Reflections on a 'virtual' practice development unit: changing practice through identity development

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Aims. This paper draws together the personal thoughts and critical reflections of key people involved in the establishment of a 'virtual' practice development unit of clinical nurse specialists in the south of England.

Background. This practice development unit is 'virtual' in that it is not constrained by physical or specialty boundaries. It became the first group of Trust-wide clinical nurse specialists to be accredited in the UK as a practice development unit in 2004.

Design and methods. The local university was asked to facilitate the accreditation process via 11 two-hour audio-recorded learning sessions. Critical reflections from practice development unit members, leaders and university staff were written 12 months after successful accreditation, and the framework of their content analysed.

Findings and discussion. Practice development was seen as a way for the clinical nurse specialists to realize their potential for improving patient care by transforming care practice in a collaborative, interprofessional and evolutionary manner. The practice development unit provided a means for these nurses to analyse their role and function within the Trust. Roberts' identity development model for nursing serves as a useful theoretical underpinning for the reflections contained in this paper.

Conclusions. These narratives provide another example of nurses making the effort to shape and contribute to patient care through organizational redesign. This group of

nurses began to realize that the structure of the practice development unit process provided them with the means to analyse their role and function within the organization and, as they reflected on this structure, their behaviour began to change.

Relevance to clinical practice. Evidence from these reflections supports the view that practice development unit participants have secured a positive and professional identity and are, therefore, better able to improve the patient experience.

Key words: advanced practice, clinical specialist, nurses, practice development, reflection, role development

Introduction

This paper draws together the personal thoughts and critical reflections (Graham *et al.* 1998) of key people involved in the establishment of a 'virtual' practice development unit (PDU) of clinical nurse specialists (CNSs) in the south of England. This unit is both unique and virtual in that it is not constrained by physical or speciality boundaries, as most PDUs are. These CNSs have come together to clarify their philosophy and purpose via the PDU accreditation process. Their achievements, successes, difficulties and concerns are presented here in the form of reflective narratives (Graham 2000), along with how Roberts' (2000) identity development model for nursing served as a useful theoretical underpinning on which to reflect. These narratives provide another example of nurses making the effort to shape and contribute to patient care through organizational redesign (Graham 2003), a topic that will be increasingly important in future care.

Although this unit became the first group of Trust-wide CNSs in the UK to be accredited as a PDU in 2004, their journey began well before this. In the absence of clear guidance from regulatory bodies, the CNSs began meeting to try to clarify and define their role and responsibilities. Practice development was seen as a way for them to realise their potential for improving patient care and the PDU provided a means for the CNSs to analyse their role and function within the Trust.

Background

Practice development units are reported to have developed out of dissatisfaction with the capacity of nursing development units to address the multidisciplinary nature of health care (Page *et al.* 1998, Fatchetta *et al.* 2001). Practice development is about improving patient care by transforming care practice in a collaborative, interprofessional, evolutionary manner underpinned by the development and active engagement of practitioners drawing on a wide range of approaches (Garbett & McCormack 2002, Page 2002). However, in the quest for improved patient-centred care, a nursing voice is essential. Unfortunately, there is a sense that nurses harbour feelings of inferiority about themselves and their work (Freshwater 2000) which has led to a lack of voice and, therefore, authority within the healthcare system. Lynaugh and Fagin (1988) suggest that nurses need not feel like this, although, commenting that:

The confluent of paradoxes, problems and characteristics of nursing development can be responded to in two ways. One is to bewail our failures and accept the inability in the face of an historically hostile environment. The other is to wonder at and celebrate the accomplishments of nurses…who persist and achieve in spite of being held back by some of the most powerful forces in our society. (p. 184)

The early work around nursing development units and PDUs (Page *et al.* 1998, Gerrish 2001) suggests that such groups can put the patient at the centre of care and give nurses the voice they need to make a difference. In fact, nursing leaders can assist nurses in finding their voice by helping them understand the dynamics of the workplace (Freshwater 2000). Within this context, the Director of Nursing of a National Health Service Trust in the south of England set forth her vision: that the decentralization of autonomy should be key to the future functioning of the Trust, particularly in relation to the principle of shared governance; that is, providing workers within an organization with mechanisms to influence policy, strategy and service (Maas & Specht 1994, Porter O'Grady 1994). Located in a relatively wealthy and advantaged socio-economic constituency, the Trust comprises one community hospital and one district general hospital housing a range of services on a campus consisting of Victorian and contemporary facilities. By commissioning a virtual PDU made up of CNSs from across the Trust, the Director of Nursing hoped that this group could establish itself as more of a corporate body, willing to take on issues of leadership beyond their speciality and current way of working. The goal was that the CNSs could find their voice, as individuals and for nursing in

general, and thereby contribute to the development of the organization.

