates me. It shouldn't be about he is a doctor or she is an ENP, it's about the role you are fulfilling. You do get some that are quite reluctant. I do utilise them for bloods and things, it's not always easy. ENP 2*

## 5.4 Theme 3: The missing chapter: education

Figure 6. Photograph presented by ENP 4: *'I missed the introduction'*



This photograph is a visual representation of the overarching theme of education as participants describe how gaps in their undergraduate training impacted on their role development and professional identity. This theme considers gaps in knowledge and training relating to the ENP role. The theme describes the participants' perceptions of their undergraduate degree training and their post-graduate education, in-house and 'on the job' training. Support for training and education locally and nationally is also included within this theme. The theme is split into three sub-themes which are: undergraduate nurse education; knowledge; post qualifying education and training.

### 5.4.1 Sub-theme 1: undergraduate education.

Emerging from the case were perceived gaps in the undergraduate nursing programme relating to anatomy and physiology, decision making, clinical examination

and pathophysiology, in comparison to the undergraduate training of medical colleagues. Participants shared a sense of 'missing out', 'lacking in-depth basic knowledge' and (needing to) 'catch up'. ENP participants were clear that education plays an essential part in role development, and this should start during pre-registration training in order to provide a foundation on which to build in subsequent courses. The following quotes are examples of participants' feelings relating to this:

- *Being a student nurse puts you on the right path, but it doesn't prepare you for what you are seeing. ENP 5.*
- *I missed Chapter 1. I missed the introduction, they (medics) have a lot of anatomy, physiology and all that kind of stuff and it's over a five year period. If you put the very basics of listening to a chest and all those kinds of things in undergraduate training by the time you came to post graduate you're already comfortable with this and you can build on it. ENP 4*
- *(Participant shows a picture of 'Act 2'). I feel as though I have come to the show in Act 2. I didn't get Act 1. I am going to spend the next 25 years filling in what Act 1 was all about, whereas medical colleagues got in from the start, I walk in just as the curtains are about to open on Act 2. ENP 2*

The perception of 'missing out' was common across the focus groups, and whilst some respondents didn't specifically refer to this as 'missing out' it was evident that there was a perceived gap in their initial training compared to their medical colleagues:

- *We are not taught in our pre-reg training how to manage risk, doctors are. They are so much more comfortable with managing risk because of their training. We have to make this up during our ENP training. ENP 10*
- *My knowledge is not on a par to a registrar, they have a different knowledge base... Sometimes I feel 'arghh' what if they ask me awkward questions. ENP 3*
- *We didn't do enough medical model, definitely not, it was very fashionable at that time to learn about the concepts and make us very academic and professional and clever and didn't do enough of the basic training of anatomy, physiology. I feel I ended my four years with a degree and sort of really intellectualised nursing without enough of the real medical basics. ENP 9*

Interestingly, the managers agreed that the undergraduate nursing programme does not equip them sufficiently, and this did not relate just to ENP preparation, as this manager explains:

- *I don't think the pre-registration programme works; it doesn't prepare them enough for what it is really like. They have not had the exposure or experience to be effective practitioners. We run a preceptorship programme (a year-long*



support programme for newly qualified nurses), *and some of them want to be identified differently to the other band 5s, they still see themselves as learners for a long time after they qualify. SM 2*

She goes on to say:

- *It's different now; we have band six's who are only 18 months in post and are the future sisters, and we don't prepare them for this. SM 2*

In terms of preparing nurses for advanced practice roles, this senior manager did not feel that the undergraduate programme prepared them sufficiently:

- *It requires a lot of investment from us, they don't teach them systems in the way they need to or clinical reasoning. We have fed this back; the nurses need to be ready for what's out there and they are not. SM 1*

#### 5.4.2 Sub-theme 2: knowledge

Participants were prompted to discuss knowledge in relation to where (and from whom) they draw their knowledge. Most participants felt that this was not straightforward, and discussed drawing on both medical and nursing educational models. Nursing was at the forefront of their knowledge base, although some of the participants recognised that they had moved closer to a medical model:

- *I think we use medical standards, guidance that is learnt mostly from medics but you've always got your nursing hat on haven't you? Your intuition for example you have seen this before and there is something wrong with this kid, there is more than a medical thing going on, there is something going on in the family. ENP 6*
- *I think it (knowledge) is drawn from all ways. Increasingly we have to prove ourselves, in terms of the medical model as we now taking roles away from doctors and doing roles beyond what we were originally trained for. ENP 9*

However, one of the participants felt strongly that their knowledge base was still very clearly rooted in nursing:

- *My knowledge is rooted in nursing; I don't identify myself with that group (medics) ENP 4*

Some of the participants recognised that they are drawing on both a medical and nursing theoretical model, and seemed quite comfortable with this. As these participants explain:

- *I think the clinical examination side is medical based and we have learnt that from doctors but the bit that makes this job different is the holistic attitude where you deal with the whole thing not just someone's head; it's about how are things at home? Does he know about a good diet to make it heal well and not picking at it with dirty fingers, that's from our nursing base? ENP 6*
- *Knowledge comes from many places, I am drawing on my knowledge base on a patient by patient basis, with my colleagues in the area and probably a handbook (laughs). My Master's helped me understand stuff I didn't understand, filling in the blanks... like the light bulb moment when you figure out why you did what you did. ENP 2*
- *It has evolved for me (shows a picture of the Gaoling Bridge see Appendix Ten). This represents the meeting of minds if you like between the nursing and medical side of me. In order for me to do and be the practitioner I have had to merge the nurse and the medical side. ENP 2*

For one of the participants it was described as a different type of knowledge that keeps growing:

- *We have a broad knowledge base and lots of shop floor experience but this knowledge is a different type of knowledge. It just keeps growing and growing (shows a picture of a researcher in a rainforest). There is so much to learn it's overwhelming and you don't know what you don't know. It's a bit of everything. ENP 5*

Later in the conversation this participant returned to the notion of one knowledge:

- *Eventually there won't be a difference, so you could go to a doctor or an ENP, anyone that has the knowledge. ENP 5*

Senior managers also felt that the boundaries of knowledge were blurring, as this manager explains:

- *It's a bit of a blur, the edges are blurring more and more. When I started my training 30 years ago it would have been impossible to imagine that we would have nurses seeing, treating and discharging patients. We didn't even give IVs (intravenous injections). However I think it's still a very different approach a nurse would make to a doctor, even with the same patient. SM 2*

#### 5.4.3 Sub-theme 3: post graduate education and training

Participants were clear that a post registration course was important, and should be at least degree level. The participants in the case had all attended a 60 credit short course at degree or Master's level. Completion of the full degree or Master's programme was optional for each individual. Some of the participants had gone on to complete the full Master's programme, whilst some had stopped when they finished the 60 credits. Participants agreed that the lack of standardisation of educational programmes (and therefore role preparation) nationally had created differences in role. They felt this was frustrating, and hampered their role progression as an individual and impacted on the reputation of ENPs. The following examples demonstrate this frustration:

- *When I got my qualification as an ENP there was no real standard. You could do a course for 6 weeks and call yourself an ENP, or you could do a degree course. ENP 6*
- *The xx girls and boys do a 6 week in house training and call themselves ENP's, that's very frustrating. When you think of the work that we have done academically, and the qualifications we have gained and the work that has gone towards that. ENP 1*
- *Doing my MSc makes me feel as though I am officially an Advanced Practitioner. ENP 2*

This ENP went on to explain how differences in educational preparation led to tensions between groups of ENPs:

- *I was very annoyed when she used the Advanced Nurse Practitioner (ANP) title after doing a 6 week minor illness course...I rocked up with an MSc in my hand, 2 degrees and a diploma and that bugged me that she was calling herself the same as me. ENP 2*

Experience and 'years on the job' was also a common feature of the discussion, and for one participant this was felt to be just as important as education:

- *I think I am a good nurse practitioner because of my grounding and working my way up slowly from being a student nurse. Years of experience progressed into being a nurse practitioner and then the ever extending scope of practice. ENP 1*

The managers also expressed uncertainty about the pathway that leads to becoming an advanced practitioner:

- *I think the educational path to advanced practice is unclear, I know there is a Master's in Advanced Practice, but I am not sure everyone does it all and the pathway isn't clear. SM 1*

This uncertainty continued when asked if all advanced practitioners should do a full Master's:

- *Mmm I guess so, it's difficult. I can certainly see the change in my practice as a leader from doing a Master's course. But do you exclude some good clinicians because they don't want to do a Master's programme? SM 2*

One participant felt that there should be one pathway that everyone follows, regardless of background:

- *Whatever the background, you should all have similar training once you have got to a certain point, you all follow a similar pathway. ENP 5*

When ENPs were prompted to suggest what they felt should be in the Master's programme, elements of clinical training were considered the main focus, followed by leadership. Interestingly, this manager didn't think that understanding and influencing government policy is something that these practitioners should do:

- *I think it would be predominantly clinical with some leadership, how to lead a team, facilitate, confidence in decision making and managing risk. I wouldn't see reviewing government policy and influencing on this scale as part of their role, they work 12 hour shifts there is only so much they can do in that time. SM 1*

ENP participants and senior managers agreed that in-house support and ongoing training are crucial to the role, and that this should not be confined to the classroom:

- *Once they have completed the ENP programme at UWE they continue with an in-house programme to keep their skills up. There is a level of scrutiny around their documentation so we have some governance around making safe and appropriate decisions. SM 2*
- *We need lots of support during and after the UWE course, it's a bit hit and miss but the other ENPs are really supportive. I would really value a structured programme that consolidates everything after the course. ENP 12*

## 5.5 Theme 4: The meandering river: career structure

Figure 7. Photograph presented by ENP 5: *'Drifting around with no pathway'*



This photograph is a visual representation of the overarching theme of career structure as participants used this picture to demonstrate the lack of career structure associated with the role. : This theme relates to career structure for ENPs, and role expansion into advanced practice. Other key concepts within this theme include education pathways linked to career structure, and barriers to advancing career pathways. The theme has been split into two sub-themes: career pathways; role expansion.

### 5.5.1 Sub-theme 1: career pathways

Participants in the case expressed different views on where they would progress to once established in the role, although it was clear that they felt a career structure was important for the experienced ENP:

- *Some people view it as a job, and some a career, some have no choice as they have to earn money. I think we all (ENPs) fancy the ANP role at the major end but some aren't so sure. ENP 2*
- *For those of us that will be here forever need to know there will be something else. We need to know what the next challenge will be. Not everyone wants a clinical route, it might be managing or lecturing. Everyone has their own plan. ENP 1*
- *We need to have clear development and progression and not presume everyone wants to be a manager, there needs to be a clearer path and people take different paths, I think. I think the opportunities for Nurses and Nurse*

*Practitioners are huge, but you have to be quite motivated and make your own path and have quite clear ideas. ENP 9*

Some participants used the visual image of a meandering river to reflect on their nursing journey to ENP and beyond in a positive way, relating to the role as constantly developing and growing. The following selection of extracts demonstrates this:

- *The river keeps going and I know some bits will pop off. I can't go back to being a general nurse, that door has closed. For me it's about growth and development. Parts of my career have changed and gone, others keep going (just like the river). ENP 6*
- *We are constantly growing and learning, your confidence keeps growing. There are interesting times ahead, we need to keep up with the change. ENP7*
- *My professional identity is not static, it's grown over the years and it's got more growing to do. I don't know which direction it will go but you have to nurture it. You don't start off and think 'oh yes in 10 years I will have done that. I don't know which bit of the long windy road I will end up on, networking and meeting people can take you in all sorts of directions. ENP 3*
- *There are so many opportunities, it's not predictable and it remains quite fresh and interesting to be a Nurse Practitioner as you just don't know where you are going to be. ENP 8*

One participant used a different visual image to represent the same theme; that of a constantly changing, growing and evolving career:

- *I chose that (a picture of a tree with hands for leaves) because I guess of the caring side of nursing and the hands-on nature of the job and in terms of something that is growing forever sort of, I suppose again tied into knowledge and longevity of a career. I don't know how I ended up in nursing, I can speculate now, but for me nursing is something that continues to grow and evolve and change and I think that is where the tree comes from, ENP 9*

For others, however, the river symbolised a frustration with the lack of career structure for ENPs. This seemed linked to a sense of disempowerment, with some feeling overly influenced by medicine:

- *Medics have a straight river and they know exactly what they want to do, they have clinical supervision and organised teaching and exams and constant supervision and stuff they have to pass but at least they know where they are going. We don't. ENP 4*
- *You know you want to work towards being an ENP but once you are there you don't really know what you are doing and you just seem to drift around, you think you know what you want but there is no pathway. ENP 5*

- *There needs to be a development pathway, band 8 ENP's working in majors. I don't feel empowered to move forward. ENP 4*

This participant expanded further on the power relationship between medicine and nursing, in relation to the new advanced practice standards:

- *We are still held back by medicine, look at the new standards that have come out, we still need consultant weight behind it... It comes back to the power in the consultant group. If the RCN had developed it would not be held in such high esteem. ENP 4*

The discussion turned to the difference in educational preparation between nurses and doctors, and one focus group discussed the education requirements for ENPs to become a registered non-medical prescriber (this allows practitioners to have the same prescribing rights as doctors). These participants felt that nurses had to do far more than their medical colleagues, leading to a power imbalance:

- *All the things we have to do on the prescribing course, the medics don't do in their training. They were saying to me 'what are you doing all that for? We just learnt as we went along and that was it'. ENP 4*
- *Yes they learn most of it from the sisters on the ward who point out when they have prescribed the wrong stuff or say 'just sign this'. ENP 5.*
- *Again more hoops, it's very frustrating. ENP 4*

The lack of structure and feeling disempowered, combined with a perception of still being heavily influenced by medicine, took on a further dimension as some of the participants felt that this had an impact on their professional identity. One participant reflected on this issue:

- *I certainly don't feel like we identify as one group, we are trying to be a bit of everything. We are trying to be a bit of a nurse, a bit of a doctor so we are impinging on everyone else's role and they are getting worried that we are taking over. We are a new professional group that is still evolving; we haven't got a strong academic base yet, not many PhDs and so on, so consultants still have a massive say in what we do. We need to be less reliant on doctors. ENP 4*

#### 5.5.2 Sub-theme 2: role expansion

Some of the participants talked about advancing their skills into the 'major end' of the ED, where patients with more serious conditions are usually treated. Historically, these

patients are seen by doctors, although it is now becoming more common for advanced practitioners (nurses or others) to take on this role. For most of the participants who worked within the ED, the 'major end' was associated with advanced practice. This seemed a natural and welcome extension of their role, although it came with some additional frustrations and anxiety:

- *I do like the minor end and minor injuries but I do look forward to extending that when we do eventually go into majors as Advanced Nurse Practitioners. ENP 1*
- *If you want to get a band 8 there isn't anything yet, I know it's being worked on but it's frustrating. ENP 5*
- *There isn't anyone or anything to follow unless you want to be a nurse consultant but getting to majors as a band 8 there isn't a structure. It's frustrating really, I know I am harping back to the medical thing but I have to jump through many more hoops than they do. I can't ask for a CT scan but the doctors can and yet they have not had any more training than I have on this. ENP 4*

Expansion of the role was clearly linked to education and learning. Although the participants acknowledged that there is no clear pathway, they had a sense that they needed to keep learning, growing and developing:

- *There is so much out there to learn that sometimes it is overwhelming and you don't know what you don't know. The more you know the more you don't know. ENP 5*
- *Depending on what education is available will depend on which way you will grow. ENP 3*
- *If you think about how we started, a couple of us and we would see superficial burns and sprained ankles. When you think how our scope has changed over the years, our role has gained credibility over the years. Our scope gets bigger and bigger and we just take it in our stride and strive for the next thing, always looking to expand the role. It keeps it interesting for us. ENP 1*

The senior managers also felt that role expansion was a natural progression within the nursing profession generally, and within the ENP role specifically:

- *I see our expectations of all nurses becoming greater and greater, our expectations of a 6 will become greater, and then the same for band 7s who would become advanced practitioners. There isn't clarity nationally about what this looks like, but I think the expectations are pretty high. SM 1*



Interestingly, one of the senior managers was also interested in role expansion for the unqualified workforce, and saw this as a way of supporting the advanced practitioners:

- *I don't think we use our unregistered workforce as efficiently as we could. If they undertook some of the 'tasks' such as dressings, bloods etc. it would free up time for the advanced practitioners to take on more complex stuff. SM 1*

It was clear that advancing and moving on to the next role were important factors in job satisfaction:

- *What I am always striving for is to be able to advance my practice and I think I've tried to do that throughout my career, I am always looking to the next thing and taking it a bit further an a bit further than the next thing. ENP 9*
- *I love my role and always want to advance further, I am confident in seeing anything that comes through the door and can take each case as far as I can. ENP 13*

Role expansion was perceived as a natural progression, and it was evident from all the participants that this was linked to increased confidence and job satisfaction. As this participant explains:

- *My confidence still grows all the time and I am taking on and seeing more and more, we have to provide a flexible service and whatever changes come we have to keep up. It keeps it interesting. ENP 7*

## 5.6 Theme 5: The expert practitioner: leadership and expertise.

Figure 8. Photograph presented by ENP 9: *'The wise old owl'*



This photograph is a visual representation of the overarching theme. One of the participants used a photograph of an owl to describe his/herself in relation to their perception of their own leadership within the role. This theme includes several elements of leadership. Some viewed their role as involving leadership, whereas others felt that this was not part of their role, and viewed themselves as 'clinical experts'. Leadership for some was something that 'others' did. Also included within this theme is leadership from a broader context, in terms of outward facing leadership in a professional sense. Therefore, this theme has two sub themes: clinical leadership; 'the bigger picture'.

