Identifying Specialist Practice as part of Practice Development Unit Development

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Glossary

CDU:	Clinical Development Unit
ENB:	English National Board for Nursing, Midwifery & Health Visiting
NDU:	Nursing Development Unit
NMC:	Nursing & Midwifery Council
PDU:	Practice Development Unit
PQ1:	Post-Qualifying Level One
PQ2:	Post-Qualifying Level Two
WEHT:	Winchester & Eastleigh Hospital Trust

Executive Summary

Introduction

The number of CNSs (clinical nurse specialists) appears to be on the increase, yet there is no national agreement on the capabilities required for such roles. Cogent evidence for their effectiveness is sparse. This is the current context for a group of Trust-wide CNSs seeking accreditation as a PDU (Practice Development Unit) within WEHT (Winchester and Eastleigh Healthcare Trust). This report synthesises data from 11 focus groups held with PDU CNSs; and literature findings relating to the CNS role.

Setting the scene

In-depth literature searching took place in July 2002 and August 2003. PDUs are reported to have developed from an NDU (Nursing Development Unit) model. What research there is focuses on NDUs rather than PDUs or CDUs (Clinical Development Units), and is predominantly qualitative owing to its complex nature. The full potential of these development units is yet to be realised, although there is evidence to suggest that units are successful in improving patient and staff satisfaction and nursing practice. There are no known examples in the literature of 'virtual' PDUs comprised of a Trust-wide group of senior nurses. PDUs must demonstrate their worth if they are to survive. Work by Page et al. (1998) and Cattini and Knowles (1999) demonstrates the importance of the relationship between PDUs and their host organisations. Current understanding about the role of the specialist practitioner and the nature of specialist practice within the UK is in need of clarification. It is expected that the NMC will initiate consultation on specialist roles during 2004. Evidence of CNS effectiveness in the UK is limited, and better quality evaluation is needed.

Research process

To facilitate PDU accreditation 11, two-hour learning sessions, following a co-operative learning style (Kagan, 1992) were arranged with IG between April 2002 and March 2003. The first part of the sessions focused on a subject relevant to PDU development. Appropriate general discussion was audio tape-recorded. The second part of the sessions was an audio tape-recorded focus group that looked at the roles and responsibilities of CNSs (see Appendix 1). Each recording was transcribed and studied at least three times to ensure transcription accuracy and produce detailed charts. The framework of their content was then analysed (Richie & Spencer, 1994). Preliminary analyses were carried out on the first four focus groups, and findings fed back to CNSs in both written (Keen, 2002) and verbal form (18th October 2002 – see Appendix 2).

Findings and discussion

A total of 16 CNSs attended the 11 sessions. Their titles covered wide-ranging areas. All had spent an average of six years at WEHT. Just under a third held undergraduate degrees. CNS posts had arisen in an organic manner and mainly due to medical consultant need. Consequently, no two posts or CNS career pathways were the same. Nevertheless, CNS descriptions of their work could be categorised into three key (linked) roles – those of care giver, information giver and change initiator. Seven statements give meaning to CNS practice at WEHT: advanced communication skills, changing practice, expert, information giver, leadership, patient advocate and quality care. Qualitative and quantitative studies from the literature review show good levels of congruence with these findings. Political or corporate practice is the missing element from these studies. There is concern over the amount of time CNSs at WEHT spend on administrative tasks.

The CNS relationship with the PDU may be classified into two overarching themes: PDU process and vision for the future. CNSs believed they developed individually and as a group as a result of the PDU submission process. They were much more cohesive and more able to look beyond their service to improve practice. Working as a virtual PDU, that is, not based on a ward or as part of a medical speciality, provided logistical challenges. The importance of unit leaders is highlighted by a number of good quality studies. It is unclear whether members of the PDU understand the causal link between unit leadership and success, and if so, how they will protect and nurture it (Graham, 2003). Three project areas – succession planning, nurse-led clinics and documentation – have been chosen to start the PDU rolling. Main barriers to PDU success were limited budgets, medical consultants and other nurses. CNSs demonstrated limited comprehension that, as a corporate body, a PDU could design business plans to reduce potential barriers.

At present, CNSs do not view themselves as part of the corporate agenda – yet this is their vision. Their relationship with the Trust is characterised by dichotomy and frustration. Agendas do not match and neither do perceptions of value. The literature demonstrates that the most important factor related to an NDUs stability is the relationship with its host organisation. The relationship at WEHT needs attention if the PDU is to continue thriving.

Implications

The main findings of this report are timely. The NMC is about to consult on competencies for specialist practice. The NHS needs to develop a nursing career structure that reflects discrete roles, levels of practice and autonomy based on relevant programmes of preparation (Daly &

Carnwell, 2003). To this end, we advocate a two-stage post-qualifying (PQ) curriculum for CNSs at WEHT: PQ1 and PQ2. PQ1 would be pitched at level H – the academic equivalent of an undergraduate's final year – designed for novice CNSs or those about to become a CNS. PQ2 would be aimed at Masters level for more experienced CNSs wishing to develop their potential and/or move onto more senior and advanced nursing roles.

The syllabus would include a focus on leadership, corporate and political roles, business planning, negotiating agendas and so on (see page 36). This proposed type of professional development is not about clinical practice but political acumen and professional business management. A more central corporate leadership role coupled with a relevant preparation programme will enable CNSs and the PDU to address the fact that their full potential is yet to be realised.

Implicit in the PQ framework and emphasis on political/corporate practice is the need for a stronger relationship and increased understanding between the Nursing Directorate(s) (and others) and CNSs/PDU. How committed is the Trust to empowering this group of nurses to change healthcare practice and services? CNS/PDU potential to do so is immense.

Introduction

The number of clinical nurse specialists (CNSs) appears to be on the increase in response to reductions in junior doctors' hours, recruitment and retention problems, National Service Frameworks, Government targets for health outcomes and patient demand (Daly & Carnwell, 2003). However, there is no national agreement on the competencies or capabilities required for such roles. While the role is often introduced to improve service, evidence for its subsequent effectiveness is sparse. This is the current context for a group of Trust-wide CNSs seeking accreditation as a Practice Development Unit (PDU) within WEHT (Winchester and Eastleigh Healthcare Trust). This report synthesises data from 11 focus groups held with PDU CNSs and literature review findings relating to CNS roles to answer the overarching research question: 'what is the role of the clinical nurse specialist?'

Background

Context of Change

The Trust, just like all NHS providers, is facing major change due to policy development in health care. Change, on a par with the implementation of the NHS in 1948, is facing every NHS and associated organisation. In order to negotiate this change and achieve the quest of NHS reform i.e. patient-centred care and patient choice (Institute of Medicine, 2001; Kendall & Lissauer, 2003), leadership and strategic thinking need to be in place.

That leadership was in the form of the Nurse Director who decided to use the principle of shared governance (Porter O'Grady, 1994) as the motivator for change and improvement. Shared governance provides workers within an organisation with the mechanism to influence policy and strategy. It is a means of giving voice to workers at the coal-face of delivery by providing a structured and systematic process of intra-organisational communication (Maas & Specht, 1994).

The Trust vision is to bring about a decentralised system of governance that encourages autonomy. Organisational commitment to this was to be realised through the adaptation of various activities. They key activity was to be that of education and development. All workers within the Trust would be offered the opportunity to participate in various work-based co-operative learning projects steered by Bournemouth University and the Trust, through the position of a lecturer practitioner and senior lecturer in nursing leadership and health improvement. These individuals, in tandem with other University personnel, would provide various learning opportunities. These opportunities would allow role change and service re-engineering to take place.