Design and methods

The local university (IG and SK) was asked to facilitate the process of PDU accreditation via 11 two-hour audio-recorded learning sessions, including a one-hour focus group. The agreed aim for this study was set as 'what are the main roles and responsibilities of CNSs?'. Ethical approval was granted by the appropriate Local Research Ethics Committee and written informed consent was obtained from the CNSs. Previous findings from this study have been published in this journal (Graham *et al.* 2006). However, what follows are the critical reflections of the PDU leaders (CF and DR) and the professor of nursing development (IG) on the above process, in addition to written reflections from 10 of the 32 PDU members on whether the PDU process had assisted in personal and group development. Written 12 months after successful PDU accreditation, these reflections have been distilled onto A4 charts and the framework of their content has been analysed (Ritchie & Spencer 1994). This has since been re-worked into the current manuscript using the sub-headings of forging an identity, raising awareness and overcoming oppression.

Findings and discussion – reflections on the PDU

Forging an identity through PDU accreditation and working as a team (CF)

In April 2004 we became the first group of Trust-wide CNSs in the UK to be accredited as a PDU. In many ways, this PDU is unique in that it is not constrained by the same physical or speciality boundaries that a nursing (UK) (Chin & McNichol 2000) or clinical (Australia) (Greenwood & Parsons 2002a,b) development unit has with its responsibilities for the admission, care and discharge of patients. Instead, we are made up of a group of nurses and their extended multi-professional teams who have a strong association and relationship through shared roles and a mutual aim – to provide quality, evidence-informed care to people who use services and their carers. As others have put it, we are 'without walls' (Graham *et al.* 2006).

Our journey began some time before we decided to seek accreditation as a PDU. Initially, we started meeting as a group of CNSs to try to clarify and define our roles in the absence of clear guidance from the UK's regulatory body for nursing, midwifery and health visiting at the time, the UKCC. As a group, we completed some work on analysing our

positions within and beyond the organization, defining our CNS role within the Trust and adapting the UKCC's Higher Level of Practice competencies for any such definitions (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, UKCC 2002). Despite limited evidence for the effectiveness of the CNS role in the UK (Notter 1995, NRU 1998, Hobbs & Murray 1999, Jolly *et al.* 1999, Bradley & Lindsay 2004, Forbes *et al.* 2003, Loveman *et al.* 2003), we believed we were making a difference and had a lot to offer but that we lacked support in some aspects of our role. There was a strong feeling that we needed a collective voice and mutual support from peers within the group to meet our developmental needs. As such, we defined potential areas of growth as personal and professional development, service development and developing others to improve patient care. We subsequently decided, by group consensus, to seek accreditation as a PDU and a development plan was written outlining the growth proposed over this period. Themes were taken from the internal and external analyses mentioned above. The plan was influenced by the Trust strategies, *The NHS Plan* (DoH 2000) and *Agenda for Change* (DoH 2004) and by local and national strategies, and its objectives were evidently linked with current Trust and nursing directorate strategies.

As appointed group leader, CF took a transformational approach to promoting and implementing the vision of the group (Johns & Freshwater 2005). However, leading the PDU was like a rollercoaster ride. The ups were the times when people had 'cathartic' moments about what it meant to be part of the PDU, when the whole group came together, when people who would not normally have done so embarked on joint projects, when projects were completed, and just having fun working together. The downs were occasions when few people turned up for steering group meetings, having difficulties getting some projects off the ground, waiting for email responses, trying to meet deadlines, and difficulties in motivating some members of the group to participate.

Not all of the objectives in the development plan were met due to constraints. However, a great deal of work was undertaken and this was demonstrated in the range of projects submitted for accreditation (Rooke & Best 2005). The projects were linked to service, personal and group development and, most importantly, were about providing excellent, improved care to people who use services and their carers.