### 5.6.1 Sub-theme 1: clinical leadership

Within the focus groups the participants were prompted to reflect on whether they see themselves as leaders. This provoked a varied discussion on what leadership is. Some

of the participants described themselves as 'clinical leaders', while others did not see themselves as leaders *per se*, and described 'clinical expertise' rather than leadership:

- *Not where I am particularly, I think we are very much in it together... I feel part of a team, I don't feel like a leader from an ENP point of view. ENP 3*
- *I don't see myself as a leader, I see myself in a supportive role, part of a very strong team, but I see xx as our leader. ENP 1*
- *We are the clinical experts I guess. ENP 7*

Interestingly, the senior managers also recognised that some ENPs would not see themselves as leaders. As this manager describes:

- *There are a lot of band sevens in the ED and I don't think they (ENPs) would see themselves as leaders. She goes on to explain that ENPs (band seven) think that 'this is my lovely little clinical world and I don't know that I really want to touch the managerial role'. I don't think they see themselves as leaders of a team, they might see themselves as leaders within their client group and little team but not the bigger picture within the ED and beyond. SM 2*

However, when asked whether they should or could adopt more of a leadership role the senior manager was unsure whether they have the right skills, as this extract explains:

- *The ENPs don't have the same breadth of knowledge, they have clinical specialist knowledge but not the breadth around the strategy it would take to run a department and deliver some of the HR performance, capabilities, sickness etc. they have not had the exposure, it's not part of their training. SM 2*

Later in the conversation the manager concedes that the ENPs are 'protected' from a lot of strategic activities within the organisation, and questions why this is:

- *I think perhaps we protect them, I send it all to xx but not to them, they are not on my band 7 circulation list but perhaps they should be, I expect the clinical nurse specialist to do all that so why shouldn't we expect the ENPs? This has given me food for thought (laughs) SM 2*

As the discussion proceeded within the ENP focus groups, some of the participants felt strongly that leadership doesn't have to mean that only one person can lead. As ENP 2 continues:

- *A leader doesn't have to mean that you are a step above the rest that is not what I mean. I still think you can lead in terms of how you work, how you present*

*yourself and how you are amongst others and still work really well within the team, so I would say I am a leader. ENP 2*

Again, the issue of roles became a challenge for those who were an ENP on some days, and a 'shop floor shift co-ordinator nurse' on others:

- *For the ENP group no, (in response to the prompt "do you see yourself as a leader?") but of the nursing yes, shop floor nursing definitely. ENP 5*

Participants in the nurse-led unit were clear that their role contained elements of leadership, and those participants saw themselves as clinical leaders:

- *We need to know how to get the best out of the staff, motivate them. ENP 7*
- *Come on, just see a few more patients, do you need a hand, how are you getting on? It's a lot of that really. We need to support the band 6's. ENP 6*
- *You need leadership skills to be able to negotiate with other specialists... It's implicit isn't it? Things like being assertive, telling someone what they need and being clear on advice or referrals, that's leadership isn't it? ENP 8*

This participant felt strongly that leadership skills are an important aspect of the clinical role, and gave examples to demonstrate this:

- *Being confident, and clear, being able to negotiate, to influence. You do play the game, you have to negotiate 'this patient is really interesting, you need to see this gentleman, let me tell you all about him' if you just mumble away on the phone you are not going to get that referral, it's all about having those leadership skills I think. ENP 6*

#### 5.6.2 Sub-theme 2: seeing the bigger picture

The discussion in the focus groups moved on to influencing, and considered the 'bigger picture' in terms of leadership, influencing policy and driving the profession forward. Some of the participants described leadership as something that 'others' should do, and didn't see it as part of their role:

- *This is where we rely on people like xx and the Chief Nurse, they should be driving this, supported by us, they have more time to do this, it's part of their role ENP 4*

Interestingly, one of the senior managers agreed with this, suggesting that the role of the ENP was more about clinical leadership:

- *I recognise that most of the time they are on the shop floor making decisions, supporting teams to keep the patients safe. I see that is their role fundamentally. SM 1*

For other ENPs, it was more about some clinicians not wanting to be leaders:

- *There are lots of people doing this at senior level, so they are autonomous practitioners, they understand the service and the needs of the service but if you asked them to become a leader for the day they would struggle and say 'I am a clinician and just want to get out there and do my job'. ENP 8*

The conversation moved on to whether all ENPs have the ability to become a leader:

- *It (leadership) takes a long time to grasp, some people have been doing this for a long time and just can't be leaders, they are good solid practitioners but there is something about individuals that makes them good leaders, and not everyone has this. ENP 7*

Time was viewed as a barrier to the consideration of wider issues, and this was compared to how medical consultants have time allocated to non-clinical work:

- *The consultants get time for non-clinical work, we don't. Perhaps that is the reason they are able to influence things on top of their power base. They have the opportunity to go to meetings, read and network. We don't. ENP 4*

For some of the ENPs pushing the profession forward was something they felt they should do, although a lack of dedicated time was again noted as a barrier:

- *I see myself as a leader in terms of my profession, we should be pushing the profession forward. The problem is we don't get time to do any of that stuff. ENP 2*

Interestingly, those at the nurse led unit were more likely to think about government policy and the impact on their working environment. When asked about whether they consider such issues, two of the participants indicated that they did:

- *Absolutely yes, we don't know our budgets yet for next year and neither do the commissioners. ENP 6*
- *Lots all the time, we talk about as a team at our team meetings, it's important to us. ENP 8*

## 5.7 Summary of chapter

This chapter has presented the findings of the ENP focus groups and the senior manager interviews. Five overarching themes were identified, and these have been presented in this chapter. The five key themes are: the key to identity (the role); value for money (perceptions); the missing chapter (education); the meandering river (career structure); the expert practitioner (leadership and expertise). The participants were asked to bring photographs that represented images of their professional identity, and some of these were reproduced in this chapter to illustrate the themes. These themes will be analysed and explored in the following chapter.

## 6. Discussion

### 6.1 Introduction

The previous chapter presented the results from the case study using an approach described by Braun and Clarke (2013) which identified five key themes and sub-themes. In this chapter themes will be discussed and analysed in relation to the overall research aims which were, as explained in greater detail in Chapter One were to:

- Explore the concept of professional identity within the role of ENP.
- Identify what factors contribute (positively or negatively) to a sense of professional identity.
- Consider the implications for managers, organisations and educationalists of changing identities within emerging roles in healthcare.

To support the aims of the research the following sub-questions were devised, and this chapter examines the findings in relation to the following questions:

What are the key factors that influence a sense of identity and autonomy for the nurse practitioner?

Sub-questions were developed from the main research question:

1. From which sources do ENPs draw their knowledge base from and why.
2. Does the title ENP or ANP give post holders a sense of identity and if so why?
3. Is there a perceived link between professional autonomy and professional identity?
4. Do medical colleagues positively or negatively influence an ENPs perceived sense of autonomy and/or identity?
5. Does location or organisational structure have an influence on perceived autonomy and or identity?

Following the discussion of the results and reflexivity, this chapter will explore limitations of the study and outline aspects of new knowledge that this study has identified. It will outline implications and recommendations for educationalists, employers and commissioners who are responsible for ensuring the development of the future workforce and policy makers. Finally, the chapter concludes with recommendations of areas for future research.

## 6.2 Summary of key findings

This study identified several key factors that could influence the ENPs sense of professional identity. From the outset participants expressed an overwhelming sense of pride in their role which was linked to job satisfaction. However, there was also a strong sense of responsibility and managing risk that came with the role which was also linked to the sense of pride participants felt which contributed to job satisfaction. Some of the participants in this case were unsure of who they felt more aligned to (i.e. nurses or doctors) as whilst many were proud to be a nurse and made clear links to identifying with nursing (rather than medicine) many of the participants felt uncomfortable with the word 'nurse' in their title and felt that this hampered progression of the role. This uncertainty was mixed with a sense of guilt as their role had changed and this was linked to issues such as: titles, working with other nurses and perceptions of the role.

Nearly all of the participants in this study felt that they provided additional care to patients in that they provided the '*whole package*' and were '*holistic*' in their approach which they felt was unique to their role. The study revealed that most of the participants in the case felt that the general public, senior managers and other healthcare professionals do not understand their role and this caused a sense of frustration and at times even resentment. It was important for these participants that the general public understood that they were more than '*normal nurses*', and many of the participants felt that the media undermines the perception of nursing and extended roles. For example, the image of nursing was cited as someone '*mops your brow*', and television programmes such as '*casualty*' were referred to as '*unhelpful*'. Relationships were important to the participants, but those who worked within the ED felt less certain who their peers or teams were. In contrast, the ENPs working in the nurse-led unit felt

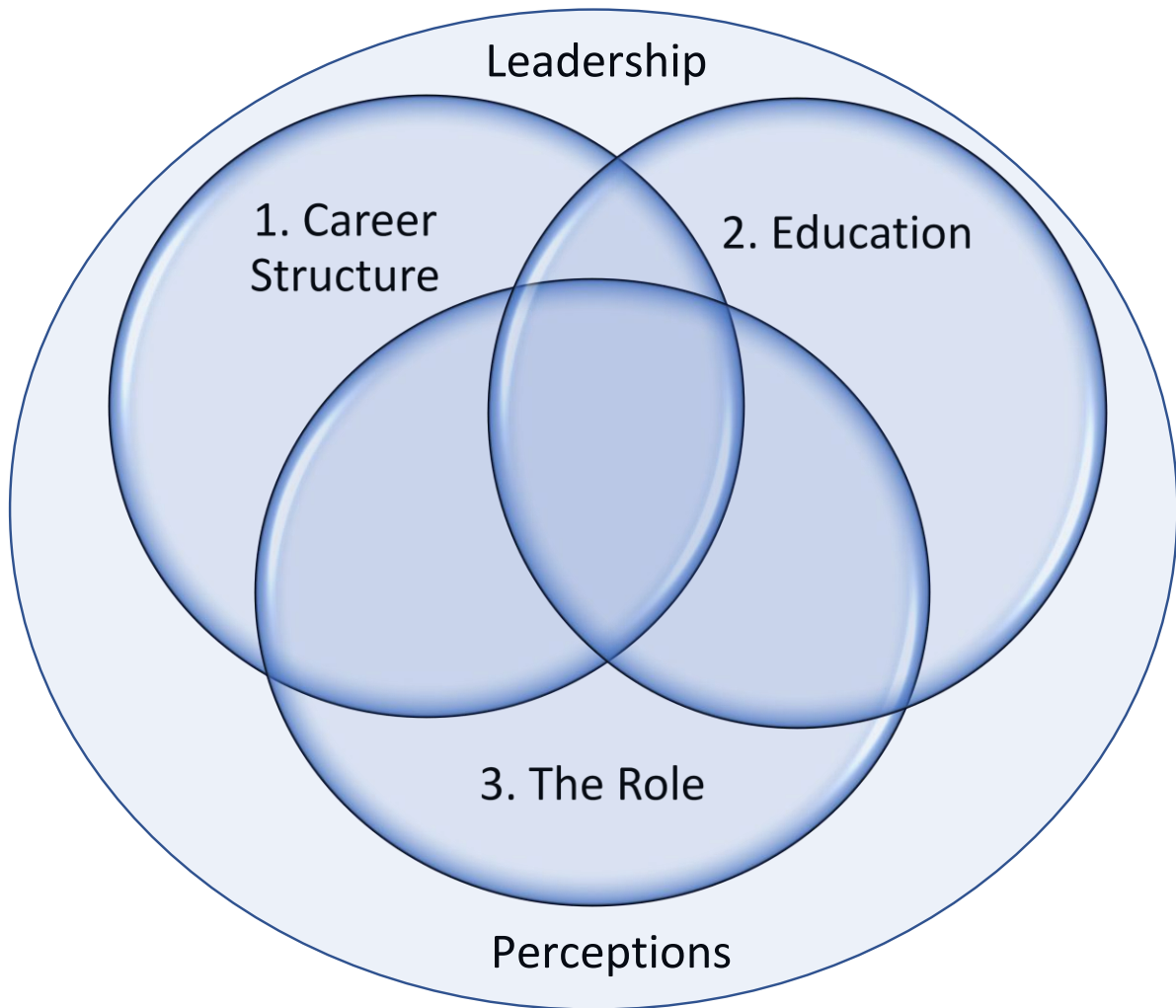


surer of who their peers were and had a strong sense of teamwork and shared responsibility.

Most of the participants in this case felt that their undergraduate pre-registration training had not equipped them for advanced roles, and the senior managers agreed that that undergraduate training could do more to prepare nurses for the new emerging roles with a greater emphasis on leadership. However, most of the participants also agreed that training for advanced roles should be at Master's level although some felt (including one of the senior managers) that this might preclude a good nurse with experience rather than academic ability. All participants in this study felt that there is a lack of career pathways for ENPs, and would value opportunities to develop in areas such as advanced practice roles. A lack of career structure having become an ENP caused a sense of despondency amongst some of the participants, and this was linked to a sense that the role was perceived to be less important than that of their medical colleagues. This, in turn, undermined loyalty to the organisation, and participants expressed frustration at the lack of investment in the role from their employing organisation and society more broadly. Participants were less certain of their role as a leader within the team, and nearly all felt that leading the profession, research, policy and education were things that 'others' should do.

The themes and sub-themes have been considered in relation to the literature and theoretical concepts and frameworks outlined in Chapter Two. Five themes were initially developed, however, the themes of 'perceptions' and 'leadership' were consistent across all themes and overlapped each of the other themes. This is represented in the conceptual framework in Figure Nine. Therefore, this chapter will focus on three overarching areas encompassing the themes of leadership and perceptions: the role; education; career structure. Each of these are underpinned by relevant literature and theoretical concepts.

Figure 9. A conceptual framework representing the interaction of the key themes.



The diagram demonstrates a relationship between the five themes identified in the findings. Central to the themes of 'career structure', 'education' and 'the role' are the themes of 'leadership' and 'perceptions'.

### 6.3 The role

One of the key findings from this study was that participants enjoyed their role and gained a huge amount of job satisfaction from the role itself. Despite acknowledging that they dealt with uncertainty, conflict and a degree of risk management within the role, participants at both the MIU and ED demonstrated confidence in what they do and were proud of their role. Participants also reported high levels of job satisfaction and self-confidence relating to delivering high quality care, clinical expertise and they gained job satisfaction from the autonomous nature of the role by delivering the '*whole package*' to patients. Some participants also reported feelings of uncertainty and frustration and were less confident in other areas of the role such as relationships with other nurses, public perception of the role, education and career structure which may be impacting on both job satisfaction (and therefore their professional identity).

These findings are similar to those found in a small study by Lloyd-Rees (1916). Lloyd-Rees (2016) also examined how ENPs viewed their role in a small qualitative study (n=8), and found high levels of job satisfaction and motivation despite respondents reporting issues of conflict with other nurses, a lack of understanding of the role outside of the ED and concerns around remuneration of the role and lack of educational standards for preparation of the role.

Interestingly, there is a wealth of literature supporting patient satisfaction within non-medical extended roles but there is less literature examining job satisfaction from the emic perspective of the ENP. There is, however, a plethora of literature that examines job satisfaction in nursing within other sectors such as acute care (e.g. Dunn *et al.* 2005; Hayes *et al.* 2010).