Support was given to matron and nurse consultant posts, as well as reviewing the role of ward sister/charge nurse, senior nurse manager and the CNS. What was being sought was a shared responsibility approach by the nurse executive and her colleagues. Change and improvement is everybody's business and the role of the Trust was to set the vision and provide the support in terms of infrastructure and money to bring about change. Practice Development Unit accreditation was seen as a means of achieving change, enhancing job and role satisfaction and ensuring patient care was supported by educational and research initiatives.

The CNS group and the CNS role itself was well recognised within the Trust. However, the Nursing Directorate hoped that the CNS group could establish itself as a more corporate body within the Trust, and that its members would be willing to take on issues of leadership beyond their speciality and current way of working. While it was suggested that they were bringing about change and improvement within their individual services, this was not disseminated to the rest of the Trust, particularly at a corporate level – any changes and/or improvements were mostly unknown and unacknowledged.

The Nursing Directorate was seeking an integrated model of change and development and wanted the CNSs to define their role, not only at an individual level but at a team and corporate level as well. The CNSs themselves were aware that the Trust wanted them to look at their role and critically examine its effectiveness. Therefore, with the support of the Nursing Directorate, they started to look at how they could play a key part in the Trust's vision for the future. Taking the PDU accreditation route was seen as a way of doing this.

Literature Search

The central aim of the literature search was to identify the most cogent research around the role of the clinical nurse specialist. Particular emphasis was placed on UK, Scandinavian, Australian and US-based studies, and those using practice, nurse or clinical development units as their context. Literature searching took place in two stages: between 18th-25th July 2002 (Keen, 2002) and 19th-20th August 2003. The following databases were searched: MEDLINE (1985-2003), British Medical Journal (1994-2003), British Nursing Index (1985-2003), RCN journals, ISI Web of Science (1981-2003), Psychinfo (1984-2003), International Bibliography of the Social Sciences (1980-200), National Research Register, Ingenta (1988-2003), Cochrane and ABI Inform (1986-2003). Hand searching was not necessary as these databases cover major journals such as *Clinical Nurse Specialist, British Journal of Nursing, Journal of Advanced Nursing* and so on.

A combination of different search terms were used within these databases, for example, clinical nurse specialists, nurses in advanced practice, nurse-clinicians, nurse-consultants, nurse-practitioners and advanced practice nurses. Search strategies produced reference lists of manageable length with three exceptions; British Nursing Index, MEDLINE and ISI Web of Science databases produced in excess of 14,000 hits. These results were combined with other key terms such as Australia, review article, practice development unit, autonomy and/or role. Abstracts and titles of all hits were then searched through to acquire the most relevant articles relating to the overarching aim. National Research Register project leaders were followed up by telephone to obtain relevant 'grey' reports. Copies of articles were also (gratefully) gleaned from a CNS's personal library file. Secondary analysis of approximately 300 publications (see references and bibliography) forms the foundation of what follows.

PDU Context

The PDU at WEHT is preparing its submission for accreditation. It must provide information on the unit, the service it provides and reasons for seeking accreditation. The submission must demonstrate clear philosophy and vision, and clear leadership, staff development and partnership structure; alongside showing how a spirit of enquiry and the use of critically appraised evidence will be developed. How the PDU is supported, resourced and integrated into a strategic plan for practice development will also be assessed. Members of the unit have attended a

'Taming the Dinosaur' induction programme covering these and other elements of submission documents (IHCS, 2002b). Although the PDU will be assessed according to the same criteria as other practice and nursing development units (NDU), this PDU differs from nearly all others by the nature of its 'virtual' status. In other words, it has not been established around a base consisting of a number of wards within the same speciality, but is made up of a Trust-wide collection of clinical nurse specialists. The implications of this are explored later in this report.

There is wide agreement in the literature that the PDU concept stems from an NDU pioneered by Pearson at Burford Community Hospital near Oxford (IHCS, 2002a). Within this unit, nurses became responsible for the admission, care and discharge of patients, calling on doctors when necessary (Chin & McNichol, 2000). At base level, NDUs promote excellence in nursing, midwifery and health visiting by being a laboratory and powerhouse for clinical practice development (Christian & Norman, 1998). The NDU model was promoted by the Department of Health and the King's Fund in 1991 with short-term funding (see Gerrish (1999) or Atsalos & Greenwood (2001) for a history of NDUs). The universities of Leeds and Bournemouth recognised a lack of sustainability with the above short-term central funding model, and developed a complementary accreditation scheme (Gerrish, 1999).

The PDU is reported to have developed out of dissatisfaction with the capacity of the NDU to address the multidisciplinary nature of health care (Fatchetta et al., 2001; Page et al., 1998). In other words, practice development is the responsibility of the multidisciplinary team, and therefore does not confine itself to a uni-disciplinary focus (IHCS, 2002a; 2002b; Page et al., 1998). Garbett and McCormack (2002) provide a useful concept analysis of practice development, which is said to have the following attributes: it centres on improving patient care through the transformation of care practice and culture 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).

This is not to say that a PDU model is better than an NDU one; local circumstances dictate choice. What research there is focuses on NDUs rather than PDUs and Clinical Development Units (for CDU research see: Greenwood (2000a; 2000b); Greenwood & Gray (1998); Greenwood & Parsons (2002a; 2002b); Happell & Martin (2002)). Authors tend to focus either on leadership (Atsalos & Greenwood, 2001; Bowles & Bowles, 2000; Christian & Norman, 1998; Flint & Wright, 2001; Graham, 2003; Redfern & Stevens, 1998) or on reporting their own groups (Bates, 2000; Kirkby, 2000; Mischenko, 2002; Wright, 2001).

PDU Research

Although there is no known research describing or assessing the work of a 'virtual' PDU, research by Page et al. (1998) and Gerrish (1999; 2001) appears useful for understanding how a PDU works. Seacroft PDU was established around the base of four wards in a medical and elderly unit with the aim of supporting multidisciplinary practice development and research. Although the membership of the Seacroft unit is distinctly different to that of Winchester, Page et al.'s book provides a detailed account of the process of accreditation, factors affecting teamwork, the philosophy, vision and structural systems of the PDU, and its project and dissemination focus (1998; pp32-3, 50, 54, 213). The latter pages contain a hidden but stern warning: the unit no longer exists. After weathering five years of major NHS reform, ward closures, expansion to include remaining medical specialities, and changes in leadership, changes in structure and priorities of its own Trust and other (undisclosed cultural and organisational) competing priorities forced the PDU to close. The author's note on the final page is that

> '…it will be essential for future leaders to adapt the model to their own specific setting, to work hard at harnessing enduring senior management support, and to demonstrate clearly the contribution of the unit to organisational priorities' (Page et al., 1998 p258; also see Redfern & Stevens, 1998).

Gerrish (1999) analysed the work of four purposively chosen NDUs and two PDUs (out of a total population of 46). Both PDUs were complex units (cardiology n=100 and general medicine n=400) within large acute hospitals and primarily comprised nurses and members of the professions allied to medicine. A pluralistic evaluation model was used to evaluate programmes with reference to the objectives, outcomes and overall success of units. Data was collected through individual interviews (n=32) with clinical leaders, steering group members, senior management, and the accreditation staff/team, alongside documentary analysis and focus groups with unit staff (n=6). As with most studies, there was little evidence of impact on patient care. Indeed, consideration could have been given to methods of measuring research-based practice, clinical and client outcomes, impact on policy development, team working and the effectiveness of staff development programmes and dissemination strategies (Gerrish, 1999). Gerrish (2001) concludes in a similar fashion to Turner Shaw and Bosanquet (1993); NDU/PDU efficacy and effectiveness is not fully demonstrated.