When CF took over as the chair of the group, it was evident that there were some barriers to the CNSs taking control of their future development as senior nurses within the organization. There was a fear of and blame on external

sources for their failure to move forward. The 'threat' of having to attain higher academic level accreditation and regulatory difficulties with defining and taking forward registration of advanced and/or specialist roles caused a great deal of anxiety and uncertainty. Initially, CF felt it was my responsibility to lead the group and its members to an understanding of how they could have more control over their own destiny. An important piece of work was the development of our own competency framework; this acted as a powerful tool in both stating implicitly what a CNS does and in raising confidence in the group members to take responsibility for controlling how their role was defined. As illustrated in the following statement by DR, a much greater sense of identity and professional responsibility has been inspired by the PDU process:

It was a good learning experience to work with CF and to appreciate our different styles of working, which in fact were complementary. It was also refreshing to work with other CNSs that I would not usually have worked within my daily practice. One of the main reasons for my involvement with the group was to help me to refocus on my professional identity. Having worked in the community setting for a number of years, with many different teams in both health and social care, and with the associated blurring of roles, it was sometimes difficult to remember my nursing roots. By becoming a member of the group I have redefined my role as a CNS and very much feel part of a wider nursing network within the Trust.

When an opportunity arose in the Trust for clinical teams to apply for PDU funding, CF saw it as a vehicle for further developing the group. The acceptance of the group onto the programme and the subsequent offer of extra support from IG in our development were well received by the group. Action learning sets and focus groups helped give the group a vision for where and how the CNS role would be embedded in the organization of the future. Undoubtedly, the group's profile within the Trust has been raised by achieving PDU accreditation but the challenge for the future is to demonstrate our worth both clinically and economically to the wider audience (Turner-Shaw & Bosanquet 1993, Gerrish 2001).

From CF's perspective, she was able to develop her leadership skills, gain a greater understanding of the 'bigger picture', work with other speciality teams on projects that have had an impact across the Trust and has gained enormous pride in this group of extraordinary people. CF considers herself fortunate to have worked with DR as her deputy because we have great complementary skills, and the model of succession planning should ensure the group is able to maintain a high level of leadership into the future.

Raising awareness and planning for the future (DR)

When we started our journey, one of our aims was to raise the CNS profile within the Trust – this was certainly achieved by gaining accreditation. What we did not anticipate was the amount of interest this would generate. The challenge now is to maintain this profile at both local and national levels. The first CNS PDU annual report in April 2005 reflects the range of publicizing activities we undertook and demonstrates that members of the PDU continue to lead and develop practice (Rooke & Best 2005).

After successful accreditation, some of the PDU members (10 of 32 CNSs) provided written reflections on whether the PDU process had assisted in personal and group development. Answers were unequivocally positive in both areas. The common theme linking personal and group development was being able 'to see more clearly'. In terms of group development, this meant being more aware of individuals' roles within the organization. The common goal of accreditation 'brought us together and communication between us has improved'. This made the group more cohesive and more of 'a team'. At a personal level, 'it has enabled me more clearly to see what I do well and what I could improve on'; 'I feel much more politically aware and am better at seeing the bigger picture'.

However, one of the main difficulties resulting from these developments is that those on the fringes of the PDU activity were now even more distant. This may have an effect on the future of the group. We also realised from the literature the damage that poor succession planning could do to the PDU's effectiveness (Page *et al.* 1998, Redfern & Stevens 1998). Therefore, when CF moved to another job within the Trust, it was beneficial that she was able to continue as leader until we achieved accreditation, from which point DR took over. A period of adjustment followed with the establishment of a new leadership structure. Before her departure, CF had recommended a division of leadership responsibilities with the aim of spreading the workload across a number of PDU members: a chair person, a deputy chair, a PDU lead and a deputy PDU lead. The new chair and deputy chair of the CNS group were recruited early on but, owing to the PDU workload, the deputy chair moved position and became the deputy PDU lead. It then took several months to recruit a deputy chair.

The problem is that members seem unwilling to put themselves forward and take on leadership roles, despite encouragement and gentle persuasion. Members of the core group who have been actively involved for a number of years have led the group's development to date. They now feel it is time for those CNSs who joined the group more recently to

volunteer for leadership positions. It is unclear how this problem will be resolved but it is likely to remain a constant challenge.