Hayes *et al.* (2010) identified three variables that were essential to nurse job satisfaction; inter-personal factors (autonomy, direct patient care, professional relationships and educational opportunities), extra-personal which included factors beyond their control such as pay, organisational policy and organisational constraints and thirdly intra-personal factors such as coping mechanisms, education and experience. Desborough *et al.* (2013) identified similar characteristics in a study examining job satisfaction with a group of ENPs and identified that autonomy within the role was a key factor of satisfaction, but only when coupled with supportive and

cohesive professional relationships with both medical and nursing staff. In addition, the ability to deliver high quality patient care was also identified as a factor supporting positive job satisfaction. Areas that were identified that diminished job satisfaction within the Hayes *et al* study included access to appropriate education, support and mentorship and lack of role clarity.

### 6.3.1 Self-esteem

As noted in Chapter Two, self-confidence and self-esteem are linked to professional identity through the construct of self-concept (Arthur and Randle 2007; Johnson *et al.* 2012 and Kroger and Marcia 2011). Positive self-esteem is also linked to positive performance (and job satisfaction) (Bjorkstrom *et al.* 2008), and as noted previously studies have consistently demonstrated that ENPs perform as well as their medical counterparts in helping reduce waiting times whilst contributing to patient safety. This suggests that they have a strong sense of self-esteem, confidence and ability around the clinical aspects of the role. Assuming that self-esteem and confidence impacts positively on professional identity (as reported in the literature in Chapter Two), this would suggest that most participants in this study have a strong sense of professional identity relating to role clarity, clinical expertise and their levels of autonomy. They were, however, less certain about their identity in relation to other 'professional' aspects of their role such as perceptions of others, relationships and education, and their career. These may be contributing factors to a less certain (or more confused) professional identity in these areas, which will be discussed later in this chapter.

The participants in this case clearly had a sense that they were 'different' from other nurses, but were equally clear that they were not doctor substitutes. The participants tried to articulate what made them different, and for most the difference was linked to managing risk, litigation and autonomy/responsibility. Interestingly, whilst managing risk and the fear of litigation were important factors in determining what the ENPs did, this did not detract from their overall sense of enjoyment for the job. These findings are in line with older studies; for example, Tye and Ross (2000) found that managing risk and uncertainty, and a fear of litigation, were factors that were seen as a barrier to development, and the need for organisational support was apparent. However, despite these barriers a desire to progress the role boundaries was also evident in both my study and in the Tye and Ross (2000) study.

Participants in my study also reported feeling disappointed with the lack of understanding of the autonomous nature of the role from their senior managers. This is an important finding for managers who may be experiencing work fatigue or retention problems within the ENP workforce, as job satisfaction is clearly linked to perceived levels of autonomy within the role and constraints around this may be impacting on ENP performance and overall job satisfaction. Findings from this study support the findings from the Piil (2012) and Desborough (2013) study in identifying that autonomy is linked to job satisfaction, and is an important factor in contributing to the ENPs professional identity. In the Piil (2012) study autonomy in decision making was identified as a significant component of the ENP's professional identity, but as with others (e.g. Desborough 2013) she found that factors that impeded their autonomy included decisions made by doctors and managers which impacted directly on job satisfaction and arguably influenced their sense of identity.

It is worth noting that the studies to date have been small, and therefore further research exploring links between autonomy, job satisfaction and workforce planning would be of value.

### 6.3.2 Transition

Participants in this study sensed some sort of 'transition' as they described '*moving away from their traditional nursing roots into something different*' and they described being '*somewhere in between*' medicine and nursing. Role transition is a key element of the successful implementation of the ENP role (MacLellan and Higgins 2015) as the individual moves from being in a traditional nursing role into one of being an ENP as they redefine their role and re-establish themselves within the healthcare team (Szanton *et al.* 2010). Transition involves the nurse moving away from the traditional caring humanistic models of nursing practice and cultures into a sphere of practice that incorporates a biomedical model of diagnosis, prescribing and treatment. The literature examining the transition of nurse to ENP describes the experience as 'uncomfortable', 'difficult', 'stressful' and 'turbulent' (Cusson and Strange 2008; Yeager 2010; Newhouse 2011).

Some of the participants in my study identified feeling guilty about the transition as they '*didn't feel like a nurse anymore*' and didn't '*relate to nursing*' in the same way.

This echoes the literature around transitioning as ENPs move from a place of comfort and familiarity to a place of unknown territory (MacLellan 2015). Studies have examined the transition of a student nurse into a qualified nurse, and establishing a professional identity within this transition is seen as a key factor in relation to retention and confidence within their new role (Johnson *et al.* 2012). In the same way that student nurses continue to engage in construction and deconstruction of their identity through clinical practice, interaction with other healthcare professionals and education, it appears that ENPs also undergo a continual change of identity as they transition into a new role through the same processes.

Bridges (2003) proposes that all transitions have three phases: an ending followed by a neutral zone and finally a new beginning. The first phase (ending) is associated with changing identity as the practitioner loses their status as a nurse but is not accepted as an ENP. Bridges describes this loss of identity as the 'in-betweenness', as practitioners describe insecurity and uncertainty and confusion. The second phase (the neutral zone) is described as a period of being 'in limbo' as the ENP feels vulnerable with the new emerging identity and lacks self-confidence. However also within this phase new networks are developed and there is dynamic change and growth. The third phase (new beginnings) involves new attitudes, new values and new identities as the ENP adapts to their role. However, it is important to note that each phase is not time-limited, and is a dynamic process with each practitioner moving through the phases at different times and speeds.

Crafter and Maunder (2012) agree, suggesting that the transition process is a period of individual adjustment and an important element in shaping professional identity. They go further, suggesting that each period of readjustment depends not only on the practitioner (and their previous experience and background) but the acceptance and support of the healthcare team within which they work and organisational readiness for such roles in the workforce. In relation to this study, some participants were unsure of their alignment and whether they still felt like 'a nurse'. It would appear from the work of Bridges that some of the ENPs in this study were going through different phases of transition, as some were more experienced than others. It is worth noting here that the acceptance and support of others within the healthcare team also impacts on the transition. Participants in this study (and previous studies) described some experiences of conflict from other nurses, uncertainty around teamwork and the

perception that senior managers did not understand and support the role, all of which impact on successful transition. Previous experience and education preparation is also a key factor in determining successful transition and the development of identity, and this will be discussed later in this chapter.

### 6.3.3 Socialisation

If we relate this 'transition' to the process of socialization, as described in Chapter Two, ENPs are adapting their 'attitudes', 'values' and 'norms' (Anderson 1993; Oermann 1999) as they move into their new roles and re-evaluate their position. It is arguable that the description that participants offered in this study around feelings of '*guilt*', '*being separate*', and feelings of '*uncertainty*' are characteristics of a socialization process (or transitional process), whereby practitioners are evolving into a different role with a different identity. However, it is worth noting that both the notion of socialization and transformation assumes that the role the ENP is moving into has an established and well-defined identity, with the practitioner 'knowing' when they have reached it.

As described in Chapter Two, the role of the ENP has evolved in an *ad hoc* manner over thirty years, and without any formal educational requirements with a range of titles and varied role definitions. It could be suggested that for many practitioners working under the umbrella term of advanced practice the lack of role clarity and uncertainty of definition has stopped them successfully transitioning into the third phase. This, in turn, has impacted on their professional identity and understanding of what they are, and left them situated in the second phase feeling isolated, uncertain or 'in limbo' (Bridges 2003).

### 6.3.4 The 'third space'

Given these concerns, an alternative and arguably more relevant approach to the transitional model as described above is offered here; that of the 'third space' outlined in Chapter Two. As noted previously, the 'third space' or 'in between space' describes a phenomenon that takes place when two different cultural systems come into contact, and those operating within this space often combine elements of both to create something unique (Jacobs and Brandt, 2012). The participants in my study articulated

that they felt that they draw on elements of both nursing and medicine to perform the role. One participant suggested, when showing a picture of the Gaoliang Bridge (see Appendix Ten), that it represents *the 'meeting of minds, between the medical and nursing sides of me'* This resonates with the work of Bhabha (1994), as he suggests that identity within the third space is not an affirmation of a pre-given identity. Similarly, Chulach and Gagnon (2015, p55) assert that *'identity for ENPs is actively constructed within a dominant discourse on knowledge, expertise, autonomy and healthcare'*, which aligns with the perceptions of the participants in this study as they continue to use their nursing knowledge and their newly acquired medical knowledge to formulate *'a different knowledge'*.

Participants in this study, explained a sense of feeling *'different'* and with *'a different head to other nurses'*. This echoes the description of the third space which has been described as *'a 'boundary zone' where two cultures meet, hybrid identities take shape and new discourses are created'* (Verbaan and Cox 2014, p2). The participants in this study also described areas of conflict and tension between themselves and other nurses. As one participant noted, junior nurses do not treat them in the same way as doctors, and *'if they don't get the answers they want they go up the hierarchy (to doctors)'*. Similarly, there is a reluctance amongst some junior nurses to carry out tasks given to them by ENPs. This tension is frequently reported in the literature (Thrasher and Purc-Stephenson 2007; Lloyd-Rees 2016), and often attributed to a change in role boundary and misunderstanding of roles.

However, the notion of the third space goes further, suggesting that as traditional values and practices are scrutinised by others, resulting in cultural clashes (between nurses and doctors and also between nurses and ENPs), there is constant renegotiation as boundaries change and redefined identities and cultures emerge with new values, philosophies and practices (Chulach and Gagnon 2015). Further to this, Rashotte (2010) argues that during this period of redefining identity, ENPs often encounter challenges from others related to their constructed identity through their decision making, clinical expertise and an undermining of their years of experience. This further accounts for the conflicts described in this study, and within the literature. Bhabha (1994) suggests that this failure to recognise expertise and experience, coupled with a lack of recognition for the health outcomes that ENPs can provide, may result in a projected distorted identity for the ENP. Practitioners operating within this



space need the skills to strategize and navigate through this turbulent discourse, and as the participants in this study alluded to this can be challenging, leading to feelings of guilt and uncertainty.

It is worth returning to the work of Bourdieu and the concepts of cultural capital, habitus and fields in relation to the formation of professional identity and the findings of this thesis. As described in Chapter Two, Bourdieu asserts that the social world is divided into 'fields' within which professional groups occupy dominant positions and whereby deep rooted beliefs and identity are formed and held, suggesting that movement between fields is difficult and uncommon. Previously published literature described how nursing has struggled to adopt the status of a profession and how nursing's reliance on medicine has, over time, ensured it remains within a 'nursing habitus' with lower social status and a less defined identity.

As noted above, some participants in this study explained that they '*don't feel like a nurse anymore*' and that they have a '*different head to other nurses*', which suggests that they are moving away from the traditional 'nursing habitus' into something different. Equally, however, participants in this study did not see themselves as doctor substitutes with the implication that they are not moving into a medical space. Applying Bhabha's 'third space' theory would suggest that these practitioners are moving into a 'new space' (or field) which counters Bourdieu's notion that fields exist autonomously and moving between fields is difficult. However, participants in this study and others do share feelings of conflict with other professionals which indicates that this movement into a 'different field' does not come easily and is not without its challenges. This may in part be due to what Bourdieu describes as their cultural capital which, as described previously, is a collection of symbolic elements such as skills, clothing or credentials. Sharing the same 'things' gives individuals a sense of belonging, or as Bourdieu puts it 'people like us' (Bourdieu 1999). Participants in this study described uncertainty around issues such as titles, education and uniform which supports the findings from other studies. This, along with the lack of national regulation and standardisation of the role, has potentially resulted in practitioners being unable to develop the sense of 'people like us' that Bourdieu describes, in that they do not share (as a collective group) the same credentials, titles, uniform or even role definition and skill set leaving an uncertainty around the sense of belonging within the new group.

Further, this sense of belonging is inextricably linked to Bourdieu's notion of habitus in that it relates to how people within a certain group behave and understand the world (or space) that they occupy. Participants in this study reported feelings of conflict around how they interact with others and uncertainty about the perception that the public (and others) have of them which suggests an uncertainty as to how to behave within their habitus, described by Bourdieu as their 'feel for the game'. Nurses in the traditional role have a good understanding of how they behave, act and think about situations and their 'feel for the game' is secure. Arguably, those moving into new roles such as the ENP have less certainty about how they should behave and are therefore less certain of their 'game'.

Bourdieu suggests that habitus allows people to successfully navigate social environments, but is not something that can be determined by structures or free will. He asserts that it is created by an interplay over time and that within a field people experience power in different ways depending on which field they are in at a given moment. Relating this to this study and others is informative, in that participants who worked within the ED were less clear about who their peers were whilst those working in a nurse led unit had a stronger sense of teamwork. This is explored further later in this chapter, although it worth noting here that, as Bourdieu asserts, belonging to a team (or a club) is an important component of cultural capital and over time creates a strong sense of belonging, and therefore identity.

This thesis therefore recommends that further understanding of the notion of the 'third space' and the development of 'cultural hybridity' within the role would help to support practitioners as they move into a different space. Success of this new occupancy will only happen over time with support from the organisations within which they work, and from the educationalists who support them through this transition.

### 6.3.5 Perceptions

This case study identified that participants felt that the public do not understand their role, and misconceptions surrounding the role are not helped by the portrayal of nurses in the media. Most of the participants in this case spent time trying to educate the public about their role, although acknowledged that things had improved over time.

The participants expressed a view that patients still expect to see a doctor, and during each consultation time was spent explaining the role. For some, the portrayal of nurses within the media was seen as a negative and contributory factor to the public not understanding the ENP role, and participants expressed disappointment at how the stereotypical image of nursing (*'someone who mops your brow, gives you a commode and wipes your bum'*) as female dominated subordinate to medicine still persists today. The literature in Chapter Two discussed how the image of nursing has impacted negatively on the development of nursing as a profession and despite the nursing discipline undergoing significant changes over the last thirty years, this has not resulted in a public image that recognizes the scientific and professional development of nursing (ten Hoeve 2013). Hoskins (2014) found in her study that when the treating healthcare professional (HCP) was a female, patients were more likely to assume they were a nurse, and if they were male the patient was more likely to assume he was a doctor. This was consistent with previous studies (Horman *et al.* 1987), suggesting that traditional stereotypes of men being doctors and women being nurses still persists today. As noted previously, the literature suggests that the way in which a group is perceived by the public impacts on their self-esteem and concept of self (beliefs, values and behaviours), which in turn influences performance and contributes to identity.

One of the sub-question in this study was to explore whether the title of ENP or ANP impacted on a sense of professional identity. As reported previously, all of the participants were proud of being a nurse, however many participants in this study felt uncomfortable about using the word 'nurse' in their title when introducing themselves to patients and other HCPs, and felt that the word nurse *'held them back'*. One respondent commented that they felt the patient would feel *'short changed'* if the patient knew they were not a doctor. Although this view was shared widely across the focus groups, one or two participants did feel comfortable with using the word in their title and felt quite protective of it. It is unclear whether this lack of confidence in the title 'nurse practitioner' can be attributed to the ongoing debate about the stereotypical view of nursing, and the dominance of medicine portrayed by the media and elsewhere, or whether through the process of transition the participant did not feel like a nurse anymore and was adopting a 'cultural hybridity' as a different type practitioner. Equally, as outlined above, the view by many of the participants in this study that the

public do not understand the role may have contributed to the mixed picture relating to titles. Arguably, if the role was clearly defined and there was a greater understanding of the role by the general public it may be that ENPs would feel more confident about having the word nurse in the title. This again, suggests that more work is needed in developing public awareness of the role.

As described previously, patient satisfaction with ENP care is high, and studies consistently demonstrate that patients are supportive of the ENP role (Griffin and Melby 2005; Jennings *et al.* 2008; Melby *et al.* 2010). However, Hoskins (2014) found that even though patients were satisfied with their treatment they would prefer to be seen by a doctor if given the choice. She argues that this may be because patients have a lack of understanding of the education and preparation that underpin the ENP role, and as participants in this study suggested, public understanding of the role is hindered by a lack of media coverage of nurses as independent autonomous practitioners.