Gerrish lists eight ways in which the success of units is given meaning, and nine factors influencing success. Success is described in terms of

achieving optimum practice, providing a client-oriented service, achieving outcomes for practice development, effective team working, enabling practitioners to develop their full potential, a strategic approach to change and autonomous functioning. These criteria are inextricably linked to the criteria for accreditation. Gerrish's approach assumes that accreditation criteria are synonymous with success in terms of patient or client outcome – this may not be the case. As she notes, the conception of success may be so context specific that the findings lack generalisability. However, the fact that these and the following findings reflect the broader literature enhance their validity (Gerrish, 2001).

Factors influencing success are split into factors affecting the team and those external to the team (Gerrish, 1999). Those affecting the team include the clinical leader, staff turnover and staffing levels and organisational factors such as the size of the unit, supporting infrastructure, organisational change and financial and physical resources. Those factors influencing success external to the team include management and medical support, educational links, the steering group and the Trust board. In general, there is a lack of clarity within these factors - for example, management support could conceivably be classed as an organisational factor. This reflects perhaps the rather messy nature of research within this field – one where boundaries are not easily defined.

There are, of course, a number of methodological problems in demonstrating patient benefit and outcome: no agreed standards on what constitutes a unit, determining appropriate outcome measures, the difficulty of matching settings for comparative work, and identifying causal relationships (Gerrish, 2001). Nevertheless, future units must be able to demonstrate their worth if they are to survive. This is the PDU literature's central message.

CNS Research

Current understanding about the role of the specialist practitioner and the nature of specialist practice appears to be in disarray. Titles such as clinical nurse specialist are being adopted in a variety of settings with little consensus on the nature of such roles. This confusion makes it difficult to come to a universally accepted definition of specialist nursing practice, let alone of advanced practice. The main criteria for a specialist in nursing practice appears to be an expert in a defined clinical area of knowledge and practice. CNSs are found primarily in institutional settings, typically in staff positions. However, many and varied organisational arrangements are described in the literature. Regardless

of organisational placement and reporting mechanisms, the CNS usually works from a 'home base' and is available for consultation from other units. Many CNSs have clinical faculty appointments. The common element, however, is the direct and continuous involvement with patients and families with emphasis on a nursing versus a medical model of care. Practice (actual ongoing direct experience with patients and families) provides the content and directs participation in various sub-roles such as clinical research, consultation, teaching, leadership and administration.

Evidence of CNS effectiveness in the UK is limited (for instance, see Bradley & Lindsay, 2003; Forbes et al., 2003; Loveman et al., 2003; Notter, 1995; NRU, 1998). However, those operating in a well-defined role delivering clinical care seem to be effective (Hobbs & Murray, 1999). Garvican et al. (1998) demonstrated that patients were very or mostly satisfied with service from two breast care clinic specialists. Jolly et al. (1999) found no significant differences between intervention and control groups in their primary care follow-up by specialist liaison nurses of patients with angina and myocardial infarctions. Hobbs and Murray (1999) conclude that the clinical and cost-effectiveness of specialist nurses in each role and setting need to be evaluated.

For the amount of literature available on specialist practice roles, clearly defined, and well thought out and conducted research studies examining specialist practice roles are thin on the ground. Better quality evaluation is needed. Studies use peer and post-holder recognition, educational achievement, role effectiveness, personal qualities, professional activities and general clinical status to try to distinguish between specialist practice and other roles. The literature is full of attempts to draw up lists of attributes for specialist nurses. Some of these are reproduced in this report to demonstrate the similarity between them. Chunking an individual's work into, for example, research, education, leadership and clinical practice can also be problematic. There can be problems with what individuals mean by 'research', and where research ends and clinical practice takes over. Role functions such as these are often inextricably linked.

Some commentators believe that this drawing up of lists is a fascinating re-run of attempts to define 'nursing' over the last 50 or so years – and is just as mis-placed. The bottom line is that specialist nursing practice needs to be defined in terms of what it means individually, as a PDU and in a corporate context. This assumes, of course, that Trusts and other employers are prepared to accept liability for changing roles and innovation.

In the US, the CNS needs a second degree – the roles of expert clinician, educator, consultant, researcher, manager and administrator are combined with those of a change agent, collaborator, clinical leader, role model and patient and/or staff advocate (Ormonde-Walshe & Newham, 2001; Redekopp, 1997). Although a role may include these elements, the literature displays a diversity in role description (Redekopp, 1997). Practice and education roles appear the biggest by far (Payne & Baumgartner, 1996). Much of the US literature is either personal opinion, anecdotal, descriptive, self-report or methodologically unsound.

To help in the process of defining specialist practice, there are a number of key pieces of work worth considering. Arguably the most relevant is Cattini and Knowles's (1999) work on the development of core competencies for clinical nurse specialists within an outer London NHS Trust. The UKCC's (2002) report on the higher level of practice pilot gives an up-to-date picture of where nursing is at in its thinking around higher level practice. Finally, the nursing research unit at Birmingham University offers a national perspective of Chief Nurse views on specialist practice (NRU, 1998).

Cattini and Knowles (1999) gathered a group of clinical nurse specialists working in a district hospital to ask: what is the role of the CNS and how does it differ from that of other nurses? The group included specialists in cancer services, pain control, diabetes, accident and emergency, infection control, ophthalmology and stomach care. They carried out a role analysis to identify common areas of practice. Meetings took place every six to eight weeks, spread over two years. The development of generic competencies produced a bond between specialities and provided a network of peer support and clinical supervision. The results of this pragmatic work, although not placed within any research or theoretical framework, have been reproduced by Keen (2002; Appendices 3-7) with the lead author's permission. As the authors note, this generic framework could be used for performance development, succession planning, marketing purposes, enabling continued professional development, job description evaluation (Cattini & Knowles, 1999), and practice development. The main limitation of this work is that the primary care components of many CNS roles are left out.

As with the Seacroft PDU work described in the *PDU research* section, the Cattini and Knowles paper contains a similar warning. Owing to change in the perceived importance of this project by a new Director of Nursing, this work has recently ceased (Pat Cattini, personal communication, 2002), highlighting the likely importance of organisational and senior management support for any practice development work.

The Higher Level Practice report provides a description of clinical nurse specialists (CNSs) and nurse practitioners (NPs) (UKCC, 2002). CNSs are experts in a particular speciality or client group with post-qualification education in specialist clinical practice, care and programme management, clinical practice development and leadership. The title is not regulated. The difference between nursing practice within a speciality and being a nurse specialist is noted. NPs first worked in primary care for clients with undifferentiated health problems, and later in secondary care with such titles as advanced practitioner or advanced nurse practitioner. The report states that both roles provide some sort of alternative medical role, although there are those who might contest this statement (UKCC, 2002). In 1997 those with a CNS or NP title could take the specialist practitioner qualification if they met certain standards of the time. From November 2003, a new nursing register has been made available (NMC, 2003) and, for the first time, the NMC can prescribe the competencies for specialist and advanced practice nursing, including protection of title for some roles.

A national survey was sent to all chief nurses in the UK, including directors of nursing, in late 1997 with a response rate of 57% (NRU, 1998). Specialist practice was regarded as distinct from advanced in that such practitioners are required to focus on a specific, well-defined area of clinical practice to develop an in-depth knowledge and skill base. Once this has been achieved, the nurse can then undertake designated responsibilities in teaching, research activities, management and act as a resource for others. In the eyes of a chief nurse, specialist practice therefore reflected medical specialities and a strong educational role with regard to staff, patients and carers. It is noted that only 25% of the original sample replied to questions on the difference between specialist and advanced practice. This could indicate that chief nurses are not confident in articulating their views. Greater clarity on the differences between clinical nurse specialists and advanced roles may be provided by the NMC as above.