DR will soon be handing over to the deputy chair following submission of the second CNS PDU annual report. In this instance, our succession planning has been successful! DR has gained much valuable experience from the PDU journey and has enjoyed the challenge of leading a group of senior nurses and the recognition it has given her. Personal development opportunities have been endless, not least for her leadership skills. The best example of this lies in her trying to remain positive about the PDU even when some colleagues appear negative or unmotivated. This negativity may be associated with a lack of understanding of the PDU process or simply a feeling of being overwhelmed by the work that needs to be done in addition to managing the day-to-day patient caseload. By remaining positive, keeping the momentum going and maintaining good communication, she believes that her leadership is more likely to be effective. However, despite the difficulties of maintaining this momentum and vision amidst challenging patient caseloads, there is much evidence to demonstrate the continued development of the PDU. DR's hope is that there are enough committed CNSs to take on the challenges of leading the PDU through re-accreditation and beyond so that the hard work to date is not lost.

Overcoming oppression and developing an identity (IG)

In many respects, IG's reflections focus on the notion of oppression. Oppressed group behaviours were first described with regard to the colonization of Africa and Native America. Freire (1971) developed a model of oppressed group behaviour and instruction for liberation which was based on his work with Brazilians, Indians and Africans who had been dominated by the Portuguese. He explained that the circle of oppression is a learned belief by dominated people that pinpoints how they are inferior. Although this belief is not accurate, it occurs because the dominant group creates norms and values for the culture in its own image and the dominant group initially has the power to enforce it.

Because of a lack of power and control in the workplace and because health care has primarily occurred in the hospital, nurses have been viewed as an oppressed group (see Roberts 1983, 1996, 1997, 2000). Sociologists have traced the beginning of this domination or colonization of nursing to the early 1900s when medicine became the dominant force and the care of the sick became institutionalized. Other authors have documented nursing's lack of control and autonomy in hospitals and argue that hospital administrators and physicians have benefited from this exploitation of nurses (Ashley 1979, Lovell 1981).

Allan and Hall (1988) explain that the values of nursing are rarely recognizable in patient care because the values of medicine and the medical model have been accepted as the norm. Nursing identity has been subsumed under medicine which claims that all health care is its own legitimate domain; defining nursing within this domain is therefore systematic of its marginality. Medicine controls the healthcare environment and so controls nursing; nursing is constantly compared with medicine and made to feel inferior (Allan & Hall 1988).

Characteristics of oppressed groups have frequently been found in nurses, such as a lack of self-esteem. In his seminal work observing communications between physicians and nurses, Stein (1967) described nurses making recommendations to physicians but doing so in a way that made the physicians think it was their idea. Such a submissive attitude may no longer be needed and yet it continues as a learned response. Chandler (1995) observed that nurses lacked a public voice but describes their importance to patient care as silent. DeMarco (2002) found that nurses silenced themselves as a strategy to avoid conflict and to maintain the status quo within the hospital. Glass (1998) found that nurses traditionally thought that being a good nurse meant not challenging the system. In his most recent study, Valentine (2001) found that avoiding and compromising were the most common conflict management strategies used by nurses. This style of communication is part of the cycle of oppression because it discourages dissent and positive expressions about nursing.

It has also been noted that nursing leaders or managers have not been particularly helpful in changing the status quo. Nurse leaders and managers need to possess extraordinary insight, ability and skill to empower their staff while remaining loyal to the agenda of administration and medicine. Therefore, as IG looks at the work of this group of CNSs and at what they have done in their development as an accredited PDU, it is clear that they have understood who they are and what they are to develop the type of service and identity they think is important for patient care within the overall organization.

In their annual report, the PDU quote the Deputy Chief Nursing Officer for England who commented on what they had achieved, not just within the Trust and locally but nationally. The group only then began to appreciate the importance of their achievement on a national scale. Therefore, the model of identity development for nursing (Roberts 2000) serves as a useful theoretical underpinning on which to reflect on the achievement of this PDU.

The first part of the model that Roberts cites is an examined acceptance; which encompasses acceptance of the roles of nurses, their questions of belief in the power structure, their belief that physicians and administration should control the system, and their internalized negative view of nursing. In the reflective work we did together during several learning sets and discussion groups (Graham *et al.* 2006) prior to accreditation, IG would argue that this group of CNSs began to understand the nature of the work that they did and the importance of their work in achieving patient care: how they needed to develop partnerships and alliances, build an agenda, understand on a macro level how health policy was being implemented, and understand how that translated on a micro level so that they could put forward their views from a rational and logical perspective.