Some of the participants in this study related the lack of public understanding of the role to the issue of pay, as some of the participants felt less valued by managers (and society) as they were paid less than their medical colleagues (*'money equals respect...shows value in our society'*). For another participant remuneration for the role was important (*'remuneration is a big issue for me'*) and others highlighted that they felt the service they delivered did not match the salary (*we are a bargain for what we are doing*). Others (Melby *et al.* 2010; Lloyd-Rees 2016) agree, and acknowledge that ENPs do not receive the same financial remuneration as doctors, which may contribute to a sense of feeling less respected. The issue of remuneration was not discussed in all of the focus groups, and therefore it is not possible to identify if this was a common perception across the whole case, however what is clear from this study and the current literature is that there are gaps in the understanding of the role within the general public (and the media), and that further research is needed to examine the impact of the media on raising public awareness of the role as it continues to develop and expand.

As noted above, the participants in this study held different views on the title of the role. Some felt that having the word nurse in the title was important as it differentiated them from doctors, while others felt it confused patients and held them back. One

senior manager in this study also expressed confusion, and was uncertain as to which title should be used for the role. All the participants in this case were proud of the role, and yet there was internal conflict about using the term nurse within their title. The internal conflict found in this study suggest that if ENPs are uncertain about their professional identity, their title appears to be a significant factor in this. The participants in this study, as with other studies (Tye and Ross 2000; Martine and Considine 2005; Fisher 2006; Thrasher and Purc-Stephenson 2007; Lloyd-Rees 2016), support the need for a standardised approach to the title (and educational preparation), despite being unsure of what that title might be.

Whilst this study cannot demonstrate whether the title of ENP gives the post holder a sense of identity or not, it does support the need for a standardised approach. The inconsistency in titles is certainly causing uncertainty and conflict within the role, and this has been demonstrated to contribute to a lack of identity. Cashin *et al.* (2007) suggest that the only way to ensure the success of a new role is to establish a clear vision of the desired outcomes and the steps required to achieve them, with a widely recognised and consistently used title to delineate the role. As noted previously, attempts to standardise and define 'advanced practice' have been largely unsuccessful, as the title still is unprotected within the UK. As noted above, Bourdieu (1973) asserts in his theory on cultural capital that institutionalised cultural capital refers to a person's qualifications, credentials or title (Bourdieu 1973), which signifies competence and authority. In other words, when applied to the role of ENP it could be argued that having one title (protected) with a standardized approach would help instil a sense of collective authority and cohesion within this group of practitioners. This would, in turn, support their own 'hybrid' professional identity, both internally within the healthcare system and externally to the general public.

### 6.3.6 Teamwork

Effective teamwork was considered in this case to be an important factor for establishing a strong sense of identity, although being part of team had different connotations for those working in the ED compared to those working in a nurse-led unit. This case identified that participants who worked in a nurse-led unit had a stronger sense of teamwork, and were clearer who their peers were. For those working in the ED some participants described the team as other ENPs, while others referred

to the wider team of nurses and doctors. Participants in the nurse-led unit also expressed a stronger sense of '*shared responsibility*', supporting Bourdieu's notion that those who operate in a smaller, well defined 'club' exhibit characteristics associated with a strong sense of belonging. Examining the work of Bourdieu on cultural capital is helpful in understanding the connection between teamwork and identity. As described above, he asserts that a shared sense of belonging to either a club, programme of study or profession results in a sense of 'collective identity' that has a powerful impact on success as those within the 'club' have a strong sense of belonging and this contributes to a shared sense of ownership and cohesion.

In examining the research sub- question of whether medical colleagues have a positive or negative influence on the ENPs' perceived sense of identity or autonomy it appears that those who work in a nurse-led unit do have a stronger sense of who their team are, and demonstrate a 'shared vision'. This may contribute to a stronger sense of identity, as studies indicate that positive relationships do impact on a positive identity (Horrocks *et al.* 2003). However, this study cannot demonstrate whether the influence of medical colleagues within the ED has a direct impact on identity or autonomy as participants also shared perceptions of conflict with other members of the team, for example between other nurses and senior managers.

Effective inter-professional working contributes to patient safety (Lloyd-Rees 2016), and studies have consistently described that confusion between role boundaries contributes to conflict between HCPs, and acts as a barrier to effective implementation of the role (Thrasher and Purc-Stephenson 2007; Cheng and Chen 2008; Lloyd-Rees 2016). Participants who worked at the ED in my study also expressed tensions between their role and that of the ED nurse, citing conflict around the distribution of tasks and a lack of understanding on the part of junior nurses of the role and the level of responsibility held by the ENP. This is of particular importance, as professional identity is influenced by relationships with team members and the community within which one operates (Williams and Sibbald 1999; Horrocks *et al.* 2003). Interactions with others and conflict can have a negative impact on developing a professional identity.

Therefore, it is essential that HCPs have a good understanding of each other's roles in order to work effectively as an interdisciplinary team, but it is also important that

ENPs working within the ED establish a strong sense of who their team is, and a sense of shared responsibility. As noted previously, a positive identity contributes to positive performance and therefore this thesis recommends that practitioners, employers and educationalists should support ENPs in developing a strong team ethos and a shared responsibility. In addition, as the new national standardised ACP role is implemented within EDs, there is an opportunity to formally evaluate (through a 360 degree feedback for example) how the role interacts with the interdisciplinary team, and the influence of medical colleagues (and others) on professional identity.

Lave and Wenger (1991) suggest that through the concept of situated learning and Communities of Practice (which is based on the collaboration of peers where individuals work to a common purpose defined by knowledge rather than the task) practitioners become confident in their identity. This could be a useful vehicle to support the development of team cohesion through the transfer of knowledge and will be discussed further later in this chapter. However, in order for this to be successful the participants in the CoP need to have a clear understanding of 'the team' which further supports the notion that building an effective team is an important element in developing identity. Arguably, as the role continues to develop and ENPs develop confidence within 'the third space' their sense of 'who they are' and who their team is will support this development.

#### 6.3.7 Organisational loyalty

The final sub-question of this study related to the influence of location or organisational structure on perceived autonomy and identity. The participants in this case described feelings of loyalty to their peers and departments, although, it was evident in this study that loyalty to both organisations was less apparent. This seemed to be linked to the perception that the participants had regarding senior managers. Most of the participants reported that they felt that senior managers did not understand the role and were unsupportive of them (*'there is no back up from them'*). Senior managers, however, articulated an understanding of the role in relation to the clinical aspect, and spoke of the high regard they have for the role (*'they are such an important part of the nursing workforce'*), though were less clear about other elements of the ENP role such as leadership and titles. Senior managers also felt that ENPs operate within their own sphere and do not look outside of their department at the *'bigger picture'*. This gap in

perceptions was further evidenced as participants felt that senior managers focused on achieving targets and saw the ENPs as a means to achieve the targets at a lower cost.

Identification with the workplace is closely linked to organizational commitment, and is closely aligned with loyalty and job involvement and satisfaction (Cook and Wall 1980). When exploring this further the concept of the psychological contract as outlined in the work of Rousseau (1989) can be useful in exploring how the relationship between employer and employee can impact on organisational loyalty, commitment and identity. A psychological contract refers to the reciprocal promises that occur between employer and employee, and can either lead to a positive relationship with enhanced performance or a breakdown in trust resulting in dissatisfaction and poor retention.

Within the NHS the psychological contract has traditionally been based on relationships and trust, rather than contractual obligations. Recent studies suggest that when nurses view their employer as having fulfilled promises made to them they are more satisfied, and are likely to be more committed to both the organisation and profession (Rodwell and Gulyas 2013). Rodwell and Ellershaw (2016) found in their study of nurses' perception of psychological contract that a breach in promises (the psychological contract) has a disproportionate impact on trust, and a negative effect on job satisfaction and retention for nurses. This is an important finding relating to this study as it suggests that a breach in the psychological contract can have a disproportionate effect on the relationship between the ENP and the senior manager.

Whilst this thesis does not demonstrate a breach of the psychological contract *per se*, it does demonstrate that there is a misunderstanding of perceptions between the ENP and the senior manager, which arguably may have been brought about from a breach in the psychological contract. This area is worthy of further exploration and research, as the implications for practice are two-fold. Firstly, managers need to be aware of the importance of effective communication and understand the disproportionate effect that a breach can have in undoing a lot of effort in fulfilling employment-related promises. Secondly, the implications this has for retention of the workforce. Whilst it is not possible from this study to completely answer the question whether organisational structures impact on perceived identity it does demonstrate that there is uncertainty between managers and ENPs which arguably impacts on levels of job satisfaction



Further, it appears from the literature and the perceptions from the participants within this study that organisational identity is linked to job satisfaction and as alluded to previously there are strong links between job satisfaction and positive professional identity.

## 6.4 Education

### 6.4.1 Undergraduate nurse training

This case identified that participants felt a sense of '*missing out*' in their undergraduate training. On further probing, this referred to elements of their current role which they felt would have helped them in the transition to ENP, for example elements of clinical examination, decision making and a greater understanding of pathophysiology. It was evident from the case that participants were concerned that they had a lot of '*catching up to do*' to be '*on par*' with their medical colleagues, and this was a source of frustration. This finding is interesting as it reopens the discussion on whether nursing is seen as a science or an art, and has implications for undergraduate pre-registration curriculum design.

Over time nursing ideologists have attempted to capture the unique nature of nursing, and produced a range of theoretical frameworks to describe the essence of nursing activity (Orem 1980; Roper *et al.* 1996). When nursing moved into Higher Education (HE) in the early 1990s this was viewed by many nursing academics as confirming the academic status of nursing (Andrew *et al.* 2009), and the legitimisation of a quasi-professional status for nursing. The curriculum focused on the development of a body of scientific and quasi-scientific knowledge (King 1981; Royal College of Nursing 2003). This was alluded to within this study, as one participant reported '*learning about concepts, and training that intellectualised nursing without enough of the medical basics*'. However, not all view this as a positive move, and much of the literature and reported media suggest that a university educated nurse cannot care for patients as well as one that was 'trained' exclusively within the National Health Service. Others go further, suggesting that the essence of nursing is being corroded by the drive to '*academicise the non-academic*' (McNamara 2008, p73). Butler *et al.* (2006) suggest that a lack of specialist discourse and uniqueness, combined with constant borrowing

from other disciplines such as medicine, has stopped nursing from becoming a discipline in its own right. This is evident in a recent shift to return to a more task-oriented medical model approach as roles boundaries blur and both undergraduate and postgraduate curricula are adopting elements of a medical model. As Brook and Crouch (2004) describe, this move will cause concern to nursing ideologists who believe in the therapeutic value that nursing has to offer patients.

The inconsistency in the literature was echoed in this case as participants expressed concerns and uncertainty over their undergraduate education and the lack of preparation for the role (*'being a student puts you on the right path but it doesn't prepare you'*). Senior managers in this study concurred with this suggesting that *'it doesn't prepare them for what it's really like'* as they *'lack exposure'*. What was evident from the case was the feeling that a move to incorporating a more biomedical curriculum into the undergraduate programme would support role development. However, it is worth noting that not all student nurses will want to move into 'advanced practice' roles, and for some individuals developing a different pathway may be more relevant. This might include a route into management, or towards a more therapeutic or community-focused career. One of the senior managers reported that nurses are going into senior roles with higher levels of responsibility much sooner than previously, and that the undergraduate curriculum does not prepare them for the acceleration *'we have band sixes (senior staff nurses) who are only eighteen months in post and we don't prepare them for this'* Therefore it is worth considering that nursing may need to develop 'pathways' within the final year of the undergraduate programme that would allow students to choose their career path and undertake appropriate education and practice to support this.

Anecdotally, some undergraduate programmes have attempted to include choice in their curriculum, however this tends to be for one 'option' module in the third year and is not a 'formal pathway'. Nursing curricula are, however, restricted by the NMC who develop nursing standards that HEIs must adhere to. It is worth noting that a new set of standards are due for publication in 2018, and early indications suggest that there will be more emphasis on preparing students for advanced roles with the inclusion of clinical examination skills including chest auscultation, preparation for non-medical prescribing on qualification and a focus on leadership, decision making and influencing. This will be an interesting development for both HEIs and clinical practice

and will need further exploration as the new standards are embedded into curricula. Alongside this, the recent development of the nursing apprenticeship model, which shifts the focus of learning back into practice arenas and is more akin to the hospital-based apprenticeship model favoured by Nightingale (1859), as well as the continued emergence of new roles, suggests that flexibility will be key in future undergraduate nurse education delivery. Whilst it is not the intention of this thesis to explore the intricacies of the undergraduate nursing curriculum, this study supports the notion of developing a 'pathway approach' to qualification, and suggests that a range of options and approaches should be considered by curriculum planners within HE institutes.

#### 6.4.2 New knowledge

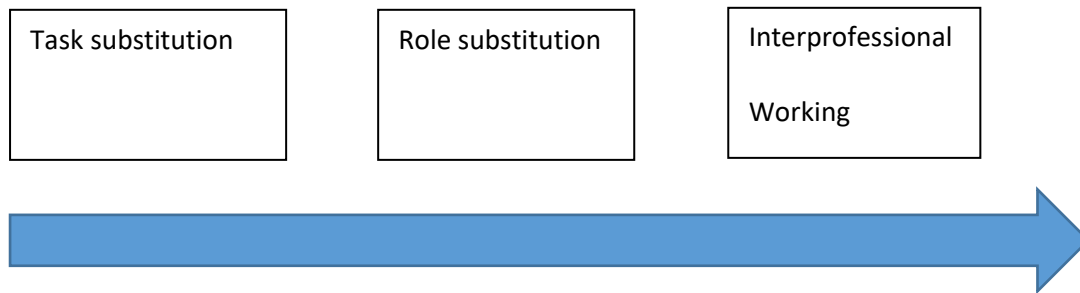
During all the focus groups participants were prompted to reflect upon where they drew their knowledge from as this was one of the sub-questions for the study. The majority of participants in this case expressed that their knowledge came from a range of sources '*knowledge comes from many sources*', and they described using both nursing and medical knowledge. As discussed in Chapter Two, knowledge is seen as a highly prized possession and is associated with power and identity (Tajfe and Turner 1986), and therefore the holder of the knowledge will have a powerful identity with a strong sense of ownership or self-determination. The participants in the case identified that they held a '*different type of knowledge*', which distinguished them from both nursing and medicine. For one participant, this was seen as developing into '*one knowledge*', whereby the foundations of their nursing knowledge combined with biomedical knowledge. The literature in Chapter Two outlines the historical lack of a standardized approach to education for the preparation of the ENP role, resulting in a role that has developed in an *ad hoc* manner without defining its knowledge base (Currie and Crouch 2008; Keating *et al.* 2010). Brook and Crouch (2004) described ENPs being 'topped up' with medical knowledge. The ENPs in this study, however, support the notion that their knowledge is not one that is 'topped up', but rather a combination of knowledge that has amalgamated into one to form a '*new knowledge*'

This amalgamation of knowledge, as discussed previously, results in a joining of cultures (cultural hybridity) which is a dynamic process, and is where new 'hybrid identity' (and knowledge) is formed. Participants in this case spoke of the need to develop their '*own knowledge*' that was '*less reliant on doctors*'. This was linked to the

notion of being a '*new professional group that is still evolving*', and one that hasn't got a '*strong academic base*' yet. This finding suggests that when attempting to answer the question of 'where do ENPs draw their knowledge from?' ENPs recognise that they are a new and emerging professional group that needs to develop their own body of knowledge and identity, and that they require support and recognition to achieve this. Recognising that they are operating within the 'third (hybrid) space' will allow them, or give them permission, to develop and grow the new knowledge and professional identity that these participants suggest is needed.

It is important to note that whilst the development of a new identity will go some way towards supporting ENPs to 'own' their own knowledge, and therefore expand and professionalise the role, it may be in conflict with the current and previous government agendas to develop roles that cross role boundaries and develop flexible models of care delivery with an emphasis on interprofessional education (IPE) (DH 2014). A widely accepted definition of interprofessional learning is when two or more professions learn with, from and about each other to improve collaboration and the quality of care (CAIPE 2002). Hoskins (2011) discusses the relationship between interprofessional working and role substitution and suggests that whilst interprofessional working is viewed as a positive development, role substitution is not. She identifies that this is related to the connotation that role substitution is linked to the dismantling of professional identity and their underlying philosophical approaches. Adapting the concept proposed by Headrick *et al.* (1998) of a spectrum of interprofessional activity, Hoskins (2011) suggests that there is a spectrum of interprofessional activity that starts with task substitution, ends with interprofessional working and places role substitution somewhere between them (see Figure Ten). She suggests that ENPs have moved along the spectrum towards interprofessional working, as other professions begin to understand and accept the role and their specific knowledge. The findings from this study support this notion, but build on this further by suggesting that ENPs are operating within a different space (the third space) which is multifaceted, and where new identity is formed under the influence of overlapping factors that impact on the development of their professional identity. This is conceptualised in Figure Eleven on page 187.