To end this section, a number of qualitative studies examine the CNS role, for example, Bousfield, 1997; Bamford and Gibson, 1999a; 1999b; 1999c; 2000; Gibson and Bamford, 2001; Ibbotson, 1999; Loftus and McDowell, 2000; McCreaddie, 2001; Martin, 1999. This data will be presented and discussed in the Findings and Discussion section.

Research Process

Table 1. Research process summary

2002	
April-July:	Four learning sessions.
July:	Literature search – first stage.
September:	Ethical approval granted.
October:	Production of interim report (Keen, 2002) and verbal feedback of interim findings to PDU.
September-December:	Four learning sessions.
2003	
January-March:	Three learning sessions.
April-July:	Data analysis.
August:	Literature search – second stage.
October:	Production of final report.

To facilitate PDU accreditation, 11, two-hour learning sessions with IG were arranged between April 2002 and March 2003. The first part of the sessions focused on a subject relevant to PDU development, such as nursing theory, practice development, empowerment, education and learning, or dissemination and networking. Appropriate general discussion was audio tape-recorded. The second part of the sessions was an audio tape-recorded focus group that looked in more detail at the roles and responsibilities of clinical nurse specialists (see Appendix 1).

The first two focus groups were conducted by IG; the remainder by SK. Each recording was transcribed and studied at least three times to ensure transcription accuracy and produce detailed charts. The framework of their content was then analysed (Richie & Spencer, 1994). Preliminary analyses were carried out on the first four focus groups and the findings fed back to CNSs in both written (Keen, 2002) and verbal form (18th October 2002 – see Appendix 2). At this stage, seven key questions were asked:

1. Is the WEHT PDU really a PDU or an NDU (nursing development unit) – or both? For instance, to what extent does it have a uni- or multidisciplinary focus? Related to this, how inclusive should the membership of the WEHT PDU be – for example, should it include specialist midwives or health visitors, nurse consultants or (advanced) nurse practitioners?

2. How does a PDU demonstrate its worth?

3. How does a PDU embed itself within, and ensure a sustainable relationship with, its host organisation and senior management contained therein? Again, related to this, how can PDU alliances be forged with, for example, the Trust board, consultant body, Director of Nursing, universities, and other senior nurses (including CNSs)?

4. Given that the WEHT PDU is a 'virtual' unit and not one with overall or direct managerial responsibility for a service, what impact might this have on 'project focus' and the implementation of any project recommendations?

5. Given Hobbs and Murray's (1999) assertion that specialist nurses seem to be effective in well-defined roles, how much more and what type of work needs to be completed to define the CNS role (including philosophy), with special reference to a) general nurses; b) other senior nurse roles; and c) succession planning?

6. How, and with what methods, can the cited barriers to CNS effectiveness and PDU success (Keen, 2002) be overcome?

7. The importance of unit leadership (particularly transformational leadership) and associated structures, and the opportunities of being an agent of change are recognised in the literature. What steps can be taken to nurture leaders and avoid the dangers of overload?

Seven further learning sessions were completed until March 2003. Ethical approval for the study was granted on 4th September 2002. What follows is a combined analysis of all 11 learning sessions, interspersed with relevant literature. Any text using quotation marks ('') refers to verbatim quotes from the focus groups or other discussion. Quotations have been rendered into a readable form, for example the 'hmms' or 'umms' are omitted. Care has been taken not to change the emphasis of what was actually said.

Findings and Discussion

CNS Profile

A total of 16 CNSs attended the 11 sessions; all but one was female, with an average session attendance of five (range 2-10; mode 5). Ten CNSs attended at least three meetings – over time, the majority of the discussion was completed by these individuals. Eleven (out of 16) CNSs supplied shortened CV data; of the five that did not, two left WEHT during the course of the research. The CNSs had spent an average of six years at the Trust (range 1-13). Their titles covered wide-ranging areas, for example, gastrology, infection control, palliative care, clinical informatics, community neurological rehabilitation, respiratory care, nutrition, pain management and tissue viability. Aside from numerous ENBs, other levels of qualification are summarised below:

- Undergraduate degree: 5
- Post-graduate degree: 2
- Other post-graduate qualification: 2
- Registered for MSc/PhD: 2
- NVQ Level 4 management: 2
- Diploma: 5
- Teaching certificate: 2

Description of CNS Role

Space does not allow for detailed narration of each individual's journey to become a CNS. However, there are a number of points worth noting. Some WEHT posts arose because of consultant not patient need. Consequently, no two posts are the same:

> *'We're all different; that is what makes it more difficult to define us.'* (Transcript 3, June 2002; p11)

Some manage nurse-led services and are sessional, and others major on education and teaching, receive direct referrals, or have a Trust-wide remit. A few do not see patients. Each story is different – there has often been no plan to these careers. Indeed, there is still no pathway to become a CNS. By their own admission, they 'fell into it quite by accident'. For many, this has been an (enjoyable) organic process, and one where the individual has 'added something of value to the people they serve'. Nevertheless, CNS descriptions of their work allow loose characterisation into three key but inextricably linked roles – care giver, information giver and change initiator.

This profile and description interested the Nursing Directorate who felt that the unselective development of the CNS had not allowed maximisation of their potential. The Nursing Directorate expressed the view that the focus of the CNS role should be on improving the patient experience. However, it was also felt that the CNS had failed to develop such skills as business planning, research critique or political acumen and was therefore left out of decision-making processes and influence, thereby not achieving focus at a team or corporate level. The Directorate wished to bring them into mainstream leadership activity so that the Trust, and therefore the patients, would benefit more fully.

Care giver

The following sentence sums up the CNS view of a care giver: 'Quality' care given to patients by an 'expert' who considers her/himself an 'outsider'.

> '[Expert] *patient care means knowing when to stop treatment with lung cancer for example...it might be practical, that is, putting on stoma bags or helping them or family deal psychologically with losses associated with disease...it's about being the expert, rather than the more novice practitioner.'*
> (Transcript 1, April 2002; p1)

> *'It means listening to what patients are and are not happy with.'*
> (Transcript 2, May 2002; p4)

An expert worked at a higher level of practice, had a high level of, and confidence in, their clinical expertise, and was an individual whose outside credibility was viewed as 'expert'.

Clearly the work of Benner (1982) has been influential here, as has the more recent Higher Level of Practice (HLP) document (UKCC, 2002). The HLP descriptor is worth reproducing here for comparative purposes. Data provided by WEHT CNSs shows a reasonable level of face validity with what follows, except perhaps in understanding the social, economic and political context of health care.