The second element of the model is awareness building. Through the learning sets, the group began to realize a sense of injustice about how they felt they were marginalized. Although the Director of Nursing had encouraged them to understand the processes of the Trust, how things were tabled and debated at board level, and what important processes needed to be understood or undertaken, she thought they had been somewhat naïve, as highlighted in our previously published report (Graham & Keen 2004). The group began to appreciate that it was not a fair world and that they needed to negotiate to gain the resources they needed for their work. Others also began to see the importance of their efforts and to put aside any feelings of disgruntlement and annoyance. The CNSs had an over-riding sense of being wronged or victimized and they now needed to work within the wider nursing group to gain support for the position of nursing. This meant thinking about student nurses, succession training and the role of staff nurses and where they fitted into the plan of CNS service development.

The third element of the model is connection – affiliation with nursing groups and depending on the support of other nurses for new ideas affirms the positive identity of a nurse. What does revisiting the nature of nursing and the purpose of nursing, and understanding the issues around CNSs who were part (and not part) of this development mean? What relationship did they have with ward systems and the consultant nurses within the Trust? How did they build a collegiate system of nursing? Where did they fit with the Director of Nursing and her staff? Were they naturally allied to the physicians with whom they worked closely or were they more closely allied to other groups? Understanding the connections between them and the wider elements of the Trust and Primary Care Trusts was an important aspect for the CNSs to think through and understand. It was about them coming to terms with themselves and their roles and behaviour. It was about how they developed business and development plans and presented themselves in such a professional manner as to overcome their oppression.

The fourth aspect of the model is synthesis – in other words, to internalize new positive views of nursing, evaluate others on an individual basis, increase interdisciplinary involvement, develop a strategically arrived at solution to an approachable problem, and understand that nurses are different but equal. IG believes the CNSs began to think through all these issues. They developed a more positive view of nursing and its purpose and role, and that purpose and role is very much linked to the needs of clients and their families. They evaluated others on an individual basis and found that an interdisciplinary approach was very much in the interest of the client group they served. They developed themselves much more powerfully in terms of their strategic thinking and looking at their future projects. At events subsequent to PDU accreditation, they seemed to be taking the strategic view that Roberts calls for.

The last element of the model is political action – that there is a commitment to change, to being actively involved and to having a broad scope of activities to further social justice. Nursing, the CNSs would argue, is about social justice. The purpose of the PDU is about continuous change, continuous quality improvement and looking for something to achieve social justice. The PDU is about the socialization and individual behaviour of the nurses who formed the PDU, not just perhaps as nurses but as individuals. The CNSs were the products of a system that often devalued and oppressed them, but by coming together to form the PDU they began to understand the power of a group and how a group with a shared value, philosophy and belief can have a significant impact on shaping and contributing to the healthcare system.

Conclusions

By the Director of Nursing commissioning this virtual PDU made up of CNSs, her desire was for them to find their voice, as individuals and for nursing in general, thereby contributing to the development of the organization. In reviewing the literature on PDUs, nursing development units' and clinical development units' (Gerrish 2000, Greenwood 2000, Gerrish 2001, Greenwood & Parsons 2002a,b, Graham 2003, Graham *et al.* 2006) certain characteristics (i.e. low self-esteem, inter-group conflict, poor communication and lack of group pride and cohesion) are often evident during the beginning phase of PDU accreditation. As IG's narrative shows, these characteristics relate in part to the oppression of nurses in general. The PDU process, however, helps

individuals gain the opposite characteristics, thereby helping them to reach their optimal potential. The evidence from all three reflections contained in this paper supports this view in that the participants on this PDU journey have secured a positive personal and professional identity and are therefore better able to improve the patient experience.

The quest for an identity often involves self-respect, political power and economic status. The focus of this PDU has been on enhancing the considerable impact that nurses have on the system already. The work of Glass (1998) identified that nurses' survival is often dependent on sharing their views with other nurses. Glass found that, once nurses had recognized the value of their own voice and could then effectively listen to and value each other in their own right, change occurred – she found that once nurses felt safe to speak, they experienced some degree of power.

The five aspects of Roberts' (2000) identity model for nursing provide a useful theoretical underpinning to reflect on the achievement of this PDU. The PDU members began to understand who they were by defining their role and what they needed to be to develop the type of service and identity they thought important for patient care (examined acceptance). This included the development of partnerships and alliances (connection) to connect with wider elements of the Trust, once they had built a strategic agenda (synthesis). The group had become increasingly aware (awareness building) that they needed to negotiate within these partnerships and alliances to gain the resources needed to fulfil their strategy. These negotiations were of a political nature (political action) (Graham *et al.* 2006). As CF and DR note in their narratives, a much greater sense of identity and professional responsibility was the result.