Figure 10. Interprofessional theoretical framework (Hoskins (2011), adapted from Headrick *et al.* 1998)



(Used with permission of the author)

#### 6.4.3 Communities of practice to support learning

It is worth returning to the work of Lave and Wenger (1991), who originally described the concept of a Community of Practice (CoP) as an approach to learning that incorporates elements of identity, situation and active participation. Wenger (2002) believes that professional learning and development are about communities, their identities and their practice. CoP are formed around '*groups of people who share a common concern or interest who wish to deepen their knowledge and expertise in a particular subject or discipline*'. (Wenger *et al.* 2002, p4). The CoP is described as '*a vehicle for collaboration, allowing members to enter dynamic and engaged relationships with colleagues*' (Andrew *et al.* 2009, p609). As noted previously, some of the participants in this study were unsure who their team are. Bligh *et al.* (2002) suggest that CoP allows the person to move from '*individual level dependence to team focused levels of trust, potency and commitment*' (Bligh *et al.* 2002, p300), suggesting that a CoP is a useful tool in harnessing a sense of teamwork and shared leadership. However, for a CoP to be successful there needs to be a sense of belonging, participation and collaboration (Wenger *et al.* 2002) as a CoP works on the premise that there is a shared goal, or that participants are working towards the same goal, and that participants engage in '*the process of being active participants in the practices of social communities and constructing identities in relation to these communities*' (Wenger 1998, p4). In other words, the participants of the CoP need to be actively involved in the creation of the CoP, and have a shared team ethos. The participants

from the nurse-led unit in this study shared a stronger sense of team work with a shared sense of responsibility, and therefore would potentially have a stronger base to develop a CoP. That said, as described in Chapter Two, CoPs can have diverse membership and are not limited to one particular group. It could be suggested that for those ENPs working in a multidisciplinary team a more diverse CoP may be beneficial, and will support the transition and socialisation process as described previously.

The success of a CoP is dependent on the commitment of its members. Some participants in the study felt that they were not given time for personal development, and referred to *'teaching sessions being cancelled'* and *'no time for non-clinical work'*. The senior managers' perception of the role (*'most of the time they are on the shop floor, seeing patients... that is fundamentally their role'*) suggests that there would need to be a shift in priorities for the development of a CoP, and this would be a substantial challenge in today's NHS climate. Whilst many of the participants describe a *'supportive leaning environment'* during the course, and for some a period of consolidation was also given and viewed positively, there was a perception that afterwards there were fewer opportunities for development. The implications from this study suggest that managers and commissioners of services and educationalists should invest time in their ENPs and programmes of study by developing a strong sense of cohesion and team ethos amongst the ENP team. This will not only have a positive impact on organisational loyalty (and retention), but will enable the development of practice, knowledge and identity through a CoP approach.

#### 6.4.4 National standards for advanced practice

In line with the literature in Chapter Two, all the participants in this study felt that the lack of a national standardised education programme to prepare for the role had hampered the development (and expansion) of the role. Participants in this study agreed with the findings of other studies (Currie and Crouch 2008; Keating *et al.* 2009; Lloyd-Rees 2016) that the lack of a standardised educational preparation for the role had impacted negatively on both their professional development and on the perception of them by other HCPs. This has created tensions within teams, and undermined successful implementation of the role. As already noted above, the transition to the role of ENP can be challenging in relation to acceptance of the role by other HCPs, lack of role clarity and support from the team during and after the transition, and

arguably the lack of consistency in education preparation has influenced this. Participants in this study demonstrated frustration at the varied range of courses, and felt that all programmes should be a minimum of degree level. Participants were less clear on whether they should be 'required' to do a full Master's to gain recognition for the role, with one suggesting that *'my MSc makes me feel as though I am officially an advanced practitioner'* and others focusing on their years of experience (*'years of experience progressed into being a nurse practitioner'*).

As described to in Chapter Two, all nurses qualify with a degree, and therefore all 'new' advanced practitioners will already have a degree and will be working towards a Master's level programme. It is still unclear, however, whether this will be a full Master's for Advanced Practice. Clearly the uncertainty around titles and role clarity is again highlighted as the practitioners in this study were certain of their ENP role but less sure whether this meant they were 'Advanced Practitioners'. This uncertainty was also linked to career progression once in role (which will be explored later in this chapter), and contributed to the uncertainty around the difference between the ENP role and 'advanced practice'. Senior managers were also unsure of the difference; *'I think the educational path to advanced practice is unclear'*.

This research demonstrates further the desire from practitioners and managers to have a standard approach to education preparation and title for the role(s) that sit under the 'advanced practice' umbrella. As noted in Chapter Two, there have been some important developments in trying to establish this with the introduction of a nationally standardised 'advanced practice framework' which clearly identifies the 4 areas of advanced practice: clinical expertise; leadership; research; education/mentoring. Whilst this is a welcome development, there are implications for both clinical practice and educators. For example, most of the participants in this study (practitioners and managers) expressed that the role is primarily clinical, and therefore evidencing the other three pillars will be potentially challenging. Most university courses are focused around clinical examination, diagnostic reasoning and prescribing. However, there will be a need for educationalists to ensure their curriculum supports practitioners to develop the other aspects of the advanced practice model.

This is likely to prove equally challenging when ENPs enter clinical practice, as currently the focus is around the clinical elements of the role, and whilst practitioners may be supported (financially and with protected time) to develop this element, it is likely to fall to practitioners themselves to fund the development of the other pillars (leadership, education and research). In a climate where practitioners are taking on additional responsibilities and increasingly working unsocial hours to meet service demand without recognition in their pay, self-funding a full Master's programme may not prove sustainable, and will impact on job satisfaction and retention. As noted by Hoskins (2014), senior nurses were once attracted to the role in order to work more social hours, however the workforce is becoming more mobile as they search for a 'more attractive' offer of working conditions. The participants in this study recognise the value of support for education and training, and this may well be an incentive for sustaining an expanding ENP workforce.

Many of the Advanced Practice Master's programmes within the UK are now multiprofessional, and with the advanced practice framework being adopted across other HCPs it is likely that this will continue to expand. This supports the government push for a flexible workforce and further burring of boundaries, however it is important to consider professional identity within this development. Many degree programmes now include modules on IPE which usually translates into developing some understanding of how different groups of professionals work. Traditionally, postgraduate education has been largely uni-professional, with nurses undertaking programmes which specialise in their subject area or role. However, with the emergence of new (and similar) roles under the umbrella of advanced practice, nurses, paramedics and others are often taught together. As discussed in Chapter One nurses (and other HCPs) start to develop their professional identity before they enter the profession, which is then augmented during their degree programme. By the time the nurse (or paramedic or doctor) qualifies they have a strong professional identity that influences how they practice within the healthcare team, and how they learn and develop their new roles and skills. Professional identity is multifaceted but arguably the ontological assumption of the individual or professional group will impact on their identity. This is an important consideration as how a professional group 'sees the world' or understands how truth is developed will impact on role development. For example, nursing generally comes from a humanistic (relativism) interpretation of the



world (Denzin and Lincoln 2000), whereas a paramedic is more aligned to a biomedical (realism) perspective. This is an important consideration and challenge for educationalists who are teaching the same content to develop a 'generic' advanced practitioner role, each of whom may develop their own 'new knowledge', with differing professional perspectives and interpretations of that knowledge.

## 6.5 Career structure

### 6.5.1 Role expansion

All participants in this case expressed a desire and need to have a more structured career pathway once they became a qualified ENP. This was a strong feature of all the focus groups, however those who worked in the ED expressed a stronger motivation for further career development which was associated with moving to the 'major end' to see more complex patients. Two of the participants chose a photograph to demonstrate this (meandering river), whilst a third chose a winding road as an illustration. For some of the participants there was sense of frustration that a career pathway was not established. Participants shared a sense of disempowerment as a result, and for two participants this was associated with being heavily influenced by medicine (*we still need consultant weight behind it* (the new advanced practice standards). It was also felt by a few participants that support for career development was weighted towards their medical colleagues as *'teaching is never cancelled for them (medics) but ours often is'*. Interestingly, in one focus group during the discussion about in-house teaching one of the participants alluded to needing 'permission' to go ahead and meet to discuss patient cases through informal learning. As one participant noted *'I complained about teaching being cancelled and xx said that we should go and meet anyway even if the session is cancelled, I didn't realise we could do that'*. Whilst this was not evident in all the focus groups, those who worked in the ED appeared less certain in recognising their own contribution and responsibility for making changes to the perceived 'status quo'. This also linked to perceptions around leadership which will be discussed later in this chapter.

As noted previously, all the participants in this study demonstrated a strong sense of job satisfaction which is linked to autonomy and decision making (Hayes *et al.* 2010).

Participants in this case described job satisfaction also being linked to career development (*'I love my role and want to advance further'*), and role expansion was a common theme shared across all of the focus groups. As described previously, there have been important developments within the ENP role and across advanced practice roles more broadly with the implementation of the 'advanced practice framework', which recognises the four pillars of advanced practice. As noted previously, the Nuffield Trust articulates the difference between an advanced practice role and an extended role as:

*'Extended roles are roles where registered professionals take on tasks not traditionally within their scope of practice but which do not require training to Master's degree level. Advanced roles meanwhile refer to those roles that require registered professionals to undertake additional training at Master's level or above'* (Imison et al. 2016, p2).

Whilst this is a very welcome differentiation, and the introduction of the framework is a positive move towards standardising advanced practice roles, implementation within both clinical practice and HE institutions will be challenging for several reasons. Firstly, as the participants in this study (and previous studies) have highlighted there is a vast range of titles and roles within the 'advanced practice' umbrella, and without a clear and distinct clarity of role definition (e.g. when does an extended role become advanced), implementation will be challenging. Secondly, regulation of the role is key and without recognition from the nursing and midwifery governing body (the NMC) regulating this development will also be difficult as practitioners will not be required to 'register' their Master's qualification with their professional governing body. The Royal College of Nursing (RCN), which is the professional body for nursing and midwifery, has attempted to support the implementation of the framework and regulation of the role by adopting the RCEM model of 'credentialing', whereby practitioners gain formal recognition for their expertise and skills across the four pillars of advanced practice. This process is open to members and non-members (for a fee) and in return individuals will be given a certificate, badge and placed on a register. Renewal to the register will be required every three years for a fee. At present this is a voluntary process, and whilst it is recognised as a welcome move forward, it is arguable that without

practitioners gaining monetary recognition in their pay for obtaining this certificate it is debatable how successful it will be.

Within the last two years there has been an attempt by some NHS Trusts and Health Education England to pilot the development of an advanced practitioner role within the ED who would (on completion of the programme) be able to see more complex patients in the 'major end' of the department, associated with an element of financial recognition. The role development allows the individual (non-medical practitioner) to undertake a five-year programme which typically involves a two year training post at band 7, and on completion of the programme the role would be enhanced to a salary scale of 8a. The trainees follow the Royal College of Emergency Medicine (RCEM) programme as discussed in Chapter Two, and are usually required to complete:

- Masters in Advanced Practice.
- RCEMACP curriculum clinical competencies in practice.
- RCEM E-portfolio completion.
- Direct patient care: to develop above clinical competencies.
- Three to six monthly ED Consultant clinical educational meetings.
- In-house dedicated tACP training programme.
- Attendance at joint medical and ACP weekly training.
- RCEM credentialing.

This is a highly resource intensive programme, and the pilots to date have been partly funded by HEE and partly funded by individual NHS Trusts. As noted above, participants in this study were supportive of the development of ACPs (*'there is lots of evidence to support the ACP role and we have been pushing for ages to implement a major end practitioner'*), however, they also demonstrated caution as support from the organisation is essential (*'we would need the Trust to support it, at present they would rather pay for an expensive locum than pay for one of us to develop the skills'*). A lack of support and time to develop the role, and inconsistency in role development, are consistently identified in the literature as a barrier to successful implementation of a new role (Currie and Crouch 2008; Keating *et al.*, 2009; Lloyd-Rees 2016). It is still early in the adoption phase, and whilst there is little empirical evidence to date of the impact of the role, anecdotal evidence suggests benefits such as reduced length of

patient stay, improved care, reduced costs, more efficient services and improved patient and staff satisfaction (Miller *et al.* 2009). That said, it is worth adding caution to the implementation of the ACP role in a piecemeal approach, as this participant suggest: *'I think it will go some way to standardising the role but again it's not obligatory, you can chose to do it, and actually it's quite expensive'*. This thesis echoes the literature in support of the implementation of a national standard, however a rigorous approach to implementation from Health Education England, by adopting a co-ordinated national approach, is required to ensure that previous barriers to role development are not repeated and the potential success of the role is fully maximised.

### 6.5.2 A mixed picture of leadership

One of the four pillars of advanced practice as defined within the framework is leadership. It was apparent from the case that not all ENPs saw themselves as 'leaders', although most described themselves as experts within their field. Those participants who worked in the nurse-led unit recognised that leadership was an important aspect of their role and used words such as *'motivating staff'*, *'morale'*, *'support'* and *'negotiation'* to describe their leadership. For those who worked in the ED there were mixed views. Participants who had dual roles (working both as an ENP and a shift co-ordinator) described leadership as something they did when *'not in black'* (which is the colour of the ENP uniform). This suggests that they saw themselves as leaders when in charge of the shift but not when they were working as an ENP. The participants who worked in the ED solely as ENPs also had mixed views, with some describing leadership as something *'others would do'*, whilst others felt they would like to do more, such as *'push the profession forward'*, but felt that a lack of time was a barrier to achieving this. This part of the role seemed to be perceived as a 'luxury', rather than an essential component. Senior managers equally reflected this mixed picture as they described the role as primarily *'clinical experts'* who *'kept patients safe'*. However, for one of the senior managers the interview allowed her time to reflect on this, and as the interview progressed she considered that perhaps the ENPs could be a useful resource around leadership that was currently underutilised.

Studies examining nurse leadership have also found a similar mixed picture. Antrobus and Kitson (1999) in their study found that leadership within clinical practice had poor status compared to leadership within the academic, management and political domain.

They suggested that 'clinical leaders' play a vital role in the development of innovation in practice, however they have limited resource and personal investment from organisations, and the clinicians do not consider themselves as 'leaders'. They concluded that to enable clinical leaders to operate as policy shapers and change makers a re-structure in career pathways for these practitioners is needed. The mixed views from ENP participants and senior managers in this study appear to agree with the literature in that that these practitioners are unsure of their role as leaders, and are perhaps an important untapped resource for NHS organisations to draw upon during a climate of change and reorganisation.

### 6.5.3 Influencing others

As noted in Chapter Two, ENPs are regarded by front line nurses (FLNs) as 'opinion leaders' (Gerrish *et al.* (2011) who influence the practice of others. In addition to this, it is expected that ENPs base their own practice on research evidence, and also influence the practice of others by acting as change agents in order to facilitate evidence based practice (EBP) among FLNs (DH 2003). Skills such as clinical leadership, change management, IT competency and protocol development are cited as essential for the delivery of evidence-based practice (Gerrish *et al.* 2011). However, there is limited research examining how ENPs select and use evidence within their own practice, and how they influence others. In the Gerrish *et al.* (2011) study ENPs cited heavy workload as the biggest barrier to not being able to promote EBP, and a quarter of the respondents (n=855) indicated that they did not have time to keep up to date with current research. Whilst half of the respondents considered themselves competent in reviewing and using evidence, only one quarter felt confident in undertaking research. This is in line with other studies (Profetto-Mcgarth *et al.* 2007) which identified that ENPs lacked confidence to undertake research and attributed this to a lack of time and heavy workloads. Whilst my study did not specifically explore using EBP as a source of leadership and influencing others, some of the participants recognised that influencing was part of the role '*being able to negotiate, to influence*', however for others this was less evident. As noted above, those who worked in the ED did not necessarily recognise their role as change makers or negotiators within their own sphere of influence. It would appear from the literature and the mixed picture presented by participants in this study that further research is needed to explore the

role of the ENP as a leader both at the organisation level and as a group of practitioners to help influence and shape policy and practice.