> 'Practitioners who are working at a higher level of practice use their knowledge and skills as a basis from which further to develop practice. They understand the implications of the social, economic and political context of health care. Their wisdom, expertise, maturity, experience and critical judgement are demonstrated through a broadening and deepening of their practice and knowledge. Patients, clients and fellow professionals acknowledge their expertise in areas such as

> therapeutics, the biological, social and epidemiological sciences, the use and effects of drugs, and their enhanced skills in areas such as empowerment, communication and consultation. Practitioners working at a higher level of practice use complex reasoning, critical thinking, reflection and analysis to inform their health assessments, clinical judgements and decisions.
>
> Practitioners working at a higher level act as leaders for change with individuals, groups and communities. They cross professional and agency boundaries to achieve this. They network locally, regionally, nationally and internationally, and recognise the ethical, legal and professional constraints on practice. They assess and manage risk.
>
> Those working at a higher level of practice have aspects of education, research and management included within their role but the main focus, purpose and impact of their work are individuals (patients and clients) and groups (including carers) or communities. They can identify their own and others' personal development needs and take effective action to address them. Practitioners working at a higher level of practice are likely to have made best use of the wide range of educational and development opportunities available to them, learning not only through formal educational programmes but also from their own practice and from the individuals with whom they work. Such practitioners will have a track record of practice and innovative service development, including taking a lead in the implementation of policy, national frameworks and quality improvement.
>
> Practitioners working at a higher level of practice are engaged in flexible cross-boundary partnership working. They are actively involved in facilitating communication and understanding between individuals, groups, professions and managers. Practitioners working at a higher level of practice have the capacity to bring about change and development within their own and others' practice and within the services in which they work.' (UKCC, 2002: p8)

Quality care meant holistic care, not that any CNS admitted actually giving truly holistic care. It was an ideal they never achieved but kept working towards:

> *'It's not about you finding out everything, though others might be covering those angles – you professionally assimilate that information to make a decision based on a holistic view of the patient.'* (Transcript 3, June 2002; p7)

Good care was considered informal and about the relationship between carer and those cared for. It was important to walk empathetically with the patient as a '*partner, not a recipient of care*' (Transcript 8, December 2002; general discussion).

From the outside, CNSs believe they are viewed as having a task orientation:

> *'Yet a lot of what we do is work on quality issues – quality is hard to quantify...management are constantly asking us what we do – it is not always quantifiable. They don't do the same for consultants.'* (Transcript 1, April 2002; p7)

The added value of being a CNS compared with say, a medic, was the ability to see the whole person. Differences between the CNS and the generalist nurse included an extended knowledge base, their environment, that is, office rather than ward-based, and the ability to manage workload and time more effectively:

> *'For example, you can make a conscious decision to spend more time with patients...it is very difficult for ward nurses or even managers to do that.'* (Transcript 3, June 2002; p10)

Also, they worked in a more autonomous manner:

> *'Even if you don't know the answer to things, you have the ability to go and find out and follow that through – we have more freedom and resources than registered nurses.'* (Transcript 5, September 2002; p3)

Being an outsider meant having a broader role than a registered nurse:

> *'We are the jam in the sandwich, to hold all the things together* (p10)*...as an outsider you come in and things looks odd and different, but when you are there all the time you don't necessarily notice everything.'* (Transcript 3, June 2002; p14)

However, they were not so much of an outsider that colleagues did not talk to them; that is, an outsider but with insider knowledge and relationships.

Information giver

Information giving was about empowering patients:

> *'Giving them the information so they can make informed choices.'* (Transcript 1, April 2002; p1)

> *'Walking with them is how you empower patients...it's about giving them the confidence.'* (Transcript 9, January 2003; p1)

Information giving was also about 'seeking information and ideas to help improve nurses' knowledge or improve patient care or outcome' (Transcript 2, May 2002; p4), and is therefore linked to being an 'expert'.

> *'Even though I have an extended knowledge base in one part of the human body I am constantly giving that knowledge to others as I can't see every patient in the total area, so it's my responsibility to share knowledge with others, educate others...we would de-skill them if we didn't and just told them what to do.'* (Transcript 3, June 2002; p11)

Initiator of change

One CNS went so far as to say that the defining characteristic of a CNS was their 'pedigree of change initiation'. Changing practice was linked to the concepts of autonomy and authority. The following quotes give a flavour of the perceived importance of this area.

> *'I see things from a different perspective. I have more freedom now to see a change/influence, than I would have done. I have a different angle on care given...it's about quality of care.'* (Transcript 6, October 2002; p7)

> *'CNSs have the confidence, knowledge and skills to be able to follow things through as senior nurses...knowing what systems are in place. We marry confidence with sensitivity. The difference between my work as a senior staff nurse is that now I can implement a bit more. I have the know-how, the accessibility, the clout; I know who to talk to and be able to say I want to do it, I will do it.'* (Transcript 3, June 2002; p8-9)

> *'You have permission to keep up with developments and initiate change...it's using your skills to enable other nurses to develop theirs, so they can change practice.'* (Transcript 3, June 2002; p11)

> *'As part of my role I spend a lot of time changing people's attitudes to patients – that's the hard part – challenging people – you need strength.'* (Transcript 3, June; p13-14)

Part of being a change initiator meant CNSs considered themselves 'self-starters', 'pro-active', 'self-directed', 'motivated', 'tenacious', 'manipulators', and in short, 'able to make a difference'.

In summary and based on this sample of 16 CNSs, the seven crucial statements that give meaning to CNS practice at WEHT are:

- Advanced communication skills;
- Changing practice;
- Expert;
- Information giver;
- Leadership;
- Patient advocate;
- Quality care.

These aspects of practice could be labelled as the bespoke aspects of CNS preparedness. Therefore, any PQ programme of development should focus on these aspects of the CNS role and activity to ensure that CNSs hold creditability, authority and confidence in their post. After all, CNSs should demonstrate competence above and beyond the level of even an experienced registered nurse in named areas. It was felt by the group that these were the areas that defined the role of a WEHT CNS.

O'Hanlon and Gibbon's review of the literature suggests specialist practice has the following attributes:

- Patient care;
- Clinical practice;
- Practice development;
- Educational research;
- Management;
- Clinical supervision;
- Change agent;
- Staff support role;
- Leadership;
- Family support;
- Care/programme management. (O'Hanlon & Gibbon 1996; p12)

Findings from qualitative studies also show good levels of congruence with the seven statements. Martin (1999) managed a group of CNSs over 16 focus groups to generate a model of CNS service reflecting an acute and community Trust. The expert practitioner is someone who works in complex environments as an effective time manager and has personal qualities that include being supportive, inspiring confidence, being persuasive, accepting, tolerant and questioning (Martin, 1999). McCreaddie (2001) interviewed 20 so-called CNSs. The findings from

this study must be treated with care, however, as the author included at least two nurse practitioners within the sample (p36). CNSs identified their key role as being a communicator-carer. Isolation and lack of line manager support affected their work the most. In general, CNSs struggled to fulfil their research role and undertake research in particular.

Bamford and Gibson (2000; Gibson & Bamford, 2001) also examined the role of a CNS and how it differed from other nurses. Five focus groups were conducted over two NHS Trust settings. Again, their results must be interpreted with caution as both group convenors were new to focus group management. Apart from those in the table below, the key themes were personal qualities, supportive strategies and future role development. Finally, Bousfield (1997) took a phenomenological approach to investigate how a group of seven CNSs experienced their roles. The role elements detailed below appear to be at slight odds with findings from previous work. In her view, a CNS should be enabled to lead, be a change agent, develop knowledge, skills and expertise to a high academic standard, have financial and administrative resources and have the role legitimised by the employing authority – the latter elements were not experienced by many of her sample. The experience of WEHT CNSs is closest to Bousfield's analysis. The CNS role elements from these four pieces of qualitative research are summarised below:

Table 2. Summary of CNS role elements from the literature

Martin, 1999	**McCreaddie, 2001**	**Bamford & Gibson, 2000; Gibson & Bamford, 2001**	**Bousfield, 1997**
• Collaborative care • Patient care • Education • Consultation • Networking • Organisational development • Practice development • Information resource	• Communicator-carer • Clinical • Teacher and resource • Administrator • Procedures and protocols • Researcher	• Clinical • Education • Consultancy • Research • Liaison • Administration	• Leadership • Knowledge • Lack of support • Isolation • Poor time management • Conflict • Disempowerment • Burnout

Chadderton (2000) provides a further strategic 'grey' (unpublished) review on the role of CNSs amidst changes in clinical structures at the University Hospital of Wales: 70 out of 92 CNSs completed a postal questionnaire. Specialists divided their time into expert practitioner, trusted colleague, teacher and researcher. Most specialists spent 50% of

their time providing hands-on patient care. About three-quarters spent half a day a week on research, ten hours on teaching, and about 25% of their time giving advice and support to colleagues. Specialists (68%) spent up to half a day a week on administrating their posts. A similar 64% spent up to a further half a day on secretarial work. This represented a considerable loss of time to patient care. The top three outcomes of the specialist role were viewed as the provision of patient information, education and support; support and education for colleagues; and expert disease and symptom control.