In the midst of growing complexity and uncertainty, the PDU process offered an opportunity for reflection, support, insight and connection. This helped the group change the cycle that kept them feeling powerless by finally achieving PDU status; yet not without cost. There have been two unintended consequences from these developments. Firstly, some PDU members have clearly been left behind – those on the fringes are now even more distant. Secondly, and confirmed by the literature (Page *et al.* 1998, Redfern & Stevens 1998), leadership plays a crucial role in the effectiveness of PDUs. As DR notes, members seem unwilling to put themselves forward and take on leadership roles, despite encouragement and persuasion.

Nevertheless, what is most apparent is the realization that nurses can be visible and make a difference within their organization. These narratives provide another example of nurses making the effort to shape and contribute to patient

care through organizational redesign. These CNSs, it could be said, began to take responsibility for their own behaviour and so take the lead in changing the system.

It can be argued that change must involve both the person and the system because environmental conditions are so intertwined with the individuals. West (1993) states that first we must acknowledge that structure and behaviour are inseparable; that institutions and values go hand in glove. How people act and how their lives are shaped is often dictated or determined by the larger circumstances in which they find themselves. This group began to realize that the structure of the PDU process provided them with the means to analyse their role and function within the organization and, as they reflected on this structure, their behaviour began to change.

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Contributions

Study design: IG, CF, DR; data analysis: SK, CF, DR, IG; manuscript preparation: CF, IG, DR, SK.

References

Allan J & Hall B (1988) Challenging the focus on technology: a critique of the medical model in a changing health care system. *Advances in Nursing Science* **71**, 1542–1547.

Ashley J (1979) *Hospitals, Paternalism and the Role of the Nurse*. Teachers College Press, New York.

Bradley P & Lindsay B (2004) Specialist epilepsy nurses for treating epilepsy (Cochrane Review). In *The Cochrane Library 1*. John Wiley & Sons, Chichester.

Chandler G (1995) Taking the private voice public – sharing nursing knowledge. *Revolution* **5**, 80–83.

Chin H & McNichol E (2000) Practice development credentialing in the United Kingdom — A unique framework for providing excellence, accountability and quality in nursing and healthcare. Available at: http://www.nursingworld.org/ojin/topic12/tpc12_5.htm (accessed 25 April 2007).

DeMarco R (2002) Two theories/a sharper lens: the staff nurse voice in the workplace. *Journal of Advanced Nursing* **38**, 549–556.

DoH (2004) *Agenda for Change: Final Agreement*. Department of Health, Leeds.

DoH (2000) *The NHS Plan: A Plan for Investment, a Plan for Reform*. Her Majesty's Stationary Office, London.

Fatchetta A, Dorsman J & Kitching N (2001) Reflections on an NDU. *Primary Health Care* 11, 19–20.

Forbes A, While A, Dyson L, Grocott T & Griffiths P (2003) Impact of clinical nurse specialists in multiple sclerosis – synthesis of the evidence. *Journal of Advanced Nursing* 42, 442–462.

Freire P (1971) *Pedagogy of the Oppressed*. Herder & Herder, New York.

Freshwater D (2000) Crosscurrents: against cultural narration in nursing. *Journal of Advanced Nursing* 32, 481–484.

Garbett R & McCormack B (2002) Focus: a concept analysis of practice development. *NT Research* 7, 87–100.

Gerrish K (2000) Nursing development units: factors influencing their progress. *British Journal of Nursing* 9, 626–630.

Gerrish K (2001) A pluralistic evaluation of nursing/practice development units. *Journal of Clinical Nursing* 10, 109–118.

Glass N (1998) Becoming de-silenced and reclaiming voice: women nurses speak out. In *Nursing Matters: Critical Sociological Perspective* (Kelener H & McNerney F eds). Churchill Livingstone, Australia, pp. 121–138.

Graham I (2000) Reflective practice and its role in mental health nurses' practice development: a year long study. *Journal of Psychiatric Mental Health Nursing* 7, 109–117.

Graham I (2003) Leading the development of nursing within a nursing development unit: the perspectives of leadership by the team leader and a professor of nursing. *International Journal of Nursing Practice* 9, 213–222.

Graham I & Keen S (2004) *Identifying Specialist Practice as Part of Practice Development Unit Development*. Bournemouth University, Bournemouth.