As noted above, the four pillars of the advanced practice framework outlines that leadership, education and research are the three other pillars, and are therefore assumed to be an integral element of the ACP role. However, the competencies that the framework is based on are primarily focused on the clinical aspects of the role. Undertaking a full Master's will undoubtedly equip students with the research and leadership skills required, however as noted in the literature these skills need time to refine, develop and cement in practice.

It is worth noting here that nurse consultants, who were introduced in the late 1990s to strengthen clinical leadership, provide new career opportunities and enhance patient care (DH 1999) also embraced the four key elements of advanced practice. A plethora of studies have attempted to evaluate the impact of the role (Kennedy *et al.* 2012), and although these studies suggest that they have had a positive impact on both patient and professional outcomes, nurse consultants consistently report that they need organisational support to develop their leadership skills (Rosser *et al.* 2017). Guest *et al.* (2001) recognised in an early evaluation of the role that support from employers was challenging. Rosser *et al.* (2017) found in her study evaluating the effectiveness of action learning sets to enhance clinical leadership that leadership and expert clinical practice dominated their practice, leaving less time to undertake research. The findings in the Rosser *et al.* study support other studies that report challenges with integrating research into practice, and in supervising and undertaking research (Currie 2007). Most of the participants in this study also highlight that time and support from the organisation is a barrier to undertaking research or education activities, and this is commonplace across the literature. Interestingly, the participants in the Rosser *et al.* study did recognise the influence they were having on the wider organisation, and notably were moving from a 'permission seeking' environment to a more autonomous and independent environment. As highlighted previously, some of the participants in this study alluded to 'needing permission' to be independent practitioners. Whilst there is clearly a need for the development of the ACP within urgent care to meet service demand, it is important that service needs do not overtake the development of the other aspects of the ACP role, and support from employers will be paramount to its successful implementation.



## 6.6 Summary of chapter

This chapter has explored the findings of the study in depth, in relation to the relevant literature and the research questions posed. From the evidence in this study and the related literature, it is apparent that the concept of professional identity is multifaceted and this thesis has explored the factors that influence the perception of professional identity for a group of practitioners across two urgent care settings. Whilst it was not possible to draw comparisons across the settings for all aspects of the research, it was apparent that all participants in this study had a great sense of pride and job satisfaction within their role, despite feelings of frustration and uncertainty relating to the perceptions of others (including misperceptions between ENPs and managers), titles, career development, and organisational support. All of these are reported in the literature as factors influencing a sense of professional identity. Participants at the nurse-led unit had a greater sense of team cohesiveness, and a shared responsibility. The study also found that participants did not feel that their undergraduate education had prepared them for the role, and that a national standard of education is important, but will require organisational support.

ENPs in this study recognise that they are different from other nurses, but equally they are not a doctor substitute. They draw their knowledge from a range of sources and are developing a 'new' body of knowledge. Applying the work of Bhabha to these findings suggests that ENPs have developed a 'hybrid role', that is they have developed a new knowledge (and professional identity) that operates in a different space (or 'hybrid space') to that of a nurse or a doctor. The theories of Bourdieu suggest that moving into a new space is complex and goes beyond the professional context because behaviour, culture and identity within one's own habitus is often fixed and not the result of free will. However, Bhabha argues that movement into a different space can occur, whilst acknowledging that this is likely to involve conflict and cultural clashes. This is an important finding as understanding this concept will help both educationalists and managers in supporting the development of the role; not only within that of the ENP, but also within the development of other advanced practitioners.

These findings raise several important considerations for both organisations and educationalists. Participants identified that team work is important, and this is



associated with loyalty and job satisfaction (Paille and Raineri 2016). The CoP framework provides a mechanism to support the development of teamwork alongside knowledge transfer and professional identity. However, this would need commitment from organisations to develop. A greater understanding of the role both within organisations and externally would help develop trust, loyalty and improve the recruitment and retention of staff. Participants also recognised that a lack of career structure impacted on job satisfaction; therefore the development of a national framework within the advanced practice role will support both job satisfaction and role expansion, thereby achieving effective succession planning for organisations. Finally, participants and managers felt that current undergraduate training did not adequately prepare them for the role, and therefore HEI's will need to consider how best to support the development of new roles within the undergraduate curriculum.

The following chapter will draw the study to a close and outline areas of new knowledge and areas for further research and exploration. Recommendations for educationalists, NHS Trust managers and commissioners of services will be further outlined. It will conclude with a reflection on the limitations of the study.

## 7. Conclusion

### 7.1 Introduction

This study set out to explore perceptions around issues of identity and autonomy within the role of the ENP. In doing so, the following aims have been addressed:

- Explore the concept of professional identity within the role of ENP.
- Identify what factors contribute (positively or negatively) to a sense of professional identity.
- Consider the implications for managers, organisations and educationalists of changing identities within emerging roles in healthcare.

The literature review described in Chapter Two identified research gaps relating to the issues of identity and autonomy, and these underpinned the development of the research question:

What are the key factors that influence a sense of identity and autonomy for the nurse practitioner?

A qualitative approach was selected, using case study as the chosen methodology. Five research sub-questions were identified to help interrogate the research question. These were:

1. From which sources do ENPs draw their knowledge base, and why?
2. Does the title ENP or ANP give post holders a sense of identity, and if so why?
3. Is there a perceived link between professional autonomy and professional identity?
4. Do medical colleagues positively or negatively influence an ENP's perceived sense of autonomy and/or identity?
5. Does location or organisational structure have an influence on perceived autonomy and/or identity?

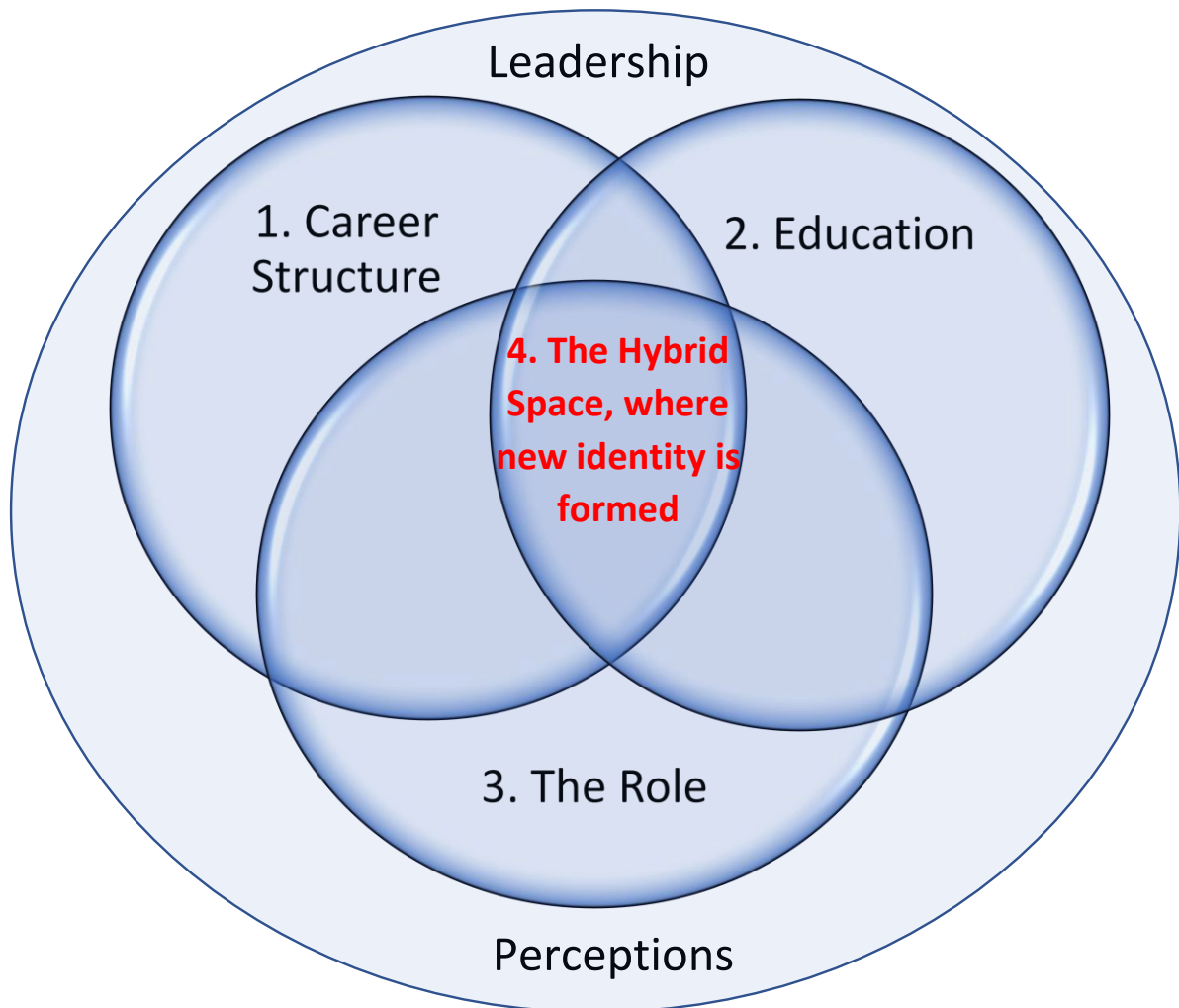
Data was collected through focus groups and semi-structured interviews. Participants in the focus groups were asked to use photographs to conceptualise their perceptions of professional identity and prompt areas for discussion. Themes were generated using the Braun and Clarke (2013) thematic analysis model, and participant photographs were used as visual representations of the themes.

Findings from this study have contributed to the development of new knowledge in four key areas:

Firstly, this study found that many factors influence the ENP's sense of professional identity, and these broadly fit into three categories: career structure; education; the role. This thesis proposes that at the centre of the three key factors sits a 'third (or hybrid) space', where the ENP operates and a new professional identity is formed. This has been conceptualised in a new framework as demonstrated in Figure Eleven (page 187). The framework demonstrates the multi-faceted relationship between the three key factors which influence professional identity. Central to this, is the 'third (or hybrid) space' which is occupied by the ENP and where their professional identity is situated and formed. Within this space a new body of knowledge is formed contributing to the formation of a new identity. Applying the work of Bhabha (1994) to the findings of this study, whilst considering the theories of Bourdieu (1973), suggests that whilst it is not an easy transition to make, moving into a new professional space and developing a new identity is possible. This appears to be an emerging area as it becomes more common for 'traditional' professional roles to expand into domains previously occupied by medicine in response to increasing service demand. This is an important finding for practitioners, educationalists and commissioners of healthcare because with hybridity comes some uncertainty and conflict as new identity is formed and new practices, philosophes and re-defined professional boundaries emerge. As the role continues to evolve it is crucial that we anticipate a change in culture, and support both the practitioners undergoing the change and those who work alongside them as this is clearly a contributing factor to the conflict that participants in this study (and other studies) describe. It is important to recognise that during this period of identity redefinition practitioners will need skills to negotiate and navigate through the turbulent period, whilst their colleagues will need support to understand these changes in role and identity. Further, issues relating to the public perception of nurses and the

associated health outcome measures that the ENP can offer, as identified in this and previous studies, suggest that raising public awareness of the role would support the evolving formation of a new identity.

Figure 11. A conceptual framework representing the interaction of the key themes and the 'third (or hybrid) space' where new identity is formed.



Secondly, ENPs in this study demonstrated high levels of job satisfaction despite ongoing uncertainties around issues such as titles, role expansion, education and conflicting perceptions of the role between managers and ENPs. Job satisfaction is linked to autonomy and identity formation which is closely aligned to organisational identification. The work of Rousseau (1989) explores how the relationship between

employer and employee can impact on organisational loyalty, commitment and identity. Applying this work to the findings of this study suggests that there may be a breach in the psychological contract between the employer and the employee as perceptions between the ENP and senior manager are conflicting. This could have a negative impact on both identity formation and organisational loyalty (and therefore the retention of ENP staff).

Thirdly, this study found that career structures within the role are important, and a lack of career structure led to frustrations and disempowerment, contributing to a negative impact on identity formation. As advanced practice continues to evolve, and with the development of the RCEM programme, a more structured approach may be offered for ENPs as they develop along the advanced practice continuum (conceptualised in Figure 1B). However, there is a possibility that this 'two tier' structure of ACPs and ENPs will leave many ENPs feeling more frustrated and disempowered since many will not progress to become ACPs. It is therefore important for ENPs to recognise their own strength and position within the field, and their expertise within the domain of minor injuries and illness, so that they develop strong leadership and ownership of knowledge within this area of urgent care provision. As noted within this study and by others, ENPs are now a well-established part of the workforce and deliver effective outcomes to patients presenting with minor injuries and illness. They therefore have a role to play in the leadership of this vital area of healthcare.

Finally, this thesis highlights that whilst ENPs see themselves as clinical experts they do not see themselves as leaders of teams, change-makers or influencers. ENPs in this study sought 'permission' to develop. As the roll-out of ACPs continues, it will become increasingly important for ENPs and ACPs to be able to articulate their worth, and support from organisations to develop this will be key. The development of a community of practice within organisations could be a useful vehicle to support this role development.

The thesis will now conclude by reflecting on the doctoral journey and the methods and methodology chosen. It will summarise the new areas of knowledge and make recommendations for future research. In addition, it will make recommendations for both educationalists and senior managers and commissioners of healthcare, based on the findings of the study.

## 7.2 Reflection on the doctoral journey

My desire to do the professional doctorate came from both being a practitioner in emergency care and an academic. At the start of the journey I was leading the ENP programme of study, however as the journey progressed I moved into a more strategic role within the faculty. However, my interest in advanced practice has remained, and this doctorate has enabled me to broaden my thinking in three areas. Firstly, it has helped me understand the challenges faced when the ENP course has finished, and how important it is that the programme of study supports student ENPs during the transition from being a student ENP to a confident independent practitioner. Further, the course must equip new ENPs with the tools needed for accessing ongoing continued professional development (CPD), and an understanding of the importance of development in all four pillars of advanced practice. Secondly, from a clinical practice perspective the thesis has considered how crucial organisational support is in developing loyalty (which supports staff retention). This can help practitioners fully embed the role to become the unique 'hybrid' practitioner, whilst tapping into a wealth of experience and talent around leadership. Thirdly, the thesis has developed my thinking within my current role about how the faculty can strategically support the development of advanced practice across all disciplines, incorporating all four pillars of advanced practice through a structured approach that will need to begin at undergraduate level and follow through to Master's Level.

From a personal perspective, the doctoral journey has enabled me to develop the resilience, tenacity and rigour of a researcher while maintaining the sense of pragmatism and flexibility required to undertake research and implement its findings

## 7.3 Reflection on the methodological approach

I adopted a qualitative approach to the study, as the main purpose was to explore concepts and perceptions around issues of identity and autonomy within the ENP role, and this lends itself to a qualitative approach. Denzin and Lincoln (2011) highlight that qualitative research seeks to clarify the meaning of social contexts within participants' natural settings. Having explored qualitative methodologies, case study was chosen

as it seeks to explore what is going on rather than account for it (Partlett and Hamilton 1974). I wanted to understand what the ENPs were feeling, and explore their experiences within their institutions, and case study research supports this type of exploration (Keen and Packwood 2000). Selecting the case was more problematic as there are several eminent case study authors who describe case study methodology. However, having explored both Stake (1995) and Yin (2009) I concluded that a mixed approach would support the exploratory nature of the study, and so adopted both an intrinsic (in-depth exploration of a group of ENPs) and an instrumental approach (what other variables impact on the participant such as organisational structure). In my initial thinking, I considered a collective case study as participants were drawn from two organisations. However, as the study progressed it became apparent that the case was in fact the whole group of ENPs rather than the organisations in which they worked. Whilst some comparisons were made between the two groups there were many commonalities, and it was evident from the results that in the main the whole group of practitioners represented a homogenous group of ENPs. Flyberg (2006) and Stake (1995) support this type of mixed approach, as the most important element to a case is to maximise what can be learnt and not the typicality of it.

#### 7.4 Reflection on the research methods

The use of photographs as a prompt for discussion around the ENPs' perceptions of their identity was discussed with my supervisors prior to data collection. Initially, I considered using photographs as a formal method of data collection, however having explored this option I decided to use them as prompts for discussion for two reasons. Firstly, the feedback in the pilot study focus group suggested that participants felt some uncertainty around the photographs; in particular, they were unsure of what they should take a photograph of, and what they should say about them. Secondly, as a new researcher I felt less confident in using the photographs as a method of data collection and as I was also the facilitator of the focus group I decided that I did not want to be too distracted with ensuring the data from the photographs was captured correctly. During the pilot, it became evident that making sure the camera captured the photographs was quite challenging, and I found myself moving between the camera and the group too much. However, the feedback from the pilot did help me in

that I was able to give some clear and reassuring guidelines to participants about the nature of the photographs.