Williams et al. (2001) attempted to compare CNSs with stakeholders' (consultants, nursing colleagues) views of their roles. The main discrepancy was over the extent to which the specialists were involved in management (20% actual versus 11% perceived – clinical practice 41%; education 15%; consultancy 15%; research 9%). Some WEHT CNSs also completed an activity log over a number of months (Transcript 4, July 2002; p9) – the most concerning result was that 25% of their time was spent on administrative activities.

CNS roles tend to work closely with medical specialists and be condition specific, for example breast care, and they practice in an area where a diagnosis or differentiation of the condition has already been made (Roberts-Davis & Read, 2001). Their roles are usually technical and can be updated by continuous professional development; by comparison the advanced nurse practitioner role is process specific, grounded in practice and reflection (Carnwell & Daly, 2003). Attributes, as above, also collude with the American definition; that CNSs are involved in direct care but with responsibility for teaching, providing advice, acting as a change agent and research (NRU, 1998). The one area missing from these lists is political or corporate practice.

CNS Relationship with the PDU

CNS relationship with the PDU may be classified into two overarching themes: PDU process and vision for the future.

PDU process

There was no doubt in the minds of those attending the PDU learning sessions that they had 'developed' both individually and as a group as a result of the PDU submission process. The most frequently mentioned benefit was that:

> *'We are getting better at looking outside our boxes, realising that others have the same issues…the benefit of the PDU is getting you to look outside your service.'* (Transcript 5, September 2002; p1)

Others gained confidence from this 'to think where I am going from here and how I can use my knowledge to impact people' (Transcript 5, September 2002; p1). PDU meetings stopped being feedback oriented:

> *'We're evolving...and becoming more cohesive.'* (Transcript 1, April 2002; p5)

People stopped talking about their 'own bit' (Transcript 9, January 2003; general discussion) realising they had a lot more in common. This process is recognised in the literature (e.g. Kirkby, 2000) and took two years. The good progress made in these two years inspired CNSs to move forward:

> *'As we can see it has improved things...I feel much more part of a team than a year ago.'* (Transcript 5, September 2002; p1)

> '[Two years ago] *we weren't part of PDU thinking then...we sent a pro-forma round of what everyone was doing and got 20 responses; now there's a mass of nurse-led stuff going on, and it's quite grown up – that wouldn't have happened a couple of years ago...our new document 'Innovations For Practice' is very impressive.'* (Transcript 10, February 2003; p1)

Towards the end of the learning sessions, some participants thought they were less 'politically naïve'.

While this new found cohesion improved attendance at general PDU meetings, it was not translated into participation at learning sessions. Improved cohesion was limited to a 'hard core' only (Transcript 1, April 2002; p8). Much discussion centred on who to invite as part of the unit and how to get them involved. These difficulties arose because the unit was a 'virtual' PDU, not based on a ward or as part of a medical speciality – a PDU without walls. Getting 'everyone together, practically, to do all this work, is the hardest part' (Transcript 2, May 2002; p2). Other PDUs are afforded the luxury of their own office or resource room (Bates, 2000). At the heart of deciding whether to invite other CNSs, medics, nurse consultants, matrons, ward managers and sisters was the understanding that any sustained impact on or improvement in practice required a multidisciplinary operation. To this end, contact with other PDUs and PDU representation at relevant committees and meetings was also considered crucial.

Before further investigation into PDU systems and structures was completed, baseline work was carried out on theoretical underpinnings

and definitions. Defining themselves, 'who we are and what we do', was 'most important' (Transcript 5, September; p1). CNSs found this a nebulous task, suggesting they had not attempted it before.

> *'We have to keep our theoretical underpinnings basic and simple...we're coming from our different angles, working with our own clients and areas.'* (Transcript 3, June 2002; p1)

One participant wondered what hope they had of defining what a PDU was about when nursing had failed to do this for the last 100 years (Transcript 3, July 2002; p7). The answer lay in grasping that it was not about nursing per se, but the 30 or so PDU members. By the eighth learning session one CNS commented:

> *'...I have only just got my head round this* [the PDU]*. It's hard to be confident about something that is nebulous. When you understand more you begin to feel confident about explaining it to other people...you can't be empowered in something you don't understand'.*

The same CNS went on to define the PDU as:

> *'A group of nurses trying to improve practice on a range of levels* [from international to bedside] *– and to do that there have to be various processes, partnerships and frameworks...it is for patients and is on-going...before, I did not understand how it was going to be relevant.'* (Transcript 8, December 2002; general discussion)

This CNS unknowingly articulated Garbett and McCormack's definition of practice development as outlined on page 12.

To address what the PDU was about, CNSs also had to define what they were about individually. For example, what do they bring to nurse endoscopy compared with their medical colleagues? PDU work had been completed on core job descriptions and measurement against the HLP document. Issues of leadership and succession planning came to the fore here when CNSs observed the 'death' of a colleague's work once they left the Trust and were not replaced. This work included professional development planning for individuals and teams, and skills analyses.

Turner Shaw and Bosanquet published their longitudinal evaluation of four King's Fund NDUs in 1993 and assessed the key factors affecting NDU success. Lasting over two a half years, the evaluation included

participant observation, over 400 interviews and two batteries of questionnaires. Views of NDU staff and leaders, ward sisters, nurse managers, new post holders and members of other disciplines were obtained. Strangely though, the views of senior management appear absent from this work. The role of NDU leader was crucial to their success but carried with it the risk of overload. Clear personal specification for leadership posts allowed for succession planning. Recognition was given to the time required to develop teams and staff within them. A supportive environment was one with good organisational, library and secretarial support.

The importance of unit leaders is highlighted by a number of other studies that used the clinical leader as a focus (see Bowles & Bowles, 2000; Flint & Wright 2001). The expectation that units would explore and develop the clinical leadership role was examined with the DoH-funded NDUs (Christian & Norman, 1998). Interestingly, 16 of 28 units had more than one leader in three years. Four groups of leaders were distinguishable from interview and questionnaire data: those units with shared leadership and those individuals with a professional advisor, senior management responsibility or unit management role. Predictably, those unit leaders without unit managerial responsibility reported frustration at being unable to bring about change. Again, this brings home the importance of cultivating a corporate relationship with the Trust (Rycroft-Malone et al., 2002).

Furthermore, preliminary findings from a leadership inventory study shows that NDU leaders were more transformational than their matched counterparts (Bowles & Bowles, 2000; Rycroft-Malone et al., 2002). Even transformational leaders need leadership to sustain confidence and motivation (Atsalos & Greenwood, 2001). Australian research within CDUs demonstrates four main stresses to which leaders are vulnerable (Greenwood, 2000a; 2000b): unrealistic self-expectations exacerbated by pressure to achieve; underestimated challenges of the PDU leadership role; promised management support not always forthcoming; and power struggles between nurses, client groups, doctors and managers. It is unclear from the focus group data whether members of the PDU understand the causal link between unit leadership and success, and if so, how they are to protect and nurture it (Graham, 2003).