Graham I, Waight S & Scammell J (1998) Using structured reflection to improve nursing practice. *Nursing Times* 94, 56–59.

Graham I, Fielding C, Rooke D & Keen S (2006) Practice development 'without walls' and the quandary of corporate practice. *Journal of Clinical Nursing* 15, 980–988.

Greenwood J (2000) Clinical development units (nursing): issues surrounding their establishment and survival. *International Journal of Nursing Practice* 6, 338–344.

Greenwood J & Parsons M (2002a) The evaluation of a clinical development unit leadership preparation program by focus group interviews. Part 1. Positive aspects. *Nurse Education Today* 22, 527–533.

Greenwood J & Parsons M (2002b) The evaluation of a clinical development unit leadership preparation program by focus group interviews. Part 2. Negative aspects. *Nurse Education Today* 22, 534–541.

Hobbs R & Murray ET (1999) Specialist liaison nurses: evidence for their effectiveness is limited. *British Medical Journal* 318, 683–684.

Johns C & Freshwater D (2005) *Transforming Nursing Through Reflective Practice*, 2nd edn. Blackwell Publishing, Oxford.

Jolly K, Bradley F, Sharp S, Smith H, Thompson S, Kinmonth A-L, Mant D for the SHIP Collaborative Group (1999) Randomised controlled trial of follow-up care in general practice of patients with myocardial infarction and angina: results of the Southampton heart integrated care project (SHIP). *British Medical Journal* 318, 706–711.

Lovell M (1981) Silent but perfect partners: 'medicines' use and abuse of women. *Advances in Nursing Science* 3, 25–40.

Loveman E, Royle P & Waugh N (2003) Specialist nurses in diabetes mellitus (Cochrane Review). In *The Cochrane Library 3*. John Wiley & Sons, Chichester.

Lynaugh J & Fagin C (1988) Nursing comes of age. *Image* 20, 184–189.

Maas M & Specht JP (1994) Shared governance in nursing: What is shared, who governs and who benefits. In *Current Issues in Nursing*, Chapter 55 (McCloskey JM & Grace HK eds). CV Mosby Publications, St Louis, MO. pp. 398–406.

Notter J (1995) Marketing specialist practice to managers and purchasers. *British Journal of Nursing* 4, 1330–1334.

NRU (Nursing Research Unit) (1998) *A Survey of Specialist and Advanced Nursing Practice in the United Kingdom*. University of Central England, Birmingham.

Page S (2002) The role of practice development in modernising the NHS. *Nursing Times* 98, 34–36.

Page S, Allsopp D & Casley S (eds) (1998) *The Practice Development Unit. An Experiment in Multidisciplinary Innovation*. Whurr, London.

Porter O'Grady T (1994) Whole systems shared governance: creating the seamless organisation. *Nursing Economics* 12, 187–195.

Redfern S & Stevens W (1998) Nursing development units: their structure and orientation. *Journal of Clinical Nursing* 7, 218–226.

Ritchie J & Spencer L (1994) Qualitative data analysis for applied policy research. In *Analysing Qualitative Data* (Bryman A & Burgess RG eds) Routledge, London, pp. 173–194.

Roberts SJ (1983) Oppressed group behavior: implications for nursing. *Advances in Nursing Science* 5, 21–30.

Roberts SJ (1996) Breaking the cycle of oppression: lessons for nurse practitioners. *Journal of the American Academy of Nurse Practitioners* 8, 209–214.

Roberts SJ (1997) Nurse executives in the 1990s: empowered or oppressed? *Nursing Administration Quarterly* 22, 64–71.

Roberts SJ (2000) Development of a positive professional identity – liberating oneself from the oppressor within. *Advances in Nurse Science* 22, 71–82.

Rooke D & Best C (2005) *Winchester and Eastleigh Healthcare NHS Trust (WEHT) Clinical Nurse Specialist Practice Development Unit 1st Annual Report*. WEHT, Winchester.

Stein L (1967) The nurse–doctor game. *Archives of General Psychiatry* 16, 699–703.

Turner-Shaw J & Bosanquet N (1993) *Nursing Development Units. A Way to Develop Nurses and Nursing*. King's Fund, London.

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

Valentine PEB (2001) A gender perspective on conflict management strategies of nurses. *Journal of Nursing Scholarship* 33, 69–74.

West C (1993) *Race Matters*. Beacon Press, Boston.