On reflection, the photographs proved to be a success in that participants really enjoyed showing their photographs and explaining their meaning. They reported that it gave them a sense of importance, and was 'quite cathartic' and fun. Kennedy *et al.*(2014) highlight that the professional characteristics of ED nurses is that they do generally talk about their feelings, and the use of photographs in this study proved to be a useful medium which was successful in getting participants to talk in depth about their feelings, and make analogies from their photographs more easily. The use of photographs in this context demonstrates that this could be used in other situations when supporting students or participants to discuss their feelings, for example supporting practitioners as they move into their new role.

Focus groups as the primary source of data collection allowed me to gather data that provided insight into perceptions and attitudes in a natural setting (Freeman 2006). Participants were able to talk freely and enjoyed the relaxed atmosphere that was created. It also allowed the participants to set the direction of the conversations whilst being prompted by me as the facilitator to ensure the discussion stayed focused on the research questions. However, from a novice researcher perspective focus groups are challenging to manage to ensure that the conversations flows and is not dominated by one person. In part, this was helped by having small focus groups who all knew each other. As noted in Chapter Four, the use of a diary after each focus group (and interviews) also helped as I was able to note the practical challenges and dynamics after each focus group, and adapt my style accordingly. The excerpt in Appendix Eleven demonstrates how this helped me change the format to allow the discussion to flow more freely. The key challenges in using focus groups were the operational aspects of getting the group together and ensuring that they all brought their photos with them. After the first focus group, I adopted a different approach to bringing the photographs to the group in that I emailed the participants a week before the focus group offering to print them. This proved much easier for the participants as they were able to use their phones to email the photographs to me, which was more convenient for them. In the future, I would provide this option from the start of the study, and would try to be as flexible as possible in timings and location as this proved to be challenging due to shift work.



## 7.5 Summary of New Knowledge

This thesis has contributed to the development of new knowledge in several ways:

- ENPs in this study recognise that they are different from other nurses, but equally they are not a doctor substitute. They draw their knowledge from a range of sources and are developing a 'new' body of knowledge. Applying the literature to these findings suggests that ENPs have developed a 'hybrid role' that is developing a new knowledge (and professional identity) that operates in a different space (or 'hybrid space') to that of a nurse or a doctor. This is conceptualised in Figure Eleven which is a conceptual framework demonstrating the relationship between the three key areas, central to which, is the 'third (or hybrid) space' which is occupied by the ENP and where this thesis proposes is where new identity is situated and formed.
- ENPs in this study demonstrate high job satisfaction, despite ongoing frustrations and uncertainties around role expansion and education, title and support from the organisation. Job satisfaction is linked to autonomy, and based on this study and the literature reviewed autonomy and professional identity are closely linked, which raises the question of how this knowledge can be applied to recruitment and retention within organisations.
- Career structure for ENPs is important. This was a key finding in this study, in that participants felt that a lack of career structure and role expansion led to frustration and disempowerment.
- ENPs within this study see themselves as possessing clinical leadership skills and expertise, but do not see themselves as leaders of teams, change makers or influencers over bigger issues such as policy or research. Senior managers also did not view them as leaders, but did highlight that this is an area that should be developed in the future. This will become increasingly important with the ongoing roll out of the ACP framework, which identifies four pillars of advanced practice: clinical expertise; leadership; education/coaching; research. These elements should be incorporated into programmes of study to support the development of all four pillars.

## 7.6 Recommendations for educationalists

The findings from the study have been explored in the context of the underpinning literature, and this thesis makes the following recommendations:

- Advanced practice programmes need to ensure that the four pillars of ACP are fully incorporated into the programme. Of particular importance is the development of leadership attributes and independence, encouraging practitioners to move away from 'permission seeking' behaviours to those of strategic influencers and change makers.
- Credentialing will become increasingly important, and HEIs need to support all practitioners through this process.
- A CoP framework would support practitioners to develop their newly acquired knowledge, and also support the development of knowledge transfer, teamwork and a shared vision to harness their professional identity.
- HEIs must consider how to support the development of new roles within the undergraduate curriculum, and the journey from undergraduate nurse to ACP.

## 7.7 Recommendations for NHS trust managers and commissioners of health care

- Introduce a national standardised approach to implementing the ACP framework through HEE regions.
- There is a need to further understand roles within the health care environment. This is at both operational level and organisational level. Developing a mutual understanding of roles will develop trust, loyalty and improve recruitment and retention within organisations.
- ENP teams need to develop a cohesive team ethos that supports the development of the service. This could be done through the CoP framework, as it would support the building of a team and the development of knowledge transfer and professional identity.
- ENPs could play an important role in leadership and change management, and support to develop this is needed. In addition, practitioners will need the

opportunity to develop other aspects of the ACP role such as research and education.

- A framework for a developing career structure within the role will support job satisfaction, role expansion and help with succession planning.

## 7.8 Future research

This study was underpinned by examination of the supporting literature, and has identified the following areas for future exploration and research:

- Further research on the link between professional identity and commitment to the organisation. As outlined in this study, identification within the workplace is closely linked to organisational commitment, and is aligned to job satisfaction. The work of Rousseau (1989) explored the relationship between employer and employee through the psychological contract concept (the reciprocal promises between employer and employee), which can either lead to a positive relationship with enhanced performance or a breakdown in the relationship often resulting in poor retention. ENPs and managers in this study reported misperceptions of the role which could contribute to a breakdown in the psychological contract. Therefore, further research on this relationship relating to ENPs and new roles would be beneficial for organisations experiencing recruitment or retention problems.
- A national evaluation of the impact of the new ACP framework on career pathway development, and the effectiveness of credentialing.
- Further exploration of the 'hybrid practitioner', and the concept of cultural hybridity (Bhabha 1994) which describes a phenomenon when elements of different cultural systems come together to form something new (such as the ENP role).
- Exploration of the undergraduate curriculum that supports development of advanced roles.
- Further research is required on patient understanding of the ENP role, and how the public interpret the role.

## 7.9 Limitations of the study

Whilst the study has answered the research question, and achieved its aims, there are several limitations that need to be considered. This was a small study that explored in-depth the perceptions of ENPs from two different NHS organisations. As noted previously, some comparisons were drawn between the two organisations, but a larger scale study would enable further comparisons to be made. In addition, due to the small numbers, demographics were not included in the study as this may have potentially breached anonymity. Therefore, a larger study would allow the inclusion of demographics to add a further dimension to the analysis. The focus groups only met once, and while this provided enough data to analyse and generate themes to address the research question, it would be helpful to undertake further follow up focus groups with the participants to explore whether their perceptions change over time. Finally, case study research is often criticised for its lack of generalisability, and it could be suggested that the findings from this study are not generalizable to the wider population. However, it is worth noting that generalisability is not purely related to the number of cases or participants. Skate (2005) suggests that in most case studies modified generalisation takes place whereby an entirely new understanding may not be reached, but refinement of understanding is. Sandelwoski (2004) supports this notion and offers an alternative version of generalisability; that of analytic or idiographic generalisability, whereby deep interpretation of the data contributes to the wider knowledge.

## 7.10 Concluding remarks

This thesis has made a unique contribution to the body of existing knowledge about the evolving role of the ENP, and about the development of advanced practice. It has revealed further insights into factors that support the development of professional identity within the role, which could be transferred to other emerging roles such as paramedic practitioners and physician's associates. The study has explored the implementation of the new national standardised ACP framework, and recognises that this important development within the advanced practice arena will need further evaluation. Finally, the results of this thesis will be useful to both educationalists and commissioners of healthcare, in order to support the successful introduction of emerging new roles to effectively meet steadily increasing service demand.

## Appendices

### Appendix 1: Results of the literature search

	Search History	Results 1980-2015	Results 2016-2017
Search no:	Data bases searched: CINAHL MEDLINE British Nursing Index EMBASE		
1	Emergency Nurse Practitioner	18, 250	
2	Emergency Practitioner	24,213	
3	Advanced Nurse Practitioner	32, 272	
4	Advanced Clinical Practitioner	34,436	
5	Emergency Nurse Practitioner* or Advanced Nurse Practitioner* or Advanced Clinical Practitioner	54,940	4,331
6	Title	691	36
7	education	641,664	51,040
8	Scope of practice	202	34
9	Professional identity	132,290	543
10	5&6	58	3
11	5&7	413	23
12	5&8	165	24
13	5&9	19	2

## Appendix 2: Focus group prompt sheet.

### **Identity crisis within the role of the Nurse Practitioner? A study exploring the issues of autonomy and identity.**

#### Focus Group Schedule:

The participants will be asked to bring to the focus group a selection of photographs that best describe their feeling about professional identity. This will act as an ice-breaker and allow participants to set the agenda for the focus group. Issues from the discussion will emerge and this will form the basis of the discussion.

Prompts for the themes are as follows although this may change subject to initial discussions:

What is professional identity?

How can you define it within your role?

Allegiance issues- medical/nursing/organisation

Conflict within role relating to identity-other nurses/medics/AHP/titles of role.

Autonomy- does identity relate to this?

Knowledge base?-education preparation for role.

Location- does this affect autonomy? Medical input?

## Appendix 3: UWE ethics approval letter.



Faculty of Arts, Creative Industries and  
Education  
Frenchay Campus  
Coldharbour Lane  
Bristol BS16 2QY

Tel: 0117 328 1170

UWE REC REF No: ACE/15/02/20

24<sup>th</sup> March 2015

Dear Sally

**Application title: Identity crisis within the role of the Nurse Practitioner? A study exploring the issues of autonomy and identity**

Your ethics application was considered by the Faculty Research Ethics Committee and, based on the information provided, has been given ethical approval to proceed with the following conditions:

This work, based on exploring the identity of nurse practitioners, presents an opportunity to explore a community of practice under pressure during a constant state of evolution in the NHS. The methodology seems both appropriate and likely to yield interesting results. The blend of case study, focus groups and interviews does not appear to demonstrate ethical issues beyond 'normal' community of practice settings. We would like you address the following conditions in turn. The comments included at the end are suggested changes but are not conditions for approval.

**Condition 1:** information sheets, consent forms etcetera should be on UWE headed notepaper. On the information sheet the contact details for Sally Moyle should be repeated at the end under 'further information'.

**Condition 2:** On both consent forms the word patient is included – I think this is an error and should read "participant".

**Condition 3:** On the focus group consent form it is stated that the data will be anonymised. Given that video will be used the consent form needs to give more detail how the video data will be used and how it will be anonymised. Participants need more detail here so that they know what they are consenting to.

**Condition 4:** On the focus group information sheet it states that either audio or video will be used. It should be specified which media will be used or whether there is a choice for participants (i.e. a tick box).

**Comment 1:** The researcher and supervisor may wish to consider what action might be taken if a 'whistle blowing' scenario were part of an interview or focus group response although I would not anticipate such a disclosure.



**Comment 2:** there are some minor layout or proof reading issues on the consent and 'invitation to participate' letters (e.g. educationalists (plural), placing of tick boxes etc.).

**Comment 3:** The wording on the letter regarding focus groups needs editing – focus groups are mentioned twice in a sentence towards the end.

**Comment 4:** Please can you also send us confirmation that you have been given Trust approval.

If these conditions include providing further information please do not proceed with your research until you have full approval from the committee. You must notify the committee in advance if you wish to make any significant amendments to the original application using the amendment form at <http://www1.uwe.ac.uk/bl/blresearch/researchethics.aspx>.

Please note that any information sheets and consent forms should have the UWE logo. Further guidance is available on the web: <http://www1.uwe.ac.uk/aboutus/departmentsandservices/professionalservices/marketingandcommunications/resources.aspx>

The following standards conditions also apply to all research given ethical approval by a UWE Research Ethics Committee:

1. You must notify the relevant UWE Research Ethics Committee in advance if you wish to make significant amendments to the original application: these include any changes to the study protocol which have an ethical dimension. Please note that any changes approved by an external research ethics committee must also be communicated to the relevant UWE committee.
2. You must notify the University Research Ethics Committee if you terminate your research before completion;
3. You must notify the University Research Ethics Committee if there are any serious events or developments in the research that have an ethical dimension.

Please note: The UREC is required to monitor and audit the ethical conduct of research involving human participants, data and tissue conducted by academic staff, students and researchers. Your project may be selected for audit from the research projects submitted to and approved by the UREC and its committees.

We wish you well with your research.

Yours sincerely



**Matthew Partington**

Chair Faculty of Arts, Creative Industries & Education  
Research Ethics Committee

*c.c Richard Waller*

Appendix 4: Bristol Royal Infirmary R&D approval



Dr Rebecca Hoskins  
Consultant Nurse  
Emergency Care  
Queen's Building  
University Hospitals Bristol NHS Foundation Trust  
Upper Maudlin Street  
Bristol BS2 8HW

Research and Innovation  
University Hospitals Bristol NHS Foundation Trust  
Education & Research Centre Level 3  
Upper Maudlin Street  
Bristol BS2 8AE

Tel: 0117 342 0233  
Fax: 0117 342 0239

[research@uhbristol.nhs.uk](mailto:research@uhbristol.nhs.uk)  
<http://www.uhbristol.nhs.uk/research-innovation>

22/07/2015

NHS Permission for Research has been granted for the study detailed below at University Hospitals Bristol NHS Foundation Trust (UH Bristol). Permission is subject to any conditions and is effective from 22<sup>nd</sup> July 2015 until 31<sup>st</sup> May 2016.

Dear Dr Hoskins

RE: Identity crisis within the role of the Nurse Practitioner? A study exploring the issues of autonomy and identity – UH Bristol R&D No: AN/2015/4923

NHS permission for the above research has been granted on the basis of the application submitted and a favourable opinion from an authorised REC.

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, Good Clinical Practice, and NHS Trust policies and procedures. As Principal Investigator it is your responsibility to ensure you and your team are familiar with relevant research related policies and procedures; these can be found at [http://www.uhbristol.nhs.uk/media/2411190/research\\_policy\\_final\\_v0.8\\_24.02.15.pdf](http://www.uhbristol.nhs.uk/media/2411190/research_policy_final_v0.8_24.02.15.pdf)

It is also a condition of NHS Permission at this site that local recruitment data is uploaded to the EDGE system and the study record is kept up-to-date. Please contact the Research Management Office if you are unsure how to do this.

The following conditions must be met prior to recruitment commencing:

- A site file is set-up and delegation log established.

UH Bristol is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. For further details about monitoring arrangements please contact the Research Management Office. The Research Management Office will monitor recruitment on an on-going basis and can provide support and advice if you are experiencing problems in meeting your targets within the agreed time frame.

.../...

Page 2  
Dr Rebecca Hoskins  
22<sup>nd</sup> July 2015  
AN/2015/4923

The Research Management Office should be notified of any urgent safety measure taken in order to protect research participants against any immediate hazard to their health or safety. This should be within the same time frame as notification to the REC and any other regulatory bodies and should include the reasons why the measures were taken and any plan for further action.

NHS indemnity is provided for the period of permission given above. Requests for changes to the period of permission (e.g. an extension of the study) must be made to the Research Management Office before permission ceases with an explanation as to why the change is being sought.

All amendments (including changes to the local research team) need to be submitted in accordance with regulatory and national requirements which can be found on IRAS. Please note if we are sponsoring this study separate notification of an amendment already authorised by us as sponsor for submission to the regulatory bodies is not required, the sponsor authorisation will cover R&D acknowledgement of the amendment at this trust. The Research Management Office also needs to be notified if there are any changes to the study status.

We wish you every success with this study.

Yours sincerely,



Diana Benton  
Head of Research and Innovation/Deputy Director of Research

Copy to:

Mrs Sally Moyle – Chief Investigator

Professor Jenny Ames – Associate Dean, UWE

**Identity crisis within the role of the Nurse Practitioner? A study exploring the issues of autonomy and identity.**

**Participant Information Leaflet (focus groups)**

We are inviting you to participate in a research study because you are a band 7 Nurse Practitioner working in either a Minor Injury Unit or an Emergency Department. Before you decide whether or not to take part in this study it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Ask us if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.

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

We are conducting focus groups to explore issues around autonomy within current practice and aspects of professional identity.

**Why have I been invited to take part?**

You have been invited to take part because you are a band 7 ENP working in either an Emergency Department in a large NHS Trust or a Minor Injury Unit within a community setting.