The long-term vision of a virtual PDU meant breaking work up into smaller pieces, as evidenced by Bates (2000) and Bowles and Gallie (1998):

> *'It is important to divvy up the work; it is too much work for one individual – we can't have lots of meetings as we can't afford the time...by splitting up into smaller groups with someone taking the lead means that person can feedback to the main group...not everyone can come to the main meetings.'* (Transcript 4, July 2002; p2)

This was one way of helping those on the fringe to participate.

Three topics areas were chosen to start the PDU rolling: succession planning, nurse-led clinics and documentation. A training matrix incorporates all the elements needed to ratify potential projects, including aims, measurement of objectives and dissemination strategy. Details of current and completed projects are placed on the 'Y' drive.

> *'Project topics are all things we struggle with on our own – suddenly we are able to do it together. There are others who feel the same, but we did not have the opportunity to say what we are going to do about it.'* (Transcript 8; general discussion)

By cutting their teeth 'on projects we need to bring things out into the open – there are an awful lot of prejudices and misunderstandings about our [CNS] role. We need to build confidence and good foundations before any open meetings discussing our [CNS] role' (Transcript 11, March 2003; general discussion). This project process would allow the PDU to become more visible as 'CNSs [at present] work in their own compartments' (Transcript 8, December; general discussion).

The PDU has already started work on where its potential barriers are. Aside from the consultant body, limited budgets are the main barriers.

> *'We have to live with limited budgets, and take opportunities when budgets are passed out...and it works if you can take these opportunities and use resources properly.'* (Transcript 9, January 2003; p6)

Ward nurses are also viewed as a barrier to PDU impact:

> *'Either we can't get the nurses off the wards* [e.g. for training] *or they are not interested.'* (Transcript 10, February 2003; p8)

CNSs appeared to be passive recipients of any blows a barrier might give, and demonstrated limited understanding that, as a corporate animal, a PDU could design business plans to reduce potential obstacles.

Vision for the future

Aside from meaningful desires to be 'more cohesive' and 'self-confident' as a unit with 'increased self-belief', their main vision was to have a 'heightened Trust profile'. In other words, the PDU of the future would be a 'corporate body':

> *'We're seen as individuals not as a corporate body.'* (Transcript 2, May 2002; p1)

> *'We need to get more business minded.'* (Transcript 11, March 2003; general discussion)

The distilled charts of the focus group discussions demonstrate how their sense of corporate destiny becomes more explicit as time goes on. In July 2002, some participants 'had not thought about writing position papers on behalf of CNSs' yet understood this as 'more powerful than doing work in our own areas (p4):

> *'...I didn't see our role as that corporate...it's a more powerful voice, a more credible force.'* (Transcript 4, July 2002; p10)

By December 2002, they had moved to producing 'a strategy, that will be more visible than the PDU submission document to go to Trust board, PCTs, and managers – to advertise our service and what we do, and where we are going, what we've done...the strategy will link in with the Trust strategy...and it will go to the finance people too' (Transcript 8, December 2002; p6-7). CNSs also expressed a desire to include the voice of the patient in the PDU.

Acceptance as a 'corporate body' would imply demonstrable worth to the organisation. In turn, this should attest to the PDUs impact on policy development, team working, staff development programmes, dissemination strategies, and clinical and other client outcomes; those areas from the literature where PDUs need future focus (Gerrish, 2001; Page et al., 1998; Turner Shaw & Bosanquet, 1993).

CNS relationship with the Trust

Given that CNSs view the PDU as a 'team responsibility' (Transcript 2, May 2002; p10) and not a corporate body – 'part of the Trust agenda' (Transcript 1, April 2002; p2) – it is no surprise to find that CNSs characterise their relationship with the Trust in terms of dichotomy. Differing agendas and perceptions of value form the main tenets of this strenuous relationship, with an undercurrent of frustration running through both.

Differing agendas

CNSs understood the Trust agenda as:

> *'Them wanting us to push people through very quickly...cutting down the waiting lists, reducing length of stay and complications.'* (Transcript 3; May 2002; p3)

Targets had to be achieved within the context of tight but constantly changing guidelines; 'targets that aren't related to quality or clinical need' (Transcript 11, March 2003; general discussion). The Trust looked at it 'from a speedier service angle, but forget the huge educational loop...the service is sold on quantity but it is actually a quality service...and number crunchers do not like quality' (Transcript 1, April 2002; p7). CNSs saw themselves working at the quality and clinical need end of the spectrum. The Trust agenda rarely matched what they saw as a 'shop floor agenda' (Transcript 11, March 2003; general discussion).

Frustration was apparent with the lack of joined-up thinking:

> *'The Trust seems to do things in a very piecemeal fashion. There is no overall plan or strategy on how to develop services...it's all crisis management...and those teams with the biggest voice or waiting lists win...for example we're getting an extra consultant but we don't have enough nurses or equipment to facilitate the reduction in waiting lists needed – they'll just move people from one waiting list to another.'* (Transcript 8, December 2002; p4)

Another CNS described what frustration meant:

> *'It's like as long as you are meeting the targets you are fine, but if you go to them and say this is about to happen, because it is not happening, it's GO AWAY...it's all reactive.'* (Transcript 8, December 2002; p4-5)

This was like saying 'you've got all these qualifications and had all this training, but we don't actually believe you' (Transcript 8, December 2002; p6). Frustration was also felt when nursing was not valued in its own right, either in terms of referrals – 'not being able to refer to my peers for nursing needs' (Transcript 8, December 2002; p5) – or the way medical and nursing targets are perceived. This is perhaps because medicine knows how to ask for resources and nursing does not.

The role of the Trust was to lead improvement and change. The role of groups like the CNS group was to negotiate how that change could be

achieved. The Trust is dependent on groups such as the CNSs for sharing their perspectives and views, but they need to know how to use the systems and processes that already exist in getting these expressed. The CNSs cannot afford to be naïve or to be victims. They hold their destiny in their own hands in terms of how their services will develop.

They need to develop skills of political negotiation, business planning and evaluation; only then will their voices be heard. Shifting the balance of power will provide different systems to enable those voices to be heard. Coming together as a strong, clinically-based group within the Trust and adopting mature and sensible ways of behaving can only benefit patients and their experiences (Hart, 2004, p292).

Value

> *'Our seniority is paid lip service to* (p2)*... we're classed as* [consultants'] *nurses...it's all part of how we feel the outside world of the Trust views us.'* (Transcript 1, April 2002; p6)

This insecurity and perceived lack of value was linked to a lack of credibility, for example with regard to desks, computers, offices and administration support. Yet some CNSs, as a result of their involvement with the PDU, had been co-opted onto a number of senior committees:

> *'This would not necessarily have happened before.'* (Transcript 5, September 2002; general discussion)

Some chief officers were 'more receptive to nursing than others [when compared with medicine]…some committees are better than others' (Transcript 2, May 2002; p10).

This perception of value led to some CNSs feeling disempowered:

> *'On one hand they expect us to be all grown up on one level, e.g. nurse-led clinics, and then they don't actually credit us with asking our opinion on subjects.'* (Transcript 11, March 2003; general discussion)

The warnings contained within the work of Cattini and Knowles (1999) and Page et al. (1998) about the importance of a PDU's relationship with its host organisation are stark. These are backed up by NDU research. In 1994, Redfern and Stevens (1998) undertook a further review of the Department of Health-funded NDUs, addressing their values and aims, work organisation, multi-professional working, resources and the effect of the host organisation. Questionnaires and interviews were administered to NDU leaders (n=23, out of a total population of 30). Their findings are

worth repeating to give context to the role of a PDU. The top three aims were to promote needs-led, individualised, partnership-based practice; to promote excellence in practice; and to promote staff support and development. Most endorsed primary nursing as their preferred mode of practice. Multi-professional working was a common feature. Nearly all had links with educational institutions and had the support of their Trust and senior management. Major organisational change coupled with a lack of senior support affected only a minority of NDUs. Thus, the most important factor related to an NDU's stability was the relationship with its host organisation. Given these warnings, and the evidence presented in these sections, it is not difficult to work out that the current relationship between WEHT and the CNS PDU is in need of attention.