**Do I have to take part?**

No, taking part in this focus group is entirely voluntary. If you do not wish to take part then simply tell the researcher that you are not interested.

**If I do take part, what will I be asked to do?**

The focus group will be made up of about 4-6 people. You will be asked to bring to the focus group a selection of photos that you have taken that you feel represents your professional identity. This will be a prompt for the discussion. The researcher will facilitate the focus group. The session will be videotaped in order that the researcher can accurately use the information gained. The tapes will be transcribed by the researcher who has a responsibility to maintain your confidentiality. The focus group will last for no more than 2 hours.

**Expenses and payments**

It is not envisaged that you will incur any expenses as this will take place within your working day.

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

No risks to your health have been identified in you taking part in this study. The main disadvantage to you will be in giving up your time to take part in the focus group.

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

No personal benefits to you have been identified. By taking part in this study you will be contributing to our understanding of a range of issues that may affect job satisfaction, staff retention and will help managers, educationalist and policy makers prepare Emergency Nurse Practitioners for the future.

**Confidentiality- who will know I am taking part in the study?**

We respect your privacy. The video tapes will be kept securely in a locked filing cabinet in a locked office. Only the researcher and the supervision team will have access to them. The tapes will be transcribed by the researcher. Your identity will be anonymised. All the participants will be given a unique code so there is no risk of any personal information being obtained by anyone other than the researcher. After the study is complete, the video tapes will be securely destroyed. No other parties (e.g. your line manager) will be given this information.

**What will happen to the results of the study?**

The results of the study are expected in 2017, and a summary of the study will be published and available for you to read. The results may be reported in professional publications but it will be impossible to identify you personally from these results.

**What if there is a problem?**

If you have a concern about any aspect of this study, you should speak to the researcher (Sally Moyle) who will do their best to answer your questions Tel 0117 3285660 or email [Sally.Moyle@uwe.ac.uk](mailto:Sally.Moyle@uwe.ac.uk) . If you remain unhappy and wish to complain formally you can do this by contacting Dr Richard Waller on 011732 84100

**What will happen to the results of the study?**

The information you give will be kept secure. It will be destroyed after the research study is completed. It is anonymous and you cannot be identified from this information. Once analysed, the overall results of the study will be published in a healthcare journal and be available for healthcare staff and the public to read. It will be impossible to identify you or any other person from the published results.

**Who is organising and funding the research?**

The study is being organised by academic staff from the University of the West of England. The research is being undertaken as part of a Professional Doctorate from the University of the West of England, Bristol.

**Who has reviewed this study?**

The research has been reviewed by the University of the West of England. Approval has also been granted by the relevant Research and Development Centres in the NHS Trusts that participants work in.

**What happens now?**

Please make sure you have read the information provided and understood what is being asked of you. The researcher will be happy to answer any questions you have about the study before you agree to take part. If you are happy to take part, please complete the attached consent form and send back in the SAE. The researcher will be in touch with you to arrange a date and venue. Thank you for taking the time to consider this request.

**Further information**

Should you have any questions about the study please feel free to contact Sally Moyle [Sally.Moyle@uwe.ac.uk](mailto:Sally.Moyle@uwe.ac.uk) who is co-ordinating the study.

Appendix 6: Consent form (focus group)

Identity crisis within the role of the Nurse Practitioner? A study exploring the issues of autonomy and identity.

Participant Identifier

Initial each box

**CONSENT FORM (focus group)**

1) I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2) I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason.

3) I understand that the focus group will be videotaped. I understand that relevant sections of the video tapes may be seen by the research team from the University of the West of England. I give permission for these individuals to have access to this. I understand that in the dissemination of the project my identity will be anonymised.

4) I agree to take part in the focus group and understand that the researcher will contact me regarding arrangements for the focus group.

Name of participant

Date

Signature

Name of researcher

Date

Signature

*When completed; 1 for the participant, 1 for the researcher,*

## Appendix 7: Consent form (interview)

DATE

Dear

**RE: Research Study; Exploring Nurse Practitioners perceptions of Autonomy and professional Identity.**

I am contacting you to invite you to take part in the second phase of the study, which is a semi-structured interview in order to further explore issues around professional identity and autonomy for ENPs.

The aim of this is to advise educationalists, clinical managers and policy makers to ensure they are best able to support and develop Emergency Nurse Practitioners in their role.

The interview would take place at your place of work and will be facilitated by myself. The interview would take no more than one hour. I enclose an information sheet about the interviews and study.

Thank you for considering this request. Please could I ask you to contact me by either:

- emailing me at : [Sally.Moyle@uwe.ac.uk](mailto:Sally.Moyle@uwe.ac.uk)
- or ringing 0117 3285660

Yours sincerely

Sally Moyle  
[Sally.Moyle@uwe.ac.uk](mailto:Sally.Moyle@uwe.ac.uk)

Identity crisis within the role of the Nurse Practitioner?  
 A study exploring the issues of autonomy and identity.

Participant Identifier

Initial each box

**CONSENT FORM (Interview)**

1) I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2) I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason.

3) I understand that the interview will be audiotaped and that my identity will be anonymised. I understand that relevant sections of the audio tapes may be listened to by the research team from the University of the West of England. I give permission for these individuals to have access to this.

4) I agree to take part in the interview and understand that the researcher will contact me regarding arrangements for the interview.

Name of participant                      Date                      Signature

Name of researcher                      Date                      Signature

*When completed; 1 for the participant, 1 for the researcher*



Appendix 8: Fifteen point check list for thematic analysis (Braun and Clarke 2013)

<b>Process</b>	<b>No</b>	<b>Criteria</b>
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all themes have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent and distinctive.
Analysis	7	Data have been analysed, interpreted, made sense of, rather than just paraphrased or described.
	8	Analysis and data match each other-the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well organised story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done- i.e. described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as active in the process: themes do not just 'emerge'

## Appendix 9: Examples of thematic analysis coding

Excerpt from transcript	Code	Sub-theme	Theme
<p>Ok, well I think, if I answer the first part, I have never thought of myself as Doctor and anything like and if anyone, when patients mistakenly call me a Doctor I say, 'please don't insult me', I tell them 'I am a Nurse and my name is xx' and I will always be a Nurse. I think there is quite a strong distinction of the ideas of nursing and our colleagues on the medical side and I think that is a distinction I would always like to keep. I don't think I am just a Nurse, I don't think any of us are just a Nurse are we? I think that role of Practitioner is something I am quite proud of and I think it is quite a thing. The biggest thing in nursing is to take the step from being a Nurse that does what the Doctors says to becoming the Nurse that does what the Doctors does, but I think you are still a Nurse essentially. The clinical skills, these come mostly from</p>	Nurse not a doctor (1)	Role definition	Identity/role
	Distinction between nurse and doctor –we need to keep it. (2)	Role definition	Identity/role
	Not 'just a nurse' more than that, it's quite a thing-proud of it. .big step from doing what the dr tells you to doing what the dr does. (2)	Role definition	Identity/Role
	Experience is the most important thing-not education and qualifications (3)	Knowledge	Education

<p>experience, I think I have been around a while and it is more to do with that than any academic qualifications I have gained, I think they have been very useful but I think most are based on experiences I have had.</p> <p><b>So the knowledge you have acquired, you generally feel you have acquired from experienced practice?</b></p> <p>Yea, Google helps, before we had that, everything had to be looked up in a book and if you didn't have that book you had to look for it and it was difficult to access the right amount of knowledge but having everything at your fingertips, you think 'well I have done this god knows how many times, I can't remember the last time I looked, so I'll check a resource' and so I will look and see what they are saying about it now. Sadly sometimes on a day off I'll think 'wonder if this has changed' and I'll look it up if I have time, so things like that I keep up with on that</p>	<p>Uses the internet a lot to check things/refresh/update. (4)</p>	<p>Knowledge</p>	<p>Education</p>
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<p>anything you know where there is a change in technology or a change in methodology, like you've seen some antibiotics....</p>	<p>Knowledge comes from education (5)</p>	<p>Knowledge</p>	<p>Education</p>
<p><b>Where does the knowledge come from?</b></p> <p>Well it comes from education doesn't it?</p> <p>It comes from experience of having contact with patients and also from what we have seen someone else do, whether that's a Doctor or a Nurse or College or papers, or just talking to another Specialist and that could be a Nurse or a Doctor.</p>	<p>Seeing others do it helps. Contact with patients (6)</p>	<p>Teamwork/knowledge</p>	<p>Education</p>
<p><b>Do you think as a group of Nurse Practitioners we draw our knowledge from a medical model or a nursing humanistic model as those are 2 distinct models that go back to where we come from?</b></p> <p>I think both. I think we use medical standards, national guidance that is learned mostly by</p>	<p>Standards and evidence comes from a medical model but always have the nursing hat on (7)</p>	<p>Knowledge</p>	<p>Education</p>

<p>medics but now also Physio's, Nurses, Specialists, but then you've always got your nursing head on haven't you? Your intuition, 'seen this before and here is something wrong with this kid, there is more than a medical thing going on, there is something going on in the family?'</p>	<p>Intuition is key. (8) Something going on with the family- outside of what they might present with. (9)</p>	<p>Role definition  Knowledge</p>	<p>Identity/Role  Education</p>
<p><b>So you draw on everything you've done as a Nurse to do that?</b></p>	<p>We think about how they will cope at home-drs don't (9)</p>	<p>Role definition/knowledge</p>	<p>Identity/Education</p>
<p>Definitely, although Doctors don't not do that but it is so part of you physic to think how someone copes at home?</p>	<p>Clinical exam is medical model (10)</p>	<p>Knowledge/training</p>	<p>Education</p>
<p>I think the clinical side the examination side particularly is medical based and I think we learn a lot and are always looking back to 'how did the Doctor used to do this when I used to work there'? I think that part....</p>	<p>Use nursing base to supplement the exam-and give advice</p>	<p>Experience/role definition</p>	<p>Identity/The role</p>

<p>Yes but the bit that makes this a different job is almost that holistic attitude where you are dealing with the whole thing not just someone's head, it's 'how do you do this and what is at home?' and 'does he know about a good diet to make it heal well' and not picking at it with dirty fingers and that's probably from our nursing base.</p> <p>And their age and experience of life?</p> <p>Yes.</p>	<p>Holistic attitude (11)</p>	<p>Role definition</p>	<p>Identity/The role</p>
<p><b>Ok, so in terms of the role, what do you call yourselves, what is your title?</b></p>	<p>Nurse in title (12)</p>	<p>title</p>	<p>Identity/The role</p>
<p>I always say Nurse, but my title is Nurse practitioner.</p> <p>Nurse Practitioner.</p>	<p>NP (13)</p>	<p>title</p>	<p>Identity/The role</p>
<p><b>Xx what do you call yourself?</b></p>	<p>Calls self a Nurse (14)</p>	<p>title</p>	<p>Identity/The role</p>

<p>Nurse.</p> <p><b>Ok. Do you get a sense that the title has any bearing on your sense of identity of who you are, or could you be called anything?</b></p> <p>I think it is a bit of each as we all have an idea of our own identity, I would say this, if they Doctor I say Nurse, I rarely tell people I am a Nurse Practitioner, if they ask I would but if I was talking to a colleague...</p> <p>I do as well...</p> <p>If I am talking to a colleague in the profession I tell them I am a Practitioner as they understand what that means if I am talking to a patient I am always a Nurse.</p> <p>I think as well if you start talking about Nurse Practitioning, because it is a new concept to the general public, they think you are a GP's</p>	<p>Use 'practitioner' when talking to other professional but nurse when talking to a patient. (15)</p> <p>Use different title depending on who I talk to.(16)</p> <p>Public don't understand what a nurse practitioner does. (17)</p>	<p>Public perceptions/ other HCP's perceptions</p> <p>Title</p> <p>Public perception</p>	<p>Perceptions</p> <p>Identity/Role</p> <p>Perceptions</p>
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<p>Practice Nurse, as that's what they associate a Practitioner with 'oh, you're like the Practice Nurse in our surgery', and actually we are very different to that and I think it is easier to say 'I am one of the Nurses'. That nursing counts as so much.</p> <p>I feel really passionate about saying Nurse Practitioner, I feel really proud of being a Nurse Practitioner.</p> <p>I agree with you but I am not sure all the general public get the concept.</p> <p>I know that but I feel it is part of my role to educate them and say 'this is a new type of Nurse where we have done things differently and are practicing differently; we do have a different role'. I feel quite passionate about that.</p> <p><b>Yes.</b></p>	<p>Important to educate the public about role. (18)</p> <p>Public don't get the role (17)</p> <p>Part of role to educate public about role(18)</p> <p>Always say NP (13)</p>	<p>Public perception</p> <p>Public perception</p> <p>Public perception</p> <p>Title</p>	<p>Perceptions</p> <p>Perceptions</p> <p>Identity/Role/Perceptions</p> <p>Identity/Role</p>
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<p>I thought, you're part of a forest, on your own.</p> <p><b>Can you just show the camera?</b></p> <p>Xx shows a picture of a forest).</p> <p>Sometimes you just have to swing on your own as even your colleagues are busy, you have to make a decision and from my point of view I am very comfortable with that, I am happy on my own but I know I have a big team, a group of people who help me and that's the forest and others available on the phone and I can call an ambulance if I need to. There is something about Nurse Practitioners being comfortable with risk and being willing to put an end to something and say 'I think this is what's wrong with you today, this is my plan, what do you think?'</p> <p>Yea, I think that's true and there is not a log of ego involved with this so we know the</p>	<p>Even though part of a big team you have to get on with it on your own, make decisions, comfortable with that, have a big team around us (forest) when you need it. (16)</p> <p>Comfortable with risk (16)</p> <p>Comfortable with asking each other for advice-important.</p>	<p>Role definition/teamwork</p> <p>Role definition</p> <p>Teamwork</p>	<p>Identity/Role</p> <p>Identity/Role</p> <p>Identity/Role</p>
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<p>group decisions are strong decisions and if you're not quite sure what to do with a patient, you'll ask. There is never a thought of 'I don't an top ask, I don't want to show myself up, I don't want to share my lack of knowledge or my lack of confidence', that never seems to exists, there is a sense of, we are all in that place, we all need things occasionally and think 'I don't really know what to do with this', so you are never worried about asking your colleagues for help. I think there is a tremendous...</p> <p><b>It's that sense of team ownership and team work?</b></p> <p>Yes and group decisions are strong the more inputs you got on something , the more information you have and the more likely you will make the decision and I think that is like intrinsic to the way we were here, if you worked in true isolation, a much higher job,</p>	<p>Teamwork important(17)</p> <p>Ask for help from colleagues</p> <p>Group decisions can be helpful. (18)</p>	<p>Teamwork</p> <p>Teamwork</p> <p>Teamwork</p>	<p>Identity/Role</p> <p>Identity/Role</p> <p>Identity/role</p> <p>!</p>
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although we don't have Medics, we support each other.	Support each other (19)	Teamwork	identity/role
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Appendix 10: Photograph presented by participant 2: 'the meeting of two minds'



## Appendix 11: Extract from diary after focus group

The participants had brought their photos on their phone and had not printed them out. They had mis-understood the brief and hadn't realised I wanted a paper copy. I need to clarify this for future groups. I will ask them to email me their photos and I can print them off to make it easier for the participants. We managed to get the photos up on the screen but this meant I had to keep moving the video to capture both the photo and the group. Although this was a logistical nightmare, it did help the group relax.

The group seemed nervous and conscious of the camera at the start of the focus group and unsure of the 'rules' of interaction. I had originally planned for each participant to talk about their photo and then discuss the issues after each participant had showed all their photos. However, it soon became apparent that this stilted the flow so by the time participant 2 showed their photos I let the discussion follow the photo. Although this was more challenging for me (logistically and conceptually) it did put the participants at ease and allowed the discussion to flow more freely.

The focus group relaxed as time went on and we broke for coffee and cake and took comfort breaks as required. Participants felt comfortable challenging each other although I could sense some tensions within the group when people didn't all agree.

The discussion came to natural end and we had a debrief. This was helpful to release some of the tension that had developed when participants didn't agree. They laughed at how they were all so forthright and had plenty to say.

Lessons for next time:

Ask for photos to be emailed ahead of time to ease pressure of printing

Be clear with ground rules and that there is no 'right or wrong'

Allow the photos to be discussed in any order at any time to give ownership to participants and allow a more free flowing discussion.

Debrief is important!

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