It is true that the need for attention is being realised, hence the current support and activity given to the CNS group over the last year. Within the Trust as a whole, things have moved a long way over the last three years. The CNSs must see themselves as part of that overall change and development. The Trust realises that the group has some special development needs and this work is part of the process of addressing that. Reflection on attitude and belief is required by all parties when involved in major change. Only then will new mental models (Senge, 1994, p235) be formed.

Implications

The main findings of this report are timely. The NMC is about to prescribe competencies for specialist practice (NMC, 2003). Bamford and Gibson (2000; Gibson & Bamford, 2001) agree that the specialist role needs structure for its potential to be reached. CNSs need to take the initiative and identify criteria, clinical experience and education for the role – and this is exactly what the PDU, in part, is doing. The challenge facing the NHS today is to capitalise on new nursing roles and develop a coherent approach to career structure that reflects discrete roles, levels of practice and autonomy, based on relevant programmes of preparation (Daly & Carnwell, 2003). To this end, the findings from this study advocate a two-stage post-qualifying curriculum for CNSs at WEHT – PQ1 and PQ2.

Given that about one-third of CNSs at WEHT are qualified to undergraduate level, PQ1 would be pitched at Level 3 – the academic equivalent of an undergraduate's final year. It could be made a pre-requisite for becoming a CNS or for novice CNSs. Once achieved, this professional development would provide currency in both academic and professional credits. PQ2 would be aimed at Masters level for the more experienced CNSs wishing to develop their potential and/or move onto more senior and advanced nursing roles.

Based on this study, the syllabus would include topic areas such as leadership; corporate and political roles; business planning; negotiating agendas; advanced communication skills; succession planning; entrepreneurship; reflexivity and reflective practice; understanding nursing roles; barriers to practice; changing practice; expert practice; health improvement and measurement; staff and patient empowerment; advocacy; and practising functional skills amidst future implications.

This type of professional development is not about clinical practice per se, but political acumen and professional business management. This is their future; indeed, a future that is not recognised in the literature, a future where groups of CNSs will become self-managed along the lines of some community nurses already (Mischenko, 2002). The 'political or corporate practice' element is missing from all lists of CNS attributes studied. CNSs have, thus far, not been asked to fulfil corporate roles, so it is no surprise to find them needing and asking for development in this area. For example, CNSs appear to spend too much time on administration and do not have enough space or facilities, so why have they not made a business plan for more space? Answer: 'in my service there is no medic to say he wants more money' (Transcript 8, December

2002; p4). CNSs have developed under medical control – programme emphases will help them nurture their autonomy, become more visible and come out from the shadow of medical dominance. They require a better development programme, aside from technical skill, to engage their world with that of WEHT. This is even more important as services become increasingly nurse-led.

A more central corporate leadership role, coupled with a relevant preparation programme, will enable CNSs and the PDU to address the fact that CNS and PDU efficacy and effectiveness are not fully demonstrated; their potential is yet to be realised. As a research culture develops through post-qualifying programmes and PDU projects, role confusion will reduce and the ability to attribute patient outcome to the contribution of CNSs should increase. The potential for increases in responsibility and leadership, and improvements in practice and service, are immense.

Implicit in the PQ framework and in the emphasis on political/corporate practice is the need for a stronger relationship and increased understanding between the Nursing Directorate and CNSs/PDU. CNS relationships with ward managers, sisters, matrons, nurse practitioners and consultants are key to the development of practice. The Nursing Directorate may act as a conduit to these relationships. Following on from this, the group of CNSs taking part in this study are a disparate group. Why are some engaged and others not? Can the Trust allow them to ignore an expectation of professional development? More generally, the list of seven questions asked of the PDU during interim feedback still stands (p18).

Finally, how committed is the Trust to empowering this group of nurses to change healthcare services? A learning organisation (Rycroft-Malone et al. 2002) is more conducive to facilitating change because it creates cultures that pay attention to individuals, group processes and organisational systems. To what extent is the Trust a learning organisation? In a recent *British Medical Journal* editorial (Stewart, 2003), Professor Stewart concluded that the NHS must revitalise a research ethos in its organisation to ensure it can deliver optimal care for years to come; we hope the afforded support is ‘considerable’.

The Trust is endeavouring to strategically think around the processes of empowerment. For the CNSs to engage in these processes they need to clarify what it is they want and what they want to negotiate for. What is their vision for improved patient services and choice, and how are they going to share this with others? What processes of engagement will they use to participate as a group and as individuals in the change agenda?

The Trust would welcome views and ideas on how the Trust will deal with the following:

- Foundation hospital status;
- Agenda for change;
- Knowledge and skills framework;
- Choice and access to services;
- Health inequalities;
- GMS contract;
- Consultant contract;
- European work directive;
- Modernising doctors' careers;
- Health service frameworks;
- Evidence-based practice.

Over to you!

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Appendix 1

Focus Group Guide for CNS/PDU Project

The design of the focus group guide is linked to the seven standards of higher level practice (UKCC, 2002) and initial discussions between the PDU and Bournemouth University. The guide does not explicitly cover relationships with educational or national governing institutions. Emphasis is placed on 'main' responsibilities, yet these may not be the most important or crucial to role success.

- What do you currently consider are the main aspects of your role?

- What do you think are your main responsibilities towards the Trust?

  As appropriate:

  How will you achieve these?
  Who are your allies?
  What are the barriers?

- What do you think are your main responsibilities towards patients?

  As appropriate:

  How will you achieve these?
  Who are your allies?
  What are the barriers?

- What do you think are your main responsibilities to each other?

  As appropriate:

  How will you achieve these?
  Who are your allies?
  What are the barriers?

- What are your main responsibilities towards the team (nurses/medics/others)?

  As appropriate:

  How will you achieve these?
  Who are your allies?
  What are the barriers?

Appendix 2

Findings from the first four focus groups

Advanced practice nurse (APN) drivers	**Key themes from literature**	**Differences and commonalities between APNs**	**PDU issues**	**More general challenges**
Modernisation agenda Advanced technology Need for specialisation UKCC/NMC reports e.g. HLP RCN work Modern doctors (hours etc) Needs of patients	Medical/nursing overlap – alternative medical role Lack of regulation Advanced practice nurse role confusion – lack of definition – leads to Trusts taking responsibility for new roles and operational definitions Education or experience? Preparation and little systematic succession planning Autonomy and accountability Other countries	Motivation for increased numbers Reduced over time Prescribing activities Education Perception of others Conceptions of role elements such as leadership Differentiation? Nursing skills Patient care Research Transformational leadership	Organisational/ senior manage-ment support (relationship, resource, time and legitimisation) Woods (2000) experienced to advanced stages of idealism, organisational governance and resolution Uni- or multi-disciplinary? Demonstrating client outcome/impact Key alliances Pulling together Succession planning	Demonstrate (cost) effectiveness Advance theory and research activity Continual quality improvement work Partnerships Increased presence in health community What nursing skills are brought to extended tasks? Overcoming barriers from professional colleagues